HUMAN SERVICES
DEPARTMENT

State of New Mexico Human Services Department

Medicaid Managed Care Services Agreement

Among

New Mexico Human Services Department,

New Mexico Behavioral Health Purchasing Collaborative

and

Western Sky Community Care, Inc.

PSC 18-630-8000-0035 A4
CFDA 93.778

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STATE OF NEW MEXICO HUMAN SERVICES DEPARTMENT

MEDICAID MANAGED CARE SERVICES AGREEMENT PROFESSIONAL SERVICES CONTRACT CENTENNIAL CARE 2.0

This Agreement (the "Agreement" or the "Contract") is made and entered into by and between the New Mexico Human Services Department ("HSD"); the New Mexico Behavioral Health Purchasing Collaborative (the "Collaborative"); and, Western Sky Community Care, Inc. including any successors and/or assignees ("CONTRACTOR"); and is to be effective upon signatures by all parties.

RECITALS

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 (NMSA 1978, 13-1-28 et seq.) pursuant to NMSA 1978, § 13-1-98.1, because it is for the purpose of creating a network of health care Providers to provide services to Medicaid-eligible Recipients that will or are likely to reduce health care costs, improve quality of care or improve access to care;

WHEREAS, this Agreement is subject to NMSA 1978, § 9-7-6.4; and

WHEREAS, the Special Terms and Conditions for New Mexico's Section 1115 wavier between the Centers for Medicare & Medicaid Services and HSD necessitate certain revisions to the Contract;

NOW, THEREFORE, FOR AND IN CONSIDERATION of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, HSD, the Collaborative and the CONTRACTOR (each individually a "Party" and collectively the "Parties") hereby agree as follows:

1 Introduction

1.1 References to the "State" shall mean the State of New Mexico including, but not limited to, any entity or agency of the State of New Mexico.

1.2 All of the CONTRACTOR's responsibilities pursuant to this Agreement must be performed in the continental United States of America and, where specified, in the State of New Mexico.

1.3 All services purchased under this Agreement shall be subject to the following provisions, which are incorporated herein by reference and shall include, but are not limited to:

1.3.1 The Request for Proposal (RFP), all RFP amendments, HSD's answers to offerors' questions and HSD's written clarifications;

1.3.2 The CONTRACTOR's proposal (including any and all written materials presented in the oral presentation during the procurement process, if any) where consistent with this Agreement and subsequent amendments to this Agreement; and

1.3.3 All applicable instruments HSD may use from time to time to communicate, update, and clarify information including, but not limited to: letters of direction, Managed Care Policy manual, Systems Manual, guidance memoranda, correspondence, and other communication including all updates and revisions thereto, or substitutions and replacements thereof. These instruments are governed by the provisions of this Agreement, in the event of conflict.

1.4 The Parties understand and agree that references to specific statutes, regulations, dates and other matters of a similar nature refer to currently existing and known statutes, regulations and dates. The Parties understand and agree that such existing statutes, rules, regulations and dates may change after execution of this Agreement, and that new enactments, adoptions, amendments, substitutions, replacements, successors or the like shall be given full force and effect and shall govern this Agreement in the spirit in which this Agreement is made.

1.5 The CONTRACTOR shall have the regulatory authority, prior to Go-Live, to enter into capitated agreements, assume risk and meet applicable requirements and/or standards delineated under State and federal statutes and regulations.

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

1.7 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 Agreement. The Parties agree to document agreements in writing prior to implementation of any new Contract requirements.

1.8 The Parties to this Agreement acknowledge that references to HSD in Sections of this Agreement related to Behavioral Health will also include the Collaborative, whether or not such Sections explicitly include the Collaborative.

1.9 The CONTRACTOR shall provide the Alternative Benefit Plan (the "ABP") in accordance with the State's approved Medicaid State Plan and this Agreement. Unless explicitly stated otherwise, all provisions of this Agreement shall apply to the Alternative Benefit Plan and to categories of eligibility that are covered under the Alternative Benefit Plan.

1.10 The CONTRACTOR shall, by Go-Live, have a D-SNP agreement in good standing with CMS.

1.11 The CONTRACTOR's cost proposals have been generally accepted by the HSD and in accordance with Section 7 of the RFP. The CONTRACTOR will have adjustments made to the Capitation Rates for the impacts of items excluded for the Cost Proposal and any adjustments deemed "material" by HSD and its actuaries. The adjustments will reflect known changes to the population and services to be covered under this Agreement effective January 1, 2019. Adjustments may include: (i) significant changes in program demographics; (ii) programmatic changes (benefits or reimbursement) occurring after the procurement but before Go-Live; and (iii) list of excluded cost proposal rate elements outlined in the cost proposal narrative including but not limited to 1115(a) waiver renewal, add-on PMPMs and assessments) effective January 1, 2019. The CONTRACTOR's cost proposal will be adjusted based on the relative position of its proposal within the rate range.

1.12 The CONTRACTOR shall provide ownership and control information as related to the CONTRACTOR and any Subcontractors as required per 42 C.F.R. § 438.608(c).

2 Definitions, Acronyms and Abbreviations

1115(a) Waiver refers to the State of New Mexico's Medicaid demonstration project, authorized by CMS pursuant to Section 1115(a) of the Social Security Act to implement Centennial Care.

Abuse means: (i) any intentional, knowing or reckless act or failure to act that produces or is likely to produce physical or great mental or emotional harm, unreasonable confinement, sexual abuse or sexual assault consistent with the Resident Abuse and Neglect Act, NMSA 1978, 30-47-1, et seq.; or (ii) provider practices that are inconsistent with sound fiscal, business, medical or service-related practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not Medically Necessary Services or that fail to meet professionally recognized standards for health care. Abuse also includes Member practices that result in unnecessary cost to the Medicaid program pursuant to 42 C.F.R. § 455.2.

Ad Hoc Reports or Requests are deliverables. Deliverables are scheduled and unscheduled reports or requests for information by HSD. The CONTRACTOR will receive, in writing, direction related to the required content and format. HSD will also provide a due date and will indicate if a deliverable is subject to monetary penalties in accordance with 7.3 of this Agreement.

Adult means an individual age nineteen (19) or older unless otherwise specified.

Alternative Benefit Plan (ABP) means the services outlined in Attachment 5. The ABP lists the Covered Services available to Members in the Other Adult Group and may include the Parent/Caretaker and Transitional Medical Assistance Categories unless the Member is ABP Exempt.

Alternative Benefit Plan Exempt (ABP Exempt) means a Member subject to coverage under the ABP and who has been determined as meeting the definition and criteria of Medically Frail or is otherwise exempt from mandatory enrollment in the ABP as further explained in Section 4.5.1.5 of this Agreement. An ABP Exempt Member is eligible to choose between ABP services outlined in Attachment 5 and the Covered Services listed in Attachment 2.

Advance Directive means written instructions (such as an advance health directive, a mental health advance directive, a psychiatric advance directive, a living will, a durable health care

power of attorney or a durable mental health care power of attorney) recognized under State law (whether statutory or as recognized by the courts of the State) relating to the provision of health care when an individual is incapacitated. Such written instructions must comply with NMSA 1978, § 24-7A-1 through 24-7A-18 and 24-7B-1 through 24-7B-16.

Advanced Practice Registered Nurse (APRN) means a graduate level prepared registered nurse who has completed a program of study in a specialty area in an accredited nursing program, taken a certification examination in the same area, and been granted a license to practice as an advanced practice nurse with an expanded scope of practice; individuals are authorized to practice in the roles of certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA) and clinical nurse specialist (CNS).

Adverse Benefit Determination means, for purposes of an appeal: (i) the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) the failure of the CONTRACTOR to provide services in a timely manner, as defined by HSD; (v) the failure of the CONTRACTOR to complete the standard resolution of grievances and appeals within specific time frames set forth in 42 C.F.R. § 438.408; and (vi) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

Agency-Based Community Benefit means the consolidated benefit of home and community-based (HCBS) and personal care services (PCS) that are available to Members meeting the nursing facility level of care. A list of the services available in the Agency-Based Community Benefit is included in Attachment 2.

Aggregate Lifetime Dollar Limit means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. § 438, Subpart K, a dollar limitation on the total amount of specified benefits that may be paid.

Agreement Termination Date means the effective date of termination of this Agreement.

ALTSD means the New Mexico Aging & Long-Term Services Department

Annual Dollar Limit means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. § 438, Subpart K, a dollar limitation on the total amount of specified benefits that may be paid in a twelve (12) month period.

Appeal means a request by a Member for review by the CONTRACTOR of a CONTRACTOR's Adverse Benefit Determination.

Authorized Agent is a person designated by the Member to have access to medical and financial information for the purposes of offering support and assisting the eligible Member in understanding waiver services.

Authorized Certifier means one of the following, the CONTRACTOR's CEO, CFO or an individual with delegated authority to sign for and who reports directly to the CONTRACTOR's CEO and/or CFO.

Behavioral Health is the umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health conditions and substance use disorders (SUDs).

Behavioral Health Planning Council (BHPC) means the body created to meet federal and State advisory council requirements and to provide consistent, coordinated input to the Behavioral Health service delivery system in New Mexico.

BHS means the Behavioral Health Services division of the Children, Youth and Families Department and is the children's behavioral health authority of New Mexico

Birthing Options Program means the State of New Mexico operated program that provides birthing options to pregnant women.

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

Business Days means Monday through Friday, except for State of New Mexico holidays.

CAHPS means the Consumer Assessment of Healthcare Providers and Systems.

Calendar Days means all seven days of the week, including State of New Mexico holidays.

CAP means corrective action plan developed by the CONTRACTOR.

Capitation Payment means a payment the State makes periodically to a CONTRACTOR on behalf of each Member enrolled under a contract and based on the actuarially sound Capitation Rate for the provision of services under the State plan and the 1115(a) Waiver. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Capitation Rate means a fixed monthly PMPM (per member per month) by Rate Cohort for the Covered Services provided to Members and includes the operational functions required in the Agreement including amounts for taxes determined by the taxing authority. Capitation Rate is adjusted for the ACA Section 9010 Health Insurance Providers Fee once CONTRACTOR liabilities are known. Amounts associated with I/T/U services are excluded from the Capitation Rates.

Care Coordination Level (CCL) identifies the level of support a Member needs through Care Coordination services for the Member to improve or maintain and manage their individual health needs effectively.

Centennial Care means the State of New Mexico's Medicaid program operated under Section 1115(a) of the Social Security Act waiver authority.

Centers for Independent Living are typically non-residential, private, non-profit, consumer-controlled, community-based organizations providing services and advocacy by and for persons with all types of disabilities. Their goal is to assist individuals with disabilities to achieve their maximum potential within their families and communities.

Certified Family Support Worker (CFSW) means Family Peer Support Workers who are primary caregivers and have "lived-experience" of being actively involved in raising a child with emotional, behavioral, mental health and/or substance use challenges. This includes young

people with neurobiological differences as well as those diagnosed with a severe emotional disorder or substance abuse disorder. Endorsement for credentialing includes successful completion of a training program. CFSW also must pass the credentialing exam administered by the New Mexico Credentialing Board for Behavioral Health Professionals and remain current with continuing education requirements.

Certified Peer Support Worker (CPSW) is an individual in recovery from mental health and/or substance use issues who has been found eligible to be trained by HSD's Office of Peer Recovery and Engagement (OPRE), successfully completed the training program offered by OPRE, has passed the certification examination administered by the New Mexico Credentialing Board for Behavioral Health Professionals, has obtained certification and is current with continuing education requirements.

Certified Registered Nurse Anesthetist (CRNA) means a registered nurse who is

licensed by the board for advanced practice as a certified registered nurse anesthetist and whose name and pertinent information are entered on the list of certified registered nurse anesthetists maintained by the board.

C.F.R. means the Code of Federal Regulations.

Child means an individual under age nineteen (19) unless otherwise specified.

Claim means a bill for services submitted to the CONTRACTOR manually or electronically, a line item of service on a bill, or all services for one Member within a bill.

Clean Claim means a Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in HSD'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.

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

Cold Call Marketing means any unsolicited personal contact by the CONTRACTOR with a potential Member for the purpose of Marketing.

Collaborative means the interagency Behavioral Health purchasing collaborative, established under NMSA 1978, § 9-7-6.4, responsible for planning, designing and directing a statewide Behavioral Health system.

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.

Community Health Representatives (CHR) means a Tribal or Native individual who is a community-based, well-trained, medically-guided, who may include traditional Native concepts in his/her work conducting outreach to American Indian Members. They also provide health promotion and disease prevention services to their communities.

Community Health Workers (CHWs) are frontline public health workers who are trusted members of the community they serve. CHWs function as a liaison/link/intermediary between health and social services and communities to facilitate access to services and improve the quality and cultural competence of service delivery.

Comorbid Conditions the presence of one or more additional disorders (or diseases) co-occurring with a primary disorder or disease; or the effect of such additional disorder(s) or disease(s). The additional disorder or disease may also be behavioral or mental.

Compliance Officer shall have the meaning ascribed to such term in Section 3.3.3.7 of this Agreement.

Comprehensive Care Plan (CCP) means a comprehensive plan of services that meets the Member's physical, behavioral and long-term needs.

Comprehensive Needs Assessment (CNA): The CNA is an assessment of the Member's Physical, Behavioral health and Long-Term Care needs; it will identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the Member's assessed needs. The CNA may also include a functional assessment, if applicable.

Confidential Information means any communication or record – whether oral, written, electronically stored or transmitted, or in any other form – consisting of: (i) confidential Member

information, including protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) and 42 C.F.R. § 2; (ii) all non-public budget, expense, payment and other financial information; (iii) all privileged work product; (iv) all information designated by HSD or any other State agency as confidential and all information designated as confidential under the laws of the State of New Mexico; and (v) information utilized, developed, received, or maintained by HSD, the Collaborative, the CONTRACTOR, or participating State agencies for the purpose of fulfilling a duty or obligation under this Agreement and that has not been disclosed publicly.

Contract Administrator shall have the meaning ascribed to such term in Section 7.41 of this Agreement.

Contract Manager shall have the meaning ascribed to such term in Section 3.3.4 of this Agreement.

Contract Provider means an individual provider, clinic, group, association, vendor or facility employed by or under a provider agreement with the CONTRACTOR to furnish Physical Health, Behavioral Health or Long-Term Care Covered Services to the CONTRACTOR's Members under the provisions of this Agreement.

CONTRACTOR Proprietary Software means software: (i) developed by the CONTRACTOR before the effective date of this Agreement; or (ii) software developed by the CONTRACTOR after the effective date of this Agreement that is not developed for HSD, in connection with this Agreement nor with funds received by HSD.

Co-payment means a fixed dollar amount that a Medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be paid at the time of service or receipt of an item (if applicable).

Core Service Agencies (CSA) means multi-service agencies that help to bridge treatment gaps in the Child and Adult treatment systems, promote the appropriate level of service intensity for Members with complex Behavioral Health service needs including SUD, ensure that community support services are integrated into treatment and develop the capacity for Members to have a

single point of accountability for identifying and coordinating their Behavioral Health, physical health and other social services.

Covered Services means those physical, Behavioral Health and Long-Term Care services listed in Attachment 2 or the ABP services listed in Attachment 5 of this Agreement that are to be delivered in accordance with this Agreement.

Criminal Justice-Involved Recipient is a person who has a formal relationship with the criminal justice system, including but not limited to an incarcerated individual, an incarcerated individual who is eligible for release, an individual in the community who is on probation or has an ongoing relationship with the criminal justice system and an individual serving a jail or prison sentence within the community.

Critical Incident means a reportable incident that may include, but is not limited to: Abuse, neglect, exploitation, death, environmental hazard, law enforcement intervention and Emergency Services.

Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and Marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

Custom Software means any software developed by the CONTRACTOR or HSD in conjunction with this Agreement and with funds received from HSD. The term does not include the CONTRACTOR's Proprietary Software or Third-Party Software.

CYFD means the New Mexico Children, Youth and Families Department.

DCAP means a directed corrective action plan developed for the CONTRACTOR by HSD.

Delegated Model permits MCOs to delegate the overall provision of Care Coordination to Providers, health systems, agencies and/or organizations as part of a value-based purchasing arrangement or health home while the MCO retains oversight and monitoring functions.

Developmental Disability 1915(c) Waiver means the State of New Mexico's Medicaid home and community-based waiver program for individuals with developmental disabilities authorized by CMS pursuant to Section 1915(c) of the Social Security Act.

Directed Payment Provider payments as directed by HSD and approved by CMS in accordance with 42 C.F.R. § 438.6(c).

DOH means the New Mexico Department of Health.

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

Dual Eligible Special Needs Plans (D-SNP) means 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.

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, Diagnostic and Treatment (EPSDT) means the federally required Early and Periodic Screening, Diagnostic and Treatment program, as defined in Section 1905(r) of the Social Security Act and 42 C.F.R. § 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 State plan.

Electronic Health Record (EHR) means a record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status,

laboratory test results, radiology images, vital signs, personal statistics such as age and weight and billing information.

Emergency Medical Condition means a physical health or Behavioral Health condition manifesting itself through acute symptoms of sufficient severity (including serve pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; or (iv) serious disfigurement to the Member.

Emergency Medical Transportation means services provided by ground or air transportation for an emergency medical or behavioral health condition as described in NMAC 8.324.7.

Emergency Room Care means a portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Emergency Services means Covered Services that are inpatient or outpatient and are: (i) furnished by a provider that is qualified to furnish these services; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

Encounter means a record of any Member Claim adjudicated by the CONTRACTOR or any of its Major Subcontractors and Subcontractors, including a Medicare Claims for which there is no Medicaid reimbursement and/or record of any Member service or administrative activity provided by a CONTRACTOR or its Major Subcontractor and 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 is information about claims adjudicated by the CONTRACTOR, or any of its Major Subcontractors or Subcontractors for goods and/or services rendered to Members. Such information includes whether Claims were paid or denied and any capitated or subcapitated payment arrangements made.

Excluded Services means services that are not Covered Services as defined in this Agreement.

External Quality Review (EQR) means the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness and access to the health care services that a MCO (described in § 438.310(c)(2)), or its CONTRACTORS furnishes to Medicaid beneficiaries.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358 or both. Failure to report means failure to submit a complete, timely and accurate report, in the specified format in accordance with Section 4.21 of this Agreement.

Fair Hearing means the administrative decision-making process that requires aggrieved individuals to be given the opportunity to confront the evidence against them and have their evidence considered by an impartial fact finder in a meaningful time and manner.

FAQs means frequently asked questions.

Federally Qualified Health Center (FQHC) means an entity that meets the requirements of, and receives a grant and funding pursuant to, the Public Health Service Act. An FQHC also includes an outpatient health program, a facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638) and an Urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act, codified at 25 U.S.C. 1601 et seq.

Financial Requirements means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. § 438, Subpart K, deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include premiums or aggregate lifetime or annual dollar limits.

Fiscal Management Agency (FMA) means an entity contracting with the State that provides the fiscal administration functions for Members receiving the Self-Directed Community Benefit. The FMA must be an entity operating under Section 3504 of the IRS code, Revenue Procedure 70-6 and Notice 2003-70, as the agent to Members for the purpose of filing certain federal tax forms and paying federal income tax withholding, FICA and FUTA taxes. The FMA also files State income tax withholding and unemployment insurance tax forms, pays the associated taxes and

processes payroll based on the eligible Self-Directed Community Benefit services authorized and provided.

Force Majeure means any event or occurrence that is outside of the reasonable control of the Party concerned and that is not attributable to any act or failure to take preventive action by the Party concerned.

Fraud means an intentional deception or misrepresentation by a person or an entity, with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes Fraud under applicable civil and/or criminal federal or state law.

Frontier means the following counties in New Mexico: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola.

FTE means full-time equivalent.

FTP means file transfer protocol.

Go-Live means the date on which the CONTRACTOR assumes responsibility for the provision of Covered Services to Members. As of the date of this Agreement, the Go-Live date is January 1, 2019.

Grievant means a Member, a Member's representative or provider who files a grievance with the CONTRACTOR.

Grievance means an expression of dissatisfaction about any matter or aspect of the CONTRACTOR or its operation, other than a CONTRACTOR Adverse Benefit Determination.

Habilitation Services and Devices means services and devices designed to help achieve maximum independence for members 18 years and older who are assessed to need daily support or supervision with the acquisition, retention, or improvement of skills related to living in the community and to prevent institutionalization or residential type services. Habilitation services and devices should ensure the member's health and safety while providing the opportunity to live in a typical family setting. Family living is intended to increase and promote independence and

to provide the skills necessary to prepare the member to live on their own in a non-residential setting.

HCBS means home and community-based services.

Health Care Acquired Condition (HCAC) means a medical condition with which an individual was diagnosed that could be identified by a secondary diagnostic code described in Section 1886(d)(4)(D)(iv) of the Social Security Act (other than deep vein thrombosis or pulmonary embolism following total knee replacement or hip replacement surgery in pediatric and obstetric patients).

Health Education means programs, services or promotions that are designed or intended to inform the CONTRACTOR's existing or potential Members about issues related to healthy lifestyles, situations that affect or influence health status, or methods or modes of medical treatment.

Health Home means an individual provider, team of health care professionals or health team that meets all federal requirements and provides the following six services to persons with one or more specified chronic conditions: (i) comprehensive care management; (ii) Care Coordination and health promotion; (iii) comprehensive transitional care/follow-up; (iv) patient and family support; (v) referral to community and social support services; and (vi) use of Health Information Technology (HIT) to link services, if applicable.

Health Information Exchange (HIE) means the transmission of health-care-related data among facilities, health information organizations and government agencies according to national standards. HIE is also an entity that provides services to enable the electronic sharing of health information.

Health Information Technology (HIT) means the area of information technology involving the design, development, creation, use and maintenance of information systems for the health care industry.

Health Insurance means insurance that covers the whole or a part of the risk of a person incurring medical expenses, spreading the risk over a large number of persons.

Health Literacy means the degree to which Members are able to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Healthcare Effectiveness Data and Information Set (HEDIS) means the tool used by health plans to measure performance of certain health care criteria developed by the National Committee for Quality Assurance.

Health Risk Assessment (HRA) means the HSD approved and standardized health screening questionnaire, used by the CONTRACTOR to provide individual Members with an evaluation of their health risks and identification of their current health needs.

Healthy Dual means a Member who is eligible for full Medicaid and Medicare and is not accessing Long-Term Care.

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.

HIPF means Health Insurance Providers Fee.

HITECH Act means the Health Information Technology for Economic and Clinical Health Act of 2009; 42 U.S.C. 17931, et seq.

HSD means the New Mexico Human Service Department or its designee.

Home Health Care means medically necessary health services furnished to members, including home health services described in 42 C.F.R. § 484 and 42 C.F.R. § 440.70.

Home Visiting is a pilot project in HSD-designated counties to provide Medicaid-reimbursable services for certain prenatal and post-natal care to eligible pregnant women.

Hospice Services means palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill Medicaid recipients and their families.

Hospitalization means the period of stay in a hospital that is twenty-four (24) hours or longer.

Hospital Outpatient Care means medical or surgical care that does not include an overnight hospital stay as described in NMAC 8.311.2.14.

IADL means instrumental activities of daily living.

Independent Consumer Supports System (ICSS) means a system established by HSD, that operates independently from the Centennial Care MCOs, that assists Members to understanding and navigate the managed care environment and to resolve problems regarding services, coverages, access and rights.

Indian Health Service (IHS) means the division of the United States Department of Health and Human Services responsible for providing health services to Native Americans.

In Lieu of Services or Settings means alternative services or services in settings that are not Covered Services, but are medically appropriate and cost-effective substitutes for Covered Services.

Institution for Mental Disease (IMD) shall have the same definition as found in 42 C.F.R. § 435.1010 for purposes of the Agreement – an inpatient or residential facility of more than 16 beds that specializes in psychiatric care. Medicaid funds are not available to these facilities for Members between the ages of 22 and 64. Specifically, Title XIX of the Social Security Act restricts Medicaid reimbursements to Institutions for Mental Diseases (IMD) [42USC 1396d].

I/T/U means the Indian Health Service, Tribal health Providers and Urban Indian Providers, including facilities that are operated by a Native American/Alaskan Indian tribe, authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

JUST Health means Justice-Involved Utilization of State Transitioned Healthcare. Under the JUST Health automated system, Medicaid eligibility is retained but suspended for justice-involved individuals in jails, prisons and juvenile detention facilities. Upon the release from incarceration/juvenile detention facilities certified and/or operated by CYFD, their full Medicaid benefits are reinstated.

Key Personnel refers to those positions listed in Section 3.3.3 of this Agreement.

Kinship Support means assistance provided to relative and kinship caregivers to help obtain case management, behavioral/medical health services, educational support, financial assistance, legal advocacy; and other services in an effort to increase stability in the family setting, allow children to remain connected to their families and culture, and reduce long term effects of childhood trauma.

Legacy CONTRACTOR means a Centennial Care CONTRACTOR who provided Medicaid Covered Services January 1, 2014 through December 31, 2018.

Limited English Proficiency (LEP) means the restricted ability to read, speak, write or understand English by individuals who do not speak English as their primary language.

Long-Term Care is the overarching term that refers to the Community Benefit, the services of a Nursing Facility and the services of an institutional facility.

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

Major Subcontractor means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services under the Agreement.

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

Marketing means any communication from a CONTRACTOR to individuals, who are not enrolled with the CONTRACTOR, that can reasonably be interpreted as intended to influence a Recipient or potential Member to enroll in that particular CONTRACTOR’s MCO and not to enroll in (or to disenroll from) another MCO.

Marketing Materials means materials that are produced in any medium, by or on behalf of the CONTRACTOR that can reasonably be interpreted as intended to market to a Recipient or potential Member.

Medically Fragile 1915(c) Waiver means the State of New Mexico's Medicaid home and community-based waiver program for the medically fragile, authorized by CMS pursuant to Section 1915(c) of the Social Security Act and/or classified by category of eligibility code "095".

Medically Frail means an Adult Member who would be covered under the Alternative Benefit Plan (ABP) but who has been determined as meeting HSD's definitions and criteria for the following conditions: (i) disabling mental disorder, including individuals up to age 21 with serious emotional disturbances and adults with serious mental illness; (ii) a chronic substance use disorder; (iii) a serious and complex medical condition as defined by HSD in Section 13 of the Policy Manual; (iv) a physical, intellectual or developmental disability that significantly impairs the Member's ability to perform one or more activities of daily living; or (v) a disability determination based on Social Security criteria.

Medically Necessary means physical, behavioral health, and long-term services and supports, and supplies, that: (i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain or regain the Member's optimal functional capacity; (ii) are delivered in the amount, duration, scope and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, behavioral health, and long-term care needs of the Member; (iii) are provided within professionally accepted standards of practice and national guidelines; (iv) are required to meet the physical, behavioral health, and long-term care needs of the Member and are not primarily for the convenience of the Member, the provider, or the CONTRACTOR; and (v) are reasonably expected to achieve appropriate growth and development as directed by HSD.

Member means a person who has been determined eligible for Centennial Care and who has enrolled in the CONTRACTOR's MCO.

Member Advisory Board shall have the meaning ascribed to such term in Section 4.12.2 of this Agreement.

Member Materials shall have the meaning ascribed to such term in Section 4.14 of this Agreement.

Member Rewards – The Member rewards program provides incentives to Centennial Care Members for participating in State-defined activities that promote healthy behaviors. A Member who participates in a State-defined activity that promotes healthy behaviors earns credits that are applied to a Member's account, which will be managed by the MCO. Earned credits may be used for health-related expenditures as approved under the Member Rewards program as further explained in Section 4.22.

Member Satisfaction Survey shall have the meaning ascribed to such term in Section 4.12.5 of this Agreement.

MFEAD means the Medicaid Fraud & Elder Abuse Division of the New Mexico Attorney General's Office.

MHSIP means the Mental Health Statistics Improvement Program.

Mi Via 1915(c) Waiver means a self-directed Medicaid home- and community-based waiver program for individuals with developmental disabilities and/or individuals who are Medically Fragile.

Minimum Data Set (MDS) means the standardized uniform comprehensive needs assessment of all residents in Medicare- or Medicaid-certified facilities, mandated by federal law (P.L.100-203) to be completed and electronically transmitted to the State. The MDS identifies potential resident problems, strengths and preferences.

MMIS means Medicaid Management Information System.

Native American Advisory Board (NAAB) means the New Mexico Tribes membership appointed board that meets quarterly and provides feedback to all Centennial Care MCOs on issues related to program services delivery and operations.

NCPDP means the National Council of Prescription Drug Programs.

Network means a group of doctors, hospitals, pharmacies, and other health care providers contracted directly or indirectly with a health plan to furnish covered services to its members.

New Mexico Medical Insurance Pool means the medical insurance pool created pursuant to NMSA 1978, 59A-54-1 et seq.

NMSA means New Mexico Statutes Annotated.

Non-Contract Provider means an individual provider, clinic, group, association or facility that provides Covered Services and that does not have a provider agreement with the CONTRACTOR.

Non-Medicaid Contractor means an entity contracting with a State Agency to provide medical and behavioral health services with the use of non-Medicaid funds.

Non-participating Provider means a provider that is either actively enrolled with HSD, through an approved provider participation agreement, or that has been registered with HSD by the CONTRACTOR for providing services to its members but is not in the CONTRACTOR's network.

Non-Preferred Drug means a non-covered drug, that may include both brand-name and generic drugs considered as non-formulary (also called a "Non-Preferred Drug") and is not included on a Preferred Drug List (PDL).

Non-Quantitative Treatment Limits (NQTLs) NQTLs are limitations on benefits or services that are not expressed numerically, but otherwise limit the scope or duration of benefits.

Not Otherwise Medicaid Eligible refers to individuals not eligible for Medicaid services under New Mexico's Medicaid State Plan.

Nursing Facility (NF) means a licensed Medicare/Medicaid facility certified in accordance with 42 C.F.R. § 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.

Nursing Facility Level of Care (NF LOC) means the Member's functional level is such that 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 assisted. A Member must meet the NF LOC to be eligible for nursing facility placement and community benefit services.

Other Adult Group means the category of Medicaid eligibility authorized in the Patient Protection and Affordable Care Act that covers low-income parents and childless adults between 19-64 years of age with income up to 133 percent of the federal poverty level as determined through the Modified Adjusted Gross Income test.

Other Provider Preventable Conditions (OPPCs) means other provider preventable conditions that include the following three Medicare national coverage determinations: (i) wrong surgical or other invasive procedure performed on a patient; (ii) surgical or other invasive procedure performed on the wrong body part; and (iii) surgical or other invasive procedure performed on the wrong patient.

Otherwise Medicaid Eligible refers to individuals who are eligible for Medicaid services under New Mexico’s Medicaid State Plan.

Overpayment means any funds that a person or entity receives in excess of the Medicaid allowable amount or the CONTRACTOR's allowed amount as negotiated with the Contract Provider or to which the Contract Provider is not entitled under Title XIX of the Act or any payment to the CONTRACTOR by the State to which the CONTRACTOR is not entitled under Title XIX of the Act. Overpayments shall not include funds that have been: (i) subject to a payment suspension; (ii) identified as a third-party liability as set forth in Section 4.18.11; (iii) subject to the CONTRACTOR's system-directed mass adjustments, such as due to fee schedule changes; or (iv) for purposes of filing an "Overpayment Report" as required in Section 4.17.4.2.1, less than fifty dollars ($50.00) or those funds recoverable through existing routine and customary adjustments using HIPAA compliant formats.

Outreach means, among other things, educating or informing the CONTRACTOR’s Members about Centennial Care, managed care and health issues.

Participating Provider means a provider that is actively enrolled with HSD, through an approved provider participation agreement, and is in the CONTRACTOR's network.

Pass-Through Pricing means the Pharmacy Benefit Manager charges the CONTRACTOR the amount paid to the pharmacy for a prescription drug including a dispensing fee and an administrative fee.

Patient-Centered Medical Home (PCMH) means a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.

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).

Personal Care Services (PCS) means those services established by HSD to assist individuals twenty-one (21) years of age or older who are eligible for full Medicaid coverage and meet the level of care criteria as defined by policy. PCS are provided to a Member unable to perform a range of activities of daily living and instrumental activities of daily living.

Physician Services means services provided by an individual licensed under state law to practice medicine or osteopathy.

PIPs mean performance improvement projects consistent with 42 C.F.R. § 438.330.

Plan means the scope, terms and/or condition(s) of coverage including any limitation(s) associated with the provision of the service. Plan may also refer to the Medicaid CONTRACTOR that provides Medicaid Covered Services to enrolled Centennial Care Members.

PM means a performance measure, as further explained in Section 4.12.8 of this Agreement.

Post-Stabilization Services means Covered Services relating to an Emergency Medical Condition, provided after a Member is stabilized, to maintain the stabilized condition or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Member's condition.

Pre-Admission Screening and Resident Review (PASRR) is governed by 42 C.F.R. § 483.100 through 483.138 for all individuals with mental illness or intellectual disability who apply to, or reside in, Medicaid certified Nursing Facilities. PASRR aims to determine if a resident is appropriately placed in the least restrictive environment and whether the individual can be appropriately served in the Nursing Facility, including provision of required mental illness/intellectual disability services.

Preauthorization means MCO approval necessary prior to the receipt of care. May also be referred to as prior authorization, prior approval, or precertification.

Preferred Drug means a covered drug on the health plan formulary (also called a "Preferred Drug List or PDL") that may include brand-name and/or generic drugs.

Preferred Vendor means a Major Subcontractor who provides or arranges for the delivery of a substantial portion of a Covered Service(s) to the CONTRACTOR's membership.

Premium means an amount to be paid to the CONTRACTOR by a Member for a specified period of time for Covered Services.

Prescription drug coverage means health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs means drugs and medications that, by law, require a prescription.

Primary Care means all health care and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the HSD, to the extent the furnishing of those services is legally authorized in the State in which the services are furnished.

Primary Care Physician or Primary Care Provider (PCP) means, an individual who is a Contract Provider and 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, as further described in Section 4.8.4 of this Agreement.

Project ECHO means the Extension for Community Healthcare Outcomes, conducted by the University Of New Mexico School of Medicine. The program works to develop the capacity to

safely and effectively treat chronic, common and complex diseases in Rural and underserved areas and to monitor the outcomes of this treatment.

Prospective Payment System (PPS) means a method of reimbursement in which payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service – for example, diagnosis-related groups for inpatient hospital services.

Provider means an institution, facility, agency, physician, health care practitioner, or other entity that is licensed or otherwise authorized to provide any of the Covered Services in the state in which they are furnished. Providers include individuals and vendors providing services to Members through the Self-Directed Community Benefit.

Provider Preventable Conditions (PPC) means a condition that meets the definition of Health Care Acquired Conditions or Other Provider Preventable Conditions.

Provider Satisfaction Survey shall have the meaning ascribed to such term in Section 4.12.6 of this Agreement.

Provider Workgroup means the workgroup consisting of representatives from each Centennial Care MCO, HSD, the Collaborative and Providers to work collaboratively to reduce administrative burdens on Providers by, among other things, standardizing forms and processes.

Psychotropic Drugs and Medications means the therapeutic classes of drugs and the medications listed in Attachment 8 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

QM/QI means quality management and quality improvement.

Quantitative Treatment Limits (QTL) Numerical limits on benefits or services based on frequency of treatment, number of days, days of coverage, days in a waiting period or similar limits on treatment scope or duration.

RAC means the Medicaid Recovery Audit Contractor.

Rate Cohort means and is the basis for the Capitation Rates and Capitation Payments specific to population(s) and/or Covered Services.

Recipient means an individual who is eligible for Centennial Care but has not yet enrolled in a Centennial Care MCO.

Rehabilitation services and devices means services or devices ordered by a provider to help members recover from an illness or injury.

Representative means a person who has the legal right to make decisions regarding a Member's protected health information and includes surrogate decision makers, parents of un-emancipated minors, guardians and treatment guardians and agents designated pursuant to a power of attorney for health care.

Request for Proposals (RFP) means the request for proposals issued by the State on September 1, 2017, RFP No. 18-630-8000-0001.

