MEDICAID MANAGED CARE
TRANSITION MANAGEMENT AGREEMENT

This Transition Management Agreement (Agreement) is entered into by the New Mexico Human Services Department (HSD), Blue Cross and Blue Shield of New Mexico (BCBS), Presbyterian Health Plan, Inc. (PHP), UnitedHealthcare Insurance Company (UHC), and Molina Healthcare of New Mexico (MHC), and is to be effective upon signature by all Parties.

WHEREAS, HSD has entered into four separate managed care contracts with the following entities to provide Medicaid services to eligible recipients in the State's Turquoise Care Program: Blue Cross, Presbyterian, UnitedHealthcare Insurance Company, and Molina Healthcare of New Mexico; and

WHEREAS, HSD has proposed to provide all Medicaid services to eligible recipients through Turquoise Care, currently scheduled to be operational on July 1, 2024; and

WHEREAS, on September 30, 2022, HSD issued its Request for Proposals No. 23-630-8000-0001 (RFP), for Medicaid Managed Care services through its program, Turquoise Care, currently scheduled to be operational on July1, 2024; and

WHEREAS, the Parties will enter into this Agreement, whereby each agrees to cooperate to effectively and as seamlessly as possible, transition Medicaid members from one managed care organization (MCO) to another as may be necessary, including but not limited to the preservation and transition of program and member information from one MCO to another MCO, so that the integrity of the Turquoise Care program is maintained, and all member needs are met; and

WHEREAS, HSD will select from the RFP offerors (Offerors) and enter into contracts with MCOs to provide Medicaid Managed Care services under Turquoise Care (Turquoise Care MCOs); and

WHEREAS, Turquoise Care MCOs shall participate in a readiness review period beginning November 16, 2023, through June 30, 2024, and must obtain HSD approval of all readiness elements prior to July 1, 2024; and

WHEREAS, during this readiness review period the Turquoise Care MCOs shall not be compensated for Turquoise Care readiness activities leading up to Go-Live; and

WHEREAS, HSD has identified three goals in transitioning from its current delivery system to Turquoise Care: (1) Build a New Mexico health care delivery system where every Medicaid member has a dedicated health care team that is accessible for both preventive and emergency care that supports the whole person – their physical, behavioral, and social drivers of health.; (2) Strengthen the New Mexico health care delivery system through the expansion and implementation of innovative payment reforms and value-based initiatives; (3) Identify groups that have been historically and intentionally disenfranchised and address health disparities through strategic program changes to enable an equitable chance at living healthy lives; and

WHEREAS, the parties to this Transition Management Agreement are bound by its terms and a fully executed Transition Management Agreement will be provided to all Parties.

NOTE: FAILURE TO ABIDE BY THE TERMS OF THIS AGREEMENT AND TO PROVIDE RELEVANT MEMBER DATA TO THE TURQUOISE CARE MCOs SHALL OBLIGATE CENTENNIAL CARE 2.0 MCOs TO CONTINUE TO PROVIDE AND PAY FOR SERVICES.

IT IS AGREED BETWEEN THE PARTIES:

I. DEFINITIONS

Terms used throughout this Agreement have the following meaning, unless the context clearly indicates otherwise or as may be further defined herein:

Business Associates Agreement (BAA) means a contract between entities that will use protected health information (PHI) for administrative, research, pricing, billing, or quality assurance purposes.

Care Coordination Level (CCL) means an approach to healthcare in which all members' needs are coordinated with the assistance of a primary point of contact with the purpose to increase preventive/timely care, reduce avoidable hospitalizations, improve the member experience, and delay institutionalization.

Child(ren) in State Custody (CISC) means child(ren) and youth in the legal custody of CYFD's Protective Services Division, including Native children and children never removed from the home or children returned to the home following a removal.

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

Community Benefit means both the Agency-Based Community Benefit and the Self-Directed Community Benefit subject to the annual allotment as determined by HSD on an annual basis.

Comprehensive Addiction & Recovery Act (CARA) means the Federal law requiring states to provide assistance for families to access supportive services and resources during pregnancy or following the birth of an infant when there has been substance exposure prenatally.

Centennial Care 2.0 MCOs means the managed care entities with contracts presently in effect with HSD to provide Centennial Care physical health, behavioral health, and long-term services and supports through, June 30, 2024; such entities are BCBS, WSCC and PHP.

