MEDICAID MANAGED CARE
TRANSITION MANAGEMENT AGREEMENT

This Transition Management Agreement (Agreement) is entered into by the New Mexico Human Services Department (HSD), and Western Sky Community Care (WSCC) is to be effective upon signature by both Parties.

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 WSCC was not selected as one of the Turquoise Care managed care organizations; 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, 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 WSCC 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.

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 the 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.

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.

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 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.

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

C. For WSCC:

a. In accordance with CMS regulations, WSCC must terminate D-SNP agreement(s) with CMS for New Mexico Medicaid dual eligible Members effective January 1, 2025.

b. Within thirty (30) days of the effective date of this agreement, WSCC is required to provide HSD with a plan for communication to its Members to select different Medicare coverage.

c. WSCC is required to collaborate with selected Turquoise Care MCOs to transition high-risk D-SNP Members to the selected MCOs' D-SNPs and provide monthly reporting to HSD on these efforts until all high-risk Members have been transitioned.

D. WSCC's Managed Care Services Agreement expires on June 30, 2024.

E. HSD will discuss proposed monetary penalties with WSCC prior to imposing them. WSCC will have the opportunity to dispute monetary penalties in accordance with Contract Amendment 6, Section 7.11.3. At its discretion, HSD may waive the application of sanctions, including monetary penalties, per Contract Amendment 6, Section 7.3.5.

III. TRANSITION RESPONSIBILITIES

A. To effectuate a smooth transition, WSCC and Turquoise Care MCOs are required to identify key staff to HSD within thirty (30) calendar days after the effective date of this Agreement. WSCC must maintain sufficient key staff and support staff to support all the functions and operations described below.

- (i) Member and Provider Support Services
- (ii) Member/Provider Communications
- (iii) Data/Information Technology
- (iv) Financial Reporting and Reconciliation
- (v) Managed Care Reporting
- (vi) Care Coordination.

B. Termination Plan: Within thirty (30) calendar days of the effective date of this Agreement, WSCC shall submit for HSD approval, a termination plan, describing in detail how WSCC will close out its Centennial Care obligations, utilizing a template to be provided by HSD.

IV. MEMBERSHIP TRANSITION PERIODS

A. Open Enrollment Period

- 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.

- HSD will cease new enrollment for WSCC effective beginning April 1, 2024.

V. HIGH-RISK TRANSITION WORKGROUP

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. WSCC will be required to collaboratively participate on the Transition Workgroup until all Members, data, and information have been transitioned. The Transition Workgroup should address all open critical incidents and Grievances and Appeals. 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.

VI. TRANSITIONING MEMBER DATA

A. By April 1, 2024, WSCC shall be prepared to exchange the following data for all Members:

1. All claims data;

2. All Authorization data;

3. All Comprehensive Care Assessments (CNAs) and Comprehensive Care Plans (CCPs);

4. All Long-Term Care data identifying the NF LOC/SOC dates, Comprehensive Needs Assessment (CNA) date spans, Comprehensive Care Plan (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;

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

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

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

8. CATS/CANS assessments for identified high risk Members if available; and

9. CARA plans of care.

B. WSCC shall send data for transferring high-risk Members to the Turquoise Care MCO within fifteen (15) calendar days from the date WSCC is notified by HSD, via the Member enrollment file, of the Member's choice of a Turquoise Care MCO.

C. After the initial exchange of data, WSCC 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. WSCC agrees that the most recent twelve (12) months of information regarding Member specific data shall be provided 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. WSCC agrees 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 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

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 Plans, NF LOC/SOC date spans, 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), shall include, but not limited to the following:

a) Transplant and surgery services already approved

b) Pharmaceuticals already approved (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

e) Scheduled hospitalizations (inpatient and BH)

f) Institutional care and hospice

g) Out-of-State placements

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

5. Behavioral Health out-of-home placements

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

I. Member Transfers

1. WSCC shall identify Members who are transferring out of their health plan 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

via the enrollment file 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 care coordinator and the Member. Member involvement will be based on Member choice and availability.

3. For existing Community Benefit Members who meet a Nursing Facility Level of Care (NF LOC):

    a) Monthly capitations to WSCC for Members whose NF LOC expires in July- or August 2024 and are not completed by June 1, 2024, are subject to recoupment.

    Example: Member's NF LOC expires on August 1, 2024. WSCC 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.