Retroactive Period means the period of time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date to include these situations: (i) a Member enrolled with the CONTRACTOR who has not previously been enrolled with the CONTRACTOR in the Centennial Care Program or (ii) a Member that was previously enrolled with the CONTRACTOR whose period of ineligibility or disenrollment exceeds three months. The Retroactive Period includes the full month in which enrollment notification is received by the CONTRACTOR. The Retroactive Period does not include newborns, as described in the enrollment Section 4.2 of this Agreement, and does not include Members who are established with the CONTRACTOR and whose subsequent disenrollment and retroactive re-enrollment results in no gap in coverage.

Risk Contract means the Agreement between HSD and the CONTRACTOR under which the CONTRACTOR assumes risk for the cost of Covered Services and incurs loss if the cost of furnishing services exceeds the payments under the Agreement.

RTC means residential treatment center.

Rural refers to the counties in the State that are not Frontier or Urban.

Rural Health Clinic (RHC) means a public or private hospital, clinic or physician practice designated by the federal government as complying with the Rural Health Clinics Act, Public Law 95-210.

SAMHSA means the Substance Abuse and Mental Health Services Administration.

School-Based Health Centers (SBHCs) means outpatient clinics on school campuses that provide on-site primary, preventive and Behavioral Health services to students while reducing lost school time, removing barriers to care, promoting family involvement and advancing the health and educational success of school-age children and adolescents.

Self-Directed Community Benefit means certain Home and Community-Based Services that are available to Members meeting nursing facility level of care. A list of the services available in the Self-Directed Community Benefit is included in Attachment 2.

SED means serious emotional disturbance.

Setting of Care (SOC) identifies the various settings in which a Member receives Long-Term Care services.

Shared Functions Model allows for partner Providers, agencies and/or organizations to perform some Care Coordination activities while the MCO retains other Care Coordination functions.

Short Term Medicaid for Incarcerated/Committed Individuals (STMII) means the Covered Services available to inmates or committed/detained youth, while the inmate's or committed/detained youth's Medicaid benefits are suspended. Covered Services include inpatient short-term hospital stays of 24 hours or more. Only State or County correctional facilities that are contracted with HSD to participate in the STMII program are eligible to submit Claims for Fee-for-Service (FFS) Medicaid reimbursement.

Skilled Nursing Care means a level of care that includes services that can only be performed by a licensed registered or practical nurse.

SMI means serious mental illness.

Social Security Administration Death Master File-Death Master File (DMF) from the Social Security Administration (SSA) is an electronic database that contains records of Social Security Numbers (SSN) assigned to individuals since 1936, and includes, if available, the deceased individual's SSN, first name, middle name, surname, date of birth, and date of death.

Sole Source Provider means a Contract Provider who, alone, can furnish one or more types of Covered Services to the Member(s).

Specialist means a provider who specializes in treating certain parts of the body, certain health problems, or certain age groups.

Spread Pricing means the Pharmacy Benefit Manager charges the CONTRACTOR an agreed upon unit price amount for prescriptions which may differ from what is paid to the pharmacy.

Steady State means the remainder of the Agreement term after the Transition Period.

Subcontractor means an entity with which the CONTRACTOR has, or intends to have, an executed agreement to perform any functions required under the Agreement and does not include a Provider or Contract Provider.

Substance Use Disorder (SUD) Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, tobacco, and/or other drugs despite significant related problems.

Substantially All Drugs "Substantially all" drugs means that all drugs and unique dosage forms in these categories are expected to be included in the CONTRACTOR's formulary with the following exceptions: multi-source brands of the identical molecular structure; extended release products with the immediate-release product is included; products that have the same active ingredient or moiety; and dosage forms that do not provide a unique route of administration (e.g., tablets, capsules versus tablets and transdermals).

Support Broker (SB) means an individual who provides support to SDCB members and assists the member (or the member's family or representative, as appropriate) in arranging for, directing and managing SDCB services and supports as well as developing, implementing and monitoring

the SDCB care plan and budget. Individual support brokers work for MCO-approved support broker agencies or may be directly employed by a MCO.

TDD/TTY are telecommunications devices for the deaf and/or telephone typewriter or teletypewriter devices for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. The CONTRACTOR provides a separate phone number for receiving TDD/TTY messages or uses the State/711 Relay Services.

Telemedicine means the use of electronic information, imaging and communication technologies (including interactive audio, video and data communications as well as store-and-forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.

TFC means treatment foster care.

Third-Party Software means software that is developed for general commercial use, available to the public or not developed for HSD. Third-Party Software includes, without limitation, commercial off-the-shelf software, operating system software and application software, tools and utilities.

Transition Period means the period from Go-Live to Steady State. As of the date of this Agreement, the Transition Period is anticipated to be one (1) year.

Treat First Model the Treat First model means a clinical practice approach that is used to achieve immediate formation of a therapeutic relationship while gathering needed historical assessment and treatment planning information over the course of four therapeutic Encounters.

Treatment Limitations means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. § 438, Subpart K, limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations (QTLs), which are expressed numerically (such as 50 outpatient visits per year), and non-quantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of

benefits for treatment under a plan or coverage. (See 42 C.F.R. § 438.910(d)(2) for an illustrative list of NQTLs)

Tribal means of or denoting an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. § 479 a located wholly or partially in the State of New Mexico.

Tribal 638 Facility means a Tribal facility authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act, 25 U.S.C. 450 et seq.

Urban means the following counties in New Mexico: Bernalillo, Los Alamos, Santa Fe and Doña Ana.

Urban Indian shall have the meaning ascribed to such term in 25 U.S.C. § 1603.

Urgent Care means a category of walk-in clinics focused on the delivery of ambulatory care based on the scope of conditions treated in a medical facility outside of a traditional emergency room. Urgent Care treats conditions serious enough to warrant same-day care, but not severe enough to require emergency room care.

Utilization Management (UM) means a system for reviewing the appropriate and efficient allocation of health care services that are provided, or proposed to be provided, to a Member.

Value Added Service means any service offered by the CONTRACTOR that is not a Medicaid covered benfit under this Agreement or provided in lieu of the CONTRACTOR offered service or setting.

Value-Based Purchasing (VBP) means payment arrangements with Providers that shift FFS reimbursement toward payment methodologies that reward value or improved quality of care outcomes, including but not limited to Primary Care incentives, performance-based contracts, or risk contracts such as bundled/episode payments, shared savings and shared risk, global Capitation Payments, or any other payment arrangement that HSD approves as a value-based purchasing model.

Warm Transfer means a telecommunications mechanism in which the person answering the call facilitates the transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

Waste means the overutilization of services or other practices that result in unnecessary costs.

Acronyms list:

ABA—Applied Behavioral Analysis

ABP—Alternative Benefit Plan

ACA—Affordable Care Act (Patient Protection and Affordable Care Act)

ACIP—Advisory Committee on Immunization Practices

ACT—Assertive Community Treatment

ADL—Activities of Daily Living

AHRQ—Agency for Healthcare Quality and Research

ARRA—American Recovery and Reinvestment Act

ARTC—Accredited Residential Treatment Center

BAA—Business Associate Agreement

BC-DR—Business Continuity and Disaster Recovery

BHH—Behavioral Health Home

BHPC—Behavioral Health Planning Council

BHS—Behavioral Health Services Division of CYFD

BMS—Behavioral Management Service

BP—Blood Pressure

CAHPS—Consumer Assessment of Healthcare Providers and Systems

CBMA—Community Benefits Member Agreement

CBSQ—Community Benefits Services Questionnaire

CNA—Comprehensive Needs Assessment

CAP—Corrective Action Plan

CAS—Claims Adjustment Code identifying the detailed reason the adjustment was made

CCC—Children with Chronic Conditions

CCL—Care Coordination Level

CCP—Comprehensive Care Plan

CCSS—Comprehensive Community Support Services

CD—Compact Disc

CDD—Center for Development & Disability

CEO—Chief Executive Officer

CFDA—Catalog of Federal Domestic Assistance

CFO—Chief Financial Officer

C.F.R.—Code of Federal Regulations

CHW—Community Health Worker

CHR—Community Health Representative

CIO—Chief Information Officer

CLIA—Clinical Laboratory Improvement Amendments

CLNM—CareLink NM (New Mexico's Health Home)

CMHC—Community Mental Health Center

CMMI—Center for Medicare and Medicaid Innovation

CMO—Chief Medical Officer

CMS—Centers for Medicare & Medicaid Services

CNP—Certified Nurse Practitioner

CNS—Clinical Nurse Specialist

COBA—Coordination of Benefits Agreement

CPT—Current Procedural Terminology

CSA—Core Service Agencies

CY—Calendar Year

CYFD—New Mexico Children, Youth and Families Department

DCAP—Directed Corrective Action Plan

DD—Developmental Disability

DM—Disease Management

DME—Durable Medical Equipment

DMZ—DMZ is short for DeMilitarized Zone and is software/web page for the transmission and storage of data.

DOH—New Mexico Department of Health

DSM—Diagnostic and Statistical Manual of Mental Disorders

D-SNP—Dual Eligible Special Needs Plans

DSIPT—Delivery System Improvement Performance Target

DUR—Drug Utilization Review

DWI—Driving While Intoxicated

ECHO—Extension for Community Healthcare Outcomes

EDI—Electronic Data Interchange

EEO—Equal Employment Opportunity

EHR—Electronic Health Record

ENT—Ear, Nose, Throat

EOR—Employer of Record

EPLS—Excluded Parties List System

EPSDT—Early and Periodic Screening, Diagnostic and Treatment

EQR—External Quality Review

EQRO—External Quality Review Organization

ER—Emergency Room

FAQ—Frequently Asked Question

FDA—U.S. Food and Drug Administration

FDIC—Federal Deposit Insurance Corporation

FEIN—Federal Employer Identification Number

FEMA—Federal Emergency Management Agency

FFS—Fee-for-Service

FICA—Federal Insurance Contributions Act

FMA—Fiscal Management Agency

FQHC—Federally Qualified Health Center

FS—Family Services

FTE—Full-time Equivalent

FTP—File Transfer Protocol

FUTA—Federal Unemployment Tax Act

GH—Group Home

HCAC—Health Care Acquired Condition

HCBS—Home and Community-Based Service

HCPCS—Healthcare Common Procedure Coding System

HCSC—Health Care Service Corporation

HEDIS—Healthcare Effectiveness Data and Information Set

HIE—Health Information Exchange

HIPAA—Health Insurance Portability and Accountability Act

HITECH Act—Health Information Technology for Economic and Clinical Health Act

HIT—Health Information Technology

HIV—Human Immunodeficiency Virus

HIX—Health Insurance Exchange

HRA—Health Risk Assessment

HSD—New Mexico Human Services Department

HTN—Hypertension

I/T/U—Indian Health Service, Tribal health provider and Urban Indian provider

IADL—Instrumental Activities of Daily Living

ICD-10—International Classification of Diseases, Tenth Edition

ICD-9—International Classification of Diseases, Ninth Edition

ICSS—Independent Consumer Supports System

ICWA—Indian Child Welfare Act

ID—Identification

IEP—Individualized Education Plan

IHS—Indian Health Service

IOP—Intensive Outpatient Program

IPF—Inpatient Psychiatric Facility/Unit

IPoC—Individualized Plan of Care

IPRA—Inspection of Public Records Act

IRS—Internal Revenue Service

ISP—Individual Service Plan

IT—Information Technology

IV—Intravenous

JJS—Juvenile Justice Services

JUST Health—Justice-Involved Utilization of State Transitions Healthcare

LEIE—List of Excluded Individuals/Entities

LEP—Limited English Proficiency

LISW—Licensed Independent Social Worker

LMFT—Licensed Marriage and Family Therapist

LPCC—Licensed Professional Clinical Counselor

LTC—Long-Term Care

LTSS—Long-Term Services and Supports

MAD—Medical Assistance Division

MCO—Managed Care Organization

MD—Doctor of Medicine

MDS—Minimum Data Set

MDT—Multi-Disciplinary Team

MFEAD—New Mexico Medicaid Fraud & Elder Abuse Division

MHSIP—Mental Health Statistics Improvement Project

MIC—Medicaid Integrity Contractor

MIS—Management Information System

MITA—Medicaid Information Technology Architecture

MMIS—Medicaid Management Information System

MMIS-R—Medicaid Management Information System Replacement

MST—Multi-Systematic Therapy

NCPDP—National Council of Prescription Drug Programs

NCQA—National Committee for Quality Assurance

NF—Nursing Facility

NF LOC—Nursing Facility Level of Care

NMAC—New Mexico Administrative Code

NMHIC—New Mexico Health Information Collaborative

NMMIP—New Mexico Medical Insurance Pool

NMSA—New Mexico Statute Annotated

NOME—Not Otherwise Medicaid Eligible

NPI—National Provider Identifier

NPPES—National Plan and Provider Enumeration System

NQMC—National Quality Measures Clearinghouse

NQTLs—Non-Quantitative Treatment Limits

OB-GYN—Obstetrics and Gynecology

OIG—Office of Inspector General

OMB—Office of Management and Budget

OPPC—Other Provider Preventable Condition

PASRR—Pre-Admission Screening and Resident Review

PCMH—Patient-Centered Medical Home

PCP—Primary Care Physician/ Primary Care Provider

PCS—Personal Care Service

PDL—Preferred Drug List

PHH—Physical Health Home

PHI—Protected Health Information

PIP—Performance Improvement Project

PL—Public Law

PM—Performance Measure

PMPM—Per-Member Per-Month

PPACA—Patient Protection and Affordable Care Act

PPC—Provider Preventable Condition

PPS—Prospective Payment System

PS—Protective Services

PSC—Professional Services Contract

PSR—Psychosocial Rehabilitation

Q1—First Quarter

Q2—Second Quarter

Q3—Third Quarter

Q4—Fourth Quarter

QM/QI—Quality Management/ Quality Improvement

QTLs—Quantitative Treatment Limits

RAC—Recovery Audit Contractor

RFP—Request for Proposal

RHC—Rural Health Clinic

RN—Registered Nurse

RTC—Residential Treatment Center

SAMHSA—Substance Abuse and Mental Health Services Administration

SB—Support Broker

SBHC—School-Based Health Center

SDCB—Self-Directed Community Benefit

SED—Serious Emotional Disturbance

SFY—State Fiscal Year

SMI—Serious Mental Illness

SNP—Special Needs Plan

SOE—Summary of Evidence

SSN—Social Security Number

SSRI—Selective Serotonin Reuptake Inhibitor

STMII—Short Term Medicaid for Incarcerated Individuals

SUD—Substance Use Disorder

TBD—To Be Determined

TCN—Transaction Control Number

TDD—Text Telephone

TDM—Team Decision Making

TFC—Treatment for Foster Care

TM—Tracking Measure

TPL—Third Party Liability

TTY—Telecommunication Device for the Deaf

UM—Utilization Management

UNM/CDD—University of New Mexico Center for Development and Disability

UNM—University of New Mexico

USC—United States Code

VBP—Value-Based Purchasing

VPN—Virtual Private Network

WIC—Supplemental Food Program for Women, Infants and Children

YTD—Year-to-Date

3 CONTRACTOR's Administrative Requirements

3.1 Requirements Prior to Operation

3.1.1 Licensure and Accreditation

The CONTRACTOR must have the appropriate licenses in the State to do risk-based contracting through a managed care network of Providers as provided for in the New Mexico Insurance Code, NMSA 1978, Chapter 59A et seq., valid at least six (6) months prior to the Go-Live date.

3.1.1.1 The CONTRACTOR shall be either: (i) National Committee for Quality Assurance (NCQA) accredited in the State of New Mexico or (ii) accredited in another state where the CONTRACTOR currently provides Medicaid services and initiates the NCQA accreditation process for the State of New Mexico upon notice of award and achieves New Mexico NCQA accreditation within one (1) year from Go-Live. The CONTRACTOR shall provide HSD the current and each reoccurring NCQA accreditation award letter, the Accreditation Certificate, Accreditation Summary Report and the HEDIS Score Sheet within thirty (30) Calendar Days of receipt.

3.1.1.2 To the extent the CONTRACTOR is in active pursuit of NCQA accreditation in the State of New Mexico, HSD reserves the right to request additional information regarding the CONTRACTOR's progress in achieving NCQA accreditation in New Mexico.

3.1.1.3 Failure to meet the accreditation requirements in this Section and/or failure to maintain accreditation throughout the term of this Agreement shall be considered a breach of this Agreement and may be subject to remedies for violation of, breach of, or noncompliance with Contract as described in Section 7.6 of this Agreement.

3.1.2 Readiness Period

The CONTRACTOR shall participate in a readiness review period beginning upon signature of this Agreement by all parties and through December 2018. The

CONTRACTOR must obtain HSD approval of all readiness elements prior to January 1, 2019.

3.1.2.1 The CONTRACTOR shall cooperate in readiness reviews conducted by HSD at dates and times to be determined by HSD to review the CONTRACTOR's readiness to begin operations. These reviews may include, but are not limited to, desk and on-site reviews of documents provided by the CONTRACTOR, walk-through(s) of the CONTRACTOR's operations, system demonstrations and interviews with the CONTRACTOR's staff.

3.1.2.2 The CONTRACTOR shall submit policies and procedures and other deliverables specified by HSD in accordance with Attachment 1. The CONTRACTOR shall make any changes requested by HSD to policies and procedures or other deliverables in the time frames specified by HSD.

3.1.2.3 Based on the results of the readiness review activities, HSD will issue a letter of findings and, if needed, will request an internal action plan or require a DCAP. Members may not be enrolled with the CONTRACTOR until HSD has determined that the CONTRACTOR is able to meet the requirements of this Agreement.

3.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Agreement, as determined by HSD, within the time frames specified by HSD, HSD may terminate this Agreement in accordance with Section 7.6 of this Agreement. If the Agreement is terminated in accordance with this Section 3.1.2.4, HSD shall not make any payments to the CONTRACTOR and shall have no liability for any costs incurred by the CONTRACTOR.

3.2 **General Requirements**

3.2.1 Transition Management Agreement

3.2.1.1 Immediately upon award notification of Centennial Care 2.0, a CONTRACTOR new to Centennial Care will be required to enter into a Transition Management Agreement with HSD.

3.2.1.2 For a new CONTRACTOR, the Transition Management Agreement shall be signed at the time of the notification of award.

3.2.1.3 The CONTRACTOR agrees to comply with all of the requirements within the Transition Management Agreement.

3.3 **Personnel Requirements**

3.3.1 Staffing Generally

3.3.1.1 The CONTRACTOR must notify HSD within ten (10) Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all requirements of this Agreement. If HSD determines that a satisfactory working relationship cannot be established between certain Key Personnel and HSD, it will notify the CONTRACTOR in writing. Upon receipt of HSD's notice, HSD and the CONTRACTOR will attempt to resolve HSD's concerns on a mutually agreeable basis.

3.3.1.2 The CONTRACTOR may not have an employment, consulting or other agreement with a person who has been convicted of a crime specified in Sections 1128 or 1128A of the Social Security Act for the provisions of items and services that are significant and material to the CONTRACTOR's obligations under this Agreement.

3.3.1.3 The CONTRACTOR must notify HSD within ten (10) Business Days of any change in Personnel that participates on HSD initiated Workgroups and/or Committees.

3.3.2 Minimum Key Staff Positions

The CONTRACTOR must designate key management and technical personnel who will be assigned to perform under this Agreement. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas (as opposed to multiple persons equaling a full-time equivalent). All Key Personnel shall reside in the State of New Mexico.

3.3.3 The CONTRACTOR's Key Personnel

The CONTRACTOR shall, at a minimum, employ the following Key Personnel:

3.3.3.1 A qualified individual to serve as the Chief Executive Officer (CEO). Such CEO must be employed full-time by the CONTRACTOR, must be primarily dedicated and must hold a senior executive or management position in the CONTRACTOR's organization, except that the CONTRACTOR may propose an alternative structure for the CEO position, subject to HSD's prior written approval. The CEO must be authorized and empowered to represent the CONTRACTOR regarding all matters pertaining to this Agreement;

3.3.3.2 A Chief Medical Officer/Medical Director (CMO) dedicated to this Agreement who is licensed to practice medicine in the State of New Mexico. The CMO, or his or her designee, must be available by telephone twenty-four (24) hours a day, seven days a week, for UM decisions;

3.3.3.3 A full-time senior executive dedicated to this Agreement who is a board-certified psychiatrist in the State of New Mexico and has at least five years of combined experience in mental health and substance abuse services. This person shall have or acquire specialized education or experience related to standards of care for children. This person shall oversee and be responsible for all Behavioral Health activities and take an active role in the CONTRACTOR's medical management team and in clinical and policy decisions;

3.3.3.4 A full-time senior executive dedicated to this Agreement who has at least five years of experience administering managed LTC programs. On a case-by-case basis, equivalent experience in administering LTC programs and services, including HCBS, or in managed care may be substituted, subject to HSD's prior approval. This person shall oversee and be responsible for all long- term care activities;

3.3.3.5 A full-time Chief Financial Officer (CFO) dedicated to this Agreement. The CFO is responsible for accounting and finance operations, including all audit activities;

3.3.3.6 A full-time Contract Manager dedicated to this Agreement; see Section 3.3.4 of this Agreement;

3.3.3.7 A full-time Compliance Officer, who shall lead a compliance committee that is accountable to senior management in accordance with Section 4.17 of this Agreement;

3.3.3.8 A full-time Implementation Manager dedicated to this Agreement, who shall assist the CONTRACTOR in implementing Centennial Care as well as the transition from the CONTRACTOR's implementation team to regular ongoing operations. This person shall be on site in New Mexico from the start date of this Agreement through at least six (6) months after Go-Live;

3.3.3.9 A full-time Chief Information Officer (CIO), who shall oversee and be responsible for all of the CONTRACTOR's information systems functions supporting this Agreement;

3.3.3.10 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for provider services and provider relations, including all network management issues, provider payment issues and provider education. This staff person shall, among other things: (i) educate Providers regarding appropriate Claims submission requirements, coding updates, and electronic Claims transactions; (ii) interface with the CONTRACTOR's call center to compile, analyze, and disseminate information from provider calls; (iii) identify trends and guiding the development and implementation of strategies to improve provider satisfaction; and (iv) communicate with Providers to ensure effective exchange of information and gain feedback regarding the extent to which Providers are informed about appropriate Claims submission practices;

3.3.3.11 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Utilization Management activities, QM/QI activities and program integrity;

3.3.3.12 A full-time staff person dedicated to this Agreement with the education and experience such that the staff person has the skills and/or knowledge necessary to

work on Native American health disparity issues and Cultural Competence concerns related to Care Coordination, services and care delivery;

3.3.3.13 A minimum of four (4) full-time staff persons to work directly with I/T/Us and a minimum of two (2) full-time staff persons to work directly with I/T/Us for billing and Claims issues. One of these staff persons must be proficient in at least one (1) New Mexican Native American/pueblo language;

3.3.3.14 A full-time staff person dedicated to this Agreement who shall oversee Member services including, among others: (i) the Member services call center; and (ii) the CONTRACTOR's Health Literacy and Health Education efforts;

3.3.3.15 A full-time staff person dedicated to this Agreement who shall act as Claims administrator to, among other things: (i) develop and implement a Claims processing system capable of paying Claims in accordance with State and federal requirements; (ii) develop processes for cost avoidance; (iii) ensure minimization of Claim recoupments; and (iv) meet Encounter reporting requirements;

3.3.3.16 A full-time staff person dedicated to this Agreement who shall act as the Grievances and Appeals manager to manage Member and provider disputes arising under the CONTRACTOR's Grievances and Appeals systems including Member and provider Grievances, Appeals, requests for Fair Hearings and provider Claim disputes; and

3.3.3.17 A full-time staff person dedicated to this Agreement who shall, with a significant degree of independence from the CONTRACTOR's management, act as an Ombudsman whose duties include but are not limited to impartially investigating and addressing Member issues and attempting to resolve them within the CONTRACTOR's organization; and identifying systemic issues including, but not limited to, the Members' ability to access services, to receive prompt attention from care coordinators and other personnel and to understand their rights and responsibilities under Centennial Care. The Ombudsman shall represent the Member on internal Centennial Care issues and is separate and distinct from the CONTRACTOR's Grievance system and Appeals process, as prescribed in Section 4.16 of this Agreement. Upon hiring the Ombudsman, the

CONTRACTOR shall include in its notification to HSD where in the CONTRACTOR's organizational structure the Ombudsman is located in order to assure significant independence from plan management.

3.3.3.18 A Director of Pharmacy dedicated to this Agreement who is licensed to practice pharmacy in the State of New Mexico. The Director of Pharmacy, and his or her designee, must ensure compliance with all requirements specified by the federal and State statutes and regulations including the New Mexico Board of Pharmacy.

3.3.4 Contract Management

3.3.4.1 The CONTRACTOR shall employ a qualified individual to serve as the Contract Manager for this Agreement. The Contract Manager shall be dedicated to this Agreement, hold a senior management position in the CONTRACTOR's organization and be authorized and empowered to represent the CONTRACTOR on all matters pertaining to the CONTRACTOR's program and specifically this Agreement. The Contract Manager shall act as a liaison between the CONTRACTOR, HSD, the Collaborative and other State or federal agencies, as necessary and shall have responsibilities that include but are not limited to the following:

3.3.4.1.1 Ensuring the CONTRACTOR's compliance with the terms of this Agreement, including securing and coordinating resources necessary for such compliance;

3.3.4.1.2 Overseeing all activities by the CONTRACTOR and its Major Subcontractors and Subcontractors;

3.3.4.1.3 Receiving and responding to all inquiries and requests by HSD, or any State or federal agency, in time frames and formats reasonably acceptable to the Parties;

3.3.4.1.4 Meeting with representatives of HSD and other State agencies on a periodic or as-needed basis and resolving issues that arise;

3.3.4.1.5 Attending and participating in regular meetings with HSD and other State agencies and attending and participating in stakeholder meetings;

3.3.4.1.6 Making best efforts to promptly resolve any issues related to this Agreement identified by HSD, other State or federal agencies, or the CONTRACTOR;

3.3.4.1.7 Working cooperatively with other State of New Mexico contracting partners;

3.3.4.1.8 Working with, at the Collaborative's direction, the Behavioral Health Planning Council (BHPC) and local Behavioral Health Collaboratives; and

3.3.4.1.9 Working with the Non-Medicaid Contractor and/or the Behavioral Health Collaborative in identifying the overall Behavioral Health needs of Medicaid Members to coordinate and obtain non-Medicaid services for Medicaid Member, as appropriate. The CONTRACTOR shall develop and have mutually agreed upon policies and procedures with the Non-Medicaid CONTRACTOR addressing areas such as information sharing, billing procedures and the CONTACTOR's participation in non-Medicaid initiatives.

3.3.5 Staff Training

3.3.5.1 The CONTRACTOR shall provide regular and ongoing comprehensive training for CONTRACTOR staff to ensure that they understand the goals of Centennial Care 2.0, including the integration of physical, Long-Term Care and Behavioral Health, the provisions and limitations of the ABP and the requirements of this Agreement. As issues are identified by the CONTRACTOR and/or HSD, the CONTRACTOR shall provide timely and targeted training to staff.

3.3.5.2 The CONTRACTOR shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure compliance with this Agreement. Including targeted training regarding:

3.3.5.2.1 Care Coordination;

3.3.5.2.2 Nursing Facility Level of Care Determinations;

3.3.5.2.3 Setting of Care Submissions;

3.3.5.2.4 Community Benefit Services and Supplemental Questionnaire; and

3.3.5.2.5 Behavioral Health Services.

3.3.5.3 The CONTRACTOR shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided.

3.4 **Marketing Requirements**

3.4.1 The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of Marketing Materials that, among other things, include methods for quality control to ensure that Marketing Materials are accurate and do not mislead, confuse or defraud Recipients, Members or the State.

3.4.2 HSD shall review and approve the content, comprehension level and language(s) of all Marketing Materials directed at Members before use.

3.4.3 The CONTRACTOR shall distribute its Marketing Materials statewide.

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

3.4.5 The CONTRACTOR shall comply with all federal rules regarding Medicare-Advantage and Medicaid Marketing (42 C.F.R.s § 422 and § 438) and the CMS Medicare Marketing Guidelines found at:

https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf.

3.4.6 Marketing Activities Not Permitted Under This Agreement

The following Marketing activities are prohibited, regardless of the method of communication (verbal, written) or whether the activity is performed by the CONTRACTOR directly, or by its Contract Providers, Subcontractors, Major Subcontractors, agents, consultants or any other party affiliated with the CONTRACTOR:

3.4.6.1 Asserting or implying that a Recipient shall lose Medicaid benefits if he or she does not enroll with the CONTRACTOR or inaccurately depicting the consequences of choosing a different MCO;

3.4.6.2 Designing a Marketing plan that discourages or encourages MCO selection based on health status or risk;

3.4.6.3 Offering to or initiating an enrollment request on behalf of a Recipient;

3.4.6.4 Making inaccurate, false, materially misleading or exaggerated statements;

3.4.6.5 Asserting or implying that the CONTRACTOR offers unique Covered Services when another MCO provides the same or similar services. Explaining and offering Value Added Services in accordance with this Agreement is permitted;

3.4.6.6 Using gifts or incentives other than Value Added Services to entice people to join a specific MCO;

3.4.6.7 Directly or indirectly conducting door-to-door, telephonic, electronic or other Cold Call Marketing. The CONTRACTOR may send informational material regarding its benefit package to Recipients and potential Members;

3.4.6.8 Conducting any other Marketing activity prohibited by HSD during the term of this Agreement; and

3.4.6.9 Including statements that the CONTRACTOR is endorsed by CMS, the federal or State governments, or by a similar entity.

3.4.7 The CONTRACTOR shall take reasonable steps to prevent its Providers, Subcontractors, Major Subcontractors, agents, consultants, or any other party affiliated with the CONTRACTOR from committing the acts prohibited in this Section 3.4. The CONTRACTOR shall be held liable only if it knew or should have known that the delegated Marketing activities were performed in violation as described here in and failed to take timely corrective action.

3.4.8 HSD reserves the right to prohibit additional Marketing activities at its discretion.

3.4.9 Marketing Time frames

The CONTRACTOR may initiate Marketing activities at any time, subject to the requirements and limitations in this Agreement.

3.5 **Cultural and Linguistic Competence**

3.5.1 The CONTRACTOR shall develop and implement a Cultural Competence/Sensitivity Plan, through which the CONTRACTOR shall ensure that it provides culturally competent services to its Members, both directly and through its Contract Providers, Major Subcontractors and Subcontractors. The CONTRACTOR shall participate in HSD's efforts to promote the delivery of Covered Services in a culturally competent

manner to all Members, regardless of gender, sexual orientation or gender identity and including Members who have a hearing impairment, Limited English Proficiency, a speech or language disorder, physical disabilities, developmental disabilities, differential abilities and diverse cultural and ethnic backgrounds. The CONTRACTOR shall:

3.5.1.1 Develop a Cultural Competence/Sensitivity Plan that shall be submitted to HSD for approval, describing how the CONTRACTOR shall ensure that Covered Services provided to Members are culturally competent and including provisions for monitoring and evaluating disparities in membership, especially as related to historically and socially disadvantages Members;

3.5.1.2 Develop written policies and procedures ensuring that Covered Services provided to Members, both directly and through its Contract Providers and Major Subcontractors are Culturally Competent;

3.5.1.3 Target Cultural Competence training to Member service staff and Contract Providers, including PCPs, care coordinators, case managers, home health care MCO staff, and ensure that staff at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery;

3.5.1.4 Develop and implement a plan for interpretive services and written materials, consistent with Section 4.14 to meet the needs of Members and their decision- makers whose primary language is not English, using qualified medical interpreters (both sign and spoken languages) 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;

3.5.1.5 Identify community advocates and agencies that could assist Limited-English Proficiency and/or that provide other Culturally Competent services, which include methods of Outreach and referral;

3.5.1.6 Incorporate Cultural Competence into Utilization Management, quality improvement and planning for the course of treatment;

3.5.1.7 Identify and employ resources and interventions for high-risk health conditions found in certain cultural groups;

3.5.1.8 Recruit and train a diverse staff and leadership that are representative of the demographic characteristics of the State; and

3.5.1.9 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.

3.5.2 The CONTRACTOR shall conduct initial and annual organizational self-assessments of culturally and linguistically competent-related activities and shall integrate cultural and linguistic competence-related measures into its internal audits, performance improvement programs, Member Satisfaction Surveys and outcomes-based evaluations.

3.6 **Independent Consumer Supports System**

The CONTRACTOR shall work with the State's independent consumer supports system as directed by HSD.

4 CONTRACTOR's Scope of Work

4.1 **Eligibility**

4.1.1 General

4.1.1.1 All individuals determined Medicaid eligible are required to participate in the Centennial Care program unless specifically excluded by the 1115(a) Waiver.

4.1.1.2 Recipients in the Developmental Disabilities 1915 (c) Waiver and in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver, but are required to enroll with the CONTRACTOR for all non-HCBS.

4.1.1.2.1 The CONTRACTOR shall use best efforts to contract with the UNM Health Sciences Center – Center for Development & Disability (CDD) to coordinate care for medically fragile individuals receiving EPSDT and/or Community Benefit services, and shall use all best efforts to have this contract executed prior to the 30th day of September for each year prior to the forthcoming Contract period.

4.1.1.2.2 The CONTRACTOR shall submit a copy of the contract with UNM/CDD to HSD for review prior to implementation and annually for the forthcoming Contract period by the first Business Day in October following the execution of the Contract.

4.1.1.3 HSD shall send eligibility recertification information in advance of the Members' Medicaid redetermination deadline. The CONTRACTOR shall assist the Member and facilitate in gathering the necessary documentation required for HSD or its designee.

4.1.2 Level of Care Determinations for Not Otherwise Medicaid Eligible Individuals

4.1.2.1 The CONTRACTOR shall conduct a NF LOC evaluation for individuals who are Not Otherwise Medicaid Eligible (NOME) and who, through a waiver allocation issued by HSD or its designee, are found to have indicators that may warrant a NF LOC.

4.1.2.1.1 The CONTRACTOR shall have a special unit that identifies, tracks and processes all NOMEs that are issued a waiver allocation from the Long-Term Services and Support Bureau. This includes, but is not limited to, receiving the Primary Freedom of Choice (PFoC) form, ensuring a 112 file is received from ASPEN, assignment of a care coordinator to complete the comprehensive needs assessment (CNA) and submission to the UM department for a timely NF LOC determination. The unit shall have a supervisor that oversees and ensures NOMEs are properly routed by CONTRACTOR staff until Medicaid eligibility is established.

4.1.2.2 The CONTRACTOR shall use the tools and processes that have been approved by HSD in conducting the nursing facility level of care evaluation. The CONTRACTOR shall interface with HSD's eligibility system for level of care in a file format prescribed and approved by HSD.

4.1.2.3 If a Not Otherwise Medicaid Eligible individual has met the nursing facility level of care determination, either because he or she is in a Nursing Facility or because HSD has capacity for Community Benefit services, the CONTRACTOR shall inform HSD of the individual's level of care determination.

4.1.2.4 If the individual is determined to meet a nursing facility level of care, the CONTRACTOR shall notify HSD to continue the eligibility determination process.

4.1.2.5 To ensure continuity of care for Members with a category of eligibility (COE) 92, the CONTRACTOR shall continue to determine these Members medically eligible if both of the following conditions are met: (i) the Member's condition has not changed; and (ii) the Member had a prior year NF LOC approval.

4.1.3 Level of Care Determinations for Members who are expected to always meet Nursing Facility Level of Care.

4.1.3.1 If the CONTRACTOR determines that the Member meets ongoing nursing facility level of care based on criteria prescribed by HSD and outlined in the Managed Care Policy Manual, the CONTRACTOR shall approve an ongoing NF LOC for the Member and will not annually assess the Member for NF LOC.

4.1.3.2 The CONTRACTOR is required to perform a CNA and develop an annual care plan for these Members as described in Sections 4.4.5 and 4.4.9.

4.1.3.3 The CONTRACTOR shall monitor the ongoing NF LOC status of Members, and report to HSD as required.

4.2 **Enrollment**

4.2.1 General

HSD shall enroll individuals determined eligible for Centennial Care. Enrollment in a MCO may be the result of a Recipient's selection of a particular MCO or assignment by HSD.