Day or Days means calendar day(s), unless specified otherwise in this Agreement. Timeliness or due dates falling on a weekend or on a State or Federal holiday shall be extended to the first business day after the weekend or holiday.

Dual Eligible Special Needs Plans (D-SNP) means health plans that enroll members who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid) and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Dual Eligible means an individual, who, by reason of age, income, and/or disability qualifies for Medicare and full Medicaid benefits under section 1902(a)(10)(A) or 1902(a)(10)(C) of the Social Security Act, by reason of section 1902(f) of the Social Security Act, or under any other category of eligibility for medical assistance for full benefits.

Durable Medical Equipment (DME) means equipment and supplies that are primarily used to serve a medical purpose, that are medically necessary to individuals with an illness, physical disability, or injury and that are commonly used at home.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means the federally required Early and Periodic Screening, Diagnosis and Treatment program. as defined in section 1905(r) of the Social Security Act and 42 C.F.R. Part 441, Subpart B for Members under the age of twenty-one (21). It includes comprehensive periodic and inter-periodic screening and diagnostic services to determine physical and Behavioral Health needs as well as the provision of all Medically Necessary Services listed in section 1902(a) of the Social Security Act even if the service is not available under the State's Medicaid plan.

Encounter means a record of any claim adjudicated by an MCO or any of its Major Subcontractors and Subcontractors for a Member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by an MCO or any of its Major Subcontractors or Subcontractors for a Member that represents a Member-specific service or administrative activity, regardless of whether that service was adjudicated as a claim or whether payment for the service was made.

Encounter Data means information about claims adjudicated by an MCO for goods and/or services rendered to its Members. Such information includes whether claims were paid or denied and any capitated and sub capitated arrangements.

Go Live means the date on which the MCO assumes responsibility for the provision of Covered Services to Members. For the purposes of this Agreement, the date on which Turquoise Care begins is July 1, 2024.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and codified at 42 U.S.C. §§160, *et seq*. and its regulations to include provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), codified at 42 U.S.C §§17931 *et seq*.

Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) means a program established to ensure justice-involved individuals have timely access to health care services upon release from correctional facilities. To ensure this access can occur, individuals who have active Medicaid coverage at the time of incarceration do not lose their Medicaid eligibility, rather, have their Medicaid benefits suspended after 30 days. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply while incarcerated.

Long-Term Services and Supports (LTSS) means services and supports provided to Members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may include the Member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility,

or other institutional setting.

Managed Care Organization (MCO) means an organization that participates in Turquoise Care under contract with HSD to assist the State in meeting the requirements established under NMSA 1978, §27-2-12.

Medicare Default Enrollment – means MCO's perform outreach to members who are expected to be newly Medicare eligible within 90 days to enroll into their existing Medicaid MCO's D-SNP with the option to opt out in favor of Original Medicare.

Member means a person who has been determined eligible for Turquoise Care and who has enrolled in a MCO.

Nursing Facility Level of Care (NF LOC) means the Member's functional level is such that (2) two or more activities of daily living cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate, or assistance. A Member must meet the NF LOC criteria to be eligible for long-term nursing facility and community benefit services.

Nursing Facility (NF) means a licensed Medicare/Medicaid facility certified in accordance with 42 CFR Part 483 to provide inpatient room, board, and nursing services to Members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician.

Personal Care Services (PCS) means those services established by HSD to assist individuals who are eligible for full Medicaid coverage and meet the level of care criteria as defined by policy. PCS are provided to Members unable to perform a range of activities of daily living and instrumental activities of daily living.

Patient Protection and Affordable Care Act (PPACA) means Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010).

Primary Care Physician (PCP) Lock-in means a Member must visit a certain PCP when the MCO has identified continuing utilization of unnecessary services.

Pharmacy Lock-in means a Member must visit a certain pharmacy provider when Member compliance or drug-seeking behavior is suspected.

Setting of Care (SOC) means the various settings in which the member receives long-term care services.

Service Level Agreement (SLA) means an MCO developed document that specifies the format and content in which data and information will be exchanged and transitioned.

Turquoise Care Managed Care Organization (Turquoise Care MCO) means an entity under contract with HSD to provide Turquoise Care Services to eligible Medicaid members beginning July 1, 2024.

Turquoise Care/Turquoise Care Services means covered services approved by CMS under the State's 1115(a) Waiver beginning January 1, 2024.