VII: BUSINESS ASSOCIATE AGREEMENTS (BAA) AND TRANSITION MEETINGS

A. No later than March 1, 2024, WSCC 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.

Transition Meetings for High Need Members. As needed, HSD shall schedule transition meetings. Attendance by WSCC, Turquoise Care MCOs, and other contractors are 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.

VIII: GENERAL TRANSITION REQUIREMENTS

A. Provider Management. WSCC shall maintain effective communications with its providers.

1. WSCC shall:

    a) Inform providers, in writing, at least sixty (60) calendar days prior to July 1, 2024, of the termination of their respective contracts and of the process for providers to submit claims with dates of service through June 30, 2024, but submitted after that date. The letter shall be submitted to HSD for review and approval no later than April 1, 2024 prior to its issuance to providers and must include at a minimum, the following for claims submissions:

        1) Contact information (including telephone and fax numbers); and

        2) Billing address; and

        3) Electronic submission instructions (if different than billing address)

for claims submissions; and

4) Designated point of contact for questions.

b) Allow providers the following timeframes to submit claims for services provided prior to July 1, 2024:

1) 120 calendar days from date of service to submit original claims; and

2) 90 calendar days from the paid date for adjusted claims; and

3) 210 calendar days from the date of service for claims that have third-party liability or are Medicare crossover claims; and

4) 730 calendar days from the date of service for I/T/Us to submit any claim.

c) Continue to meet the timeframes established by contract for processing all claims and submission of encounters to HSD; and

d) Meet all regulatory requirements regarding notification to HSD of terminated providers.

2. WSCC's provider telephone lines shall remain open for at least ninety (90) calendar days after the implementation of Turquoise Care. After the telephone line is no longer operational, WSCC shall have a designated point of contact, including phone number, for the remainder of the 730 Calendar related to claims issues. WSCC will provide the designated point of contact information for its HSD contract manager.

B. Member Support Services. WSCC shall maintain effective communications with Members to include:

1. Inquiries about: (i) transitioning of care; (ii) open enrollment; (iii) provider networks; (iv) Medicaid benefits and value-added services.

2. WSCC shall:

a) Inform Members in writing at least sixty (60) calendar days prior to July 1, 2024, of the transitioning of services, and other specific information as requested by HSD; such communication shall be submitted to HSD for review and approval no later than April 1, 2024.

b) All Member telephone lines shall remain open during business hours, for at least ninety (90) calendar days after the implementation of Turquoise Care.

c) Develop "final" telephone message for Members and Providers. The message shall include sources of sources of current information about Turquoise Care and the designated point of contact for provider claims. A draft of the final telephone message shall be sent to HSD for review and approval, no later than June 1, 2024. The final telephone message shall remain active until December 1, 2024. Develop final email and website messages directing Members to

sources of current information about Turquoise Care. These final messages shall be sent to HSD for review and approval no later than May 1 1, 2024.These messages shall be effective June 1, 2024, and remain active until September 30, 2024.

C. Grievances and Appeals

1. Grievances: WSCC shall resolve all open grievances within contractual timeframes.

2. Appeals based on adverse benefit determinations made after the service is rendered: WSCC shall retain responsibility for these pending appeals and shall make its determination as to the resolution to the appeal according to contractual timeframes.

3. Appeals based on adverse benefit determinations made prior to rendering services: WSCC shall notify the receiving Turquoise Care MCO for all transferring Members, of all pending appeals. Centennial Care Reporting

4. WSCC shall continue to submit all regularly scheduled and Ad Hoc reports as contractually required.

5. The run-out period shall not expire until all required report submissions are accepted by HSD. Run out reports shall include, but are not limited to, Centennial Care program reports, financial reports, Healthcare Effectiveness Data and Information Set (HEDIS), Tracking Measures (TMs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports, and reports for Delivery System Improvement Performance Targets (DSIPT).

IX. NETWORK ADEQUACY

WSCC will be required to maintain its provider network through June 30, 2024, and notify HSD of provider termination and follow the transition process outlined in the Managed Care Policy Manual. WSCC is required to maintain Subcontractor agreements until all continuing obligations under the agreement are fulfilled.

X. PERFORMANCE MEASURES AND DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGETS

A. Requirements for Centennial Care 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 targets, however, quarterly reporting will be required, and performance monitored.

2. Delivery System Improvement Performance Targets (DSIPTs) included in Contract Amendment #7 will continue to be in effect through June30, 2024, 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.

XI. 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. WSCC and the Turquoise Care 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.

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

CONTRACTOR

By: DocuSigned by: Jean D. Wilms 23EBC03009C643B... Date: 12/14/2023

Western Sky Community Care

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
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