4.2.2 Current Medicaid Recipients.

Recipients who are eligible and currently enrolled will have an opportunity to select a Centennial Care 2.0 MCO beginning in October 2018 (unless excluded from mandatory enrollment in Centennial Care). If the recipient fails to select a different MCO and his/her current MCO is also a Centennial Care 2.0 MCO, then he/she will remain enrolled with the same MCO. If the recipient fails to select a different MCO

and his/her current MCO is not selected as a Centennial Care 2.0, then he/she will be auto-assigned in accordance with Section 4.2.4 of this Agreement.

4.2.3 New Medicaid Recipients.

Individuals determined eligible for Centennial Care after October 2018 and before January 1, 2019, will select a current Centennial Care MCO at the time of application for Medicaid eligibility. These individuals will also have an opportunity to select a Centennial Care 2.0 MCO prior to January 1, 2019. Recipients eligible on or after January 1, 2019, will have the opportunity to select a Centennial Care 2.0 MCO at the time of application. Recipients who fail to select a Centennial Care 2.0 MCO at such time will be auto assigned in accordance with Section 4.2.4 of this Agreement.

4.2.4 Auto Assignment

4.2.4.1 Selected Centennial Care 2.0 MCOs that did not participate in the delivery of Covered Services under the Centennial Care program between January 1, 2014 and December 31, 2018 will receive the highest percentage of auto-assignment until a membership threshold of at least fifteen percent (15%) of the total managed care enrollment as of the last day of the month is achieved. If any Centennial Care CONTRACTOR falls below a membership threshold of fifteen percent (15%) of the total managed care enrollment it will receive the highest percentage of auto-assignment until the threshold is maintained for a period of at least one year.

4.2.4.2 Once HSD determines that the established enrollment threshold is reached per Section 4.2.4.1, the Centennial Care 2.0 CONTRACTOR(s) with the highest scoring cost proposal in the bidding process will receive the highest percentage of the auto-assignment, subject to the considerations in 4.2.4.4. For a minimum of one (1) Contract year period. HSD reserves the right to modify the auto-assignment methodology at its discretion.

4.2.4.3 HSD will auto assign a Recipient to a MCO in specified circumstances, including but not limited to: (i) the Recipient does not select a MCO at the time of eligibility or (ii) the Recipient cannot be enrolled in the requested MCO pursuant

to the terms of this Agreement (e.g., the CONTRACTOR is subject to and has reached its enrollment limit).

4.2.4.4 The auto assignment process will consider the following:

4.2.4.4.1 During the initial open enrollment period for Centennial Care 2.0, if a Recipient does not select a Centennial Care 2.0 MCO, he/she will be re-enrolled in the same MCO if the Recipient's MCO is a Centennial Care 2.0 MCO. If the Recipient's MCO is not a Centennial Care 2.0 MCO, then he/she will be auto assigned to a Centennial Care 2.0 MCO. On an ongoing basis, if a Recipient was previously enrolled with a MCO and loses eligibility for a period of six (6) months or less, the Recipient will be re-enrolled with that MCO;

4.2.4.4.2 If the Recipient has family Members in a MCO, the Recipient will be enrolled in that MCO;

4.2.4.4.3 If the Recipient is a newborn, the Recipient will be assigned to his or her mother's MCO; and

4.2.4.4.4 If none of the above applies, the Recipient will be assigned using default logic that randomly assigns Recipients to MCOs.

4.2.4.5 HSD may modify the auto assignment algorithm to incorporate criteria including but not limited to quality measures, cost or Utilization Management performance.

4.2.5 Newborns

4.2.5.1 When a child is born to a mother enrolled in Centennial Care, the hospital or other provider shall complete a Notification of Birth, MAD Form 313, or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD Form 313 the eligibility process is immediately commenced and that upon completion of the eligibility process the newborn is enrolled into his or her mother's MCO.

4.2.5.2 Medicaid eligible newborns are eligible for a period of thirteen (13) months, starting with the month of birth. The newborn shall be enrolled retroactively to the month of birth with the mother's MCO.

4.2.5.3 When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother's Qualified Health Plan is also a Centennial Care MCO, the newborn shall be enrolled retroactively to the month of birth with that Centennial Care MCO.

4.2.5.4 When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother's Qualified Health Plan is not a Centennial Care MCO, the newborn shall be auto assigned and enrolled in a Centennial Care MCO (in accordance with Section 4.2.4 of this Agreement) retroactively to the month of birth. The mother shall have one (1) opportunity anytime during the three (3) months from the effective date of enrollment to change the newborn's MCO assignment.

4.2.5.5 Newborns are not considered part of the retroactive reconciliation period if the mother of the newborn is enrolled in Centennial Care at the time of delivery.

4.2.6 Non-Discrimination

The CONTRACTOR shall accept Recipients in accordance with 42 C.F.R. § 438.206 and 42 C.F.R. § 438.3 (d) and will not discriminate against, or use any policy or practice that has the effect of discriminating against, an individual on the basis of: (i) health status or need for services or (ii) race, color, national origin, sex, disability, ancestry, spousal affiliation, sexual orientation and/or gender identity. The CONTRACTOR shall be in compliance with ACA Section 1557.

4.2.7 Enrollment Limits

HSD reserves the right to limit place limitations on enrollment with a CONTRACTOR.

4.2.8 Effective Date of Enrollment

4.2.8.1 Current Medicaid Recipients. The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.2 of this Agreement shall be Go-Live.

4.2.8.2 New Medicaid Recipients. The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.3 of this Agreement is the first day of the month in which the Recipient's eligibility becomes effective.

4.2.8.3 At HSD's discretion, the effective date of enrollment pursuant to Section 4.2.8.2 of this Agreement may be modified during the term of this Agreement. HSD will notify the CONTRACTOR of any changes to the effective date of enrollment and related processes with at least ninety (90) Calendar Days prior notice.

4.2.9 Enrollment Period

4.2.9.1 After enrolling in the CONTRACTOR's MCO (whether as the result of selection, assignment, or auto assignment), Members shall have one (1) opportunity anytime during the three (3) month period immediately following the effective date of enrollment with the CONTRACTOR's MCO to request to change MCOs. After exercising this right to change MCOs, a Member shall remain enrolled with the MCO until the annual choice period described in Section 4.2.9.2 of this Agreement, unless disenrolled in accordance with Section 4.3 of this Agreement.

4.2.9.2 Annual Choice Period. HSD shall provide an opportunity for Members to change MCOs every twelve (12) months. Members who do not select another MCO during their annual choice period will be deemed to have chosen to remain with their current MCO. Members who select a new MCO during their annual choice period shall have one (1) opportunity anytime during the three (3) month period immediately following the effective date of enrollment in the newly selected MCO to request to change MCOs.

4.2.10 Transfers from Other MCOs

4.2.10.1 The CONTRACTOR shall accept all Members transferring from any MCO as authorized by HSD. The transfer of membership may occur at any time during the year. The receiving CONTRACTOR shall not be responsible for payment of any Covered Services incurred by Members transferred to the CONTRACTOR prior to the effective date of transfer to the CONTRACTOR.

4.2.10.1.1 The CONTRACTOR shall transfer all Member information electronically to the receiving MCO as referenced in the Managed Care Policy Manual.

4.2.10.2 The CONTRACTOR shall develop policies and procedures for a mass transfer of Members, either into the CONTRACTOR's MCO to another MCO, to be reviewed and approved by HSD. The mass transfer process shall be initiated by HSD upon sixty (60) Calendar Days written notice by HSD when HSD determines, for reasonable cause, that the transfer of Members to or from the CONTRACTOR's MCO is required.

4.3 **Enrollment Data**

4.3.1 The CONTRACTOR shall receive, process and update enrollment files from HSD. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from HSD to ensure that the CONTRACTOR complies with Section 4.20.2.6.1 of this Agreement.

4.3.2 <u>Member Disenrollment Initiated by Member</u>

4.3.2.1 In accordance with Section 4.2.9 of this Agreement, a Member has the opportunity to change MCOs during the first ninety (90) Calendar Days following the effective date of enrollment with the CONTRACTOR's MCO. After exercising change rights, the Member shall remain enrolled with the CONTRACTOR until the annual choice period described in Section 4.2.9.2 of this Agreement.

4.3.2.2 A Member may select another MCO during the Member's annual choice period.

4.3.2.3 A Member may request to be disenrolled from the CONTRACTOR for cause at any time. The Member must submit a written request to HSD for approval. HSD must respond no later than the first Calendar Day of the second month following the month in which the Member files the request. If HSD does not respond, the request will be deemed approved. The Member will have access to HSD's Fair Hearing process if he/she is dissatisfied with the determination denying the

request to disenroll. The following are causes for Member initiated disenrollment:

4.3.2.3.1 The Member moves out of the State of New Mexico;

4.3.2.3.2 The CONTRACTOR does not, because of moral or religious objections, cover the service the Member seeks;

4.3.2.3.3 HSD has imposed intermediate sanctions on the CONTRACTOR in accordance with Section 7.3.3 of this Agreement;

4.3.2.3.4 If the Member is automatically re-enrolled under 42 C.F.R. § 438.56(g) if temporary loss of Medicaid eligibility caused the Recipient to miss the Recipient's annual choice period;

4.3.2.3.5 The Member needs related services (for example a cesarean Section and a tubal ligation) to be performed at the same time, the Related Services are not available within the network and the Member's PCP or another provider determines that receiving the services separately would subject the Member to unnecessary risk;

4.3.2.3.6 A Member's LTSS residential or employment supports Provider is leaving the CONTRACTOR's network. A Member may transfer MCOs at any time within ninety (90) Calendar Days from the date of notice of the Provider's departure from the CONTRACTOR's network. If the requested transfer cannot be arranged within ninety (90) Calendar Days of the Provider's departure, the Member must be permitted to remain in his/her current residence until an appropriate transfer arrangement can be made. If the residential or employment supports provider goes out of business or no longer meets Provider requirements, the CONTRACTOR must assist the Member in locating a new provider or the Member may transfer MCOs; or

4.3.2.3.7 Other reasons, including but not limited to, poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in addressing the Member's health care needs.

4.3.3 Member Disenrollment Initiated by HSD

4.3.3.1 HSD may disenroll a Member if:

4.3.3.1.1 The Members loses Medicaid eligibility; or

4.3.3.1.2 At any point in the Fair Hearing process when it is determined that such removal is in the best interest of the Member and/or HSD.

4.3.4 Effective Date of Disenrollment

All HSD approved disenrollment requests shall be effective on or before the first Calendar Day of the second month following the month of the request for disenrollment unless otherwise indicated by HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the CONTRACTOR.

4.3.5 The CONTRACTOR shall immediately update its enrollment roster based on any changes made in accordance with this Section 4.3 of this Agreement.

4.3.6 In accordance with NMAC 8.308.7.10a the CONTRACTOR shall not, under any circumstances, disenroll a member. The CONTRACTOR shall not request disenrollment because of a change in the member's health status, because of his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the CONTRACTORs ability to furnish services to either this particular enrollee or other enrollees).

4.4 Care Coordination

4.4.1 General

4.4.1.1 The CONTRACTOR shall provide Care Coordination that complies with 42 C.F.R. § 438.208 and all requirements of this Agreement.

4.4.1.2 The CONTRACTOR shall design and implement Care Coordination that includes the following steps addressed in this Section 4.4 of this Agreement, unless otherwise stated in 4.13.2 of this Agreement for a Member enrolled in a Health Home or 4.4.19.1 of this Agreement for a Member in a Full Delegation model of care coordination;

4.4.1.2.1 Perform the HSD standardized Health Risk Assessment and determine if the Member's may need a comprehensive needs assessment;

4.4.1.2.2 Place Members in the Care Coordination level(s) in accordance with standards in Section 4.4.3 of this Agreement;

4.4.1.2.3 Perform CNA (including level of care) for each Member who meets the conditions in Section 4.4.5 of this Agreement and complete the Community Benefit and Services Questionnaire (CBSQ) and Community Benefits Member Agreement (CBMA), and inform each assessed Member of community benefits in accordance with their needs;

4.4.1.2.4 Determine the Members' physical health, Behavioral Health and/or Long-Term Care needs utilizing information from the assessment process;

4.4.1.2.5 Develop and implement a CCP based on the Member's individual needs and preferences in accordance with Section 4.4.9 of this Agreement;

4.4.1.2.6 Deliver ongoing Care Coordination services based on the Member's assessed need and in accordance with the CCP and contractual obligations for frequency of contact with the Member in accordance with Section 4.4.10; and

4.4.1.2.7 Continuously assess and respond to the Member's needs for services and assistance.

4.4.1.3 The CONTRACTOR shall ensure that the CSA is included in Care Coordination processes described in this Section 4.4 including comprehensive needs assessments and care planning for those Members who utilize CSAs. For further information on CSAs, please refer to Section 4.8.10 of this Agreement.

4.4.1.4 In coordinating Members' care, the CONTRACTOR shall ensure that each Member's privacy is protected consistent with the State and federal confidentiality requirements, including those listed in 45 C.F.R.s § 160 and § 164 and 42 C.F.R. § 2.

4.4.1.5 Each Member has the right to refuse to participate in Care Coordination. In the event a Member refuses, the CONTRACTOR shall have the Member sign an HSD approved Care Coordination declination form. If a Member refuses to sign

the care coordination declination form, the CONTRACTOR shall document such refusal in the Member's record. The Member who has signed, or refused to sign, a care coordination declination form will not be assigned to Care Coordination level 2 or 3, but will be monitored by the CONTRACTOR per Section 4.4.4 of this Agreement. Members must participate in an annual CNA at a minimum in order to certify/renew their NF LOC.

4.4.1.6 The CONTRACTOR shall send the Member written notification within ten (10) Calendar Days of receiving the Member's enrollment file that explains how the Member can reach the Care Coordination unit for assistance with concerns or questions pending the HRA and Comprehensive Needs Assessment process.

4.4.1.7 Supportive Housing

The CONTRACTOR shall have a full-time Supportive Housing Specialist dedicated to this Agreement to work with Members to assess housing needs and identify appropriate resources in order to help them attain and maintain housing.

4.4.1.7.1 The Supportive Housing Specialist shall serve as the internal resource to provide training and technical assistance to the CONTRACTOR's care coordinators.

4.4.1.7.2 Supportive Housing specifically targets the following populations:

- Individuals who are chronically homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) or precariously housed;
- Individuals with frequent or lengthy institutional care;
- Individuals with serious mental illness or chronic substance use disorders, crisis stabilization, high emergency department or inpatient utilization;
- Individuals with frequent or lengthy adult residential care or treatment stays;
- Individuals with LTSS and frequent turnover of in-home caregivers or Providers; and

- Individuals at highest levels of risk for expensive care and negative outcomes, defined by a Predictive Risk Intelligence System (PRISM) risk score of 1.5 or higher or similar risk measures.

4.4.2 Health Risk Assessment (HRA)

4.4.2.1 The CONTRACTOR shall conduct the HSD standardized Health Risk Assessment (HRA) on all Members who are: (i) newly enrolled in Centennial Care; and (ii) who are not in CCL2 or CCL3 and who have a change in health condition that requires a higher level of care, per HSD guidelines and processes. The HRA is conducted for the purpose of: (i) introducing the CONTRACTOR to the Member; (ii) obtaining basic health and demographic information about the Member; and (iii) confirming the need for a CNA.

4.4.2.2 The HSD standardized HRA may be conducted by telephone or in-person; HRA information must be obtained from the Member or representative and must be documented in the Member's file. The MCO shall ensure its staff, or vendor(s) conducting the HSD standardized HRA is adequately trained to effectively conduct the HSD standardized HRA.

4.4.2.3 The HRA shall be completed with every new Member within thirty (30) Calendar Days of notification to the CONTRACTOR of the Member's enrollment in the CONTRACTOR'S MCO.

4.4.2.4 The HRA and the CNA may be performed concurrently.

4.4.2.5 The CONTRACTOR shall use the HSD standardized HRA as well as utilization and Claims data to identify a Member's current and emergent needs related to Care Coordination. The CONTRACTOR may add questions to the HSD standardized HRA only with HSD approval.

4.4.2.6 The CONTRACTOR shall make reasonable efforts to contact new Members to conduct an HRA and provide information about Care Coordination. Such efforts shall include, but shall not be limited to, engaging community supports such as Community Health Workers, CSAs and Centers for Independent Living. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone

number most recently reported by the Member and using the Member's last reported residential address. The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about Care Coordination and how to obtain an HRA. Documentation of the three (3) attempts shall be included in the Member's file. Such attempts shall occur on not less than three (3) different Calendar Days, at different hours of the day, including day and evening hours and after business hours.

4.4.2.6.1 After these attempts have been made and documented, the Member is categorized as "Unreachable" and is not assigned to Care Coordination level 2 or 3. The CONTRACTOR will perform quarterly Claims mining for these Members and will renew attempts to reach the Member if Claims mining indicates a possible need for Care Coordination unless the Member has declined Care Coordination.

4.4.2.6.2 If the CONTRACTOR has made three documented attempts to contact and has reached the Member at least once, but the Member fails to engage in either the HRA or CNA completion, then the Member is categorized as "difficult to engage" (DTE) and is not assigned to Care Coordination level two (2) or level three (3). The CONTRACTOR will perform quarterly Claims mining for these Members and will renew attempts to reach the Member if Claims mining indicates a possible need for Care Coordination.

4.4.3 Assignment to Care Coordination Levels

4.4.3.1 The HRA shall determine if a Member requires a CNA to determine if the Member should be assigned to Care Coordination level two (2) or level three (3).

4.4.3.2 Within seven (7) Calendar Days of completion of the HRA, Members who have been identified as needing a Comprehensive Needs Assessment shall be informed of such action. If the Member is enrolled in a Health Home, refer to Agreement Section 4.13.2.

4.4.3.3 Within ten (10) Calendar Days of completion of the HRA, Members requiring a Comprehensive Needs Assessment shall receive:

4.4.3.3.1 Contact information for the CONTRACTOR's Care Coordination unit;

4.4.3.3.2 The name of the assigned care coordinator (if applicable); and

4.4.3.3.3 A time frame during which the Member can expect to be contacted by the Care Coordination unit or individual care coordinator to complete the Comprehensive Needs Assessment.

4.4.3.4 Members who are identified as NOT needing a Comprehensive Needs Assessment shall be monitored by the Care Coordination unit according to the provisions in Section 4.4.4 of this Agreement.

4.4.3.5 Care Coordination Level Two (2) and Level Three (3). For Members meeting one of the indicators below, the CONTRACTOR shall conduct a Comprehensive Needs Assessment (further explained in section 4.4.5 of this Agreement) to determine whether the Member should be in Care Coordination level two (2) or level three (3):

4.4.3.5.1 Is a high-cost user as defined by the CONTRACTOR;

4.4.3.5.2 Is in out-of-State medical placements;

4.4.3.5.3 Is a dependent child in out-of-home placements;

4.4.3.5.4 Is a transplant patient;

4.4.3.5.5 Is identified as having a high risk pregnancy; Section 4.4.3.5.5.1

4.4.3.5.5.1 Pregnant Members eighteen (18) years of age and younger

4.4.3.5.6 Has a Behavioral Health diagnosis including substance abuse that adversely affects the Member's life;

4.4.3.5.7 Is medically fragile;

4.4.3.5.8 Is designated as ICF/MR/DD;

4.4.3.5.9 Has frequent emergency room use, defined as two (2) or more emergency room visits in a six (6) month period;

4.4.3.5.10 Has an acute or terminal disease;

4.4.3.5.11 Is readmitted to the hospital within thirty (30) Calendar Days of discharge;

4.4.3.5.12 Has other indicators as prior approved by HSD;

4.4.3.5.13 Is a Medically Frail adult member;

4.4.3.5.14 Has mild cognitive deficits requiring prompting or cueing;

4.4.3.5.15 Has co-morbid health conditions;

4.4.3.5.16 Requires assistance with two (2) or more ADLs or IADLs living in the community; and

4.4.3.5.17 Has poly-pharmaceutical use, defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class.

4.4.4 Requirements for Members Not Assigned to Care Coordination Level Two (2) or Level Three (3)

4.4.4.1 Members who are not assigned to Care Coordination level two (2) or level three (3) shall receive, at a minimum, the following:

4.4.4.1.1 Review of Claims data and utilization of predictive modeling software at least quarterly to determine if the Member had or may have a change in health status and is in need of a health risk assessment and/or Comprehensive Needs Assessment for potential assignment to higher level of Care Coordination.

4.4.5 Comprehensive Needs Assessment for Care Coordination Level Two (2) and Level Three (3)

4.4.5.1 The CONTRACTOR shall perform an in-person, in-home Comprehensive Needs Assessment on all Members identified for Care Coordination by an HRA, or who are already receiving Care Coordination level two (2) or level three (3) at the Member's primary residence. The CNA may be conducted outside of the Member's primary residence under the following conditions: The Member is homeless, or in a transition home; The Member is part of the jail involved population preparing for release; The Member is a newborn in an inpatient setting; or The Member is in a Health Home or a Full Delegation Model. The visit may occur at another location only with HSD approval. For Members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4.4.5.2 For all Members the CONTRACTOR shall:

4.4.5.2.1 Schedule a CNA within fourteen (14) Calendar Days; and

4.4.5.2.2 Complete the CNA within thirty (30) Calendar Days of the HRA if required, unless the Member is in a Health Home and/or using the Treat First model of care.

4.4.5.3 The CONTRACTOR shall:

4.4.5.3.1 Perform quarterly Claims mining for these Members and will renew attempts to reach the Member if Claims mining indicates a possible need for Care Coordination. Members may be categorized as "difficult to engage" (DTE), if reached at least once, when an additional two attempts to contact are documented by the CONTRACTOR. If reached, the CONTRACTOR will have the Member complete the CNA or follow the HSD approved declination process as outlined in 4.4.1.5 of the Medicaid Managed Care Services Agreement.

4.4.5.4 In performing CNA the CONTRACTOR shall use a tool that has been approved by HSD, in accordance with protocols specified by HSD, to assess the Member's medical, Behavioral Health, Long-Term Care and social needs. The tool may include the identification of targeted needs related to improving health, functional outcomes, or quality of life outcomes (e.g., related to targeted health education, pharmacy management, or to increasing and/or maintaining functional abilities, including provision of Covered Services). Any changes to the assessment tool must be approved by HSD thirty (30) Calendar Days prior to use by the CONTRACTOR.

4.4.5.5 At a minimum, the CNA shall:

4.4.5.5.1 Assess physical and Behavioral Health needs including but not limited to: current diagnosis; history of significant physical and Behavioral Health events including hospitalizations; medications; allergies; Providers; Durable Medical Equipment (DME); substance abuse screen (CAGE); family history; cognitive ability; health-related lifestyle (smoking, food intake, sleep patterns, continence);

4.4.5.5.2 Assess Long-Term Care needs including, but not limited to: environmental safety including items such as, smoke detectors, pests/infestation and trip

and fall dangers and adaptive needs such as ramps or other mobility assistance. If the Member is eligible for the Community Benefit, the CONTRACTOR shall assess for all Community Benefit services:

4.4.5.5.2.1 Identify and assess the primary caregiver to determine if respite services are appropriate; and

4.4.5.5.2.2 Identify any primary caregiver training needs and resources available for training such as the Savvy Caregiver Program, CPR, First Aid, Mental Health First Aid, etc.;

4.4.5.5.3 Include a risk assessment using a tool and protocol approved by HSD and develop, as applicable, a risk agreement that shall be signed by the Member or his or her Representative and that shall include identified risks to the Member the consequences of such risks, strategies to mitigate the identified risks and the Member's decision regarding his or her acceptance of risk;

4.4.5.5.4 Assess disease management needs including identification of disease state, need for targeted intervention and education and development of appropriate intervention strategies;

4.4.5.5.5 Determine a social profile including but not limited to: family and kinship supports; living arrangements; demographics; transportation; employment; natural supports; financial resources (other insurance, food, utilities); Medicare services; other community resources in place such as senior companion or meals-on-wheels; living environment (related to health and safety); IADLs, Individualized Education Plan (IEP); Individual Service Plan (ISP) for DD or medically fragile Members (if applicable);

4.4.5.5.6 Identify possible suicidal and/or homicidal thinking and/or planning;

4.4.5.5.7 Identify cultural information including language and translation needs and utilization of ceremonial or natural healing techniques;

4.4.5.5.8 Ask the Member for a self-assessment regarding the Member's condition(s) and service needs; and

4.4.5.5.9 Identify if the Member is receiving the Alternative Benefit Plan (ABP) and meets the definition and criteria of Medically Frail or is otherwise ABP

Exempt as described in Section 4.5.1.5 of this Agreement, notify the Member that he/she may be ABP Exempt, explain the benefit differences for ABP Exempt Members and facilitate his/her movement into the ABP Exempt benefit package (the Covered Services included in Attachment 2) at the Member's choice.

4.4.5.6 The CNA shall be conducted at least annually for CCL2 Members and at least semi-annually for CCL3 Members, or as the care coordinator deems necessary due to a request from the Member, provider or family member or as a result of change in health status or triggering event as outlined in Section 4.4.3.5.

4.4.5.7 Nursing Facility Level of Care

4.4.5.7.1 For Members who have indicators that may warrant a nursing facility level of care, the CONTRACTOR shall conduct an in-person, in-home, CNA at the Member's primary residence. The CONTRACTOR shall use the New Mexico Medicaid NF LOC Criteria and instructions to determine nursing facility level of care eligibility for all Members.

4.4.5.7.2 For Members in the Alternative Benefit Plan (ABP) who meet nursing facility level of care, notify the Member that he/she may be ABP Exempt, explain the benefit differences for ABP Exempt individuals and facilitate his/her movement into the ABP exempt benefit package (the Covered Services included in Attachment 2) at the Member's choice.

4.4.5.7.3 The CONTRACTOR shall conduct internal random sample audits of both facility and community benefit NF LOC determinations based on HSD NF LOC instructions and tool guidelines each quarter. The results and findings will be reported to HSD along with any Quality Improvement Plan Performance Improvement Plan, if necessary.

4.4.6 <u>Requirements for Care Coordination Level Two (2)</u>

4.4.6.1 Based on the Comprehensive Needs Assessment, the CONTRACTOR shall assign Care Coordination level two (2), at a minimum, to Members with one of the following:

4.4.6.1.1 Co-morbid health conditions;

4.4.6.1.2 High emergency room use, defined as three (3) or more emergency room visits in thirty (30) days;

4.4.6.1.3 A mental health or substance abuse condition causing moderate functional impairment;

4.4.6.1.4 Requiring assistance with two (2) or more ADLs or IADLs living in the community at low risk;

4.4.6.1.5 Mild cognitive deficits requiring prompting or cues;

4.4.6.1.6 Poly-pharmaceutical use is defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class; and

4.4.6.1.7 High risk pregnancy including pregnant Members who are eighteen (18) years and younger.

4.4.6.2 The CONTRACTOR shall assign a specific care coordinator to each Member assigned to Care Coordination level two (2).

4.4.6.3 Care coordinators for Members in Care Coordination level two (2) shall provide and/or arrange for the following Care Coordination services:

4.4.6.3.1 Development and implementation of a CCP;

4.4.6.3.2 Monitoring of the CCP to determine if the CCP is meeting the Member's identified needs;

4.4.6.3.3 Assessment of need for assignment to a Health Home;

4.4.6.3.4 Targeted Health Education, including disease management, based on the Member's individual diagnosis (as determined by the Comprehensive Needs Assessment);

4.4.6.3.5 Annual Comprehensive Needs Assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and if a higher or lower level of Care Coordination is needed;

4.4.6.3.6 Semi-annual in-person and in-home visits with the Member;

4.4.6.3.7 Two telephonic contacts shall occur as follows: (1) 60-90 Calendar Days and (2) 240-270 Calendar Days, from the most recent CNA;

4.4.6.3.8 The most recent CNA completion date serves as the anchor date, or begin date, for assessing the timeliness of in-person, in-home visits and telephonic contacts. When a new CNA is conducted, that becomes the new anchor date; and

4.4.6.3.9 Timeliness Schedule:

Touchpoints for CCL2	Timeliness Deadlines
Annual CNA	Anchor date
Telephonic contact	60-90 Calendar Days
In-person, in-home visit	150-180 Calendar Days
Telephonic contact	240-270 Calendar Days

After touchpoint attempts have been made and documented, Members may be categorized as "difficult to engage" (DTE) if reached at least once for their annual CNA, telephonic contact, or in-person, in-home visit when two, subsequent attempts to contact are documented by the CONTRACTOR.

4.4.6.3.9.1 The CONTRACTOR will continue attempts to reach the member quarterly or until the Member has signed, or refused to sign, the HSD approved Care Coordination declination form.

4.4.7 Requirements for Care Coordination Level Three (3)

4.4.7.1 Based on the Comprehensive Needs Assessment, the CONTRACTOR shall assign to Care Coordination level three (3), at a minimum, to Members with one the following:

4.4.7.1.1 Who are medically complex or fragile, as defined by the CONTRACTOR;

4.4.7.1.2 Excessive emergency room use as defined as four (4) or more emergency room visits in a twelve (12) month period;

4.4.7.1.3 With a mental health or substance abuse condition causing high functional impairment;

4.4.7.1.4 With untreated substance dependency based on the current DSM or other functional scale determined by the State;

4.4.7.1.5 Requiring assistance with two (2) ADLs or IADLs living in the community at medium to high risk;

4.4.7.1.6 With significant cognitive deficits; and/or

4.4.7.1.7 With contraindicated pharmaceutical use.

4.4.7.2 The CONTRACTOR shall assign a specific care coordinator to each Member in Care Coordination level three (3).

4.4.7.3 Care coordinators for Members in Care Coordination level three (3) shall provide and/or arrange for the following Care Coordination services:

4.4.7.3.1 Care coordination services listed in Sections 4.4.6.3.1-4.4.6.3.9 of this Agreement;

4.4.7.3.2 Semi-annual CNA (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and determine if a lower level of Care Coordination is needed. The semi- annual CNA should occur 150-180 Calendar Days after the annual CNA;

4.4.7.3.3 Quarterly in-person and in-home visits with the Member;

4.4.7.3.4 Four telephonic contacts shall occur as follows: (1) 25-30 Calendar Days; (2) 55-60 Calendar Days; (3) 115-120 Calendar Days; and (4) 145-150 Calendar Days, from the most recent CNA;

4.4.7.3.5 The most recent CNA completion date serves as the anchor date, or begin date, for assessing the timeliness of follow-up in-person visits and telephonic contacts. When a new CNA is conducted, that becomes the new anchor date; and

4.4.7.3.6 Timeliness schedule:

Touchpoints for CCL3	Timeliness Deadlines
Annual CNA	Anchor date
Telephonic contact	25-30 Calendar Days
Telephonic contact	55-60 Calendar Days
In-person, in-home visit	60-90 Calendar Days
Telephonic contact	115-120 Calendar Days
Telephonic contact	145-150 Calendar Days
Semi-annual CNA	150-180 Calendar Days; New anchor date
Telephonic contact	25-30 Calendar Days

Touchpoints for CCL3	Timeliness Deadlines
Telephonic contact	55-60 Calendar Days
In-person, in-home visit	60-90 Calendar Days
Telephonic contact	115-120 Calendar Days
Telephonic contact	145-150 Calendar Days

After touchpoint attempts have been made and documented, Members may be categorized as "difficult to engage" (DTE) if reached at least once for their annual or semi-annual CNA, telephonic contacts, or In-Person, in-home visits when two, subsequent attempts to contact are documented by the CONTRACTOR.

4.4.7.3.6.1 The CONTRACTOR will continue attempts to reach the member quarterly or until the Member has signed, or refused to sign, the HSD approved Care Coordination declination form.

4.4.8 Increase in Care Coordination Level

4.4.8.1 The CONTRACTOR shall develop and implement policies and procedures for ongoing identification of Members who may be eligible for a higher level of Care Coordination.

4.4.8.2 The CONTRACTOR shall use the following criteria, at a minimum, to identify Members for a Comprehensive Needs Assessment either to assess or reassess the Member's need for a higher level of Care Coordination:

4.4.8.2.1 Referral from Member's PCP, specialist or other provider or other referral source;

4.4.8.2.2 Self-referral by Member or referral by Member's Representative;

4.4.8.2.3 Referral from CONTRACTOR's staff;

4.4.8.2.4 Request from HSD;

4.4.8.2.5 Notification of hospital admission or emergency room visit (see Section 4.4.8.6 of this Agreement); and/or

4.4.8.2.6 Information from a periodic review, at least quarterly, of the following: (i) Claims or Encounter Data; (ii) hospital admission or discharge data; (iii)

pharmacy data; (iv) predictive modeling software; and (v) data collected through UM processes.

4.4.8.3 Once a Member has been identified as meeting any of the conditions listed above, the CONTRACTOR shall contact the Member within ten (10) Calendar Days of the CONTRACTOR becoming aware of the change in the Member's condition, to determine whether the Member requires a higher level of Care Coordination.

4.4.8.4 Documentation of at least three (3) attempts to contact the Member by phone (which shall include at least one (1) attempt to contact the Member at the number most recently reported by the Member and at least one (1) attempt to contact the Member at the number provided in the referral, if different), followed by a letter sent to the Member's most recently reported address that provides information about Care Coordination including the benefits of Care Coordination and how to obtain a Comprehensive Needs Assessment, shall constitute sufficient effort by the CONTRACTOR to assist a Member who has been referred, regardless of referral source.

4.4.8.5 For Members identified through notification of hospital admission, the CONTRACTOR shall work with the hospital discharge planner to determine needed services upon discharge. The CONTRACTOR shall complete all applicable screening and/or intake processes as necessary to facilitate timely transition to the most integrated and cost effective care setting appropriate to meet the Member's needs, including engaging Primary Care Providers and increasing targeted Care Coordination activities, per Section 4.4.16.

4.4.8.6 The CONTRACTOR's agreement(s) with hospitals shall require the facility to notify the CONTRACTOR within one (1) Business Day of the date a Member is admitted.

4.4.9 Care Plan Requirements

4.4.9.1 The CONTRACTOR shall develop and implement CCPs for Members in Care Coordination levels two (2) and level three (3).

4.4.9.2 The CONTRACTOR shall develop and authorize the CCP within fourteen (14) Business Days of completion of the initial Comprehensive Needs Assessment, unless the Member is in a Treat First model of care. The CONTRACTOR shall authorize services in the CCP pursuant to section 4.12.12.

4.4.9.2.1 For Members in the Treat First model of care, the CCP shall be completed within fourteen (14) Business Days of the completion of four (4) therapeutic Encounters, but no later than thirty (30) Business Days of the CNA completion.

4.4.9.3 For Members in Care Coordination level two (2) and level three (3), the care coordinator shall ensure at a minimum that the Member and Representative participate in developing the CCP.

4.4.9.4 The CONTRACTOR shall ensure that care coordinators consult with the Member's PCP, specialists, Behavioral Health Providers, other Providers and interdisciplinary team experts, as needed when developing the CCP.

4.4.9.5 The care coordinator shall verify that all decisions made regarding the Member's needs and services, including the Member's choice to receive institutional care versus HCBS, are documented in a written CCP.