II. PREREQUISITES

A. If CMS does not approve the 1115(a) Waiver, HSD may terminate this Agreement immediately without penalty by providing written notice to the Parties.

B. To align with PPACA and Medicare open enrollment, the Turquoise Care MCOs must be able to accept enrollment data by April 1, 2024.

C. All required transfers of data and information specified in this Agreement must be made electronically, unless otherwise directed by HSD.

D. All MCOs must have an agreement with CMS to offer a D-SNP to dually eligible members effective January 1, 2025.

III. TRANSITION RESPONSIBILITIES

To effectuate a smooth transition, all MCOs are required to identify key staff to HSD within thirty (30) calendar days after the effective date of this Agreement. The transition activities shall include assisting with Member transitions from a Centennial Care 2.0 MCO to a Turquoise Care MCO and ensure the sharing of documentation such as active prior authorizations, current assessments and care plans, and other necessary information to support continuity of care.

MCOs must have sufficient key staff and support staff based in New Mexico to support all the functions and operations described below.

- (i) **Provider Management**, which shall include, but is not limited to, claims and Encounter Data submissions, provider contracting and credentialing, subcontract oversight, and developing/maintaining a complete provider network.

- (ii) Member and Provider Support Services, which shall include, but is not limited to, call centers, grievances and appeals processes, and prior authorizations.

- (iii) Member/Provider Communications, which shall include, but is not limited to, Member and provider letters, Member handbook, provider directory, website, training, and cultural competency.

- (iv) Data/Information Technology, which shall include, but is not limited to, data storage and transfer, reports and support, enrollment, NF LOC/Setting of Care (SOC) submissions, claims/encounters, and system configuration.

- (v) Financial Reporting and Reconciliation, which shall include, but is not limited to, the submission of financial reports to include the evaluation and closing of reconciliations.

- (vi) Managed Care Reporting, which shall include, but is not limited to, the submission of contractually required reports.

- (vii) Long Term Services and Supports, which shall include, but are not limited to, identification, transition, and continuity of LTSS for Members with a Nursing Facility Level of Care (NF LOC) to include the transition of the NF LOC/SOC dates for Members receiving LTSS.

- (viii) Care Coordination, which shall include, but is not limited to, identification of complex cases, Members in out-of-state placement, those with special health care needs, and in special situations (such as health homes, homeless, justice-involved Members and Comprehensive of Addiction & Recovery (CARA) identified through their Plan of Care).

- (ix) Children in State Custody, which shall include, but is not limited to, all Members identified as CISC by their category of eligibility needing to transition. The CISC transition teams will need to work closely with New Mexico Children, Youth & Families Department. Members and guardians should be notified of the MCO transition. Notifications should include Care Coordination orientation, continuation of services and plan contact information.

- (x) Pharmacy, which shall include, but is not limited to, pharmacy lock-in and prior authorizations (including step-therapy protocols, lab requirements, etc.).

IV. MEMBERSHIP TRANSITION PERIODS

A. Open Enrollment Period

1. All Centennial Care 2.0 MCO Members are eligible for an open enrollment period to select a Turquoise Care MCO beginning April 1, 2024, and ending May 31, 2024, for an effective start date of July 1, 2024.

2. HSD will mandatorily enroll all current and new CISC Members to the CISC MCO, except for Native American CISC Members. The enrollment of Native American CISC into the CISC MCO shall be voluntary. Native American CISC Members may enroll with the CISC MCO, another MCO, or receive services through HSD's FFS program.

3. During open enrollment Members may remain with their Centennial Care 2.0 MCO or select a different Turquoise Care MCO. Members that do not select a Turquoise Care MCO by June 1, 2024, will be auto-assigned. Beginning July 1, 2024, there will be a ninety (90) calendar day switch period whereby Members may elect to switch MCOs

B. HIGH-RISK TRANSITION WORKGROUP

1. A High-Risk Transition Workgroup will be established thirty (30) business days prior to the beginning of transition activities to work collaboratively on transition issues as identified by HSD and the MCOs. All MCOs will be required to collaboratively participate on the Transition Workgroup until all Members, data, and information have been transitioned. The MCOs will need to identify the staff participating in the High-Risk Transition Workgroup ten (10) business days prior to the establishment of the Transition Workgroup.

V. TRANSITIONING MEMBER DATA

A. By April 1, 2024, (ninety (90) calendar days prior to Turquoise Care Go-Live), all MCOs shall be prepared to exchange the following data for all Members:

1. All claims data; and

2. All Authorization data; and

3. All Comprehensive Needs Assessments (CNA) and Comprehensive Care Plans (CCP); and

4. All Long-Term Care data identifying the NF LOC/SOC dates, CNA date spans, CCP date spans, Individual Plan of Care (IPoC), special needs, NF LOC date spans, and providers involved in service delivery and service coordination, annual budget, budget utilization, and budget date spans, as appropriate; and

5. All Behavioral Health data identifying special needs, care coordination, and any providers involved in service delivery and service coordination; and

6. All claims data as specified in the Service Level Agreement; and

7. All authorization data as specified in the Service Level Agreement; and

8. CAT/CANS assessments for identified high risk members if available; and

9. CARA Plans of Care.

B. The Centennial Care 2.0 MCOs shall send data for transferring high-risk Members to the Turquoise Care MCOs within fifteen (15) calendar days from the date the Centennial Care 2.0 MCO is notified by HSD, via the Member enrollment file, of the Member's choice of a Turquoise Care MCO, continuing through the period of open enrollment and auto-assignment, or June 30, 2024.

C. After the initial exchange of data, the Centennial Care 2.0 MCOs will continue to transmit on a weekly basis any new and updated data on a Member for whom data was previously sent (e.g., new authorizations, claims paid after the date of the initial data exchange, etc.). The format, required data elements, and method of transmission for each type of data listed in Subparagraph A above, is documented in the Service Level Agreement (SLA).

D. The Parties agree that the most recent twelve (12) months of information regarding Member specific data shall be exchanged in a format as documented in the SLA. Information shall include, but is not limited to, the following elements for all members, as applicable:

1. Category of Eligibility (COE)

2. Setting of Care (SOC), including date spans

3. Nursing Facility Level of Care (NF LOC), including date spans

4. Annual budget and budget utilization for Members enrolled in the Self-Directed Community Benefit

5. Disability indicator (For Other Adult Group members exempt from Alternative Benefit Plan/Adult Benefit Plan)
6. Care Coordination Level Assigned
7. Care Coordination Assessment Type
8. Health Risk Assessment (HRA)
9. CNA, if applicable
10. CCP, if applicable

Certain services as identified in the SLA require more than twelve (12) months of information.

E. The Parties agree information regarding Member specific data shall be exchanged in the format identified in the (SLA) and shall include, but is not limited to, the following complex medical conditions, as applicable:

1. Newborns with complex needs
2. Members with high-risk pregnancies and/or at late stage of pregnancy
3. Members in evaluation for or in the process a transplant (and type of transplant)
4. Members with terminal illness (including diagnoses)
5. Members receiving dialysis
6. Members receiving wound care
7. Members with NF LOC and receiving LTSS
8. Members enrolled in hospice
9. Members Prior authorized for surgery during the required twelve (12) month lookback
10. Members receiving substance abuse services
11. Members receiving behavioral health in out-of-home and/or inpatient placements
12. Members assigned to Core Services Agencies (CSAs)
13. Members receiving radiation and/or chemotherapy
14. Members receiving family planning services
15. Members receiving Breast and Cervical cancer services
16. Members with a serious infirmity, such as traumatic brain injury, cancer, and/or Members with chronic disease(s)
17. Members receiving Durable Medical Equipment (DME)

18. Members with complex behavioral health needs and co-morbidities

19. Members engaged in Disease Management

20. Members engaged in complex case processes

21. Members enrolled in a Patient-Centered Medical Home (PCMH)

22. Members enrolled in a CareLink NM Health Home

23. Members currently receiving residential or inpatient services out-of-state (excluding the border area providers considered in-state providers)

24. CISC Members

25. CARA Members

26. Members locked-in to a Pharmacy and/or Primary Care Physician

27. Members receiving High Fidelity Wraparound services

28. Members with a claim accumulation of $50,000 or more in the previous six months if Care Coordinator intervention was required.

F. Prior and Concurrent Authorization Data to be transmitted:

1. Requesting provider name and national provider identification number (NPI), rendering provider name and NPI, service type, frequency, date of service (if the NPI is applicable), Member name, Member Medicaid ID, Social Security Number (SSN), and Member date of birth; and

2. Prior authorized surgeries for the required twelve (12) month lookback including date of prior authorization; and

3. Pharmacy utilization, including pharmacy lock-in.

G. Assessment(s) for Members accessing and expected to access LTSS as of July 1, 2024:

1. Individualized Service Plan (ISP), CNA, and CCP, Back-up Plan, NF LOC/SOC date spans, and annual budget and budget utilization as appropriate.