4.4.9.6 The developed CCP shall at a minimum include:

4.4.9.6.1 Pertinent demographic information regarding the Member including the name and contact information of any Representative and a list of other persons authorized by the Member to have access to health care related information and to assist with assessment, planning and/or implementation of health care related services and supports;

4.4.9.6.2 Services that will be authorized by the CONTRACTOR, including the amount, frequency, duration and scope (tasks and functions to be performed) of each service to be provided;

4.4.9.6.3 Identified disease management needs including strategies, interventions and related tasks to be performed by the care coordinator and the Member;

4.4.9.6.4 A back-up plan for situations when regularly scheduled Providers are unavailable or do not arrive as scheduled; the back-up plan may include paid

and unpaid supports and shall include the names and telephone numbers of persons and agencies to contact and the services provided by listed contacts;

4.4.9.6.5 The Member's current physical and Behavioral Health conditions and functional status (i.e., areas of functional deficit), and the Member's physical, behavioral and functional needs;

4.4.9.6.6 The Member's physical environment and any modifications necessary to ensure the Member's health and safety;

4.4.9.6.7 The medical equipment used or needed by the Member (if applicable);

4.4.9.6.8 Any special communication needs including interpreters or special devices required by the Member;

4.4.9.6.9 The Member's psychosocial needs, including any housing or financial assistance needs that could impact the Member's ability to maintain a safe and healthy living environment;

4.4.9.6.10 Goals, objectives and desired health, functional and quality of life outcomes for the Member;

4.4.9.6.11 Other services that will be provided to the Member, including Covered physical and Behavioral Health services that will be provided by the CONTRACTOR to help the Member maintain or improve his or her physical or Behavioral Health status or functional abilities and maximize independence. Americans with Disabilities Act Title II regulations require public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d) (the "integration mandate") as well as other social support services and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive institutional placement, and any non-Covered Services including services provided by other community resources, including plans to link the Member to financial assistance programs including but not limited to housing, utilities and food as needed;

4.4.9.6.12 Information about services provided by Medicare payers, Medicare Advantage plans and Medicare Providers as appropriate to coordinate services for Members who are also Dual Eligibles;

4.4.9.6.13 Relevant information from the Member's individualized treatment or service plan for any Member receiving Behavioral Health services that is needed by a Provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of services;

4.4.9.6.14 Relevant information regarding the Member's physical health condition(s), including treatment and medication regimen, that is needed by a Provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care;

4.4.9.6.15 Frequency of planned care coordinator contacts needed, which shall include consideration of the Member's individualized needs and circumstances and which shall meet minimum required contacts as specified in Sections 4.4.6.3.6, 4.4.6.3.7, 4.4.7.3.2 , 4.4.7.3.3 and 4.4.7.3.4, (additional care coordinator contacts shall be provided as needed);

4.4.9.6.16 Additional information for Members who elect the Self-Directed Community Benefit including but not limited to the Member's self-assessment, (whether the Member requires an employer of record ("EOR")), the back-up plan and the approved Self- Directed Community Benefits as identified in the CNA;

4.4.9.6.17 Any steps the Member and/or Representative should take in the event of an emergency that differ from the standard emergency protocol;

4.4.9.6.18 A disaster preparedness plan specific to the Member; and

4.4.9.6.19 The Member's eligibility begin and end date.

4.4.9.7 The care coordinator shall ensure that the Member (or the Member's Representative, if applicable) understands, reviews, signs and dates the CCP.

4.4.9.8 The care coordinator shall provide a copy of the Member's completed CCP, including any updates, to the Member and the Member's Representative, as applicable. The Care Coordination team shall provide copies to other Providers

authorized to deliver care to the Member, as appropriate, and shall ensure that such Providers who do not receive a copy of the CCP are informed in writing of all relevant information needed (including all relevant HSD prescribed forms) to ensure the provision of quality care for the Member and to help ensure the Member's health, safety, and welfare, including but not limited to the tasks and functions to be performed.

4.4.9.9 For Members in an institutional facility, the Care Coordination team shall develop the CCP but may use the CCP developed by the institution to supplement the CCP.

4.4.9.10 Within five (5) Business Days of completing a semi-annual and annual comprehensive needs reassessment of a Member's needs, the Care Coordination team shall update the Member's CCP as appropriate and the CONTRACTOR shall authorize services in the updated CCP pursuant to section 4.12.12.

4.4.9.11 The Member's care coordinator shall inform each Member of his or her Medicaid eligibility end date and educate Members regarding the importance of maintaining eligibility, that eligibility must be redetermined at least once a year, and that Members will be contacted near the date on which a redetermination is needed to assist them with the process, e.g., collecting appropriate documentation and completing the necessary forms.

4.4.10 Ongoing Care Coordination

4.4.10.1 The CONTRACTOR shall conduct ongoing Care Coordination to ensure that Members receive all necessary and appropriate care. Ongoing Care Coordination functions shall include at a minimum, unless the Member is enrolled in a Health Home, the following activities:

4.4.10.1.1 Develop and/or update the CCP as needed;

4.4.10.1.2 Provide condition specific disease management interventions and strategies and educate Members with identified disease management needs;

4.4.10.1.3 Monitor treatment and coordinate with Providers to encourage best practice as it relates to tests, appointment frequency and adherence to condition specific protocols;

4.4.10.1.4 Educate the Member about his or her ability to have an Advance Directive and document the Member's decision in the Member's file;

4.4.10.1.5 Upon the scheduled initiation of services identified in the Member's CCP, the Care Coordination team (as further addressed in Section 4.4.12) shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized and that services continue to meet the Member's needs;

4.4.10.1.6 Monitor the Member's Community Benefit (as applicable) to ensure that the benefit sufficiently meets the Member's needs;

4.4.10.1.7 Identify, address and evaluate service gaps to determine their cause and to minimize gaps going forward to ensure that back-up plans are implemented and effectively working. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to and resolving service gaps in a timely manner;

4.4.10.1.8 Identify changes to the Member's risk, address those changes and update the Member's risk agreement as necessary;

4.4.10.1.9 Maintain appropriate ongoing communication with community and natural supports to monitor and support their ongoing participation in the Member's care;

4.4.10.1.10 For non-Covered Services, enlist the involvement of, and coordinate with, community organizations to provide services that are important to the health, safety and well-being of Members. This may include but shall not be limited to referrals to other agencies for assistance. The CONTRACTOR shall not be responsible for the provision or quality of non-Covered Services provided by other entities;

4.4.10.1.11 For Members meeting a nursing facility level of care, conduct a level of care reassessment at least annually and within five (5) Business Days of the CONTRACTOR becoming aware that the Member's functional or medical status has changed in a way that may affect a level of care determination.

The exception to this requirement are Members who meet ongoing NF LOC criteria as stated in Section 4.1.3.1 of this Agreement;

4.4.10.1.12 If the level of care assessment indicates a change in the level of care or if the assessment was prompted by a request by a Member or a Member's Representative for a change in level of services, the assessment shall be forwarded to the CONTRACTOR's Utilization Management Department for review of NF LOC and/or services review, as applicable;

4.4.10.1.13 If the level of care assessment indicates no change in level of care, the CONTRACTOR shall document the date the level of care assessment was completed in the Member's file;

4.4.10.1.14 Facilitate access to physical, Behavioral Health and/or Long-Term Care services as needed;

4.4.10.1.15 Monitor and ensure the provision of Covered Services as well as Value Added Services, if applicable and ensure that services provided meet the Member's needs;

4.4.10.1.16 Provide assistance in resolving concerns about service delivery or Providers;

4.4.10.1.17 Coordinate with the Member's Providers to facilitate a comprehensive, holistic, person centered approach to care that meets federal requirements for person centered planning; 42 C.F.R. § 441.301(c)(1);

4.4.10.1.18 As appropriate, ensure that all PASRR requirements are met prior to the Member's admission to a Nursing Facility, including, but not limited to, 42 C.F.R. § 483.100-138:

4.4.10.1.18.1 The CONTRACTOR must ensure all relevant Pre-Admission Screening and Resident Review (PASRR) documents for Members seeking admission into a Nursing Facility (NF) are included and reviewed as part of the NF LOC determination;

4.4.10.1.18.2 The PASRR level 1 assessment is conducted prior to the Member's NF admission as per NMAC 8.312.2.18; and

4.4.10.1.18.3 If a PASRR level 1 indicates that a PASRR level two (2) is needed, the NF must obtain approval for the NF admission from the Department of

Health PASRR program. The PASRR level two (2) assessment will identify specialized services to be provided for the Member during the NF stay;

4.4.10.1.19 Interact with both the Member and his or her Providers through modern technologies (e.g., mobile applications and tools) to facilitate better Care Coordination and promote health behaviors;

4.4.10.1.20 Update consent forms as necessary;

4.4.10.1.21 Ensure that the organization of and documentation included in the Member's file meets all applicable CONTRACTOR standards;

4.4.10.1.22 The Member's care coordinator shall inform each Member of his or her Medicaid eligibility end date and educate Members regarding the importance of maintaining eligibility which must be redetermined at least once a year; and

4.4.10.1.23 Facilitate access to supports that assess housing needs and identify appropriate resources to help Members attain and maintain community housing.

4.4.10.2 The CONTRACTOR shall provide to all Contract Providers information regarding the role of the care coordinator and shall request Providers and caregivers to notify a Member's care coordinator, as expeditiously as warranted by the Member's circumstances, of any significant changes in the Member's condition of care, hospitalizations, or recommendations for additional services. The CONTRACTOR shall provide training to key Providers and caregivers regarding the value of this communication.

4.4.10.3 The CONTRACTOR shall monitor and evaluate a Member's emergency room and Behavioral Health crisis service utilization to determine the reason for these visits. In monitoring the Member's emergency room and Behavioral Health crisis service use, the CONTRACTOR shall evaluate whether or not lesser acute care treatment options were available to the Member at the time and place when he/she accessed such services. The care coordinator shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the

Member's Providers, educating the Member, conducting a comprehensive needs reassessment and/or updating the Member's CCP to better manage the Member's physical health or Behavioral Health condition(s).

4.4.10.4 The Member's care coordinator and the Member shall participate as appropriate in the person-centered care planning and discharge planning processes. The care coordinator shall advocate for the Member and shall be responsible for coordination of the Member's physical health, behavioral health and long-term care needs. This shall include coordination with the institutional setting as necessary to facilitate access to services and to help ensure the proper management of the Member's acute and/or chronic physical health and/or behavioral health conditions.

4.4.10.5 The CONTRACTOR shall ensure that at each in-person visit the care coordinator makes the following observations, responds to any observations that require intervention and documents the observations and remedies in the Member's file:

4.4.10.5.1 Member's observed physical conditions such as changes in the Member's skin, weight, mobility and any visible injuries;

4.4.10.5.2 Member's physical environment such as safety concerns and cleanliness;

4.4.10.5.3 Member's satisfaction with services and care;

4.4.10.5.4 Member's upcoming appointments;

4.4.10.5.5 Member's mood and emotional well-being;

4.4.10.5.6 Member's falls and any resulting injuries;

4.4.10.5.7 A statement by the Member regarding any concerns or questions;

4.4.10.5.8 A statement from the Member's Representative regarding any concerns or questions (when the Representative is available); and

4.4.10.5.9 Any other observations as specified by HSD.

4.4.11 Member Case Files

4.4.11.1 The Care Coordination team shall maintain individual files for each Member.

4.4.11.2 Member case files must include, but are not limited to, the following, as applicable:

4.4.11.2.1 Pertinent demographic information regarding the Member including the name and contact information of any Representative and a list of other persons authorized by the Member to have access to health care (including Long-Term Care) related information;

4.4.11.2.2 The most current CCP, including the detailed plan for back-up Providers in situations when regularly scheduled Providers are unavailable or do not arrive as scheduled;

4.4.11.2.3 Written confirmation of the Member's decision regarding participation in the Self-Directed Community Benefit;

4.4.11.2.4 A completed risk assessment and a risk agreement signed by the Member or his or her Representative; and for Members meeting a nursing facility level of care;

4.4.11.2.5 The most recent health risk assessment, Comprehensive Needs Assessment, level of care assessment and documentation of Care Coordination level;

4.4.11.2.6 Documentation of the Member's choice of Contract Providers;

4.4.11.2.7 Signed consent forms as necessary in order to share Confidential Information with and among Providers consistent with all applicable State and federal statutes and regulations; and

4.4.11.2.8 A list of emergency contacts approved by the Member.

4.4.12 Care Coordination Staff Requirements

4.4.12.1 The CONTRACTOR may utilize a Care Coordination team approach to performing Care Coordination activities prescribed in this Section 4.4. For Members in levels two (2) and three (3), the CONTRACTOR's Care Coordination team shall consist of the Member's care coordinator and specific other persons with relevant expertise and experience appropriate to address the needs of Members.

4.4.12.2 The CONTRACTOR shall use local resources, such as I/T/Us, Patient Centered Medical Homes (PCMHs), Health Homes, Core Service Agencies (CSAs), School-Based Health Centers (SBHCs), Community Health Workers (CHWs), Community Health Representatives (CHRs), Paramedicine Programs,

Community-Based Agencies, Personal Care Service (PCS) Agencies, Centers for Independent Living and Tribal services, reimbursing them in mutually agreeable arrangements, to assist in performing the Care Coordination functions specified throughout Section 4.4 of this Agreement. The Contractor shall perform oversight of all Care Coordination functions delegated to local resources, per Section 7.14.2.1.3.

4.4.12.3 The CONTRACTOR's policies and procedures shall specify the qualifications, experience and training of each Member of the team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator. At a minimum, the care coordinator completing the Comprehensive Needs Assessment shall have a bachelor's degree and/or two (2) years of relevant health care experience. A care coordinator's direct supervisor shall have a bachelor's degree and a minimum of two (2) years of relevant health care experience.

4.4.12.4 The assigned care coordinator for Members who choose the Self-Directed Community Benefit shall have specific experience with self-direction and additional training regarding self-direction.

4.4.12.5 The CONTRACTOR shall not exceed the maximum caseload per care coordinator by designated Care Coordination level as outlined below. As the CONTRACTOR transitions more Care Coordination functions to the provider level it will collaborate with HSD to adjust Care Coordination caseload requirements.

4.4.12.5.1 Care coordination level two (2), Members not residing in a nursing facility 1:75 and Care Coordination level two (2) Members residing in a nursing facility 1:125;

4.4.12.5.2 Care coordination level three (3), Members not residing in a nursing facility 1:50; and Care Coordination level three (3) for Members residing in a nursing facility 1:125; and

4.4.12.5.3 Care coordination for level two (2), Members who participate in the SDCB 1:75; Care Coordination level three (3), Members who participate in the SDCB 1:50.

4.4.12.6 The CONTRACTOR is expected to further adjust ratios to accommodate travel requirements for those care coordinators serving Members in Rural/Frontier/Tribal areas of the State or those cases that require extraordinary efforts from the assigned care coordinator.

4.4.12.7 The CONTRACTOR shall ensure an adequate number of care coordinators are available and that sufficient staffing ratios are maintained to address the needs of Members and meet all the requirements described in this Agreement. The CONTRACTOR shall monitor staffing ratios and adjust ratios as necessary and in accordance with the maximum allowed ratios in Section 4.4.12.5 of this Agreement to ensure that care coordinators are able to meet the requirements of this Agreement and address Members' needs.

4.4.12.8 The CONTRACTOR shall submit for review and approval an annual Care Coordination Staffing Plan, which at a minimum shall specify the following: (i) the number of care coordinators, Care Coordination supervisors, other Care Coordination team members the CONTRACTOR will employ; (ii) the ratio of care coordinators to Members; (iii) the method by which the CONTRACTOR's plans to maintain ratios in accordance with the maximum ratios in Section 4.4.12.5 of this Agreement; (iv) how the CONTRACTOR will ensure that such ratios are sufficient to fulfill the requirements specified in this Agreement; (v) the roles and responsibilities for each Member of the Care Coordination team; and (vi) how the CONTRACTOR will use care coordinators to meet the needs of New Mexico's unique population.

4.4.12.9 The CONTRACTOR shall ensure that Members have a telephone number to call to directly contact (without having to disconnect or place a second call) their care coordinator or a Member of their Care Coordination team during normal business hours (8 a.m. – 5 p.m. Mountain Time). If the Member's care coordinator or a Member of the Member's Care Coordination team is not available, the call shall

be answered by another qualified staff person in the Care Coordination unit. If the call requires immediate attention from a care coordinator, the staff Member answering the call shall immediately transfer the call to the Member's care coordinator (or another care coordinator if the Member's care coordinator is not available) as a Warm Transfer. After normal business hours, calls that require immediate attention by a care coordinator shall be handled by the Member services/nurse advice line in accordance with Section 4.15.1.11 of this Agreement.

4.4.12.10 The CONTRACTOR shall encourage the use of Community Health Workers in the engagement of Members in Care Coordination activities.

4.4.12.11 If a Native American Member requests assignment to a Native American care coordinator the CONTRACTOR must employ or contract with a Native American care coordinator or contract with a CHR to serve as the care coordinator.

4.4.12.12 The CONTRACTOR shall permit a Member to change to a different care coordinator if the Member desires and there is an alternative care coordinator available. Such availability may take into consideration the CONTRACTOR's need to efficiently deliver Care Coordination in accordance with the requirements of this Agreement.

4.4.12.13 In order to ensure quality and continuity of care, the CONTRACTOR shall make efforts to minimize the number of changes in a Member's care coordinator. A CONTRACTOR initiated change in care coordinators may be appropriate in the following circumstances, where the care coordinator:

4.4.12.13.1 Is no longer employed by the CONTRACTOR;

4.4.12.13.2 Has a conflict of interest and cannot serve the Member;

4.4.12.13.3 Is on temporary leave from employment; or

4.4.12.13.4 Has a caseload that must be adjusted due to its size or intensity.

4.4.12.14 The CONTRACTOR shall develop policies and procedures regarding notice to Members of care coordinator changes initiated by either the CONTRACTOR or

the Member, including advance notice of planned care coordinator changes initiated by the CONTRACTOR.

4.4.12.15 The CONTRACTOR shall ensure continuity of care when Member or CONTRACTOR initiated care coordinator changes are made. The CONTRACTOR shall demonstrate use of best practices by encouraging newly assigned care coordinators to attend a face-to-face transition visit with the Member and the out-going care coordinator, when possible.

4.4.12.16 The CONTRACTOR shall provide initial training to newly hired care coordinators and ongoing training at least annually to all care coordinators. Training instructors from New Mexico Tribes should be utilized where appropriate. Training topics shall include at a minimum:

4.4.12.16.1 The Centennial Care program including a description of the Care Coordination levels, service limits, the Community Benefit and integration with Health Homes;

4.4.12.16.2 Care Coordination levels, HRAs, Comprehensive Needs Assessment and reassessment, development of a CCP and updating the CCP including training on the tools and protocols;

4.4.12.16.3 Nursing facility level of care evaluation and reevaluation;

4.4.12.16.4 Development and implementation of back-up plans;

4.4.12.16.5 Self-Directed Community Benefit option;

4.4.12.16.6 Coordination of care for Dual Eligibles;

4.4.12.16.7 Conducting a home visit and use of the monitoring checklist;

4.4.12.16.8 How to immediately identify and address service gaps;

4.4.12.16.9 Management of critical transitions (including hospital discharge planning;

4.4.12.16.10 Transition from institutional facilities to community settings, including training on tools and protocols;

4.4.12.16.11 Understanding the needs associated with disease states and health care conditions, including but not limited to Alzheimer’s, dementia and cognitive impairments, traumatic brain injury and physical disabilities;

4.4.12.16.12 Health Education and Health Literacy;

4.4.12.16.13 Disease management interventions and strategies and related Member education;

4.4.12.16.14 Availability of non-institutional Behavioral Health services and supports and value of providing such services;

4.4.12.16.15 Identifying Behavioral Health needs and referral process;

4.4.12.16.16 Evaluation and management of risk, including reporting Critical Incidents;

4.4.12.16.17 Identifying and reporting abuse, neglect and exploitation;

4.4.12.16.18 Fraud and Abuse, including reporting Fraud and Abuse;

4.4.12.16.19 Advance Directives and end-of-life care;

4.4.12.16.20 HIPAA;

4.4.12.16.21 Cultural diversity/competence;

4.4.12.16.22 Disaster planning;

4.4.12.16.23 Mental health first aid and other Behavioral Health conditions; and

4.4.12.16.24 Available community resources and other public assistance programs for non-Covered Services. Understanding complex trauma, trauma responsive services and supports, child and adolescent development, inter-generational approach to care, youth- and family-driven care, and teaming.

4.4.12.17 The CONTRACTOR must make reasonable accommodations for non-English and non-Spanish speaking Members who request assignment to a care coordinator who speaks their preferred language.

4.4.13 Care Coordination Monitoring

4.4.13.1 The CONTRACTOR shall develop a comprehensive program for monitoring, on an ongoing basis, the effectiveness of its Care Coordination processes. The CONTRACTOR shall immediately remediate every finding of poor performance and non-compliance identified through its monitoring process, and shall also track and trend such findings and remediations to identify systemic issues of poor performance and/or non-compliance, implement strategies to improve Care Coordination processes and resolve areas of non-compliance and shall measure the success of such strategies in addressing identified issues. At a minimum, the CONTRACTOR shall ensure that:

4.4.13.1.1 Care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured to determine effectiveness and appropriateness of processes;

4.4.13.1.2 Level of care assessments and reassessments occur on schedule and are submitted to lead or supervising care coordinator;

4.4.13.1.3 CNAs and reassessment, as applicable, occur on schedule and in compliance with this Agreement;

4.4.13.1.4 CCPs are developed and updated on schedule and in compliance with this Agreement;

4.4.13.1.5 CCPs reflect needs identified in the Comprehensive Needs Assessment and reassessment process;

4.4.13.1.6 CCPs are appropriate and adequate to address the Member's needs;

4.4.13.1.7 Services are delivered as described in the CCP and authorized by the CONTRACTOR;

4.4.13.1.8 Services are appropriate to address the Member's needs;

4.4.13.1.9 Services are delivered in a timely manner;

4.4.13.1.10 Service utilization is appropriate;

4.4.13.1.11 Service gaps are identified and addressed in a timely manner;

4.4.13.1.12 Minimum care coordinator contacts are conducted;

4.4.13.1.13 Care coordinator-to-Member ratios are appropriate;

4.4.13.1.14 Service limits are monitored and appropriate action is taken if a Member is nearing or exceeds a service limit; and

4.4.13.1.15 Members receiving the Community Benefit in HCBS settings, as defined in 42 C.F.R. § 441.301, continue receiving services using the process and/or tools prescribed by HSD.

4.4.13.2 The CONTRACTOR shall provide Care Coordination reports as directed by HSD.

4.4.13.2.1 The CONTRACTOR shall ensure that care coordination activities are occurring timely and are meeting the following performance standards on a quarterly basis:

4.4.13.2.1.1 Eighty-five percent (85%) of HRAs are completed with Members (excluding Unable to Reach (UTR), Difficult to Engage (DTE), and Refused Care Coordination (RCC) Members) who are newly enrolled in Centennial Care within thirty (30) Calendar Days of enrollment notification to the CONTRACTOR. Eighty-five percent (85%) of HRAs are completed with Members (excluding UTR, DTE, and RCC Members) who are not in CCL2 or CCL3 and have a change in health condition that requires a higher level of Care Coordination within thirty (30) Calendar Days of the CONTRACTOR's notification of the change in condition.

4.4.13.2.1.2 Eighty-five percent (85%) of CNAs (excluding Members categorized as DTE, UTR, or RCC) are completed within contract timeframes as stated in Sections 4.4.5.2.2, 4.4.6.3.9 and 4.4.7.3.6 of this Agreement.

4.4.13.2.1.3 Eighty-five percent (85%) of CCPs are developed and authorized within fourteen (14) Business Days of completion of the initial CNA, unless the Member is in a Treat First model of care, as stated in Section 4.4.9.2.1 of this Agreement, and eighty-five percent (85%) of CCPs are updated within five (5) Business Days of a semi-annual and/or annual CNA, as stated in Section 4.4.9.2.1 and 4.4.9.10 of this Agreement.

4.4.13.3 The CONTRACTOR shall develop and maintain an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the 1115(a) Waiver, federal and State statutes and regulations, this Agreement, and the CONTRACTOR's developed policies and protocols, including but not limited to the following:

4.4.13.3.1 The ability to capture and track key dates and time frames specified in this Agreement, including, but not limited to, as applicable, enrollment, date of development of the CCP, date of authorization of the CCP, date of initial service delivery for each service in the CCP, date of each level of care and needs reassessment, date of each update to the CCP and dates regarding transition from an institutional facility to the community;

4.4.13.3.2 The ability to capture and track compliance with minimum Care Coordination contacts as specified in Section 4.4 of this Agreement;

4.4.13.3.3 The ability to notify the care coordinator about key dates, e.g., eligibility end date, date for annual level of care reassessment, date of comprehensive needs reassessment and date to update the CCP;

4.4.13.3.4 The ability to capture and track eligibility/enrollment information, level of care assessments and reassessments, and needs assessments and reassessments;

4.4.13.3.5 The ability to capture and monitor the CCP;

4.4.13.3.6 The ability to track requested and approved service authorizations, including Covered Services and Value Added Services, as applicable;

4.4.13.3.7 The ability to document all referrals received by the care coordinator on behalf of the Member for Covered Services and Value Added Services, as applicable, needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the care coordinator;

4.4.13.3.8 The ability to establish a schedule of services for each Member identifying the time at that each service is needed and the amount, frequency, duration and scope of each service;

4.4.13.3.9 The ability to track service delivery against authorized services and Providers;

4.4.13.3.10 The ability to track actions taken by the care coordinator to immediately address service gaps;

4.4.13.3.11 The ability to document case notes relevant to the provision of Care Coordination; and

4.4.13.3.12 The ability to allow HSD to have remote access to case files.

4.4.14 Electronic Visit Verification System (EVV)

4.4.14.1 The CONTRACTOR, together with the other Centennial Care MCOs, shall contract with the existing EVV vendors to continue the statewide electronic visit

verification (EVV) system to monitor Member receipt and utilization of EPSDT and Community Benefit. The CONTRACTOR must comply with the EVV options: 1) use of the member's landline when the member consents to such use; or 2) use of the caregiver's personal cellular phone utilizing the Authenticare phone application with the MCO providing a monthly stipend for such use; or 3) use of a tablet allowing the Authenticare application by the caregiver, provided by the MCO to the Personal Care Services (PCS) agency. The CONTRACTOR shall maintain an EVV system capable of leveraging up-to-date technology as it emerges to improve functionality in all areas of the State including rural areas. The CONTRACTOR is responsible for issuing devices to its Providers, as needed, and shall ensure that all contracted personal care service Providers are participating in the EVV system unless granted a HSD approved written exception.

4.4.14.2 The CONTRACTOR shall ensure the following system functionality, including the ability to:

4.4.14.2.1 Log the arrival and departure of the Provider delivering the service;

4.4.14.2.2 Verify, in accordance with business rules, that services are being delivered in the correct location (e.g., the Member's home);

4.4.14.2.3 Verify the identity of the individual Provider providing the service to the Member;

4.4.14.2.4 Match services provided to a Member with services authorized in the Member's Individualized Plan of Care (IPoC), Services and Supports Plan (SSP), Individualized Treatment Plan (ITP), and/or Comprehensive Care Plan (CCP);

4.4.14.2.5 Ensure that the Provider delivering the service is authorized to deliver such services;

4.4.14.2.5.1 Ensure that the provider establishes a plan for EPSDT and Agency-Based Community Benefit services for each Member.

4.4.14.2.6 Establish a schedule of services for each Member identifying the time at which each service is needed, as well as the amount, frequency, duration and scope of each service and to ensure adherence to the established schedule;

4.4.14.2.7 Provide reasonable notification to care coordinators if a Provider does not arrive as scheduled or otherwise deviates from the authorized schedule so that service gaps and the reason the service was not provided as scheduled, are immediately identified and addressed, including through the implementation of back-up plans, as appropriate;

4.4.14.2.8 Permit the Provider to submit Claims to the CONTRACTOR (Claims from self-directed Providers shall be submitted initially to the FMA and the FMA shall provide Claims information to the CONTRACTOR as specified in the subcontract with the FMA); and

4.4.14.2.9 Reconcile paid Claims with service authorizations.

4.4.14.3 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the IPoC, SSP, ITP, and/or the CCP, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a Member is receiving services, including after the CONTRACTOR's regular business hours.

4.4.14.4 The CONTRACTOR shall submit reports on its EVV system as directed by HSD.

4.4.14.5 The CONTRACTOR shall employ a dedicated full-time staff person who is responsible for managing and overseeing all EVV system functions and requirements.

4.4.15 Transitions of Care

4.4.15.1 The CONTRACTOR must identify and facilitate coordination of care for all Members during various transition scenarios (outlined in Section 4.4.15.4) and as described in the Managed Care Policy Manual. The methods for identification of

Members in need of Care Coordination during a transition of care shall include, at a minimum:

4.4.15.1.1 The CNA;

4.4.15.1.2 PASRR;

4.4.15.1.3 MDS;

4.4.15.1.4 Provider referral including hospitals and RTCs;

4.4.15.1.5 Ombudsman referral;

4.4.15.1.6 Family Member referral;

4.4.15.1.7 Change in medical status;

4.4.15.1.8 Member self-referral;

4.4.15.1.9 Community reintegration allocation received;

4.4.15.1.10 State agency referral; and/or

4.4.15.1.11 Incarceration or detention facility referral.

4.4.15.2 For those Members who are candidates for transition to the community, the care coordinator, with the Member and/or Member's Representative, shall facilitate the development and completion of a transition plan, which shall remain in place for a minimum of sixty (60) Calendar Days from the decision to pursue transition or until the transition has occurred and a new CCP is in place. The transition plan shall address the Member's transition needs including but not limited to:

4.4.15.2.1 Physical and Behavioral Health needs;

4.4.15.2.2 Community Benefit needs;

4.4.15.2.3 Selection of Providers in the community;

4.4.15.2.4 Housing needs;

4.4.15.2.5 Financial needs;

4.4.15.2.6 Interpersonal skills;

4.4.15.2.7 Safety; and

4.4.15.2.8 Continuation of Medicaid eligibility.

4.4.15.3 The CONTRACTOR shall conduct an additional assessment within seventy-five (75) Calendar days of transition to determine if the transition was successful and identify any remaining needs.

4.4.15.4 Transition scenarios include but are not limited to:

4.4.15.4.1 Transition from a nursing facility to the community;

4.4.15.4.2 Transition for Member(s) with special circumstances;

4.4.15.4.3 Transition for Member(s) moving from a higher level of care to a lower level of care;

4.4.15.4.4 Transition for Member(s) turning twenty-one (21) years of age;

4.4.15.4.5 Transition for Member(s) changing MCOs while hospitalized;

4.4.15.4.6 Transition for Member(s) changing MCOs during major organ and tissue transplantation services;

4.4.15.4.7 Transition for Member(s) changing MCOs while receiving outpatient treatment for significant medical conditions;

4.4.15.4.8 Transition for Member(s) changing MCOs;

4.4.15.4.9 Transition for Member(s) moving from a residential placement or institutional facility to a community placement;

4.4.15.4.10 Transition for children returning home from a foster care placement;

4.4.15.4.11 Transition for Member(s) released from incarceration or detention facilities;

4.4.15.4.12 Transition for Member(s) discharging from a hospital;

4.4.15.4.13 Transition for Member(s) discharging from out-of-home placements (ARTC, RTC, GH, TFC) and crisis centers related to Behavioral Health treatment;

4.4.15.4.14 Transition for Member(s) who are preparing to receive out-of-state treatment; and

4.4.15.4.15 Transition for Member(s) from Fee-for-Service (FFS).

4.4.15.5 The CONTRACTOR is required to participate in Care Coordination efforts for justice-involved individuals to facilitate the transition of Members from prisons, jails, and detention facilities into the community, to include tribal communities and reservations for Native American members transitioning from incarceration. Care Coordination should occur prior to release, including when release from the facility occurs after business hours or on non-work days. The CONTRACTOR shall collaborate with criminal justice partners to identify Justice-Involved

Members with physical and/or Behavioral Health chronic and/or complex care needs prior to the Member's release.

4.4.16 Transition of Care Requirements

4.4.16.1 General Requirements

4.4.16.1.1 The CONTRACTOR shall establish policies and procedures to ensure that all Members are contacted in a timely manner and are appropriately assessed, using HSD prescribed time frames and processes and tools, to identify needs.

4.4.16.1.2 The CONTRACTOR shall coordinate with the discharge planning teams at hospitals and institutions (e.g. Nursing Facilities, Jails/Prisons, Juvenile Detention Centers, RTCs) to address at a minimum:

- Need for Home and Community Based Services;
- Follow up appointments;
- Therapies and treatments;
- Medications; and
- Durable Medical Equipment.

4.4.16.1.3 The CONTRACTOR shall notify the assigned CYFD permanency placement worker (PPW) for Protective Services (PS) involved children and youth within thirty (30) Business Days prior to transition in care for CYFD involved children/youth.

4.4.16.1.4 The CONTRACTOR shall perform an in-home assessment for Members who are transitioning from an inpatient hospital or Nursing Facility stay to home and/or community and may be in need of Community Benefits within three (3) Calendar Days upon notification of the transition. The assessment will address at a minimum:

- Safety in Home Environment;
- Physical Health Needs;
- Behavioral Health Needs;
- Housing Needs;
- Continuation of Medicaid Eligibility;

- Financial Needs;
- CNA if one is not in place; and
- Community Benefit needs and services in place.

4.4.16.1.5 The CONTRACTOR shall contact the Member monthly for three (3) months to ensure continuity of care has occurred and the Member's needs are met.

4.4.16.1.6 The CONTRACTOR shall not transition Members to another Provider for continuing services unless the current provider is not a Contract Provider.

4.4.16.1.7 The CONTRACTOR shall facilitate a seamless transition to new services and/or Providers, as applicable, in the CCP developed by the CONTRACTOR without any disruption in services.

4.4.16.1.8 For Members who are preparing to receive out-of-state treatment, the CONTRACTOR shall remain in active communication, which may require daily updates, with the Member and/or authorized representative about the status of the out-of-state provider agreement and authorized treatment plan until treatment begins.

4.4.16.1.8.1 The CONTRACTOR shall maintain active communication with the Member and/or authorized representative once out-of- state treatment begins, including weekends and holidays, for the duration of the treatment.

4.4.16.1.8.2 The CONTRACTOR shall resume Care Coordination activities pursuant to 4.4 of the Agreement following treatment completion and Member's return to New Mexico.

4.4.16.2 Transitions of Care Requirements for Members Transferring to Another MCO

4.4.16.2.1 The CONTRACTOR that is receiving a Member from another MCO shall obtain relevant information and data from the transferring MCO within thirty (30) Calendar Days of the Member's effective date of transfer, in order to facilitate continuity of care and a seamless transition.

4.4.16.2.2 The CONTRACTOR that is transferring a Member to another MCO shall provide relevant information and data to the receiving MCO within thirty

(30) Calendar Days of the Member's effective date of the transfer, in order to facilitate continuity of care and a seamless transition.

4.4.16.2.3 The CONTRACTOR shall ensure that any Member entering the CONTRACTOR's MCO is held harmless by the Provider for the costs of Medically Necessary Covered Services incurred due to the transfer except for applicable cost sharing.

4.4.16.3 Transition of Care Requirements for Pregnant Women

4.4.16.3.1 In the event a Member entering the CONTRACTOR's MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the CONTRACTOR's MCO, the CONTRACTOR shall be responsible for providing continued access to the prenatal care Provider (whether Contract or Non-Contract Provider) through the postpartum period, without any form of prior approval.

4.4.16.3.2 In the event a Member entering the CONTRACTOR's MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery without any form of prior approval and without regard to whether such services are being provided by a Contract or Non-Contract Provider for up to sixty (60) Calendar Days from the Member's enrollment or until the Member may be reasonably transferred to a Contract Provider without disruption in care, whichever is less.

4.4.16.3.3 If the Member is receiving services from a Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

4.4.16.3.4 If the Member is receiving services from a Non-Contract Provider, the CONTRACTOR shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the CONTRACTOR can reasonably transfer the

Member to a Contract Provider without impeding service delivery that might be harmful to the Member's health in accordance with this Section 4.4.16.3.

4.4.17 Transfer from the Health Insurance Exchange

4.4.17.1 The CONTRACTOR must minimize disruption of care and ensure uninterrupted access to Medically Necessary Services for individuals transitioning between Medicaid and Qualified Health Plan coverage on the Health Insurance Exchange.

4.4.17.2 At a minimum, the CONTRACTOR shall establish transition guidelines for the following individuals:

4.4.17.2.1 Pregnant women;

4.4.17.2.2 Individuals with significant health care needs or complex medical conditions;

4.4.17.2.3 Individuals receiving ongoing services or who are hospitalized at the time of transition; and

4.4.17.2.4 Individuals who received prior authorization for services from its Qualified Health Plan.

4.4.17.3 The CONTRACTOR is expected to coordinate services and provide phase-in and phase-out time periods for each of these individuals, and to maintain written policies, procedures and documentation to address coverage transitions.

4.4.18 Care Coordination for High Needs Populations

4.4.18.1 The CONTRACTOR shall employ or contract with dedicated care coordinators or Care Coordination supervisors with relevant expertise to meet the needs for each population listed below. The dedicated number of care coordinators for each population must be commensurate with the CONTRACTOR's membership in each of these populations.

4.4.18.1.1 Justice involved Members;

4.4.18.1.2 Traumatic Brain Injury Members;

4.4.18.1.3 Medically Fragile Members receiving case management services through UNM;

4.4.18.1.4 Individuals with Intellectual Disabilities;

4.4.18.1.5 Children and Adults with Special Health Care Needs;

4.4.18.1.6 Members with Housing Insecurity needs; and

4.4.18.1.7 Members with complex Behavioral Health needs including SUD.

4.4.18.2 High Needs Care Coordinator Roles:

4.4.18.2.1 Consult and collaborate with care team ensuring streamlined goals and non-duplication of services;

4.4.18.2.2 Develop and implement Transition of Care Plans and facilitate transitions with current Providers/facilities;

4.4.18.2.3 Pursue specialized training, expertise for their particular population's needs and available services; and

4.4.18.2.4 Provide high needs population training and consultation with other Care Coordination staff including Members who are involved with CYFD juvenile justice services, protective services, behavioral health services, and their parents and/or kinship caretakers.

4.4.19 Care Coordination Delegation

Two key goals of Centennial Care 2.0 are to transition more Care Coordination functions to the provider level and to advance Value-Based Purchasing (VBP) arrangements. To align these goals, HSD/MAD has established two Care Coordination models, the —Full Delegation Model and the Shared Functions Model.

Oversight and monitoring of Care Coordination remains the primary responsibility of the CONTRACTOR, and the CONTRACTOR is prohibited from delegating the oversight and monitoring of Care Coordination in Centennial Care to another health plan or administrative entity.

4.4.19.1 Full Delegation Model

In the Full Delegation Model, the CONTRACTOR delegates the full set of Care Coordination functions to the provider/health system (the delegate) for an attributable membership and only retains oversight and monitoring functions.

4.4.19.1.1 Full delegation of Care Coordination is permitted only when included as part of a Value-Based Purchasing (VBP) arrangement(s) that outlines a payment arrangement for the full delegation of Care Coordination and other

requirements associated with improving quality and health outcomes. Through VBPs that clearly define the terms of the VBP payment and delegation, the CONTRACTOR is able to fully delegate Care Coordination for the membership that is attributed to the delegate.

4.4.19.1.2 The VBP delivery system improvement target in Attachment 3 provides additional information about Care Coordination delegation requirements in VBP arrangements.

4.4.19.1.3 In a Full Delegation model, the delegate performs the following Care Coordination functions:

4.4.19.1.3.1 Completion of the HSD-standardized Health Risk Assessment, as applicable, to determine if the Member needs a CNA in accordance with Section 4.4.2 of this Agreement;

4.4.19.1.3.2 Completion of the CNA for those Members who meet the conditions in Section 4.4.5 of this Agreement. The delegate is not required to adhere to timelines described in Section 4.4.5 of this agreement; however, the CONTRACTOR is required to ensure that the CNA is completed in compliance with its Agreement with the Provider;

4.4.19.1.3.3 Assignment of Members to Care Coordination levels in accordance with Section 4.4.6 and Section 4.4.7 of this Agreement;

4.4.19.1.3.4 Identification of Members who may be eligible for a higher level of Care Coordination in accordance with Section 4.4.8 of this Agreement;

4.4.19.1.3.5 Development and implementation of a CCP based on the Member's individual needs and preferences in accordance with Section 4.4.9 of this Agreement;

4.4.19.1.3.6 Implementation and monitoring of the CONTRACTOR's approved CCP for Members receiving Community Benefits;

4.4.19.1.3.7 Delivery of ongoing Care Coordination services based on the Member's assessed need(s) in alignment with the CCP and contractual obligations for frequency of contact with the Member in accordance with Section 4.4.10 of this Agreement;

4.4.19.1.3.8 Maintenance of individual files for each Member in accordance with Section 4.4.11 of this Agreement;

4.4.19.1.3.9 Adherence to Care Coordination staff qualifications requirements in accordance with Section 4.4.12 of this Agreement;

4.4.19.1.3.10 Establish Care Coordination case load ratios based on the number and needs of attributed membership;

4.4.19.1.3.11 Care coordination monitoring in accordance with Section 4.4.13 of this Agreement; and

4.4.19.1.3.12 Adherence to Transition of Care requirements in accordance with Section 4.4.15 and 4.4.16 of this Agreement.

4.4.19.1.4 The CONTRACTOR shall not delegate NF LOC assessments to the delegate. NF LOC assessments and required timelines will remain the responsibility of the CONTRACTOR.

4.4.19.1.5 The CONTRACTOR shall not delegate Care Coordination for Members who are in the SDCB model. The CONTRACTOR remains responsible for all Care Coordination functions and Support Broker requirements within this Agreement.

4.4.19.1.6 The CONTRACTOR shall ensure that each Member's privacy is protected consistent with the State and federal confidentiality requirements, including those listed in 45 C.F.R.s § 160 and § 164 and 42 C.F.R. § 2.

4.4.19.1.7 The CONTRACTOR shall have written agreements with each delegate that specify delegated responsibilities, required Care Coordination Member penetration rates and annual Care Coordination targets and reporting responsibilities.

4.4.19.1.8 The CONTRACTOR shall have written procedures for monitoring and review of delegated activities including how delegated entities are evaluated for readiness to perform Care Coordination functions, how the CONTRACTOR will formally monitor the delegated entity for compliance with delegated responsibilities, how the CONTRACTOR will perform annual audits with its delegates and how the CONTRACTOR will ensure

overall quality of Care Coordination for Members served under such arrangements.

4.4.19.1.9 The CONTRACTOR remains responsible for reporting performance and tracking measures for its Members in delegated Care Coordination models as outlined in Section 4.4.19 of this Agreement.

4.4.19.1.10 The CONTRACTOR shall provide HSD with the details of the reimbursement agreement for each delegate in a Full Delegation model including provider identification number, effective dates and amount of payment per unit of service for full delegation.

4.4.19.1.11 The CONTRACTOR shall submit all payments to Providers in a full delegation model as Encounters per requirements outlined in Section 4.10 for each Member served by the delegate.

4.4.19.2 Shared Functions Model

In the Shared Functions Model, the CONTRACTOR retains some Care Coordination functions and allows other Care Coordination activities to be conducted by a partner. It does not require a VBP arrangement (although it may at the discretion of the CONTRACTOR and partner).

4.4.19.2.1 The CONTRACTOR may share Care Coordination functions to entities or individuals such as:

4.4.19.2.1.1 PCHMs;

4.4.19.2.1.2 FQHCs;

4.4.19.2.1.3 CHWs;

4.4.19.2.1.4 CHRs;

4.4.19.2.1.5 SBHCs;

4.4.19.2.1.6 Correctional Facilities;

4.4.19.2.1.7 CSAs;

4.4.19.2.1.8 Paramedicine Programs;

4.4.19.2.1.9 County entities;

4.4.19.2.1.10 Centers for Independent Living; and

4.4.19.2.1.11 Tribal Entities.

4.4.19.2.2 Potential shared Care Coordination functions may include the following:

4.4.19.2.2.1 Conducting HRAs;

4.4.19.2.2.2 Conducting CNAs;

4.4.19.2.2.3 Conducting periodic touch points with high need Members either in- person or telephonically;

4.4.19.2.2.4 Coordinating referrals and linking Members to Community Services; and

4.4.19.2.2.5 Locating and engaging with Unreachable and Difficult to Engage Members.

4.4.19.2.3 The CONTRACTOR shall develop a mutually-agreed upon reimbursement rate for shared functions of Care Coordination.

4.4.19.2.4 The CONTRACTOR shall make good faith efforts to contract with tribal organizations (I/T/Us) for shared Care Coordination functions.

4.4.19.2.5 The CONTRACTOR shall have written agreements with Contract Providers that specify shared Care Coordination functions and reporting responsibilities.

4.4.19.2.6 The CONTRACTOR shall maintain all oversight responsibilities for shared Care Coordination functions with the Contract Provider. The CONTRACTOR shall have written procedures for monitoring and review of shared Care Coordination functions including how entities are evaluated for readiness to perform shared Care Coordination functions, how the CONTRACTOR will formally monitor the entity for compliance with shared Care Coordination functions, and how the CONTRACTOR will ensure the quality of Care Coordination for Members served under these arrangements.

4.4.19.2.7 The CONTRACTOR shall be responsible for including Member outcomes from the Shared Functions Model in applicable HSD required reports including but not limited to reporting performance and tracking measures as outlined in Section 4.12 of this Agreement. The CONTRACTOR shall validate the delegated Contract Provider’s report and include the information in report submissions to HSD.

4.4.19.2.8 The CONTRACTOR shall provide HSD with the details of the reimbursement agreement for each Shared Function Model including provider identification number, effective dates and amount of payment per unit of service for the shared functions of Care Coordination.

4.4.19.2.9 The CONTRACTOR shall submit all payments to Contract Providers for shared functions of Care Coordination as Encounters outlined in Section 4.10 for each Member served by the Contract Provider.

4.5 **Benefits/Service Requirements and Limitations**

4.5.1 General

4.5.1.1 The CONTRACTOR shall provide and coordinate comprehensive and integrated health care benefits to each enrolled Member and shall cover the physical health, Behavioral Health and Long-Term Care services outlined in Attachment 2.

4.5.1.1.1 The CONTRACTOR shall provide health care services to its Members in accordance with 42 C.F.R. § 438.206 through § 438.210.

4.5.1.1.2 The CONTRACTOR shall have written standards for organ transplants that provide for similarly situated individuals to be treated alike and for any restriction on facilities or practitioners to be consistent with the accessibility of high-quality care to Members in accordance with Section 1903(i) of the Act.

4.5.1.2 If the CONTRACTOR is unable to provide Covered Services to a particular Member using Contract Providers, the CONTRACTOR shall adequately and timely cover these services for that Member using Non-Contract Providers, for as long as the CONTRACTOR's provider network is unable to provide them. At such time that the required services become available within the CONTRACTOR's network and the Member can be safely transferred, the CONTRACTOR may transfer the Member to an appropriate Contract Provider according to a transition of care plan developed specifically for the Member.

4.5.1.3 The CONTRACTOR shall provide all Members who are enrolled in the Alternative Benefit Plan (ABP) with information related to: (i) the ABP and (ii)

exemptions to mandatory enrollment in the ABP as described in Section 4.5.1.5 of this Agreement.

4.5.1.4 Members who are enrolled in the ABP are eligible to receive defined services that are Medically Necessary in the ABP if they are not ABP Exempt. Adult Members who are ABP Exempt may choose to receive the ABP outlined in Attachment 5 or the Covered Services outlined in Attachment 2. For the avoidance of doubt, Adult Members who are ABP Exempt and who select the Covered Services outlined in Attachment 2 may be eligible to receive the Community Benefit and/or nursing facility care if they meet nursing facility level of care as described in Sections 4.5.7 of the Contract.

4.5.1.5 The following individuals are ABP Exempt and may voluntarily opt-out of the ABP:

4.5.1.5.1 Individuals who qualify for medical assistance on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individuals are eligible for Supplemental Security Income benefits;

4.5.1.5.2 Individuals who are terminally ill and are receiving benefits for hospice care;

4.5.1.5.3 Pregnant women; or

4.5.1.5.4 Individuals who are Medically Frail.

4.5.1.6 Adult Members are determined to be ABP Exempt Members by either:

4.5.1.6.1 Self-identifying to the CONTRACTOR that they are exempt from mandatory enrollment into the ABP because they are an individual listed in Section 4.5.1.5 above. Adult Members may self-declare ABP Exempt status to the CONTRACTOR at any time. Upon the Member's self-identification, the CONTRACTOR, based on criteria established by HSD, shall evaluate and confirm whether the Member qualifies as ABP Exempt. The CONTRACTOR shall confirm ABP Exempt status within no more than 10 Business Days of the Member's self-identification to the CONTRACTOR. The Member remains enrolled in the ABP until the CONTRACTOR has

confirmed ABP Exempt status and the Member has chosen to receive the ABP Exempt benefit package; or

4.5.1.6.2 If an Adult Member does not self-identify as being ABP Exempt but the CONTRACTOR determines that the Member meets the ABP Exempt criteria listed in Section 4.5.1.5 above through the Care Coordination processes explained in Section 4.4 of this Contract or otherwise, the CONTRACTOR shall notify the Member that he/she may be ABP Exempt, explain the benefit differences for ABP Exempt individuals and facilitate his/her movement into the ABP Exempt benefit package (the Covered Services included in Attachment 2) at the Member's choice.

4.5.1.6.3 If the Member disagrees with the CONTRACTOR's ABP Exempt status determination, the Member may use the CONTRACTOR's grievance and appeals process as described in Section 4.16 of this Agreement.

4.5.1.7 The CONTRACTOR shall comply with 42 C.F.R.s § 438, § 440 and § 456 as they relate to the Mental Health Parity and Addiction Equity Act (Behavioral Health parity) and behavioral health parity requirements established by HSD, in addition to Autism parity established by NMSA 27-2-12 et seq. Public Assistance Act.

4.5.1.7.1 The CONTRACTOR shall provide services in compliance with the requirements in 42 C.F.R. § 438, Subpart K regarding parity in Mental Health or SUD services (see 42 C.F.R. § 438.3(n)(1)).

4.5.1.7.2 The CONTRACTOR shall cooperate with HSD to demonstrate ongoing compliance with 42 C.F.R. § 438, Subpart K regarding Behavioral Health parity. This will include but not limited to participating in meetings, providing information (documentation, data, etc.) as requested by HSD to assess ongoing parity compliance, working with HSD to resolve any non-compliance, and notifying HSD of any changes to benefits or limitations that might impact parity compliance.

4.5.1.7.3 If requested by HSD, the CONTRACTOR shall conduct an analysis to determine compliance with 42 C.F.R. § 438, Subpart K regarding Behavioral Health parity and provide the results of the analysis to HSD.

4.5.1.7.4 The CONTRACTOR shall not apply an Aggregate Lifetime Limit or Annual Dollar Limit (see 42 C.F.R. § 438.905) on any Mental Health or SUD service.

4.5.1.7.5 As specified in 42 C.F.R. § 438.910(b)(1) and (c), the CONTRACTOR shall not apply any Financial Requirement to a Mental Health or SUD service in any classification (inpatient, outpatient, emergency care, or prescription drugs) that is more restrictive than the predominant Financial Requirement of that type applied to substantially all physical health services in the same classification furnished to Members (whether or not the benefits are furnished by the CONTRACTOR). The CONTRACTOR shall follow State policy regarding copayment requirements, including populations subject to copayment, the amount of the copayment, populations and services exempt from copayments, as well as out-of-pocket maximums.

4.5.1.7.6 In accordance with 42 C.F.R. § 438.910(b)(1) and (c), the CONTRACTOR shall not apply any quantitative treatment limitation to any Mental Health or SUD service.

4.5.1.7.7 In accordance with 42 C.F.R. § 438.910(b)(2), the CONTRACTOR shall provide Mental Health and SUD services in all classifications (inpatient, outpatient, emergency care, and prescription drugs).

4.5.1.7.8 The CONTRACTOR shall not apply any cumulative Financial Requirements (see 42 C.F.R. § 438.910(c)(3)) on Mental Health or SUD services in a classification (inpatient, outpatient, emergency care, or prescription drugs) that accumulates separately from any cumulative financial requirement for physical health services in the same classification.

4.5.1.7.9 In accordance with 42 C.F.R. § 438.910(d), the CONTRACTOR shall not impose a non-quantitative treatment limitation (NQTL) on Mental Health or SUD services in any classification (inpatient, outpatient, emergency care, or

prescription drugs) unless, under the policies and procedures of the CONTRACTOR as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Mental Health or SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for physical health services in the classification.

4.5.1.7.10 Per 42 C.F.R. § 438.915(b), the CONTRACTOR shall make available to the Member the reason for any denial by the CONTRACTOR of reimbursement or payment for Mental Health or SUD services to the member.

4.5.2 Medically Necessary Services

4.5.2.1 The CONTRACTOR shall provide Medically Necessary Services consistent with 42 C.F.R. § 438.210(a)(5) including but not limited to the following:

4.5.2.1.1 A determination that a health care service is medically necessary does not mean that the health care service is a Covered Service; such determination will be made by HSD or its designee;

4.5.2.1.2 The CONTRACTOR, in making the determination of medical necessity of Covered Services shall do so by: (i) 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; (ii) considering the views and choices of the individual or the individual's Representative regarding the proposed Covered Service as provided by the clinician or through independent verification of those views; and (iii) considering the services being provided concurrently by other service delivery systems; (iv) considering the services provided at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual needs;

4.5.2.1.3 Physical, Behavioral Health and Long-Term Care services shall not be denied solely because the Member has poor prognosis. Medically Necessary 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;

4.5.2.1.4 The benefit package includes the delivery of federally mandated EPSDT services as set forth in Section 1902(a)(10) and 1905(r) of the Social Security Act. The CONTRACTOR agrees to meet all federal requirements of the EPSDT program pursuant to 42 C.F.R.s § 441.61 through § 441.62. The CONTRACTOR shall adhere to the State's periodicity schedules (as recommended by the American Academy of Pediatrics and Bright Futures) for eligible Members under twenty-one (21) years of age; and

4.5.2.1.5 Services shall be available twenty-four (24) hours, seven (7) days a week, when medically necessary.

4.5.3 Anti-Gag Requirement

4.5.3.1 The CONTRACTOR shall not prohibit or otherwise restrict a provider, if the provider is acting within the lawful scope of practice, from advising or advocating for a Member who is a patient of the provider in the following areas:

4.5.3.1.1 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 such care or treatment are Covered Services;

4.5.3.1.2 Any information the Member needs in order to decide among relevant treatment options;

4.5.3.1.3 The risks, benefits and consequences of treatment or non-treatment; or

4.5.3.1.4 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.

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

4.5.3.2.1 Objects to the provision of a counseling or referral service on moral or religious grounds, provided that the CONTRACTOR notifies Members and HSD as required by this Agreement and adheres to all requirements in 42 C.F.R. § 438.102;

4.5.3.2.2 Through written policies and procedures, the CONTRACTOR makes available information on its policies and procedures regarding such service to prospective Members before enrollment and to Members at least thirty (30) Calendar Days prior to the date the CONTRACTOR adopts a change in policy regarding such a counseling or referral service;

4.5.3.2.3 Notifies HSD 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;

4.5.3.2.4 Can demonstrate that the service in question is not included in the Covered Services; or

4.5.3.2.5 Determines that the recommended service is not a Medically Necessary Service.

4.5.4 Emergency and Post-Stabilization Services

4.5.4.1 Emergency Services shall be available to Members twenty-four (24) hours-a-day, seven (7) days-a-week.

4.5.4.2 The CONTRACTOR shall review and approve or disapprove Claims for Emergency Services based on the definition of Emergency Medical Condition specified in Section 2 of this Agreement. The CONTRACTOR shall base coverage decisions for Emergency Services on the severity of symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. The CONTRACTOR shall not

impose restrictions on the coverage of Emergency Services that are more restrictive than those permitted by the prudent layperson standard.

4.5.4.3 The CONTRACTOR shall have policies that address emergency and non-emergency use of services provided in an outpatient setting. Such policies and procedures shall include, among other things, the role of CSAs in crisis response for Members with SMI/SED.

4.5.4.4 The CONTRACTOR shall provide coverage for inpatient and outpatient Emergency Services, furnished by a qualified provider, regardless of whether the Member obtains the services from a Contract Provider, that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard. These services shall be provided without prior authorization in accordance with 42 C.F.R. § 438.114.

4.5.4.5 The CONTRACTOR shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.

4.5.4.6 Post-Stabilization Services are Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition, such that within reasonable medical probability, no material deterioration of the Member's condition is likely to result from or occur during discharge or post-discharge of the Member or transfer of the Member to another facility.

4.5.5 Birthing Options Program

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

4.5.6 Advance Directives

4.5.6.1 The CONTRACTOR shall provide Members and/or their Representatives with written information on Advance Directives that includes a description of applicable State and federal law and regulation, the CONTRACTOR's policies respecting the implementation of the right to have an Advance Directive and that

complaints concerning noncompliance with Advance Directive requirements may be filed with HSD. 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.

4.5.6.2 The CONTRACTOR shall honor Advance Directives within UM protocols.

4.5.6.3 The CONTRACTOR shall ensure that Members are offered the opportunity to prepare Advance Directives and, upon request, are provided assistance in the process.

4.5.6.4 The CONTRACTOR shall ensure that:

4.5.6.4.1 Written information is provided to Members and/or their Representatives concerning their rights to accept or refuse medical or surgical treatment and to formulate Advance Directives, and informing Members of the CONTRACTOR's policies and procedures with respect to the implementation of such rights, including the provision of a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;

4.5.6.4.2 Documentation exists in the Member's medical record and CCP, as applicable, whether or not the Member has executed Advance Directives;

4.5.6.4.3 Discrimination against Members based on whether the Member has executed Advance Directives is prohibited in the provision of care or in any other manner;

4.5.6.4.4 The CONTRACTOR complies with requirements of federal and State statutes and regulations respecting Advance Directives; and

4.5.6.4.5 Education is provided for staff, Contract Providers and the community on issues concerning Advance Directives.

4.5.7 Community Benefit

4.5.7.1 For Members meeting nursing facility level of care, the CONTRACTOR shall provide the Community Benefit, as determined appropriate, based on the Comprehensive Needs Assessment.

4.5.7.2 Members eligible for the Community Benefit will have the option to select either the Agency-Based Community Benefit or the Self-Directed Community Benefit.

4.5.7.2.1 Members selecting the Agency-Based Community Benefit will have a choice of the consumer delegated model or consumer directed model for personal care services.

4.5.7.2.2 The Self-Directed Community Benefit is further described in Section 4.6 of this Agreement.

4.5.7.3 Members may not choose to move between the Agency-Based Community Benefit and the Self-Directed Community Benefit without prior approval from HSD.

4.5.7.4 The CONTRACTOR shall track each Member's Community Benefit and provide reports on such benefit as directed by HSD.

4.5.7.5 The maximum allowable cost of care for the Community Benefit will be tied to the State's cost of care for persons served in a private nursing facility, except as described in Section 4.6.1.7. However, the maximum allowable cost of care is not an entitlement. A Member's actual cost of care for the Community Benefit will be determined by the CNA.

4.5.7.5.1 The annual cost limitation will be determined by HSD prior to the beginning of each annual period for this Agreement based on the projected cost of placement in a Medicaid custodial nursing facility, excluding State Owned Nursing Facilities for low level of care.

4.5.7.5.2 The actual amount that can be spent by a Member in his/her CCP per year is subject to the Member's CNA.

4.5.7.5.3 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HSD for expenditures exceeding the cost limitation developed by HSD in Section 4.5.7.5.1 and 4.6.1.7.1 of this Agreement.

4.5.7.6 The CONTRACTOR shall ensure that any services covered in this Agreement, or that could be authorized through a 1915(c) Waiver or a State plan amendment authorized through Sections 1915(i) or 1915(k) of the Social Security Act shall be delivered in settings consistent with 42 C.F.R. § 441.301(c)(4). The

CONTRACTOR shall monitor the provision of all community benefits to ensure provider compliance with all applicable federal Home- and Community-Based settings requirements.

4.5.8 Family Planning Services

4.5.8.1 Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall implement written policies and procedures, previously approved by HSD, that define how Members are educated about their right to family planning services, freedom of choice (including access to Non-Contract Providers) and methods for accessing family planning services. The family planning policy shall ensure that Members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following:

4.5.8.1.1 HIV and other sexually transmitted diseases and risk reduction practices;

4.5.8.1.2 Birth control pills and devices (including Plan B); and

4.5.8.1.3 That Members can self-refer to Non-Contracted family planning Providers.

4.5.9 Prenatal Care Program

4.5.9.1 The CONTRACTOR shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. Gynecological or obstetrical ultrasounds shall be provided without requiring a prior authorization of any kind.

4.5.10 Care Coordination

4.5.10.1 The CONTRACTOR shall provide Care Coordination services in accordance with Section 4.4 of this Agreement.

4.5.10.2 Section 7.2.9 of this Agreement details which Care Coordination services will be deemed medical expenses and which will be deemed administrative expenses in determining the CONTRACTOR's Medical Expense Ratio.

4.5.11 RESERVED

4.5.12 Second Opinions

Members or their Representatives shall have the right to seek a second opinion from a qualified health care professional within the CONTRACTOR's network, or the CONTRACTOR shall arrange for the Member to obtain a second opinion outside the network, at no cost to the Member. A second opinion may be requested when the Member or the Member's Representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

4.5.13 The CONTRACTOR shall not impose any enrollment fee, premium or similar charge and shall not impose any deductible, copayment, cost sharing or similar charge to Members who are Native American, who were furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or by a health provider through referral under contract health services for which Medicaid payment may be made. In addition, payment to these Providers may not be reduced by any such charges. This requirement is in accordance with Section 5006(a)(1)(A) of the American Recovery and Reinvestment Act of 2009 (ARRA).

4.5.14 In Lieu of Services or Settings

In Lieu of Services or Settings are alternative services or services in settings that are not Medicaid covered benefits, as set forth in Attachment 2, but are medically appropriate and cost-effective substitutes. The CONTRACTOR may not require a Member to use in Lieu of Services or Settings as a substitute for Centennial Care Covered Services, but may offer and cover such services or settings, if approved by HSD, as a means of ensuring that appropriate care is provided in a cost-effective manner.

4.5.14.1 The CONTRACTOR must obtain approval in writing from HSD prior to offering or paying Claims for In Lieu of Services or Settings services.

4.5.14.2 The CONTRACTOR shall ensure that the In Lieu of Services or Settings service is a cost-effective substitute for the Centennial Care Covered Service and shall provide support of the services cost effectiveness to HSD.

4.5.14.3 HSD may not consider the costs of the in Lieu of Services and Settings service in the CONTRACTOR'S Capitation Rate if the In Lieu of Services and Settings

service is not approved by HSD, is not cost effective, or the CONTRACTOR fails to provide supporting documentation to HSD.

4.5.15 Institution for Mental Disease (IMD)

To address access issues for short term, acute psychiatric and substance use disorder needs, a short-term stay (up to fifteen (15) Calendar Days per month) in an IMD may be necessary for Members between 21-64 years old during the term of this Agreement. The use of an IMD is an In Lieu of Services and Settings service, and the CONTRACTOR must meet the requirements outlined in Section 4.5.16.

4.5.15.1 The utilization of an IMD for Members between twenty-one (21) and sixty-four (64) years old is limited to fifteen (15) Calendar Days in a Calendar Month. The fifteen (15) Calendar Days may be consecutive or cumulative in a Calendar Month.

4.5.15.2 It is the responsibility of the CONTRACTOR to ensure that the fifteen (15) Calendar Day limit is not exceeded.

4.5.15.2.1 If HSD approves the IMD as an In Lieu of Service and Settings service and retrospectively finds that that the CONTRACTOR has allowed a stay of more than fifteen (15) Calendar Days in a Calendar Month, then HSD shall recoup the Capitation Payment made to the CONTRACTOR for the member and month for which a stay in excess of fifteen (15) total Calendar Days occurs.

4.5.15.3 If HSD approves the In Lieu of Service and Settings service as outlined in Section 4.5.14 and the CONTRACTOR fails to limit the stay to fifteen (15) Calendar Days, the HSD will only consider the first fifteen (15) Calendar Days in the development of prospective Capitation Rate as outlined in Section 6 and disregard costs associated with days in excess of fifteen (15) Calendar Days.

4.5.16 Justice-Involved Utilization of State Transitioned Healthcare (JUST Health)

4.5.16.1 The CONTRACTORS are responsible for Medicaid-covered inpatient or outpatient services provided to their Members during the time frame preceding any Member’s effective date as an inmate. This means that a Member may be detained or incarcerated for up to thirty (30) consecutive days before meeting the

definition of an inmate, and that this period of detention/incarceration will have no bearing on the individual's eligibility or benefit package, or on the MCO's responsibility to provide payment for Medicaid-Covered Services. Prior authorizations may be required for some services.

4.5.16.2 When an individual is considered an inmate under Section 4.5.16.1 above, the CONTRACTOR Capitation Payments will cease on the last day of the month in which the inmate's Medicaid benefits were suspended. The MCO Capitation Payment for the month in which a suspension occurred will not be recouped by HSD. The only exception to this process will be when an inmate's suspension date occurs on the first day of the month. In these cases, enrollment with the MCO will be terminated effective on the final day of the preceding month.

4.5.16.3 When an inmate is released from incarceration, MAD will reinstate the individual's Medicaid benefits. MCO Capitation Payments will generally be effective on the first day of the month in which the inmate was released and their benefits were reactivated.

4.5.16.4 The only exception to this process will be when an inmate is released on the last day of the month. In these cases, MCO Capitation Payments will begin on the first day of the next month.

4.5.16.5 As described above in Section 4.5.16.2, JUST Health individuals are defined as inmates after thirty (30) consecutive days of incarceration/detention. The CONTRACTOR retains the financial responsibility to pay for Medicaid-covered services received by incarcerated/detained members prior to the suspension of benefits for the duration of any month in which a member is enrolled and a capitation payment has been made and not recouped by HSD. Payment by HSD of inpatient hospital stays for JUST Health individuals is limited to patients from incarceration/detention facilities that have an agreement with HSD for the coverage of inpatient hospitalization. For an inpatient hospital stay of an incarcerated individual, the CONTRACTOR retains the financial responsibility to pay for any professional services related to the inpatient stay for the duration of any month in which a member is enrolled and a capitation payment has been

made and not recouped by HSD, as well as for the hospital stay if the discharge takes place during the month for which a capitation payment was made. When the recipient's enrollment is suspended on the date of discharge and the discharge takes place during a month for which the CONTRACTOR is not paid a capitation and the member is not enrolled with the CONTRACTOR, payment is made by HSD through FFS for (1) the entire hospital stay, and (2) the accompanying professional services for the time period during which the CONTRACTOR did not receive a capitation payment and member enrollment. For incarcerated individuals who are patients from incarceration/detention facilities that do not have an agreement with HSD for the coverage of inpatient hospitalization, and who are discharged during a month in which the CONTRACTOR is not paid a capitation payment and the member is not enrolled with the CONTRACTOR, the CONTRACTOR's standard processes shall apply for disenrolled individuals as described in Section 4.10.2.6.4. Medication Assisted Therapy (MAT) services may be provided in the facility of incarceration/detention by a Medicaid enrolled Provider who is certified to perform MAT services, if the services are provided prior to the suspension of the Member's Medicaid benefits.

4.5.16.6 RESERVED

4.5.16.7 The CONTRACTOR is required to designate a liaison for Justice-Involved Care Coordination and transitions of care. The designated liaison is to be the single point-of-contact to communicate with the prisons, jails, and detention facilities, and who can facilitate the Care Coordination process for Justice-Involved Members, to include Native American members transitioning from incarceration and minor members transitioning from juvenile detention facilities.

4.5.17 Tobacco Cessation Program

4.5.17.1 The CONTRACTOR shall operate a tobacco cessation program to assist Members with tobacco cessation.

4.5.17.1.1 The tobacco cessation program shall include, at a minimum, the following:

4.5.17.1.1.1 Cessation Quitline;

4.5.17.1.1.2 Group counseling;

4.5.17.1.1.3 Individual counseling;

4.5.17.1.1.4 FDA approved pharmacotherapies and/or nicotine replacement therapies (NRT) such as Bupropion, Chantix, nicotine patch, chewing gum, nasal spray, inhaler and lozenges.

4.5.17.1.2 The CONTRACTOR shall not require prior authorization for tobacco cessation services, including counseling, or nicotine replacement products or therapies. The CONTRACTOR shall have no limits on length of treatment or quit attempts per year, no step therapy requirements, and shall encourage but not require enrollment in counseling for the tobacco cessation program.

4.6 **Self-Directed Community Benefit (SDCB)**

4.6.1 General

4.6.1.1 The CONTRACTOR shall offer the SDCB to: (i) non- ABP Members who meet nursing facility level of care and are determined through a CNA/reassessment to need the Community Benefit; and (ii) ABP Exempt Members who select the Covered Services in Attachment two (2) who meet nursing facility level of care and are determined through a CNA/reassessment to need the Community Benefit. Self-direction in Centennial Care affords Members the opportunity to have choice and control over how SDCB services are provided, who provides the services and how much Providers are paid for providing care in accordance with a range of rates per service established by HSD. A list of SDCB services is included in Attachment two (2).

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HSD to provide assistance to Members who choose the SDCB. The contract shall include performance metrics that are monitored by the CONTRACTOR. The CONTRACTOR shall conduct contract oversight and ensure that FMA issues with SDCB provider payments are addressed within ten (10) Business Days.

4.6.1.3 Members who participate in the SDCB choose either to serve as the EOR of their Providers or to designate an individual to serve as the EOR on his or her behalf. A Member who is an un-emancipated minor or under guardianship cannot serve

as the EOR and must designate an individual to assume the functions on his or her behalf.

4.6.1.4 The EOR and Authorized Agent, if any, must be documented in the Member's file. The care coordinator shall also include a copy of any EOR and Authorized Agent forms in the Member's file and provide copies to the Member, the Member's Representative and the FMA.

4.6.1.5 The CONTRACTOR shall have a contract effective with the FMA for each of the periods covered by this Agreement and shall not terminate its agreement with the FMA during the term of this Agreement without engaging in mediation and/or mitigation strategies as approved by HSD.

4.6.1.6 HSD will reimburse the per member per month expenses for the required activities of the FMA in the capitated payments made by HSD to the CONTRACTOR in accordance with Section 6 of this Agreement. Costs incurred for activities not included in the per member per month payment will not be reimbursed by HSD.

4.6.1.7 "Grandfathered" Self-Directed Community Benefit Members

4.6.1.7.1 Members who were enrolled in Centennial Care effective January 1, 2014 and had approved self-directed budgets prior to December 31, 2013 that exceeded the cost limitation in Section 4.5.7.5 have been "grandfathered" with their prior approved self- directed budget, which became their annual cost limitation subject to Section 4.6.1.7.2.

4.6.1.7.2 "Grandfathered" clients, while not subject to the annual Community Benefit cost limitations imposed by Section 4.5.7.5 of this Agreement, will be subject to the CNA and CCP development process.

4.6.1.7.3 The CONTRACTOR is prohibited from imposing reimbursement modifications to existing Providers for "grandfathered" clients.

4.6.1.7.4 HSD will provide the CONTRACTOR with information to identify "grandfathered" Members.

4.6.1.8 Self-Directed Community Benefit Members

4.6.1.8.1 Members who did not have an approved self-directed budget that exceeded the cost limitation described in Section 4.5.7.5 prior to January 1, 2014 are subject to annual cost limitations defined by HSD in Section 4.5.7.5.1 of this Agreement.

4.6.1.8.2 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HSD for expenditures exceeding the cost limitation developed by HSD in Section 4.5.7.5.1 of this Agreement.

4.6.1.9 Members who enter the Self-Directed Community Benefit (SDCB) Model on or after January 1, 2019 are subject to annual limits on the following services:

4.6.1.9.1 Related Goods: $2,000 limit;

4.6.1.9.2 Specialized Therapies: $2,000 limit; and

4.6.1.9.3 Non-Medical Transportation: $1,000 limit.

4.6.2 CONTRACTOR Responsibilities

4.6.2.1 The CONTRACTOR shall ensure that the Member and/or the Member's Representative fully participate in developing and administering the SDCB, and that sufficient supports are made available to assist Members who require assistance. This includes, but is not limited to, the development of the annual budget amount based on the Member's needs as identified in the annual Comprehensive Needs Assessment. In this capacity, the CONTRACTOR shall fulfill, at a minimum, the following tasks:

4.6.2.1.1 Understand the Member's and EOR's roles and responsibilities;

4.6.2.1.2 Identify resources outside the Centennial Care program, including natural and informal supports that may assist in meeting the Member's needs;

4.6.2.1.3 Understand the array of the SDCB;

4.6.2.1.4 Determine the annual budget for the SDCB, based on the Comprehensive Needs Assessment to address the needs of the Member in accordance with the requirements stated in this Section 4.6 and the Member's Community Benefit;

4.6.2.1.5 Monitor utilization of SDCB services and goods on a regular basis;

4.6.2.1.6 Conduct employer-related activities, such as assisting a Member in identifying a designated EOR (as appropriate);

4.6.2.1.7 Identify and resolve issues related to the implementation of the CCP;

4.6.2.1.8 Assist the Member with quality assurance activities to ensure implementation of the Member's SDCB care plan and utilization of the authorized budget;

4.6.2.1.9 Recognize and report Critical Incidents, including Abuse, neglect, exploitation, Emergency Services, law enforcement involvement and environmental hazards; and

4.6.2.1.10 Monitor quality, including but not limited to: (i) the adequacy of Member-to-support broker ratios; (ii) the relationship between support brokers and care coordinators; and (iii) the services provided by support brokers.