H. Continuity of Care (Information Exchanged)

1. Approved prior authorizations must be submitted in the formats specified in the SLA (Medical, Drug, Dental, Transportation & PCS/EVV). Approved prior authorizations (all open authorizations) must be honored at a minimum by per the schedule below after June 30, 2024, unless otherwise specified in this Agreement, to include, but not limited to the following:

a) Transplant and surgery services already approved for the first sixty (60) calendar days after June 30, 2024

b) Pharmaceuticals already approved for the first ninety (90) calendar days after June 30, 2024 (formulary or preferred drug list, prior authorizations), including specialty drugs

c) Pharmaceuticals for those Members on a pharmacy-lock in and those who have short term duration prescription (e.g., 5-day, 7-day supply)

d) DME already approved for the first ninety (90) calendar days after June 30, 2023

e) Scheduled hospitalizations for the first sixty (60) calendar days after June 30, 2024 (inpatient and BH)

f) Institutional care and hospice

g) Out-of-State placements

Turquoise Care MCOs have the discretion to extend the open prior authorization to meet the needs of Members. HSD may also direct MCOs to extend prior authorizations to meet the needs of Members.

2. Prior authorization requests for services scheduled on or after July 1, 2024 must be submitted to the receiving Turquoise Care MCO within 24 hours of notification by HSD of the Member's new Turquoise Care MCO, or within 24 hours of receipt of the prior authorization request, whichever is later.

3. Pregnancy data to include third trimester and/or high-risk pregnancies

4. EPSDT visits due within the first ninety (90) calendar days after June 30, 2024

5. Behavioral Health out-of-home placements

6. Community benefits approved in the CNA and CCP until annual re-assessment

I. Member Transfers

1. Centennial Care 2.0 MCOs shall identify Members who are transferring out of the MCO and shall ensure that Member data and clinical information is transmitted to the receiving Turquoise Care MCO within fifteen (15) calendar days after notification from HSD that a Member will transfer to the Turquoise Care MCO effective July 1, 2024.

2. For members receiving care coordination, HSD recommends a warm transfer be made to the receiving Turquoise Care MCO. A warm transfer is a telephonic communication and introduction between the previous care coordinator, the new Turquoise Care MCO care coordinator, and the Member. Member involvement will be based on Member choice and availability.

3. Those Members already in Care Coordination Levels 2 or 3, and Levels A through D, will continue to receive care coordination and existing LTSS with the Turquoise Care MCOs effective July 1, 2024.

4. For existing Community Benefit Members who meet a Nursing Facility Level of Care (NFLOC):

    a) Monthly capitations to the Current MCO for Members whose NFLOC expires in July-August 2024 and are not completed by June 1, 2024, are subject to recoupment.

    Example: Member's NF LOC expires on August 1, 2024. The Current MCO is required to complete the Member's NF LOC assessment and approve or deny the NF LOC no later than June 1, 2024. If the NF LOC is not completed and submitted via the system interfaces by June 1, 2024, the capitation payment for June 2024 is subject to recoupment.

5. If applicable, Turquoise Care MCOs shall continue providing services previously authorized in the Member's approved CNA/CCP or behavioral health treatment or service plan without regard to whether such services are being provided by contract or non-contract providers.

6. The Turquoise Care MCOs shall not reduce services previously authorized in the CNA/CCP, IPoC or behavioral health treatment or service plan until the Member's care coordinator has conducted a comprehensive needs assessment (CNA) and developed a comprehensive care plan (CCP).

VI. BUSINESS ASSOCIATE AGREEMENTS (BAA) AND TRANSITION MEETINGS

A. No later than March 1, 2024, the Centennial Care 2.0 MCOs shall enter into a BAA with the Turquoise Care MCOs for the exchange of data. Such BAA shall include, at minimum, IT security protections for protected health information.

B. Transition Meetings for High Need Members. HSD shall schedule transition meetings, if necessary. Attendance by all MCOs and other contractors is required. Such meetings shall include clinical and/or operational matters and any other such matters necessary to ensure the smooth and non-disruptive transition of Members.