4.6.2.2 The care coordinator shall work with the Member to determine the appropriate level of assistance necessary to recruit, interview, hire Providers and provide the necessary assistance for successful program implementation.

4.6.3 Support Broker Functions

4.6.3.1 The CONTRACTOR shall perform, or contract with a qualified vendor to perform, the support broker functions for Members electing the SDCB.

4.6.3.1.1 If the CONTRACTOR performs the support broker functions, in addition to its employed Support Brokers, it must also offer the Member a choice of at least two additional Support Broker agencies.

4.6.3.1.2 If the CONTRACTOR does not perform the support broker functions, it must offer the member a choice of multiple contracted support broker agencies.

4.6.3.2 The CONTRACTOR shall be responsible for ensuring that all applicable requirements are met. At minimum, the CONTRACTOR (either directly or through a Subcontractor) shall perform the following support broker functions:

4.6.3.2.1 Educate Members on how to use self-directed supports and services and provide information on program changes or updates;

4.6.3.2.2 Review, monitor and document progress of the Member's SDCB services and budget;

4.6.3.2.3 Assist in managing budget expenditures and complete and submit budget revision requests;

4.6.3.2.4 Assist with employer functions, such as recruiting, hiring and supervising Providers;

4.6.3.2.5 Assist with approving/processing job descriptions for direct supports;

4.6.3.2.6 Assist with completing forms related to employees;

4.6.3.2.7 Assist with approving timesheets and purchase orders or invoices for goods, obtaining quotes for services and goods, as well as identifying and negotiating with vendors;

4.6.3.2.8 Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;

4.6.3.2.9 Facilitate resolution of any disputes regarding payment to Providers for services rendered;

4.6.3.2.10 Develop the care plan for SDCB services, based on the budget amount and ensure that it is included in the CCP; and

4.6.3.2.11 Assist in completing all documentation required by the FMA.

4.6.3.3 The CONTRACTOR shall have policies and procedures in place to ensure that support brokers and care coordinators work in a collaborative manner, and do not duplicate activities or functions.

4.6.3.4 The CONTRACTOR shall conduct an annual audit of the Support Broker network to ensure that all above requirements and those outlined in the Managed Care Policy Manual are met.

4.6.4 FMA Training

4.6.4.1 The CONTRACTOR shall work in collaboration with other Centennial Care MCOs to provide education and training to the FMA and its staff regarding key requirements of this Agreement.

4.6.4.2 The CONTRACTOR shall conduct initial education and training to the FMA and its staff at least forty-five (45) Calendar Days prior to Go-Live. This education and training shall include, but not be limited to, the following:

4.6.4.2.1 The role and responsibilities of the care coordinator, including, but not limited to, Comprehensive Needs Assessment and CCP development, CCP implementation and monitoring processes, including the development and activation of a back-up plan for Members participating in the SDCB;

4.6.4.2.2 The FMA's responsibilities for communicating with the CONTRACTOR, Members, EORs, Authorized Agents, Providers, HSD and the process by which to do this;

4.6.4.2.3 Requirements and processes regarding referral to the FMA;

4.6.4.2.4 Requirements and processes, including time frames for authorization of the Self-Directed Community Benefit;

4.6.4.2.5 Requirements and processes, including time frames, for Claims submission and payment and coding requirements;

4.6.4.2.6 Systems requirements and Health Information Exchange requirements;

4.6.4.2.7 HIPAA compliance; and

4.6.4.2.8 Centennial Care program quality requirements.

4.6.4.3 The CONTRACTOR shall provide ongoing FMA education, training and technical assistance as deemed necessary by the CONTRACTOR or HSD in order to ensure compliance with this Agreement.

4.6.4.4 The CONTRACTOR shall provide to the FMA, in electronic format (including, but not limited to, CD or access via a web link) a Member handbook and updates thereafter annually or any time material changes are made.

4.6.5 Self-Assessment

4.6.5.1 The care coordinator shall provide the Member with a self-assessment instrument developed by HSD. The self-assessment instrument shall be completed by the Member with assistance from the Member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the Member's file.

4.6.5.2 If, based on the results of the self-assessment, the care coordinator determines that a Member requires assistance to direct his or her services, the care coordinator shall inform the Member that he or she will need to designate an EOR to assume the self-direction functions on his or her behalf.

4.6.6 Back-up Plan

4.6.6.1 The support broker shall assist the Member/EOR in developing a back-up plan for the SDCB that adequately identifies how the Member/EOR will address situations when a scheduled provider is not available or fails to show up as scheduled.

4.6.6.2 The CONTRACTOR shall file a copy of the back-up plan in the Member's file.

4.6.6.3 The Member's support broker shall assess the adequacy of the Member's back-up plan on at least an annual basis and any time there are changes in the type, amount, duration, scope of the SDCB or the schedule at which such services are needed, changes in Providers (when such Providers also serve as a back-up to other Providers) or changes in the availability of paid or unpaid back-up Providers to deliver needed care.

4.6.7 Budget

4.6.7.1 The care coordinator shall develop a budget for the SDCB services the Member is identified to need as a result of the Comprehensive Needs Assessment.

4.6.7.2 The support broker and the Member shall work together to develop a plan for the SDCB services that are part of the overall CCP within the SDCB budget. The support broker and Member shall refer to the range of rates specified by HSD in selecting payment rates for Providers and vendors.

4.6.7.3 The budget for the SDCB services shall be based upon the Member's assessed needs. The Member shall have the flexibility to negotiate provider rates within the rate range and allocated budget. A Member shall have the flexibility to choose from the range of HSD specified rates for all SDCB services.

4.6.7.4 The CONTRACTOR shall evaluate the rates selected by the Member for SDCB services for reasonableness.

4.6.7.5 The support broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the SDCB care plan will necessitate adjustments to the budget and that the Member does not exceed his or her budget.

4.6.8 Provider Qualifications

4.6.8.1 The FMA shall verify that all potential Providers meet all applicable qualifications prior to delivering services.

4.6.8.2 If a Provider or employee is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. and/or is listed in the abuse registry as defined in NMSA 1978, 27-7a-1 et seq., that person may not be employed to provide any services under Centennial Care.

4.6.8.3 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a provider, such as a neighbor or a friend.

4.6.8.4 Following formal approval from the CONTRACTOR, legally responsible individuals (including parents) of minors, who must provide care to the minor, may serve as Providers under extraordinary circumstances in order to assure the health and welfare of the minor and to avoid institutionalization. The CONTRACTOR shall make decisions regarding legally responsible individuals serving as Providers for minors on a case by case basis.

4.6.8.5 Following formal approval from the CONTRACTOR, spouses of Members may serve as Providers under extraordinary circumstances in order to assure the health and welfare of the Member and to avoid institutionalization. The CONTRACTOR shall provide such approval on a case-by-case basis.

4.6.8.6 Members shall have an employment agreement or vendor agreement, as appropriate, with each of their Providers. The employment agreement/vendor agreement template shall be prescribed by HSD. Prior to a payment being made to a provider for Self-Directed Community Benefit Services, the FMA shall ensure that: (i) the provider meets all qualifications; and (ii) an employment agreement/vendor agreement is signed between the EOR and the provider.

4.6.8.7 Employment agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employment agreements shall be signed by the new EOR when there is a change in EORs.

4.6.8.8 A copy of each employment agreement/vendor agreement shall be provided to the Member and/or EOR. The CONTRACTOR shall give a copy of the employment agreement/vendor agreement to the provider and shall maintain a copy for its files.

4.6.8.9 The FMA shall ensure that an employment agreement/vendor agreement is in place for each provider prior to the provision of services.

4.6.9 Training

4.6.9.1 The CONTRACTOR shall require all Members electing to enroll in the SDCB and their EORs to receive relevant training. The support broker shall be responsible for arranging for initial and ongoing training of Members and/or EORs.

4.6.9.2 At a minimum, self-direction training for Members and/or EORs shall address the following issues:

4.6.9.2.1 Understanding the role of Members and EORs with the SDCB;

4.6.9.2.2 Understanding the role of the support broker and the FMA;

4.6.9.2.3 Selecting Providers;

4.6.9.2.4 Critical Incident reporting;

4.6.9.2.5 Abuse and Neglect prevention and reporting;

4.6.9.2.6 Being an employer, evaluating provider performance and managing Providers;

4.6.9.2.7 Fraud and Financial Abuse prevention and reporting;

4.6.9.2.8 Performing administrative tasks, such as reviewing and approving EVV electronically-captured visit information; and

4.6.9.2.9 Scheduling Providers and back-up planning.

4.6.9.3 The CONTRACTOR shall arrange for ongoing training for Members and/or EORs upon request and/or if a support broker, through monitoring, determines that additional training is warranted.

4.6.9.4 The CONTRACTOR shall arrange for initial and ongoing training of direct care Providers (not vendors). At a minimum, training shall consist of the following required elements:

4.6.9.4.1 Overview of the Centennial Care program and the SDCB;

4.6.9.4.2 Caring for elderly and disabled populations;

4.6.9.4.3 Abuse and Neglect identification and reporting;

4.6.9.4.4 Fraud and Financial Abuse prevention and reporting;

4.6.9.4.5 Cardiopulmonary resuscitation (CPR) and first aid certification;

4.6.9.4.6 Critical Incident reporting;

4.6.9.4.7 Submission of required documentation and withholdings; and

4.6.9.4.8 As appropriate, administration of self-directed health care task(s).

4.6.9.5 The support broker shall assist the Member/EOR in determining to what extent the Member/EOR shall be involved in the above-specified training. The Member/EOR shall provide additional training to the provider regarding individualized service needs and preference.

4.6.9.6 The CONTRACTOR shall verify that Providers have successfully completed all required training prior to service initiation and payment for services.

4.6.9.7 Additional training and refresher components may be provided to a provider to address issues identified by the support broker, Member and/or the EOR or at the request of the provider.

4.6.10 Monitoring

4.6.10.1 The care coordinator shall monitor the quality of service delivery and the health, safety and welfare of Members participating in the SDCB.

4.6.10.2 The care coordinator shall monitor implementation of the back-up plan by the Member or his or her EOR/Authorized Agent.

4.6.10.3 The care coordinator shall monitor a Member's participation in the SDCB to determine, at a minimum, the success and the viability of the service delivery model for the Member. The care coordinator shall note any patterns, such as frequent turnover of EORs and Providers that may warrant intervention by the care coordinator. If problems are identified, a care coordinator should also ask a

Member to complete a self-assessment to determine what additional supports, if any (such as designating an EOR or Authorized Agent) could be made available to assist the Member.

4.6.10.4 The CONTRACTOR shall adhere to all State requirements for Critical Incident identification, reporting and investigation.

4.6.11 Termination from SDCB

4.6.11.1 The CONTRACTOR may involuntarily terminate a Member from the SDCB under any of the following circumstances:

4.6.11.1.1 The Member refuses to follow HSD rules and regulations after receiving focused technical assistance on multiple occasions, support from the care coordinator or FMA, which is supported by documentation of the efforts to assist the Member;

4.6.11.1.2 There is an immediate risk to the Member's health or safety by continued self-direction of services, i.e., the Member is in imminent risk of death or serious bodily injury. Examples include, but are not limited to, the following: the Member: (i) refuses to include and maintain services in his or her CCP that would address health and safety issues identified in his or her Comprehensive Needs Assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, Care Coordination or FMA; (ii) is experiencing significant health or safety needs and refuses to incorporate the care coordinator's recommendations into his or her CCP; or (iii) exhibits behaviors that endanger him/her or others;

4.6.11.1.3 The Member misuses his or her SDCB budget following repeated and focused technical assistance and support from the care coordinator and/or FMA, which is supported by documentation;

4.6.11.1.4 The Member expends his/her entire SDCB budget prior to the end of the CCP year; or

4.6.11.1.5 The Member commits Medicaid Fraud.

4.6.11.2 The CONTRACTOR shall submit to HSD any requests to terminate a Member from the SDCB with sufficient documentation regarding the rationale for termination.

4.6.11.3 Upon HSD approval, the CONTRACTOR shall notify the Member regarding termination in accordance with HSD rules and regulations. The Member shall have the right to Appeal the determination by requesting a Fair Hearing.

4.6.11.4 The CONTRACTOR shall facilitate a seamless transition from the SDCB to ensure there are no interruptions or gaps in services.

4.6.11.5 Involuntary termination of a Member from the SDCB shall not affect a Member's eligibility for Covered Services or enrollment in Centennial Care.

4.6.11.6 The CONTRACTOR shall notify the FMA within one (1) Business Day of processing the outbound enrollment file when a Member is involuntarily terminated from the SDCB and when a Member is disenrolled from Centennial Care. The notification should include the effective date of termination and/or disenrollment, as applicable.

4.6.11.7 Members who have been involuntarily terminated may request to be reinstated in the SDCB. Such request may not be made more than once in a twelve (12) month period. The care coordinator shall work with the FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement. All Members shall be required to participate in SDCB training programs prior to re-instatement in the SDCB.

4.6.12 Claims Submission and Payment

4.6.12.1 Members shall review and approve timesheets of their Providers to determine accuracy and appropriateness.

4.6.12.2 No SDCB provider shall exceed forty (40) hours paid work in a consecutive seven (7) Calendar Day period.

4.6.12.3 Timesheets must be submitted and processed on a two (2) week pay schedule according to HSD's prescribed payroll payment schedule.

4.6.12.4 The FMA shall be responsible for processing payments for approved Centennial Care services and goods.

4.6.12.5 The CONTRACTOR shall reimburse the FMA for authorized SDCB services provided by Providers at the appropriate rate for the self-directed HCBS, which includes applicable payroll taxes.

4.7 **Value Added Services**

4.7.1 The CONTRACTOR shall offer to its Members Value Added Services that are not Covered Services. The CONTRATOR may offer Value Added Services in the ABP.

4.7.2 Value Added Services shall be approved in writing by HSD to supplement the Covered Services provided to such Members.

4.7.3 The cost of Value Added Services will not be included when HSD determines the Capitation Rate. All Value Added Services shall be identifiable and measurable through the use of unique payment and/or processing codes, approved by HSD. At the CONTRACTOR's request, HSD may assist in identifying a compliant code.

4.7.4 Value Added Services are not Medicaid-funded services; therefore, there is neither Appeal nor Fair Hearing rights. The CONTRACTOR shall send the Member a notification letter if the requested Value Added Service required prior approval and was not approved, i.e., denied.

4.7.4.1 Denial of a Value Added Service will not be considered an Adverse Benefit Determination for purposes of Appeals or Fair Hearings.

4.8 **Provider Network**

4.8.1 General Requirements

4.8.1.1 The CONTRACTOR shall comply with the requirements specified in 42 C.F.R.s § 438.12, § 438.14, § 438.207(c), § 438.214 and all applicable State requirements regarding provider networks. The CONTRACTOR shall have policies and procedures that reflect these requirements. The CONTRACTOR shall also:

4.8.1.1.1 Establish and maintain a comprehensive network of Providers capable of serving all Members who enroll in the CONTRACTOR's MCO.

4.8.1.1.2 Pursuant to Section 1932(b)(7) of the Social Security Act, and consistent with 42 C.F.R. § 438.12, not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment;

4.8.1.1.3 Not discriminate with respect to participation, reimbursement, or indemnification of 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;

4.8.1.1.4 Upon declining to include individual or groups of Providers in its network, give the affected Providers written notice of the reason for its decision;

4.8.1.1.5 Be allowed to negotiate different reimbursement amounts for different specialties or for different practitioners in the same specialty;

4.8.1.1.6 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;

4.8.1.1.7 Not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or State Children's Health Insurance Program (SCHIP) sanctions, except for Emergency Services; and

4.8.1.1.8 Provide Members with special health care needs direct access to a specialist, as appropriate for the Member's health care condition, as specified in 42 C.F.R. § 438.208(c)(4).

4.8.1.1.9 The CONTRACTOR must ensure that Members have access to a 24/7 pharmacy in each geographic location where one is available and comply with the Distance Requirements in Section 4.8.7.4 of this Agreement.

4.8.1.2 The CONTRACTOR shall submit a Provider Network Development and Management Plan as directed by HSD.

4.8.1.2.1 The CONTRACTOR shall submit a Comprehensive Behavioral Health Provider Network Development and Management Plan to be included in the submission of the Provider Network Development and Management Plan.

4.8.1.3 The CONTRACTOR must submit a provider suspension/termination report as directed by HSD.

4.8.1.4 The CONTRACTOR shall obtain HSD approval of any plan to utilize a Preferred Vendor(s) and/or Sole Source Provider(s) to substantially provide a provision of service in Attachment 2 in order to monitor potential consequences of narrowed networks or reduced Member access.

4.8.1.5 Special Provisions for the State-Teaching Hospital

4.8.1.5.1 The CONTRACTOR shall make good faith efforts to contract with the State-teaching hospital for all services provided by the State-teaching hospital, including inpatient, outpatient and physician specialty services. Agreements, which establish a limited scope of inpatient, outpatient, or physician specialty services, are not considered to be a contract for the purposes of this Section.

4.8.1.5.2 If the CONTRACTOR and the State teaching hospital are unsuccessful after making good faith efforts to enter into an Agreement the following shall apply:

4.8.1.5.2.1 The CONTRACTOR shall supply HSD with all materials related to the CONTRACTOR's proposed terms and conditions, including all proposed reimbursement schedules presented to the State-teaching hospital for HSD's review, including the proposed relativity to the Medicaid fee schedule (including the enhanced safety net care hospital reimbursement rate); When responding to a records request, to the fullest extent possible, HSD will assert the exceptions and exemptions available under applicable laws, including, but not necessarily limited to, the New Mexico Inspection of Public Records Act.

4.8.1.5.2.2 HSD may adjust the CONTRACTOR'S Capitated Rates outlined in Section 6 to reflect the exclusion of the State teaching hospital experience from the CONTRACTOR's Capitated Rates and Capitation Payments; and

4.8.1.5.2.3 If the Member requires treatment and/or care that is medically necessary and unique to the State teaching hospital and cannot be provided from

any of the CONTRACTOR's Contract Providers operating in the State of New Mexico, the CONTRACTOR shall identify an out-of-state provider for treatment within 48 hours of receiving notification of the Member's treatment and/or care needs. The CONTRACTOR shall execute a single-case agreement with the out-of-state provider that is able to perform the necessary treatment and/or care. Notification includes the following:

4.8.1.5.2.3.1 The Member or authorized representative contacts the CONTRACTOR's member services representatives via telephone, facsimile or via e-mail;

4.8.1.5.2.3.2 The referring health care provider notifies the CONTRACTOR of the need for treatment and/or care only available in New Mexico at the State teaching hospital via telephone, facsimile, or through the process established between the referring Contract Provider and the CONTRACTOR; and

4.8.1.5.2.3.3 The Member, authorized representative or referring provider notifies the Member's care coordinator of the needed treatment and/or care that is only available in New Mexico at the State teaching hospital.

4.8.1.5.3 If the CONTRACTOR must arrange for a Member to be sent out-of-state for treatment and/or care, the CONTRACTOR shall meet the following requirements. Failure to meet these requirements may result in a Sanction of the CONTRACTOR as outlined in Section 7.3 unless HSD determines the CONTRACTOR is acting in a timely manner to arrange treatment and/or care of the Member by the out-of-state provider.

4.8.1.5.3.1 Within seven (7) Calendars Days of notification about the Member's treatment and/or care needs, the CONTRACTOR shall authorize and arrange for an initial consultation with the out-of-state provider that is capable of providing the treatment and/or care.

4.8.1.5.3.2 Within seven (7) Calendar Days following the receipt of the treatment plan determined by the out-of-state provider the CONTRACTOR shall authorize and arrange for the treatment and/or care.

4.8.1.5.3.3 The CONTRACTOR shall provide a weekly report as directed by HSD that includes the status of treatment arrangements with the out-of-state provider, treatment status and progress and any complications or difficulties encountered with the arrangement for out-of-state treatment.

4.8.1.5.3.4 If the Member is unable to travel out-of-state, and the service is only available at the State teaching hospital, the CONTRACTOR must enter into a single case Agreement with the State teaching hospital.

4.8.1.5.3.5 HSD may impose monetary penalties of up to two (2) percent of the CONTRACTOR's Capitation Payment based on determination of noncompliance with these requirements in Sections 4.8.1.5.2.3 and 4.8.1.5.3 (and all sub-sections), as well as with the requirements specified in Sections 4.4.15.4.14 and 4.4.16.1.8.

4.8.2 Required Policies and Procedures

The CONTRACTOR shall:

4.8.2.1 Maintain written policies and procedures on provider recruitment, retention and termination of Contract Provider participation with the CONTRACTOR. HSD must approve these policies and procedures and may review them upon demand. The recruitment policies and procedures shall describe how a CONTRACTOR responds to a change in the network that affects access and its ability to deliver services in a timely manner;

4.8.2.2 Require that each provider either billing for or rendering services to Members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

4.8.2.3 Require that any provider, including Providers ordering or referring a Covered Service, have a National Provider Identifier (NPI) to the extent such provider is not an atypical provider as defined by CMS;

4.8.2.4 Consider, in establishing and maintaining the network of appropriate Providers, its:

4.8.2.4.1 Anticipated enrollment;

4.8.2.4.2 Expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the CONTRACTOR's population;

4.8.2.4.3 Numbers and types (in terms of training, experience and specialization) of Providers required to furnish Covered Services;

4.8.2.4.4 Numbers of Contract Providers who are not accepting new patients; and

4.8.2.4.5 Geographic location of Contract Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members; and whether the location provides physical access for Members with disabilities;

4.8.2.5 Ensure that Contract Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

4.8.2.6 Establish mechanisms such as notices or training materials to ensure that Contract Providers comply with the timely access requirements, monitor such compliance regularly and take corrective action if there is a failure to comply;

4.8.2.7 Conduct screening of all Major Subcontractors and Contract Providers, in accordance with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility and Program Criminal Records Screening Act, NMSA 1978, § 32A-15-1 to 32A-15-4, PPACA (see Section 4.17.1.7 of this Agreement) and ensure that all subcontracts and Contract Providers are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases and may not employ or contract with Providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority;

4.8.2.8 Provide to Members and Contract Providers clear instructions on how to access Covered Services, including those that require prior approval and referral;

4.8.2.9 Meet all availability, time and distance standards set by HSD and have a system to track and report this data; and

4.8.2.10 Provide access to Non-Contract Providers if the CONTRACTOR is unable to provide Medically Necessary Services covered under this Agreement in an adequate and timely manner to a Member and continue to authorize the use of Non-Contract Providers for as long as the CONTRACTOR is unable to provide these services through Contract Providers. The CONTRACTOR must ensure that the cost to the Member is no greater than it would be if the services were provided within the CONTRACTOR's network.

4.8.3 CONTRACTOR Responsibility for Providers

The CONTRACTOR shall monitor all provider activities to ensure compliance with the CONTRACTOR's and the State's policies. The CONTRACTOR shall establish mechanisms to ensure that Contract Providers comply with the timely access requirements, monitor Contract Providers regularly to determine compliance and take corrective action if there is a failure to comply. The CONTRACTOR shall educate PCPs about special populations and their service needs. The CONTRACTOR shall ensure that PCPs successfully identify and refer Members to specialty Providers as Medically Necessary.

4.8.3.1 The CONTRACTOR shall ensure HCBS provider compliance with 42 C.F.R. § 441.301(c)(4), as applicable and conduct provider monitoring as directed by HSD.

4.8.4 The Primary Care Provider (PCP)

4.8.4.1 With the exception of Dual Eligibles, the CONTRACTOR shall ensure that each Member is assigned a PCP. For Dual Eligibles, the CONTRACTOR will be responsible for coordinating the primary, acute, Behavioral Health and Long-Term Care services with the Member's Medicare PCP. For all other Members, the PCP shall be a medical or Behavioral Health 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 is prohibited from excluding Providers as Primary Care Providers based on the proportion of high-risk patients in their caseloads.

4.8.4.2 The CONTRACTOR may designate the following types of Providers as PCPs, as appropriate:

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

4.8.4.2.2 Certified nurse practitioners, certified nurse midwives and physician assistants;

4.8.4.2.3 Specialists, on an individualized basis, for Members whose care is more appropriately managed by a specialist, such as Members with infectious diseases, chronic illness, complex Behavioral Health conditions, or disabilities;

4.8.4.2.4 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”);

4.8.4.2.5 FQHCs, RHCs or I/T/Us; or

4.8.4.2.6 Other Providers that meet the credentialing requirements for PCPs.

4.8.4.3 The CONTRACTOR shall submit a PCP Report as directed by HSD.

4.8.5 Primary Care Responsibilities

4.8.5.1 The CONTRACTOR shall ensure that the following Primary Care responsibilities are met by the PCP, or in another manner:

4.8.5.1.1 The PCP shall ensure coordination and continuity of care with Providers, including all Behavioral Health and Long-Term Care Providers, according to the CONTRACTOR's policy; and

4.8.5.1.2 The PCP shall ensure that the Member receives appropriate prevention services for the Member's age group.

4.8.5.2 The PCP shall refer a Member for Behavioral Services based on the following indicators:

4.8.5.2.1 Suicidal/homicidal ideation or behavior;

4.8.5.2.2 At-risk of hospitalization due to a Behavioral Health condition;

4.8.5.2.3 Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;

4.8.5.2.4 Trauma victims;

4.8.5.2.5 Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

4.8.5.2.6 Request by Member or Representative for Behavioral Health services;

4.8.5.2.7 Clinical status that suggests the need for Behavioral Health services;

4.8.5.2.8 Identified psychosocial stressors and precipitants;

4.8.5.2.9 Treatment compliance complicated by behavioral characteristics;

4.8.5.2.10 Behavioral and psychiatric factors influencing medical condition;

4.8.5.2.11 Victims or perpetrators of Abuse and/or neglect and Members suspected of being subject to Abuse and/or neglect;

4.8.5.2.12 Non-medical management of substance abuse;

4.8.5.2.13 Follow-up to medical detoxification;

4.8.5.2.14 An initial PCP contact or routine physical examination indicates a substance abuse problem;

4.8.5.2.15 A prenatal visit indicates substance abuse problems;

4.8.5.2.16 Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

4.8.5.2.17 A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or

4.8.5.2.18 The persistence of serious functional impairment.

4.8.6 Selection of or Assignment to a PCP

The CONTRACTOR shall maintain and implement written policies and procedures governing the process of Member selection of a PCP and requests for change.

4.8.6.1 *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:

4.8.6.1.1 The CONTRACTOR shall provide the means for selecting a PCP within five (5) Business Days of processing the enrollment file;

4.8.6.1.2 The CONTRACTOR shall contact pregnant Members within five (5) Business Days of processing an enrollment file that designates the Member as pregnant to assist the Member in selecting a PCP;

4.8.6.1.3 The CONTRACTOR shall offer freedom of choice to Members in making a PCP selection;

4.8.6.1.4 The Member must have fifteen (15) Calendar Days of enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of his or 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

4.8.6.1.5 The CONTRACTOR shall assign a PCP based on factors such as Member age, residence and if known, current provider relationships.

4.8.6.2 *Subsequent Change in PCP Initiated by Member*. The CONTRACTOR shall allow Members to change PCPs at any time, for any reason. The request can be

made in writing or by telephone. If a request is made on or before the twentieth (20th) Calendar Day of a month, the change shall be effective as of the first of the following month. If a request is made after the twentieth (20th) Calendar Day of the month, the change shall be effective the first (1st) Calendar Day of the second (2nd) month following the request.

4.8.6.3 Subsequent Change in PCP Initiated by the CONTRACTOR. The CONTRACTOR may initiate a PCP change for a Member under the following circumstances:

4.8.6.3.1 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;

4.8.6.3.2 A Member's PCP ceases to be a Contract Provider;

4.8.6.3.3 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 reasonable efforts to accommodate the Member;

4.8.6.3.4 A Member has initiated legal actions against the PCP; or

4.8.6.3.5 The PCP is suspended or terminated.

4.8.6.4 The CONTRACTOR shall make a good faith effort to give written notice of termination of a Contracted Provider, within fifteen (15) Calendar Days after receipt or issuance of the termination notice, to each Member who received his or her Primary Care from, or was seen on a regular basis by, the terminated provider. In such instances, the CONTRACTOR shall allow affected Members to select a PCP or shall make an assignment within fifteen (15) Calendar Days of the termination effective date.

4.8.7 Access to Services

The CONTRACTOR shall have an adequate provider network to ensure access to quality care, and the CONTRACTOR shall demonstrate that its network is sufficient to meet the health care needs of all Members. Changes affecting access to care shall be communicated to HSD and remedied by the CONTRACTOR in an expeditious manner.

4.8.7.1 The CONTRACTOR shall have written policies and procedures describing how Members and Contract Providers access services including prior authorization and referral requirements for various types of medical and surgical treatments, emergency room services, Behavioral Health and Long-Term Care services. The policies and procedures must be approved by HSD and shall be made available in an accessible format upon request to HSD, Providers and Members.

4.8.7.2 The CONTRACTOR shall submit a Network Adequacy Report as directed by HSD.

4.8.7.3 Provider to Member Ratios

4.8.7.3.1 The CONTRACTOR shall ensure that Member caseload of any PCP does not exceed two-thousand (2,000) Members per MCO. Exception to this limit may be made with HSD's prior written consent.

4.8.7.3.2 HSD shall not establish specific specialist to Member ratios. The CONTRACTOR must ensure that Members have adequate access to specialty Providers.

4.8.7.4 Distance Requirements

4.8.7.4.1 For (i) PCPs, including internal medicine, general practice and family practice provider types and (ii) pharmacies, including 24/7 pharmacies where one is available. HSD may grant an exception to the distance standards for certain specialty providers:

4.8.7.4.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles;

4.8.7.4.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty- five (45) miles; and

4.8.7.4.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.7.4.2 For the Providers described in Attachment 6 to the Contract:

4.8.7.4.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles;

4.8.7.4.2.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD; and

4.8.7.4.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HSD.

4.8.7.5 The CONTRACTOR shall ensure that the following appointment standards are met:

4.8.7.5.1 For routine, asymptomatic, Member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than thirty (30) Calendar Days, unless the Member requests a later time;

4.8.7.5.2 For routine asymptomatic Member-initiated dental appointments, the request to appointment time shall be no more than sixty (60) Calendar Days unless the Member requests a later date;

4.8.7.5.3 For routine, symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than fourteen (14) Calendar Days, unless the Member requests a later time;

4.8.7.5.4 For non-urgent Behavioral Health care, the request-to-appointment time shall be no more than fourteen (14) Calendar Days, unless the Member requests a later time;

4.8.7.5.5 Primary medical, dental and Behavioral Health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours;

4.8.7.5.6 For specialty outpatient referral and consultation appointments, excluding Behavioral Health, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than twenty-one (21) Calendar Days, unless the Member requests a later time;

4.8.7.5.7 For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Member requests a later time;

4.8.7.5.8 For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the Member wait time shall be consistent with severity of the clinical need;

4.8.7.5.9 For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours;

4.8.7.5.10 The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription phoned in by a practitioner shall be filled within ninety (90) minutes;

4.8.7.5.11 The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need; and

4.8.7.5.12 For Behavioral Health crisis services, face-to-face appointments shall be available within two (2) hours.

4.8.7.6 The CONTRACTOR shall conduct "secret shopper" surveys semi-annually to monitor appointment timeliness. The CONTRACTOR shall submit survey results to HSD on January 31 and July 31 of each year.

4.8.7.6.1 The surveys shall be conducted with a random sample of PCPs and behavioral health providers in Frontier, Rural and Urban regions across the State to monitor the appointment standards for routine and urgent visits for children and adults.

4.8.7.6.2 The CONTRACTOR shall submit the survey scripts to HSD for approval.

4.8.8 Specialty Providers

The CONTRACTOR shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the Members are met within the CONTRACTOR's provider network. The CONTRACTOR shall also have a system to refer Members to Non-Contract Providers if Providers with the necessary

qualifications or certifications do not participate in the network. 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 furnished within the network.

4.8.9 Publicly Supported Providers

4.8.9.1 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

4.8.9.1.1 The CONTRACTOR shall make best efforts to contract with every FQHC and RHC in the State. At least one (1) FQHC shall be an FQHC that specializes in providing health care for the homeless in Bernalillo County. At least one (1) FQHC shall be an Urban Indian FQHC in Bernalillo County.

4.8.9.1.2 The CONTRACTOR shall allow its Members to seek care from Non-Contract Provider FQHCs and RHCs.

4.8.9.1.3 The CONTRACTOR shall reimburse FQHCs and RHCs as specified in Section 4.10.2.1 of this Agreement.

4.8.9.2 Local Department of Health Offices

4.8.9.2.1 The CONTRACTOR shall make best efforts to contract with public health Providers for family planning services and other clinical preventive services not otherwise available in the community, such as prenatal care or perinatal case management and those defined as public health services under State law, NMSA 1978, § 24-1-1 et. seq.

4.8.9.2.2 The CONTRACTOR shall make best efforts to contract with local and district public health offices for family planning services.

4.8.9.2.3 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.

4.8.9.2.4 The CONTRACTOR may require PCPs to contract with the Vaccines for Children (VFC) program administered by the New Mexico Department of Health.

4.8.9.3 Children's Medical Services

The CONTRACTOR shall make best efforts to contract with Children's Medical Services to administer Outreach clinics at sites throughout the State.

4.8.10 Core Services Agencies (CSA)

4.8.10.1 The CONTRACTOR shall make best efforts to contract with entities designated by the State as CSAs to manage the service delivery of Behavioral Health services, as well as provide prevention, early intervention, treatment and recovery services related to Behavioral Health for Members. The CONTRACTOR may terminate an arrangement with a CSA for cause with prior notice to HSD and the Collaborative.

4.8.10.2 HSD shall designate CSAs and, as appropriate, shall provide the CONTRACTOR an updated list of designated entities.

4.8.10.3 Specifically, CSAs shall provide:

4.8.10.3.1 Twenty (24) hours-a-day seven (7) days-a-week crisis intervention;

4.8.10.3.2 Behavioral Health services to those Members who choose CSAs as their provider;

4.8.10.3.3 Access to psychiatric evaluations;

4.8.10.3.4 Access to medication management;

4.8.10.3.5 Behavioral Health out-of-home assessment and service planning;

4.8.10.3.6 Care coordination to Members with SMI and/or SED;

4.8.10.3.7 Access to a range of other clinical Behavioral Health services; and

4.8.10.3.8 Access to comprehensive community support services ("CCSS").

4.8.11 I/T/Us

4.8.11.1 The CONTRACTOR shall make best efforts to contract with all I/T/Us in the State for services including, but not limited to, transportation, Care Coordination and case management. The CONTRACTOR is encouraged to use the sample I/T/U Addendum as described in 42 C.F.R. § 438.14 as a basis to develop an Addendum specific to New Mexico that may be used to establish network provider agreements with I/T/Us, as such agreements include the federal protections for I/T/Us.

4.8.11.2 The CONTRACTOR shall allow Native American Members to seek care from any I/T/U whether or not the I/T/U is a Contract Provider and shall reimburse I/T/Us as specified in Section 4.10.2.2 of this Agreement.

4.8.11.2.1 The CONTRACTOR shall permit Non-Contracted I/T/Us to refer Native American Members to a Contracted Provider.

4.8.11.3 The CONTRACTOR shall not prevent Native American Members from seeking care from I/T/Us or from Contract Providers due to their status as Native Americans.

4.8.11.4 The CONTRACTOR shall track and report quarterly to HSD reimbursement and utilization data related to I/T/Us.

4.8.12 Family Planning Providers

4.8.12.1 The CONTRACTOR shall give each adolescent and Adult Member the opportunity to use his or her own PCP or go to any family planning provider for family planning services without requiring a referral. Each female Member shall also have the right to self-refer to a Contract Provider women's health specialist for Covered Services 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. Family planning Providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services that are Covered Services, regardless of whether they are Providers for Centennial Care. Unless otherwise negotiated, the CONTRACTOR shall reimburse Providers of family planning services pursuant to the Medicaid fee schedule. Gynecological or obstetrical ultrasounds shall be provided without requiring a prior authorization of any kind.

4.8.12.2 Pursuant to State law and regulation, Non-Contract 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- Contract Providers.

4.8.13 Other Provider Types

The CONTRACTOR shall make best efforts to contract with additional provider types, including but not limited to:

4.8.13.1 SBHC Providers pursuant to New Mexico regulations;

4.8.13.2 State operated Long-Term Care facilities;

4.8.13.3 Support brokers to assist with administering the SDCB; and

4.8.13.4 Community Benefit Providers.

4.8.14 Standards for Credentialing and Recredentialing

4.8.14.1 The CONTRACTOR shall document the mechanism for credentialing and recredentialing of Contract Providers, or Providers it 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 shall not be discriminatory and the extent of delegated credentialing and recredentialing arrangements. The CONTRACTOR shall:

4.8.14.1.1 Have written policies and procedures for the credentialing and recredentialing process. Such process must permit Providers to apply for credentialing and recredentialing online;

4.8.14.1.2 Meet NCQA standards and State and federal regulations for credentialing and recredentialing, including 42 C.F.R.s § 455.104, § 455.105, § 455.106, § 455.107 and § 1002.3(b);

4.8.14.1.3 Use one standard credentialing form developed by the Provider Workgroup and collaborate with the other MCOs to develop other standard forms used for credentialing and recredentialing;

4.8.14.1.4 Collaborate with the other MCOs to define and use the same NCQA approved primary source verification sources;

4.8.14.1.5 Use one entity for primary source verification and collection and storage of provider credentialing/recredentialing application information, unless a more cost-effective alternative is prior approved by HSD;

4.8.14.1.6 Designate a credentialing committee or other peer review body to make recommendations regarding credentialing/recredentialing issues;

4.8.14.1.7 Participate and collaborate with any statewide initiatives to standardize the credentialing/recredentialing process;

4.8.14.1.8 Complete the credentialing process within forty-five (45) Calendar Days from receipt of completed application with all required primary source documentation. For Behavioral Health provider credentialing the CONTRACTOR shall complete the credentialing process within thirty (30) Calendar Days from receipt of completed application with all required primary source documentation;

4.8.14.1.9 Ensure credentialing/recredentialing forms require ownership and control disclosures, disclosure of business transactions and criminal conviction information;

4.8.14.1.10 Shall screen and confirm upon enrollment and re-enrollment the identity and determine the exclusion status of Providers, and any person with an ownership, or control interest, or who is an agent or managing employee of a provider against Federal databases as defined in 42 C.F.R. § 455.436 to ensure Providers are not employing or contracting with excluded individuals and do not employ or contract with Providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority;

4.8.14.1.11 Have written policies and procedures to ensure and verify that Providers have appropriate licenses and certifications to perform services outlined in their respective Centennial Care provider agreements; and

4.8.14.1.12 Maintain records that verify its credentialing and recredentialing activities, including primary source verification and compliance with credentialing/recredentialing requirements.

4.8.14.1.13 MCOs must enter provider specific contract information into its system(s), and its Claims system(s) must be able to recognize the provider as a network

provider with accuracy sufficient to pay claims no later than forty-five (45) Calendar Days after a Provider is credentialed, if required.

4.8.14.1.14 For Behavioral Health provider credentialing the MCOs must enter provider specific contract information into its system(s), and its Claims system(s) must be able to recognize the provider as a network provider with accuracy sufficient to pay claims no later than fifteen (15) Calendar Days after a Provider is credentialed.

4.8.14.2 The CONTRACTOR shall perform the following functions:

4.8.14.2.1 Credential any provider who contracts with the CONTRACTOR and maintaining complete credentialing information for these Providers;

4.8.14.2.2 Identify potential and actual Contract Providers who are enrolled with HSD as Medicaid Providers;

4.8.14.2.3 Require any Contract Provider, including network providers of an MCO subcontractor, to be enrolled through a Provider Participation Agreement with the State Medicaid Agency as a managed care provider; and

4.8.14.2.4 Refer any provider who notifies the CONTRACTOR of a change in their location, licensure or certification, or status to the New Mexico Medicaid's Provider Web Portal for updating their enrollment information/status with the New Mexico Medicaid program.

4.8.14.3 For applicable Community Benefit Providers, the CONTRACTOR shall ensure that its credentialing and recredentialing process includes assessment of each provider setting to ensure that all applicable HCB settings requirements are met.

4.8.15 Shared Responsibility Between the CONTRACTOR and Public Health Offices

4.8.15.1 The CONTRACTOR shall coordinate with the public health offices operated by the New Mexico Department of Health regarding the following services:

4.8.15.1.1 Sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations;

4.8.15.1.2 HIV prevention counseling, testing and early intervention;

4.8.15.1.3 Tuberculosis screening, diagnosis and treatment;

4.8.15.1.4 Disease outbreak prevention and management, including reporting according to State law and regulatory requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

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

4.8.15.1.6 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;

4.8.15.1.7 Home visiting programs for families of newborns and other at-risk families; and

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

4.8.15.2 The CONTRACTOR shall participate in the New Mexico Department of Health's (DOH) New Mexico State Immunization Information System to ensure the secure, electronic exchange of immunization records to support the elimination of vaccine preventable diseases.

4.8.15.3 The CONTRACTOR shall contract with the DOH Families First and Children's Medical Services (CMS) programs for case management related activities.

4.8.15.3.1 Families First Program:

The DOH Families First program provides case management functions to Prenatal and Pediatric Members.

4.8.15.3.1.1 Prenatal Members are typically seen four times during the pregnancy/postpartum, and the postpartum visit is conducted in the Member's home with the Member's consent. Families First Pediatric Members are typically seen four times per year, with at least one home visit.

4.8.15.3.2 CMS Program:

The DOH CMS program provides statewide clinic-based services to Members, ages 0-21, with chronic medical conditions.

4.8.15.3.2.1 All clinics are based in DOH Public Health Offices. CMS also coordinates and pays for specialty outreach clinics around the state to provide access to specialty care for kids with chronic conditions who live in rural areas. CMS social workers work with the medical home to provide Care Coordination and follow-up with the clinics to ensure recommendations are followed.

4.8.16 Telemedicine Requirements

4.8.16.1 In providing services under this Agreement, the CONTRACTOR shall:

4.8.16.1.1 Promote and employ broad-based utilization of statewide access to HIPAA-compliant Telemedicine service systems including, but not limited to, access to TTYs and 711 Telecommunication Relay Services;

4.8.16.1.2 Follow State guidelines for Telemedicine equipment or connectivity;

4.8.16.1.3 Follow accepted HIPAA and 42 C.F.R. § 2 regulations that affect Telemedicine transmission, including but not limited to, staff and Contract Provider training, room setup, security of transmission lines, etc. The CONTRACTOR shall have and implement policies and procedures that follow all federal and State security and procedure guidelines;

4.8.16.1.4 Identify, develop and implement training for accepted Telemedicine practices;

4.8.16.1.5 Participate in the needs assessment of the organizational, developmental and programmatic requirements of Telemedicine programs;

4.8.16.1.6 Report to HSD on the Telemedicine outcomes of Telemedicine projects and submit a Telemedicine Report as directed by HSD; and

4.8.16.1.7 Ensure that Telemedicine services meet the following shared values, which are ensuring: (i) competent care with regard to culture and language needs; (ii) work sites are distributed across the State, including Native American

sites, for both clinical and educational purposes; and (iii) coordination of Telemedicine and technical functions at either end of network connection.

4.8.16.2 The CONTRACTOR shall participate in Project ECHO, in accordance with State prescribed requirements and standards including, but not limited to, paying its fair share of administrative costs as negotiated between the CONTRACTOR and Project ECHO and approved by HSD to support Project ECHO, and shall:

4.8.16.2.1 Work collaboratively with the University of New Mexico, HSD and Providers on Project ECHO;

4.8.16.2.2 Identify high needs, high cost Members who may benefit from their Providers participating in Project ECHO;

4.8.16.2.3 Identify PCPs who serve high needs, high cost Members to participate in Project ECHO;

4.8.16.2.4 Work with Project ECHO and the UNM Section of Geriatrics (Department of Internal Medicine) to:

4.8.16.2.4.1 Create a statewide program for quality improvement in Nursing Facilities to measurably improve quality ratings over the term of the contract; and

4.8.16.2.4.2 Create a program for reduction of readmissions from Nursing Facilities to hospitals, and measurably lower readmission rates over the course of the contract;

4.8.16.2.5 Reimburse Primary Care clinics for participating in the Project ECHO model;

4.8.16.2.6 Provide Claims data to support evaluation of Project ECHO;

4.8.16.2.7 Appoint a centralized liaison to obtain prior authorizations approvals related to Project ECHO; and

4.8.16.2.8 Track quality of care and outcome measures related to Project ECHO.

4.8.16.2.9 The CONTRACTOR shall collaborate with Project ECHO to develop a quarterly report template to report number and types of Providers trained, location of Providers by county and number of cases presented for consultation.

4.8.16.3 RESERVED

4.8.17 Emergency Planning and Response

4.8.17.1 Behavioral Health

4.8.17.1.1 The CONTRACTOR shall participate in Behavioral Health emergency planning and response in collaboration with the Collaborative. The participation of the CONTRACTOR in these activities is intended to ensure that the disaster-related emotional needs of individuals with chronic Behavioral Health disorders, other special populations, the general public and emergency responders will be addressed in a systemic and systematic fashion.

4.8.17.1.2 The CONTRACTOR shall participate in planning and training activities for statewide disaster Behavioral Health preparedness and response.

4.8.17.1.3 The CONTRACTOR shall coordinate with the Collaborative to implement Behavioral Health response activities in the event of a local, State, or federally declared disaster.

4.8.17.1.4 In the event of a federally declared disaster, the CONTRACTOR shall coordinate with the Collaborative to locate Providers to participate in the FEMA- and SAMHSA-funded Immediate and Regular Service Program Crisis Counseling Services grants. The CONTRACTOR shall also serve as a flow-through entity for funding of these grants. The grants will be managed by HSD.

4.8.17.1.5 The CONTRACTOR, through specific language in its provider agreements, shall require its Contract Providers to participate in disaster Behavioral Health planning efforts at their local area level.

4.8.17.2 The CONTRACTOR shall participate in other emergency planning and response as directed by HSD.

4.9 **Provider Agreements**

4.9.1 General Requirements

4.9.1.1 In order to maximize Value-Based Purchasing initiatives and advance initiatives in Centennial Care 2.0, the CONTRACTOR is required to enter into new contracts with provider organizations to establish its Centennial Care 2.0 provider network. In limited circumstances, HSD may consider exceptions when certain Providers and the CONTRACTOR mutually agree to forgo this requirement.

4.9.1.2 The CONTRACTOR shall submit to HSD for prior review and approval templates/sample provider agreements for each type of Contract Provider. Any changes to templates/sample provider agreements that may materially affect Members shall be approved by HSD prior to execution by any provider.

4.9.1.3 In all provider agreements, the CONTRACTOR must comply with the requirements specified in 42 C.F.R. § 438.214 and must maintain policies and procedures that reflect these requirements.

4.9.1.4 The CONTRACTOR shall comply with 42 C.F.R. § 438.808 regarding exclusion of entities, including all statutes and regulations referenced therein.

4.9.1.5 The CONTRACTOR shall conduct background checks and similar activities as required under the PPACA on all Providers before entering into any agreement with such provider.

4.9.1.6 Contract Provider agreements shall be executed in accordance with all applicable federal and State statutes, regulations, policies, procedures and rules.

4.9.1.7 The CONTRACTOR must provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) about its Member Grievance and Appeals system to all Contract Providers at the time they enter into mutual agreement.

4.9.1.8 The CONTRACTOR may enter into single case agreements with Providers performing Covered Services who are not willing to become a part of the CONTRACTOR’s provider network.

4.9.2 Minimum Requirements for Contract Provider Agreements

Contract Provider agreements shall contain at least the following provisions, as applicable to the provider type:

4.9.2.1 Identify the parties of the agreement and their legal basis of operation in the State of New Mexico;

4.9.2.2 Include the procedures and specific criteria for terminating the agreement including provisions for termination for any violation of applicable State or federal statutes, rules and regulations;

4.9.2.3 Identify the services, activities and report responsibilities to be performed by the Contract Provider. Contract Provider agreements shall include provision(s) describing how Covered Services provided under the terms of the contract are accessed by Members;

4.9.2.4 Require that all Contract Providers abide by the Member rights and responsibilities as outlined in Section 4.14.4 of this Agreement;

4.9.2.5 Provide that Emergency Services be rendered without the requirement of prior authorization of any kind;

4.9.2.6 Specify the Contract Provider's responsibilities and prohibited activities regarding cost sharing as directed by HSD such as, without limitation, no cost sharing for Native Americans as set forth in Section 4.5.13 of this Agreement;

4.9.2.7 Include the reimbursement rates and risk assumption, if applicable;

4.9.2.8 Require Contract Providers to maintain all records relating to services provided to Members for a ten (10) year period and to make all Member medical records or other service records available for the purpose of quality review conducted by HSD, or their designated agents both during and after the term of the Contract Provider agreement. Such records shall be provided to HSD within two (2) to ten (10) Business Days after the date of HSD's request in accordance with NMSA 1978, § 27-11- 4(B);

4.9.2.9 Require that Member information be kept confidential, as defined by federal and State statutes or regulations;

4.9.2.10 Include a provision that authorized representatives of HSD, the Collaborative or other State and federal agencies shall have reasonable access to facilities and records for financial and medical audit purposes both during and after the term of the Contract Provider agreement;

4.9.2.11 Include a provision for the Contract Provider to release to the CONTRACTOR any information necessary to perform any of its obligations and that the CONTRACTOR shall be monitoring the Contract Provider's performance on an ongoing basis and subjecting the Contract Provider to formal periodic review;

4.9.2.12 State that the Contract Provider shall accept payment from the CONTRACTOR as payment for any services performed, and cannot request payment from HSD or the Member, unless the Member is required to pay a copayment;

4.9.2.13 State that if the contract includes Primary Care, provisions for compliance with PCP requirements delineated in this Agreement shall apply;

4.9.2.14 Require the Contract Provider to comply with all applicable State and federal statutes and regulations;

4.9.2.15 Not prohibit a Contract Provider from entering into a contractual relationship with another MCO;

4.9.2.16 Not include any incentive or disincentive that encourages a Contract Provider not to enter into a contractual relationship with another MCO;

4.9.2.17 Not contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act, 42 C.F.R. § 438.102 or in contravention of NMSA 1978, § 59A-57-1 to 59A-57- 11;

4.9.2.18 Require laboratory service Providers to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

4.9.2.19 Describe, as applicable, any physician incentive plan and any other pay for performance programs the Contract Provider is subject to;

4.9.2.20 Provide for the provider's participation and cooperation in any internal and external QM/QI monitoring, utilization review, peer review and/or Appeal procedures established by the CONTRACTOR and/or HSD;

4.9.2.21 Provide for CONTRACTOR monitoring of the quality of services delivered under the Contract Provider agreement, and specify initial corrective action that will be taken where necessary to improve quality of care, in accordance with that level of medical, Behavioral Health or LTC that is recognized as acceptable professional practices and/or the standards established by HSD;

4.9.2.22 Require that the Contract Provider comply with corrective action plans initiated by the CONTRACTOR;

4.9.2.23 Provide for the timely submission of all reports, clinical information and Encounter Data required by the CONTRACTOR;

4.9.2.24 Provide for prompt submission of information needed to make payment;

4.9.2.25 Provide for payment to the Contract Provider upon approval of a Clean Claim properly submitted by the Contract Provider within the required time frames (see Section 4.19.1.6 of this Agreement);

4.9.2.26 Specify the Contract Provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the Member's third party payer) plus the amount of any applicable Member cost-sharing responsibilities, as payment in full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable cost-sharing responsibilities;

4.9.2.27 Specify the Contract Provider's responsibilities regarding third party liability (TPL);

4.9.2.28 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any Contract Provider agreement in accordance with the terms of this Agreement and applicable statutes and regulations;

4.9.2.29 Specify that HSD reserves the right to direct the CONTRACTOR to terminate or modify the Contract Provider agreement when HSD determines it to be in the best interest of the State;

4.9.2.30 Specify that both parties recognize that in the event of termination of this Agreement, the Contract Provider shall immediately make available, to HSD or

its designated representative in a usable form, any or all records, whether medical or financial, related to the Contract Provider's activities undertaken pursuant to the Contract Provider agreement. The provision of such records shall be at no expense to HSD;

4.9.2.31 Include a gratuities clause as stated in Section 7.22 of this Agreement, a lobbying clause as stated in Section 7.23 of this Agreement and a conflict of interest clause as stated in Section 7.24 of this Agreement;

4.9.2.32 Specify that at all times during the term of the Contract Provider agreement, the Contract Provider shall indemnify and hold HSD harmless from all Claims, losses, or suits relating to activities undertaken by the Contract Provider pursuant to this Agreement;

4.9.2.33 Specify that the Contract Provider is not a third party beneficiary to this Agreement and that the Contract Provider is an independent contractor performing services as outlined in this Agreement;

4.9.2.34 Require that the Contract Provider display notices of the Member's right to Appeal adverse action affecting services in public areas of the Contract Provider's facility(s) in accordance with HSD rules and regulations, subsequent amendments;

4.9.2.35 Include that if any requirement in the Contract Provider agreement is determined by HSD to conflict with this Agreement, such requirement shall be null and void, and all other provisions shall remain in full force and effect;

4.9.2.36 Include Marketing restrictions as described in Section 3.4 of this Agreement;

4.9.2.37 Require Contract Providers to comply with Section 7.16 of this Agreement, as applicable.

4.9.2.38 Include a provision requiring, as a condition of receiving any amount of payment, that the Contract Provider comply with Section 4.17 of this Agreement;

4.9.2.39 Require Contract Providers to comply with applicable requirements of Section 3.5 of this Agreement;

4.9.2.40 Require Nursing Facility Providers to promptly notify the CONTRACTOR of: (i) a Member's admission, or request for admission to the Nursing Facility

regardless of payor source for the Nursing Facility stay; (ii) a change in a Member's known circumstances; and (iii) a Member's pending discharge;

4.9.2.41 Require Nursing Facility Providers to notify the Member and/or the Member's Representative in writing prior to discharge in accordance with State and federal requirements;

4.9.2.42 Require Providers to notify the Member's care coordinator of any change in a Member's medical or functional condition that could impact the Member's level of care determination;

4.9.2.43 Require Agency-Based Community Benefit Providers to provide at least thirty (30) Calendar Days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate Providers;

4.9.2.44 Specify that reimbursement of a Community Benefit provider shall be contingent upon the provision of services to an eligible Member in accordance with applicable federal and State requirements and the Member's CCP as authorized by the CONTRACTOR;

4.9.2.45 Require Community Benefit Providers to immediately report any deviations from a Member's service schedule to the Member's care coordinator;

4.9.2.46 Require all Contract Providers to (a) conduct screening of all employees, including those providing direct services to Members (e.g., home health, personal care), in accordance with the Employee Abuse Registry Act, NMSA 1978, § 27-7A- 3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq., and ensure that all employees are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases and (b) to not employ or contract with Providers excluded from participation in federal healthcare programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority; and

4.9.2.47 Require Community Benefit Providers to comply with all applicable, federal requirements for HCBS settings requirements.

4.10 **Provider Payments**

4.10.1 Timely Payments to All Providers:

The CONTRACTOR and any of its Major Subcontractors and Subcontractors shall make timely payments to any Provider or entity that furnished covered benefits as defined in Section 4.19 of this Agreement. The CONTRACTOR and any of its Major Subcontractors or Providers paying their own Claims are required to maintain Claims processing capabilities to comply with all State and federal regulations.

4.10.1.1 The CONTRACTOR shall ensure its Claims processing system and provider payments dependent on ICD-9 are updated and compliant with the national conversion to ICD-10.

4.10.1.2 The CONTRACTOR shall implement rate changes within thirty (30) Calendar Days after receiving the final, signed Capitation Rates.

4.10.2 Special Reimbursement Requirements

4.10.2.1 FQHC and RHCs

The CONTRACTOR shall reimburse both Contract and Non-Contract FQHCs and RHCs at a minimum of the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act.

4.10.2.2 I/T/Us

The CONTRACTOR shall reimburse both Contract and Non-Contract Provider I/T/Us at a minimum of one hundred percent (100%) of 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 by OMB for any particular service, then reimbursement shall be at an amount not less than the Medicaid fee schedule. Services provided within I/T/Us are not subject to prior authorization requirements.

4.10.2.3 Family Planning Non-Contract Providers

The CONTRACTOR shall reimburse family planning Non-Contract Providers for the provision of services to Members at a rate set by HSD.

4.10.2.4 Pregnancy Termination

4.10.2.4.1 The CONTRACTOR shall pay Claims submitted by qualified and credentialed Providers for State and federally approved pregnancy termination procedures rendered to eligible Members.

4.10.2.4.2 The CONTRACTOR shall be reimbursed by HSD for payment of Claims for the following Healthcare Common Procedure Coding System ("HCPCS") Procedure Codes: S0190, S0191, S2260, S2262, S2265, S2266 and S2267 with appropriate modifiers, as changed and as modified the following and Current Procedural Terminology ("CPT") Procedure Codes: 59840, 59841, 59850, 59851, 59852, 59855, 59856 and 59857 with appropriate modifiers, as changed and modified.

4.10.2.4.3 The CONTRACTOR shall be reimbursed for paid Claims at either the established Medicaid fee schedule or the contracted rate in the provider agreement, whichever is less, as of the date of service, plus gross receipts tax as applicable. HSD shall reimburse the CONTRACTOR with State funds for State-funded services and State funds and federal match for federally-funded services via invoicing methodology.

4.10.2.5 Non-Contract Providers for Women in the Third (3rd) Trimester of Pregnancy

If a pregnant woman in the third (3rd) trimester of pregnancy has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not a Contract Provider, the CONTRACTOR shall reimburse the Non-Contract Provider in accordance with the applicable Medicaid fee schedule appropriate to the provider type.

4.10.2.6 Reimbursement for Members Who Disenroll or Whose Enrollment is Suspended While Hospitalized

4.10.2.6.1 If a Member is hospitalized at the time of enrollment or disenrollment, the payor at the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided within a

licensed acute care facility, non-psychiatric specialty unit, or hospitals as designated by the New Mexico Department of Health until the date of discharge. Upon discharge, the Member becomes the financial responsibility of the HSD or MCO receiving Capitation Payments during the month in which the member is enrolled.

4.10.2.6.2 Discharge, for the purposes of this Agreement, shall mean: (i) when a Member is moved from or to a PPS exempt unit (such as a rehabilitation or psychiatric unit) within an acute care hospital; (ii) when a Member is moved from or to a specialty hospital as designated by DOH or HSD; (iii) when a Member is moved from or to a PPS exempt hospital (such as a psychiatric or rehabilitation hospital); (iv) when a Member leaves the acute care hospital setting to a community setting; and (v) when a Member leaves the acute care hospital setting to an institutional setting. For (v), the "discharge" date is based upon approval of the abstract and/or approval by HSD.

4.10.2.6.3 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 care facilities.

4.10.2.6.4 If a Member is hospitalized and is disenrolled from a MCO due to a loss in Medicaid coverage, the MCO is only financially liable for the inpatient hospitalization and associated professional services until such time that the Member is determined to be ineligible for Medicaid.

4.10.2.6.5 If a Member is in a Nursing Facility 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, whichever occurs first.

4.10.2.7 State-Operated LTC Facilities

The CONTRACTOR shall negotiate rate(s) and enter into agreements with DOH for State-operated LTC facilities.

4.10.2.8 Compensation for UM Activities

The CONTRACTOR shall ensure that, consistent with 42 C.F.R. § 438.3(i) 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.

4.10.2.9 Pharmacy Services

4.10.2.9.1 The CONTRACTOR may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement.

4.10.2.9.1.1 The CONTRACTOR shall ensure payment to Community-based Pharmacies on the Maximum Allowed Cost (MAC) for ingredient cost generic drugs that it is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the National Drug Code (NDC) for the drug item. Dispensing fees will be paid in accordance with the terms of the applicable pharmacies' contracts. When NADAC is not available, the MAC must be no lower than the published Wholesaler's Average Cost (WAC) listed for the NDC + 6%, The WAC must come from a published national pharmacy pricing source such as Medi-Span or First Data Bank that is not associated with the MCO or PBM.

4.10.2.9.2 The CONTRACTOR is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

4.10.2.9.3 The CONTRACTOR shall cover brand name drugs and drug items not generally on the CONTRACTOR formulary or preferred drug list when determined to be medically necessary by the CONTRACTOR or through a Fair Hearing process.

4.10.2.9.4 The CONTRACTOR shall include on the CONTRACTOR's formulary or preferred drug list 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 that 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.

4.10.2.9.4.1 The CONTRACTOR shall cover outpatient drugs as defined in section 1927 (k)(2) of the Social Security Act and comply with the requirements outlined in 42CFR 438.3 (s)(1). "Outpatient drugs" are defined as drugs which are dispensed through a prescription order for the purposes of section 1905(a)(12) of the Social Security Act.

4.10.2.9.5 The CONTRACTOR shall have an open formulary for all Psychotropic Drugs and Medications. If the prescriber certifies medical necessity in writing by noting "brand medically necessary" or "brand necessary" on the prescription, and maintains supporting documentation in the Member's medical record indicating that a generic or alternative medication does not meet the therapeutic needs of the Member, then prior authorization is not necessary for use of a brand drug. Additionally, under these circumstances, neither a demonstration of fail first, nor step therapy, will be required.

4.10.2.9.6 The CONTRACTOR shall ensure that Native American Members accessing the pharmacy benefit at I/T/Us are exempt from the CONTRACTOR's preferred drug list.

4.10.2.9.7 The CONTRACTOR shall reimburse family planning clinics, SBHCs, and Department of Health public health clinics for contraceptive agents and emergency contraceptives when dispensed to Members and billed using HCPC codes and CMS 1500 forms.

4.10.2.9.8 The CONTRACTOR shall meet all federal and State requirements related to pharmacy rebates and submit all necessary information as directed by HSD no later than 45 Calendar Days after the end of each quarterly rebate period.

4.10.2.9.9 The CONTRACTOR shall take part in a Drug Utilization Review (DUR) program that complies with the requirements set forth in 42 C.F.R. § 438.3(s) and 42 C.F.R. § 456 Subpart K, and Section 1927(g) of the Act, to assure that prescriptions are appropriate, medically necessary and minimize the potential for adverse medical results.

4.10.2.9.10 The CONTRACTOR representation on the DUR Board shall consist of one physician and one or two pharmacists.

4.10.2.9.11 When a CONTRACTOR removes drugs from its Preferred Drug List, or adds prior authorizations, quantity limits and/or step therapy restrictions on a drug, the CONTRACTOR shall provide Members with at least sixty 60) Calendar Day notice before the effective date of the change.

4.10.2.9.12 The CONTRACTOR shall ensure that contractual reimbursement methodologies between the CONTRACTOR and its Pharmacy Benefit Manager use Pass-Through Pricing methodology by no later than January 1, 2020.

4.10.2.9.12.1 If the CONTACTOR uses a Spread Pricing methodology during Calendar Year 2019 it must develop a report for HSD that identifies the actual cost of the drug, the dispensing fee paid to the Pharmacy and the "spread" amount included in the payment.

4.10.2.9.12.2 The CONTRACTOR shall report the administrative fee paid to the Pharmacy Benefit Manager as an "administrative cost" outlined in Section 7.2.7.1.38. This includes the Spread and Pass-Through Pricing approaches.

4.10.2.9.13 The CONTRACTOR, major subcontractor and subcontractor shall comply with the Pharmacy Benefit Manager Regulation Act, Sections 59A-61-7, NMSA 1978 Pharmacy Benefit Managers (PBM) operating in the state of New Mexico.

4.10.2.9.14 The CONTRACTOR shall monitor the use of controlled substances retrospectively in order to detect potential abuse or overuse and to assure the appropriate use of the drugs as the CONTRACTOR would for all drug items with diversion potential, and provide the New Mexico Human Services Department (HSD) with the oversight and monitoring programs for the utilization of controlled substances, including opioids on a quarterly basis.

4.10.2.9.14.1 The CONTRACTORS shall together convene a task force to develop a standard monitoring program for controlled substance utilization.

4.10.2.9.14.2 The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for an on-going CONTRACTOR controlled substance oversight group that reports regularly to HSD and the Behavioral Health Collaborative.

4.10.2.9.14.3 RESERVED.

4.10.2.9.15 The CONTRACTOR shall monitor the use of opioid drugs and poly-drug use retrospectively in order to detect the potential for drug overdose to assure appropriate use of the drugs as the CONTRACTOR would for all drug items.

4.10.2.9.16 The CONTRACTOR's antiretroviral drug formulary shall include "substantially all" FDA-approved antiretroviral drugs in the class existing in the standard classification systems such as those from U.S. Pharmacopeia (USP) and American Hospital Formulary Service (AHFS), and the CONTRACTOR's utilization management tools such as prior authorization and step therapy are not employed in widely used, best practice formulary models. As new antiretroviral drugs or newly approved uses for antiretroviral drugs become available, the CONTRACTOR shall expedite their P&T committee review to make a decision within 90 days to add these drugs to their formulary. The CONTRACTOR shall monitor use of antiretroviral drugs retrospectively in order to detect the potential for duplication of therapy or under-utilization to assure appropriate use of the drugs as the CONTRACTOR would for all drugs items.

4.10.2.9.17 The CONTRACTOR shall cover naloxone without requiring prior authorization or quantity limits and shall require their contracted providers to comply with all aspects of the Pain Relief Act, NMSA 1978, § 24-2D, including but not limited to offering overdose counseling education.

4.10.2.9.17.1 As new naloxone forms of administration become available, the CONTRACTOR shall cover brand name naloxone not generally on the CONTRACTOR's formulary or preferred drug list when determined to be medically necessary by the CONTRACTOR.

4.10.2.10 Emergency Services

4.10.2.10.1 Any provider of Emergency Services that is a Non-Contract Provider must accept, as payment in full, no more than the amount established by HSD for such services. This rule applies whether or not the Non-Contract Provider is within the State.

4.10.2.10.2 The CONTRACTOR shall reimburse acute general hospitals 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. § 1395(dd) and Section 1867 of the Social Security Act.

4.10.2.10.3 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 PCP 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 C.F.R. § 438.114(d).

4.10.2.10.4 The CONTRACTOR shall pay for all Emergency Services and Post-Stabilization care that are Medically Necessary Services until the Emergency Medical Condition is stabilized and maintained.

4.10.2.10.5 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 presenting 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 Appeal and Fair Hearing process.

4.10.2.10.6 The CONTRACTOR may not deny payment for treatment obtained when a representative of the CONTRACTOR instructs the Member to seek Emergency Services.

4.10.2.10.7 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 C.F.R. § 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: (i) the CONTRACTOR does not respond to a request for pre-approval within one (1) hour; (ii) the CONTRACTOR cannot be contacted; or (iii) the CONTRACTOR's 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 physician and the treating physician may continue with care of the Member until a CONTRACTOR physician is reached or one of the criteria of 42 C.F.R. § 422.113(c)(3) is met.

4.10.2.10.8 The CONTRACTOR is financially responsible for Post-Stabilization Services obtained within or outside the CONTRACTOR's network that are pre-approved by the CONTRACTOR. The CONTRACTOR's financial responsibility for Post-Stabilization Services that have not been pre-approved shall end when: (i) a Contract Provider with privileges at the treating hospital assumes responsibility for the Member's care; (ii) a Contract Provider assumes responsibility for the Member's care through transfer; (iii) a representative of the CONTRACTOR and the treating physician reach an agreement concerning the Member's care; or (iv) the Member is discharged.

4.10.2.10.9 The CONTRACTOR must limit charges to Members for Post-Stabilization Services received from Non-Contract Providers to an amount no greater than what the CONTRACTOR would have charged the Member if he or she obtained the services from a Contract Provider.

4.10.2.11 Treat First Providers

4.10.2.11.1 For certain Providers that have been designated by HSD as Treat First Providers, Outpatient BH therapy and all specialty services can be initiated and billed before a psychiatric diagnostic evaluation has been completed. The specification of a diagnosis may be deferred until after the fourth (4th) session where upon a diagnosis will then be established and appropriately documented in the medical record and on all subsequent billed Claims. There will always be a "provisional diagnosis" on any Claim through the 4th Encounter if the diagnostic evaluation has not yet been completed. This shall

include all appropriate ICD 10 classified external causes of morbidity (V, X and Y diagnosis codes) and factors influencing health status (Z diagnosis codes). In addition, Comprehensive Community Support Services (CCSS) can be initiated by the Treat First Providers without a designation of SMI, SED, or SUD. After four encounters, if continuing CCSS, a qualifying diagnosis within the SMI, SED, or SUD designation must be entered on the claim.

4.10.2.12 Nursing Facilities

4.10.2.12.1 The CONTRACTOR is responsible for paying claims for short-term NF stays for its Members. The CONTRACTOR is required to conduct a NF LOC assessment to authorize a short- term NF stay, if the Member meets the NF LOC criteria. This includes payment for short-term NF stays for duals and retro-enrollment periods. A setting of care (SOC) for a short-term NF stay should not be submitted to HSD.

4.10.2.12.2 For Members who are Medicaid only, the CONTRACTOR is responsible for paying the full amount of the short-term NF stay.

4.10.2.12.3 Related to Medicare cross-over claims, CONTRACTOR payments to nursing facilities after payments by Medicare or a Medicare Advantage Plan cannot be less than the sum of the co-insurance, deductible, and co-payment amounts calculated by Medicare or the Medicare Advantage Plan, less any applicable patient pay amount.

4.10.2.12.4 For members who are dually eligible, Medicare will pay a portion of a short-term NF stay leaving the remainder of the claim to be paid by the CONTRACTOR.

4.10.2.13 The contractor shall provide funding to contracted school-based health centers (SBHCs) to stock long-acting reversible contraceptives (LARC) for Medicaid members, as directed by the Department. Funding to stock LARC products and devices shall be made available to contracted SBHCs with the goal of ensuring same-day access to LARC devices/products for members served by SBHCs. Funding provided to SBHCs under this requirement may not preclude the

contractor's obligation to ensure the member's freedom to choose his or her method of family planning, in accordance with 42 C.F.R. § 441.20.

4.10.2.14 The MCOs will collaborate to develop and implement a FQHC residency pilot program that will be approved by HSD.

4.10.3 Non-Contract Providers

4.10.3.1 Except as otherwise precluded by law and/or specified for I/T/Us, FQHCs/RHCs, family planning Providers and Emergency Services Providers, the CONTRACTOR shall reimburse:

4.10.3.1.1 Non-Contract Providers ninety-five percent (95%) of the Medicaid fee schedule rate for the Covered Services provided; and

4.10.3.1.2 Non-Contract Nursing Facilities one-hundred percent (100%) of the Medicaid fee schedule rate for the Covered Services provided.

4.10.4 Provider-Preventable Conditions, Including Health Care-Acquired Conditions

In accordance with Section 2702 of the PPACA, the CONTRACTOR must have mechanisms in place to preclude payment to Providers for Provider-Preventable Conditions. The CONTRACTOR shall require provider self-reporting through Claims. The CONTRACTOR shall track the Provider-Preventable Conditions data and report these data to HSD via Encounter Data. To ensure Member access to care, any reductions in payment to Providers must be limited to the added costs resulting from the Provider-Preventable Conditions consistent with 42 C.F.R. § 447.26 and § 438.3 (g). The CONTRACTOR must use existing Claims systems as the platform for provider self-reporting and report to HSD via Encounter Data.

4.10.5 Physician Incentive Plans

The CONTRACTOR may operate a physician incentive plan in accordance with 42 C.F.R.s § 438.3(i), § 422.208 and § 422.210. If the CONTRACTOR implements a physician incentive plan, it must submit the plan annually to HSD at the beginning of each year of the Agreement.