GENERAL TRANSITION REQUIREMENTS

A. NETWORK ADEQUACY

Centennial Care 2.0 MCOs are required to maintain their provider network. Changes made to their provider network shall follow the requirements outlined in the Managed Care Policy Manual. Centennial Care 2.0 MCOs and Turquoise Care MCOs shall provide HSD with information related to the establishment and maintenance of their provider networks in a format and frequency as directed by HSD. Provider network information must contain, at a minimum, provider NPI, service type, contracting status, and other elements as described below:

1. Primary Care Providers
2. Pediatric Providers
3. Specialty Providers (e.g., SBHCs, CSAs, etc.)
4. Border Providers
5. Long-Term Care Providers (Nursing Facilities and Community Benefit providers)
6. IHS and Tribal 638 Facilities
7. Single Case Agreements
8. Patient-Centered Medical Homes (PCMH)
9. CareLink NM Health Homes
10. Behavioral Health providers
11. Hospital providers (including Psychiatric Hospitals)
12. FQHCs and RHCs
13. Telemedicine
14. Transportation Providers/agencies
15. Major Subcontractors (including, but not limited to, transportation, pharmacy, dental, and DME), Preferred Vendors, and Sole Source Providers.

A. PERFORMANCE MEASURES AND DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGETS

A. Requirements for Centennial Care 2.0 MCOs:

1. Performance Measures included in the Centennial Care Managed Care Services Agreement will continue to be in effect through June 30, 2024, for the Centennial Care MCOs. Centennial Care MCOs will be required to deliver their audited HEDIS for Calendar Year 2023 to HSD by June 30, 2024. Between January 1, 2024, and June 30, 2024, penalties will not be imposed for not meeting Performance Measure targetss, however, quarterly reporting will be required, and performance monitored.

2. Delivery System Improvement Performance Targets (DSIPTs) included in Contract Amendment #6 will continue to be in effect through December 31, 2023, for the Centennial Care MCOs. Between January 1, 2024, and June 30, 2024, penalties will not be imposed for not meeting Delivery System Improvement Performance targets, however, quarterly reporting will be required, and performance monitored.

B. Turquoise Care MCOs will be required to be in compliance with all Performance Measures and DSIPT requirements that are effective as of January 1, 2024.

VII. OTHER COMMUNICATION

A. All public communications regarding Turquoise Care initiated by an MCO must be submitted to HSD for review and approval at least thirty (30) calendar days prior to issuance of the communication.

B. All requests for information made to any MCO regarding Turquoise Care from the media, advocates, other entities, etc., and the MCO proposed responses must be submitted to HSD for review and approval at least ten (10) business days prior to issuance of the communication.

C. All MCOs shall jointly develop, for HSD approval, Frequently Asked Questions (FAQs) and talking points regarding transition issues within thirty (30) calendar days of the execution of the TMA.

VIII. EMPLOYMENT PRACTICES

Within sixty (60) calendar days of HSD's award notification of the Turquoise Care MCOs, all Current Centennial Care 2.0 MCOs and Turquoise Care MCOs shall identify to HSD a designated "Recruitment Specialist" within their Human Resources Department who will coordinate the recruitment, retention, and hiring of experienced and qualified staff to ensure continuity of care, and complete and effective transitions for Members.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective upon the date of HSD's signature.

CONTRACTOR

By: DocuSigned by: Nancy Smith Leslie C02C449779E84EB... Date: 12/1/2023

Blue Cross and Blue Shield of New Mexico

CONTRACTOR

By: DocuSigned by: Carolyn Ingram AD9BFBB6C9364D6... Date: 12/12/2023

Molina Healthcare of New Mexico, Inc.

CONTRACTOR

By: DocuSigned by: Brandon Fryar D52F9BF47309450... Date: 12/15/2023

Presbyterian Health Plan

CONTRACTOR

By: DocuSigned by: Andrew E. Peterson 2137C5016E17498... Date: 12/15/2023

United Healthcare Insurance Company

STATE OF NEW MEXICO

By: DocuSigned by: Kari Armijo 1BA9EB5EAD00499... Date: 12/20/2023

Kari Armijo Cabinet Secretary
Human Services Department

By: DocuSigned by: 32BE56E83D064CE... Date: 12/15/2023

John Emery, Acting Chief Legal Counsel
Human Services Department