4.10.6 Value-Based Purchasing

4.10.6.1 Provider payments in VBP programs must be based upon improved Member healthcare outcomes and/or quality scores. The CONTRACTOR must demonstrate how VBP programs improve Member outcomes/quality scores and not solely administrative efficiencies to qualify as a VBP program.

4.10.6.2 The CONTRACTOR shall develop a VBP plan for achieving the requirements of Attachment 3, Delivery System Improvement Performance Targets (DSIPT) and meeting the general expectation to reward Providers based on achieving quality and outcomes. The CONTRACTOR's plan shall be submitted to HSD annually by April 1. Upon approval from HSD, the CONTRACTOR shall implement its plan. The VBP plan, at a minimum, shall include the following:

4.10.6.2.1 The CONTRACTOR's overall approach to VBP;

4.10.6.2.2 Initiatives, goals, targets and strategies;

4.10.6.2.3 Barriers and actions to overcome barriers; and

4.10.6.2.4 Data sharing arrangements established with participating Providers.

4.10.6.3 The CONTRACTOR shall submit narrative updates to the evaluation plan to HSD quarterly that include barriers, solutions, successes, status, supportive data and other pertinent information to the delivery system improvement.

4.10.6.4 The CONTRACTOR shall submit quarterly DSIPT reports on templates provided by HSD.

4.10.6.5 The CONTRACTOR shall share performance and Claims data and lists of attributed Members with Providers on a quarterly basis for the membership that is attributed to the provider in VBP arrangements.

4.10.7 Safety-Net Care Pool Hospitals

4.10.7.1 The CONTRACTOR shall make best efforts to contract with the Providers listed in Attachment 4.

4.10.7.2 The CONTRACTOR shall pay Providers included in Attachment 4 at or above the Medicaid fee schedule for inpatient hospital services.

4.10.8 The CONTRACTOR is prohibited from paying for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

4.10.9 The CONTRACTOR is prohibited from making payment on any amount expended for roads, bridges, stadiums, or other item or service not covered under the Medicaid State Plan, a federally approved waiver or this Agreement.

4.10.10 The CONTRACTOR is prohibited from paying for an item or service for home health care services provided by an agency or organization, unless the agency has provided the state with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

4.10.11 Directed Payments

4.10.11.1 The CONTRACTOR shall comply with Directed Payments established by HSD and approved by CMS. All assurances specified in 42 CFR 438.6(c)(2)(ii)-(iii) applicable to the type of Directed Payment, as defined in 42 CFR 438.6(c)(1)(i)-(iii), and made by HSD as part of the approval process for Directed Payments are restated and reaffirmed.

4.10.11.2 HSD shall communicate the requirements of the Directed Payment to the CONTRACTOR through a Letter of Direction.

4.10.11.3 The directed payments listed in Attachment 11 are required of the CONTRACTOR, subject to annual approval by CMS unless otherwise specified.

4.10.12 Non-Risk Arrangements

4.10.12.1 The CONTRACTOR shall comply with Non-Risk arrangements established by HSD and approved by CMS.

4.10.12.2 HSD shall communicate the requirements of the Non-Risk arrangement to the CONTRACTOR through a Letter of Direction.

4.10.12.3 The non-risk arrangements comply with the upper payment limits specified in 42 CFR 447.362.

4.10.12.4 The Non-Risk arrangements listed in Attachment 12 are required of the Contractors, subject to approval by CMS.

4.11 **Provider Services**

4.11.1 Provider Handbook

4.11.1.1 The CONTRACTOR shall issue a provider handbook to all Contract Providers. The CONTRACTOR may distribute the provider handbook electronically (e.g., via its website) as long as Providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the provider.

4.11.1.2 At a minimum, the provider handbook shall include the following information:

4.11.1.2.1 A table of contents;

4.11.1.2.2 Description of Centennial Care, including eligibility, enrollment and Member assessment information;

4.11.1.2.3 Covered Services;

4.11.1.2.4 Description of the role of care coordinators;

4.11.1.2.5 Cultural competency, as well as how the provider can access language interpretation and specialized communication services;

4.11.1.2.6 Description of the Self-Directed Community Benefit and the Agency-Based Community Benefit;

4.11.1.2.7 Emergency Services responsibilities;

4.11.1.2.8 Information on Member Grievance and Appeal rights and processes, including Fair Hearings;

4.11.1.2.9 Policies and procedures of the provider Grievance system;

4.11.1.2.10 Medically Necessary Service standards and clinical practice guidelines;

4.11.1.2.11 PCP responsibilities;

4.11.1.2.12 Member lock in standards and requirements;

4.11.1.2.13 The CONTRACTOR’s Fraud and Abuse policies and procedures, including how to report suspected Fraud and/or Abuse;

4.11.1.2.14 Coordination with other Providers, Major Subcontractors or HSD CONTRACTORS;

4.11.1.2.15 Requirements regarding background checks;

4.11.1.2.16 Information on identifying and reporting suspected Abuse, neglect and exploitation of Members;

4.11.1.2.17 Prior authorization, referral and other Utilization Management requirements and procedures;

4.11.1.2.18 Protocol for Encounter Data reporting and records;

4.11.1.2.19 Claims submission protocols and standards, including instructions and all information necessary for Clean Claims;

4.11.1.2.20 Payment policies;

4.11.1.2.21 Credentialing and recredentialing requirements;

4.11.1.2.22 Confidentiality and HIPAA requirements with which the provider must comply;

4.11.1.2.23 Member rights and responsibilities;

4.11.1.2.24 The telephone number for the provider services line; and

4.11.1.2.25 A separate Section and/or addendum that specifically address the ABP services and ABP Exempt Members.

4.11.1.3 The CONTRACTOR shall disseminate bulletins as needed to incorporate any necessary changes to the provider handbook.

4.11.2 Provider Services Call Center

4.11.2.1 The CONTRACTOR shall operate a provider services call center with a separate toll-free telephone line to respond to provider questions, comments, inquiries and requests for prior authorizations. This call center and its staff must be located and operated in the State of New Mexico. At its discretion, HSD may allow specialty units such as pharmacy, dental and vision to be located out-of-state. Any exceptions must be prior approved by HSD.

4.11.2.2 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access and response standards, monitoring of calls via recording or other means and compliance with standards.

4.11.2.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to Providers' questions at a minimum from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

4.11.2.4 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, information

on how to obtain after hours UM requests and a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the automated system has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next Business Day.

4.11.2.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section 4.12 of this Agreement. The CONTRACTOR may meet this requirement by having a separate Utilization Management line.

4.11.2.6 The call center staff shall have access to electronic documentation from previous calls made by a provider.

4.11.2.7 The CONTRACTOR shall adequately staff the provider service line to ensure that the line and the Utilization Management line/queue, meet the following performance standards independently on a monthly basis:

4.11.2.7.1 Less than five percent (5%) call abandonment rate;

4.11.2.7.2 Eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds;

4.11.2.7.3 Average wait time for assistance does not exceed two (2) minutes; and

4.11.2.7.4 One hundred percent (100%) of voicemails returned by next Business Day.

4.11.2.8 The CONTRACTOR shall submit a Call Center Report as directed by HSD.

4.11.3 Provider Website

4.11.3.1 The CONTRACTOR shall have a provider portal on its website that is accessible to Providers. The portal shall include all pertinent information including, but not limited to, the provider manual, sample provider agreements, update newsletters and notifications and information about how to contact the CONTRACTOR's provider services department.

4.11.3.2 The website shall have the functionality to allow Providers to make inquiries and receive responses from the CONTRACTOR regarding care for Members, including real-time eligibility information and electronic prior authorization request and approval.

4.11.3.3 The CONTRACTOR shall have policies and procedures in place to ensure the provider website is updated regularly and contains accurate information.

4.11.4 Provider Workgroup

4.11.4.1 The CONTRACTOR shall participate in the Provider Workgroup. The Provider Workgroup shall consist of representation from each Centennial Care MCO, HSD and Providers in order to streamline documents and processes for Providers. The Centennial Care MCOs shall consult with HSD when appointing Providers to the Provider Workgroup.

4.11.4.2 The Provider Workgroup shall collaborate throughout the term of the Agreement to reduce the administrative burdens on Providers.

4.11.4.3 Specifically, the Provider Workgroup will develop, among other things, forms and templates related to: (i) credentialing; (ii) provider audits; (iii) reporting; (iv) authorizations; (v) Grievances and Appeal System; and (vi) forms for level of care determinations.

4.11.5 Provider Education, Training and Technical Assistance

4.11.5.1 The CONTRACTOR shall develop and implement a Provider Training and Outreach Plan annually to educate Contract Providers on Centennial Care requirements and the CONTRACTOR's processes and procedures. The CONTRACTOR shall also submit a Provider Training and Outreach Evaluation Report as directed by HSD.

4.11.5.2 The CONTRACTOR shall establish and maintain policies and procedures to implement the Provider Training and Outreach Plan and the Provider Training and Outreach Evaluation Report that address the following, including but not limited to:

4.11.5.2.1 The development and distribution of education and informational materials to its Contract Providers;

4.11.5.2.2 A formal process for provider education regarding the Centennial Care program, the conditions of participation in the program, and the Contract Provider’s responsibilities to the CONTRACTOR and its Members;

4.11.5.2.3 Contract Provider education and training, which must be provided throughout the Agreement term to address clinical issues and improve the service delivery system, including but not limited to, assessments, treatment or service plans, person-centered planning, timely access requirements, continuous quality improvement processes, discharge plans, evidence-based practices, models of care, such as integrated care and trauma-informed care; and

4.11.5.2.4 Training shall be offered throughout the State and at different times of the day in order to accommodate Contract Providers' schedules.

4.11.5.3 The CONTRACTOR shall provide the following information in Contract Provider trainings and educational materials and shall make such information available upon request of a Contract Provider:

4.11.5.3.1 Conditions of participation with the CONTRACTOR;

4.11.5.3.2 Providers' responsibilities to the CONTRACTOR and to Members;

4.11.5.3.3 Integrated care for Physical Health, Behavioral Health and Long-Term Care services;

4.11.5.3.4 The CONTRACTOR's Care Coordination process and systems, including policies and procedures regarding addressing the needs of and service delivery for persons with special health care needs;

4.11.5.3.5 The CONTRACTOR's definition of high-volume provider and whether or not a provider meets that definition;

4.11.5.3.6 Billing requirements and rate structures and amounts;

4.11.5.3.7 Cultural and linguistic competency and how to access educational opportunities for Providers and their staff on cultural and linguistic competency;

4.11.5.3.8 The credentialing and recredentialing process,

4.11.5.3.9 The prior authorization and referral processes, and how to request and obtain a second opinion for Members;

4.11.5.3.10 The delivery of the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;

4.11.5.3.11 Information on the CONTRACTOR's internal provider Grievance process;

4.11.5.3.12 Providers' responsibility to report Critical Incident information and the mechanism to report such information;

4.11.5.3.13 The delivery of services to children in the custody of the State or in Tribal custody, including, but not limited to, issues related to consent, progress reporting and potential for court testimony;

4.11.5.3.14 The provisions and limitations of the ABP; and

4.11.5.3.15 Provider identification of Substance Use Disorder and Serious Mental Illness.

4.11.5.4 The CONTRACTOR shall maintain a record of its training and technical assistance activities, which it shall make available to HSD and/or other State agencies upon request.

4.11.5.5 The CONTRACTOR shall provide to HSD, upon request, documentation that Contract Provider education and training is met.

4.11.5.6 The CONTRACTOR shall provide technical assistance to Contract Providers as determined necessary by the CONTRACTOR or HSD, including one-on-one meetings with Providers. This technical assistance shall be provided in a culturally competent manner.

4.11.5.7 The CONTRACTOR shall schedule Claims/billing calls at least quarterly with the Albuquerque Area I and the Navajo Area I.

4.11.5.8 The CONTRACTOR shall conduct semi-annual, in-person visits with the I/T/Us to resolve Claims/billing issues.

4.12 **Quality Assurance**

The CONTRACTOR shall comply with all HSD requirements regarding quality assurance oversight, monitoring and evaluation. The requirements include, but are not limited to, the provisions in this Section 4.12.

4.12.1 Native American Advisory Board

4.12.1.1 The CONTRACTOR shall participate in meetings with the Native American Advisory Board. At a minimum, such meetings will occur quarterly. Native

American Advisory Board Members shall serve to advise the CONTRACTOR on any issues pertaining to Native Americans including, but not limited to, issues concerning operations, service delivery and quality of all Covered Services (e.g., Behavioral Health, Physical Health and LTC), Member rights and responsibilities, the resolution of Member Grievances and Appeals, and Claims processing and reimbursement issues.

4.12.2 Member Advisory Board

4.12.2.1 The CONTRACTOR shall include a Member receiving Community Benefits on a Member Advisory Board and shall include Community Benefits as a standing agenda item for all Member Advisory Board meetings.

4.12.2.2 The Member Advisory Board shall consist of Members representing all Centennial Care populations, family members and Providers. The CONTRACTOR shall have an equitable representation of its Members in terms of race, gender, special populations and New Mexico's geographic areas.

4.12.2.3 The CONTRACTOR's Member Advisory Board shall keep a written record of all attempts to invite and include its Members in its meetings. The Member Advisory Board roster and minutes shall be made available as directed by HSD.

4.12.2.4 The CONTRACTOR shall hold quarterly, centrally located Member Advisory Board meetings throughout the term of the Agreement. The CONTRACTOR shall advise HSD ten (10) Calendar Days in advance of meetings to be held.

4.12.2.5 In addition to the quarterly meetings, the CONTRACTOR shall hold at least two (2) additional statewide Member Advisory Board meetings each Contract year that focus on Member issues to help ensure that Member issues and concerns are heard and addressed. Attendance rosters and minutes for these two (2) statewide meetings shall be made available to HSD within ten (10) Calendar Days following the meeting date.

4.12.2.6 The CONTRACTOR shall ensure that all Member Advisory Board Members actively participate in deliberations and that no one Board Member dominates proceedings in order to foster an inclusive meeting environment.

4.12.3 External Quality Review Organization (EQRO)

4.12.3.1 HSD shall retain the services of an EQRO in accordance with 42 C.F.R. § 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HSD's managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

4.12.3.2 The EQRO shall conduct all mandatory and optional activities related to EQR in accordance with 42 C.F.R. § 438.358 and CMS quality standards of the EQR protocol criteria. The CONTRACTOR shall cooperate fully with the EQRO. Required activities shall include, but not limited to:

4.12.3.2.1 EQR Protocol 1: Mandatory assessment of compliance with Medicaid managed care regulations and standards set forth in 42 C.F.R. § 438 Subpart D and the quality assessment and performance improvement requirements described in 42 C.F.R. § 438.330;

4.12.3.2.2 EQR Protocol 2: Mandatory validation of performance measures required in accordance with 42 C.F.R. § 438.330(b)(2) or performance measures calculated by the HSD during the preceding 12 months; and

4.12.3.2.3 EQR Protocol 3: Mandatory validation of performance improvement projects required in accordance with 42 C.F.R. § 438.330 (b)(1) that were underway during the preceding twelve (12) months.

4.12.3.3 The CONTRACTOR shall participate with the EQRO in various other tasks and projects identified by HSD to gauge performance in a variety of areas, including Care Coordination and treatment of special populations.

4.12.3.4 The EQRO retained by HSD shall not be a competitor of the CONTRACTOR and shall comply with 42 C.F.R. § 438.354.

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

The CONTRACTOR shall comply with State and federal standards for quality management and quality improvement. The CONTRACTOR shall:

4.12.4.1 Establish QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria;

4.12.4.2 Recognize that opportunities for improvement are unlimited; that the QM/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 reflect Member and Contract Provider input;

4.12.4.3 Have a QM/QI annual program description that includes goals, objectives, structure and policies and procedures that shall result in continuous quality improvement;

4.12.4.4 Review outcome data at least quarterly for performance improvement, recommendations and interventions;

4.12.4.5 Have a mechanism in place to detect under-and-over utilization of services;

4.12.4.6 Have access to, and the ability to collect, manage and report to HSD data necessary to support the QM/QI activities;

4.12.4.7 Establish a committee to oversee and implement all policies and procedures;

4.12.4.8 Ensure that the ultimate responsibility for QM/QI is with the CONTRACTOR and shall not be delegated to its Subcontractors;

4.12.4.9 Have an annual QM/QI work plan to be submitted in accordance with Attachment 1 and thereafter at the beginning of each year of the Agreement, approved by HSD that includes, at a minimum, immediate objectives for each Agreement year and long-term objectives for the entire term of this Agreement. The QM/QI work plan shall contain the scope, objectives, planned activities, time frames, and data indicators for tracking performance and other relevant QM/QI information, including quality improvement projects identified by HSD;

4.12.4.10 At a minimum the CONTRACTOR shall implement Performance Improvement Projects (PIPs) in the following areas: one (1) Long-Term Care Services, one (1) Prenatal and Postpartum, one (1) Adult Obesity and two (2) State directed PIPs as required by HSD and stated in the Policy Manual include: one (1) Diabetes

prevention and management and one (1) Screening and management for clinical depression:

4.12.4.10.1 PIP work plans and activities must be consistent with PIPs as required by federal and state statutes, regulations and Quality Assessment and Performance Improvement Program requirements pursuant to 42 C.F.R. § 438.330. For more detailed information refer, to the EQR "Managed Care Organization Protocol" available at http://www.medicaid.gov;

4.12.4.11 Have the ability to design sound quality studies, apply statistical analysis to data and derive meaning from the statistical analysis; and

4.12.4.12 Submit an annual QM/QI written evaluation to HSD that includes, but is not limited to:

4.12.4.12.1 A description of ongoing and completed QM/QI activities;

4.12.4.12.2 Measures that are trended to assess performance;

4.12.4.12.3 Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;

4.12.4.12.4 Development of future work plans based on the incorporation of previous year findings of overall effectiveness of QM/QI program;

4.12.4.12.5 Demonstrate that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions and regularly monitoring each intervention’s effectiveness;

4.12.4.12.6 Demonstrate that the results of QM/QI projects and reviews are incorporated in the QM/QI program;

4.12.4.12.7 Incorporate annual HEDIS results in the following year’s plan as applicable to HSD-specific programs; and

4.12.4.12.8 Communicate with appropriate Contract Providers the results of QM/QI activities and provider reviews and use this information to improve the performance of the Contract Providers, including technical assistance, corrective action plans and follow-up activities as necessary; and

4.12.4.12.9 Upon request, present the Behavioral Health aspects of the CONTRACTOR's annual QM/QI work plan during a quarterly meeting of the Collaborative.

4.12.5 Member Satisfaction Survey

4.12.5.1 As part of the QM/QI program for Centennial Care, the CONTRACTOR shall conduct an annual survey that shall assess Member satisfaction with the quality, availability and accessibility of care. The CONTRACTOR shall implement the CAHPS for all Centennial Care Members. The CAHPS 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 surveys shall address Member receipt of educational materials, Member satisfaction with Care Coordination and involvement in Care Coordination processes, including development of the CCP. The CONTRACTOR shall follow all federal and State confidentiality statutes and regulations in conducting this Member Satisfaction Survey.

4.12.5.2 HSD agrees that use by the CONTRACTOR of the CAHPS survey will be deemed to meet all of the requirements described below:

4.12.5.2.1 Establish policies and procedures for conducting relevant Member surveys and, if the Member is a minor or unable to act on his or her behalf, to survey the Member's Representative as permitted under applicable privacy statutes;

4.12.5.2.2 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. 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;

4.12.5.2.3 The CONTRACTOR shall include the HSD required supplemental survey questions approved by NCQA in its CAHPS that are listed in Attachment 9;

4.12.5.2.4 Make available results of the Member Satisfaction Surveys to Providers, HSD and Members and families/caregivers;

4.12.5.2.5 Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall Member Satisfaction Survey results; and

4.12.5.2.6 Have mechanisms in place to incorporate survey results in the QM/QI plan for program and systems improvements.

4.12.5.3 Additionally, in conjunction with the Collaborative, the CONTRACTOR shall implement the Mental Health Statistics Improvement Program (MHSIP) for Members identified as having Behavioral Health needs.

4.12.5.4 Additionally, the CONTRACTOR shall participate on the steering committee for the Consumer, Family-Caregiver and Youth Satisfaction Project (C/F/YSP) as outlined in the Managed Care Policy Manual.

4.12.6 Provider Satisfaction Survey

The CONTRACTOR shall conduct at least one (1) annual Provider Satisfaction Survey that covers Contract Providers and follows NCQA guidelines to the extent applicable. Results will be provided to HSD as directed by HSD. The CONTRACTOR shall also make a summary of the results available to interested parties. The CONTRACTOR shall have mechanisms in place to incorporate results in the QM/QI plan for program and systems improvements.

4.12.7 Practice Guidelines

The CONTRACTOR shall:

4.12.7.1 Adopt practice guidelines that meet the following requirements:

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

4.12.7.1.2 Consider the needs of the Members;

4.12.7.1.3 Are adopted in consultation with Contract Providers; and

4.12.7.1.4 Are reviewed and updated every two (2) years.

4.12.7.2 Disseminate the guidelines to all affected Contract Providers and, upon request, to Members; and

4.12.7.3 Ensure that decisions for Utilization Management, Member education, coverage of services and other applicable areas are consistent with the guidelines.

4.12.8 Performance Measures

4.12.8.1 All performance measures (PMs) and targets shall be based on HEDIS technical specifications for the current reporting year. In the event that NCQA alters the measure or technical specifications for the PMs listed, the CONTRACTOR will follow relevant and current NCQA standards. PMs and targets shall be reasonable and based on industry standards that are applicable to substantially similar populations. The CONTRACTOR shall meet performance targets specified by HSD. The PMs will be required to meet HSD designated targets for CY 2020, 2021, 2022, and 2023 detailed with each PM below.

4.12.8.1.1 Each CY target is a result of the CY 2018 MCO aggregated Audited HEDIS data, calculating an average increase for each CY until reaching the CY 2018 Quality Compass Regional Averages plus one (1) percentage point. Failure to meet the HSD designated target for individual performance measures during the Calendar Year will result in a monetary penalty based on two percent (2%) of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year, as stated in Section 7.3.3.6.7 of this Agreement. Each measure listed below shall be subject to the penalty. The CONTRACTOR will be required to collect, track, trend, and report performance measures quarterly as directed by HSD and /or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HSD and/or its designee.

4.12.8.1.2 Reporting elements and data are to be provided to HSD in the same format as the template provided by HSD, as directed by HSD. The reporting period is based upon one (1) quarter of a calendar year (e.g. Q1 Total= January-March). For the measurement period, please refer to the relevant technical specifications. For the reporting period, the MCO must refresh data for the previous two (2) quarters of the current calendar year. If a report includes data which has been refreshed beyond two (2) quarters, the report will be rejected by HSD. The report must be submitted within twenty-five (25)

Calendar Days from the end of each reporting period. If the twenty-fifth (25^{th}) Calendar Day is not a Business Day, then the report must be submitted the following Business Day. If HSD requests any revisions to reports previously submitted by the CONTRACTOR, the CONTRACTOR shall make the changes and re-submit the reports according to the timeframe set forth by HSD. The naming convention for this report is: MCO.HSDPMQXCYXX.vX. If the proper naming convention is not used, the report will be rejected by HSD.

4.12.8.2 The Performance Measures (PMs) shall be evaluated using the following criteria:

4.12.8.2.1 PM #1 (1 point) – Well Child Visits in the First fifteen (15) Months of Life (W15)

The percentage of Members who turned fifteen (15) months old during the measurement year and had six (6) or more well-child visits:

4.12.8.2.1.1 CY 2020 target is 62.62%;

4.12.8.2.1.2 CY 2021 target is 63.72%;

4.12.8.2.1.3 CY 2022 target is 64.82%; and

4.12.8.2.1.4 CY 2023 target is 65.91%.

4.12.8.2.2 PM #2 (1 point) – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

The percentage of Members ages three (3) through seventeen (17) years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity during the measurement year:

4.12.8.2.2.1 CY 2020 target is 48.52%;

4.12.8.2.2.2 CY 2021 target is 53.33%;

4.12.8.2.2.3 CY 2022 target is 58.14%; and

4.12.8.2.2.4 CY 2023 target is 62.93%.

4.12.8.2.3 PM #3 (1 point) – Prenatal and Postpartum Care (PPC)

The percentage of Member deliveries of live births between October 8 of the year prior to the measurement year and October 7 of the measurement year that received a prenatal care visit as a Member of the CONTRACTOR's

MCO in the first trimester or within forty-two (42) Calendar Days of enrollment in the CONTRACTOR's MCO:

4.12.8.2.3.1 CY 2020 target is 78.67%;

4.12.8.2.3.2 CY 2021 target is 80.70%;

4.12.8.2.3.3 CY 2022 target is 82.73%; and

4.12.8.2.3.4 CY 2023 target is 84.75%.

4.12.8.2.4 PM #4 (1 point) – Prenatal and Postpartum Care (PPC)

The percentage of Member deliveries that had a postpartum visit on or between seven (7) and eighty-four (84) Calendar Days after delivery:

4.12.8.2.4.1 CY 2020 target is 63.35%;

4.12.8.2.4.2 CY 2021 target is 64.65%;

4.12.8.2.4.3 CY 2022 target is 65.95%; and

4.12.8.2.4.4 CY 2023 target is 67.26%.

4.12.8.2.5 PM #5 (1 point) – Childhood Immunization Status (CIS): Combination 3

The percentage of children two (2) years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) haemophilus influenza type B (HiB); three (3) hepatitis B (HepB); one chicken pox (VZV); and four (4) pneumococcal conjugate (PCV) vaccines by their second birthday:

4.12.8.2.5.1 CY 2020 target is 68.01%;

4.12.8.2.5.2 CY 2021 target is 69.27%;

4.12.8.2.5.3 CY 2022 target is 70.53%; and

4.12.8.2.5.4 CY 2023 target is 71.78%.

4.12.8.2.6 PM #6 (1 point) – Antidepressant Medication Management (AMM): Continuous Phase

The percentage of Members age eighteen (18) years and older as of April 30 of the measurement year who were diagnosed with a new episode of major depression during the intake period and received at least one-hundred eighty (180) Calendar Days (6 months) of continuous treatment with an antidepressant medication:

4.12.8.2.6.1 CY 2020 target is 34.33%;

4.12.8.2.6.2 CY 2021 target is 34.76%;

4.12.8.2.6.3 CY 2022 target is 35.19%; and

4.12.8.2.6.4 CY 2023 target is 35.61%.

4.12.8.2.7 PM #7 (1 point) – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET): Initiation

The total percentage of adolescent and adult Members with a new episode of alcohol or other drug (AOD) dependence who received the following; Initiation of AOD Treatment:

4.12.8.2.7.1 CY 2020 target is 43.34%;

4.12.8.2.7.2 CY 2021 target is 44.74%;

4.12.8.2.7.3 CY 2022 target is 46.14%; and

4.12.8.2.7.4 CY 2023 target is 47.54%.

4.12.8.2.8 PM #8 (1 point) – Follow-Up After Hospitalization for Mental Illness (FUH): 30 Day

The percentage of discharges for Members six (6) years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner within thirty (30) days after discharge:

4.12.8.2.8.1 CY 2020 target is 48.42%;

4.12.8.2.8.2 CY 2021 target is 50.22%;

4.12.8.2.8.3 CY 2022 target is 52.02%; and

4.12.8.2.8.4 CY 2023 target is 53.80%.

4.12.8.2.9 PM #9 (1 point) – Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30 Day

The percentage of emergency department (ED) visits for members six (6) years of age and older with a principal diagnosis of mental illness, who had a follow up visit for mental illness within thirty (30) days of the ED visit:

4.12.8.2.9.1 CY 2020 target is 43.52%;

4.12.8.2.9.2 CY 2021 target is 45.01%;

4.12.8.2.9.3 CY 2022 target is 46.50%; and

4.12.8.2.9.4 CY 2023 target is 48.00%.

4.12.8.2.10 PM #10 (1 point) – Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

The percentage of Members eighteen (18) to sixty-four (64) years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year:

4.12.8.2.10.1 CY 2020 target is 80.63%;

4.12.8.2.10.2 CY 2021 target is 81.35%;

4.12.8.2.10.3 CY 2022 target is 82.07%; and

4.12.8.2.10.4 CY 2023 target is 82.78%.

4.12.9 Disease Management

4.12.9.1 The CONTRACTOR shall provide disease management ("DM") strategies to Members with identified chronic conditions as part of its Care Coordination processes and activities. The CONTRACTOR's DM strategies may include population identification/stratification, collaborative practice models, patient self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes.

4.12.9.2 The CONTRACTOR shall improve its ability to manage chronic illnesses/diseases/conditions through DM protocols. The CONTRACTOR shall:

4.12.9.2.1 Participate in DM projects annually;

4.12.9.2.2 Provide comprehensive DM for a minimum of two (2) chronic disease states, 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 the Agency of Healthcare Research and Quality's (AHRQ), NQMC web site, or the Care Continuum Alliance (formerly the Disease Management Association of America);

4.12.9.2.3 Submit cumulative data-driven measurements 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 shall be New Mexico Medicaid-specific;

4.12.9.2.4 Submit to HSD the CONTRACTOR's DM plan, which shall include a description of the strategies and interventions, the overall and measurable objectives and targeted interventions. The CONTRACTOR shall also submit to HSD its methodology for identifying other diseases/conditions for potential DM strategies and interventions; and

4.12.9.2.5 Submit to HSD a quantitative and qualitative evaluation of the efficacy of the prior year's DM strategies; document how well goals were addressed, such as identification, enrollment, targeted interventions and outcomes.

4.12.10 Standards for Utilization Management (UM)

The CONTRACTOR shall establish and implement a UM system that follows NCQA UM standards and promotes quality of care, adherence to standards of care, the efficient use of resources, Member choice and the identification of service gaps within the service system.

4.12.10.1 The CONTRACTOR's UM system shall:

4.12.10.1.1 Ensure that Members receive services based on their current condition and effectiveness of previous treatment;

4.12.10.1.2 Ensure that services are based on the history of the problem/illness, its context and desired outcomes;

4.12.10.1.3 Assist Members and/or their Representatives in choosing among Providers and available treatments and services;

4.12.10.1.4 Emphasize relapse and crisis prevention, not just crisis intervention;

4.12.10.1.5 Detect over-and-under utilization of services to assess quality and appropriateness of services and to assess quality and appropriateness of care furnished to Members with special health care needs;

4.12.10.1.6 Accept the New Mexico Uniform Prior Authorization Form for non-emergency medical and pharmaceutical benefits, as required per the 2019 New Mexico Health Insurance Prior Authorization Act; and

4.12.10.1.7 Respond to the prescription drug prior authorization requests in accordance with NMAC 8.308.9.26.E(7)(a)(b).

4.12.10.1.8 Ensure that prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits as specified in 42 CFR 438.910(d).

4.12.10.2 The CONTRACTOR shall comply with State and federal requirements for Utilization Management, including but not limited to, 42 C.F.R. § 438.910(d) and 42 C.F.R. § 456.

4.12.10.3 The CONTRACTOR shall manage the use of limited resources and maximize the effectiveness of care by evaluating clinical appropriateness and authorizing 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.

4.12.10.4 The CONTRACTOR shall submit to HSD on an annual basis existing UM edits in the CONTRACTOR's Claims processing system that control utilization and prevent payment for Claims that are duplicates, unbundled when they should be bundled, already covered under another charge, etc.

4.12.10.5 The CONTRACTOR shall define and submit annually to HSD a written copy of the CONTRACTOR's UM program description, UM work plan and UM evaluation, which shall include, but not be limited to:

4.12.10.5.1 A description of the CONTRACTOR's UM program structure and accountability mechanisms;

4.12.10.5.2 A description of how the UM work plan supports the goals described in the UM program description and 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 work plan must be data driven with key indicators that are used to ensure that under-and-over utilization are detected by the CONTRACTOR and addressed appropriately; and

4.12.10.5.3 A comprehensive UM program evaluation that includes an evaluation of the overall effectiveness of the UM program, an overview of UM activities and an assessment of the impact of the UM program 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 work plan.

4.12.10.6 The CONTRACTOR shall ensure the involvement of appropriate, knowledgeable, currently practicing practitioners in the development of UM procedures.

4.12.10.7 The CONTRACTOR shall submit to HSD proposed UM clinical criteria to be used for services requiring prior authorization. HSD reserves the right to review and approve all UM clinical criteria.

4.12.10.8 Upon request, the CONTRACTOR shall provide UM decision criteria to Providers, Members, their families and the public.

4.12.10.9 The CONTRACTOR shall define how UM decisions will be communicated to the Member and the Member's PCP or to the provider requesting the authorization.

4.12.10.10 The CONTRACTOR shall comply with the most rigorous standards or applicable provisions of either NCQA, HSD regulation, the Balanced Budget Act of 1997 or 42 C.F.R. § 438 related to timeliness of decisions including routine/non-urgent and emergent situations.

4.12.10.11 The CONTRACTOR shall 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. The CONTRACTOR shall contract with a Board-Certified Behavior Analyst (BCBA) for Utilization Review of Applied Behavior Analysis prior authorization requests. The CONTRACTOR must ensure the BCBA contracted has no conflict of interests with individuals and/or entities requesting prior authorization for a member.

4.12.10.12 The CONTRACTOR shall approve or deny Covered Services for routine/non-urgent and urgent care requests, requested by either Members or Providers, within the time frames as stated in the New Mexico Health Insurance Prior Authorization Act. These required time frames shall not be affected by a "pend" decision. The decision-making time frames 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-specified time frames.

4.12.10.13 The CONTRACTOR shall 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 time frames based on all applicable federal and State statutes and regulations.

4.12.10.14 The CONTRACTOR shall comply with utilization management reporting requirements as directed by HSD.

4.12.10.15 The CONTRACTOR shall ensure that the Pharmacy and Therapeutics Committee membership includes Behavioral Health expertise to aid in the development of pharmacy and practice guidelines for PCPs regarding psychotropic and antidepressant medications.

4.12.10.16 The CONTRACTOR shall develop and implement policies and procedures to issue extended prior authorization for Covered Services provided to address chronic conditions that require care on an ongoing basis. These services shall be authorized for an extended period of time and the CONTRACTOR shall provide for a review and periodic update of the course of treatment, according to best practices.

4.12.11 <u>General Requirements</u>

4.12.11.1 The CONTRACTOR shall:

4.12.11.1.1 Ensure that Covered Services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to beneficiaries pursuant to 42 C.F.R. § 440.230;

4.12.11.1.2 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;

4.12.11.1.3 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;

4.12.11.1.4 Ensure appropriate service by providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment that meets an individual's needs. Level of care and utilization control for behavioral health services shall follow the guidelines issued by HSD provided the services furnished can reasonably be expected to achieve their purpose; and

4.12.11.1.5 Define service authorization requests in a manner that includes a Member's request for the provision of services.

4.12.12 Authorization of Services

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

4.12.12.1 Have and follow, written policies and procedures for processing requests for initial and continuing authorizations for services, and require that its Major Subcontractors or Subcontractors do the same;

4.12.12.2 Have in effect mechanisms to ensure consistent application of UM criteria for authorization decisions;

4.12.12.3 Consult with the provider when appropriate;

4.12.12.4 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 a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, such as the CONTRACTOR's medical director;

The CONTRACTOR shall contract with a Board-Certified Behavior Analyst (BCBA) for Utilization Review of Applied Behavior Analysis prior authorization requests. The CONTRACTOR must ensure the BCBA contracted has no conflict of interests with individuals and / or entities requesting prior authorization for a member; and

4.12.12.5 Adjudicate routine prior authorization requests within seven (7) Business Days after receipt of all necessary and relevant documentation supporting a prior authorization request. Prior authorizations shall be deemed granted for determinations not made within the seven (7) Business Day turn-around time, except where:

4.12.12.5.1 An extension of up to fourteen (14) Calendar Days may be granted if a Member or provider requests an extension;

4.12.12.5.2 The CONTRACTOR justifies (to HSD upon written request) a need for additional information and how the extension is in the Member's best interest;

4.12.12.5.3 If the CONTRACTOR extends the time frame, the CONTRACTOR must give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a Grievance in accordance with Section 4.16 of this Agreement if he or she disagrees with the decision; and

4.12.12.5.4 In cases in which the provider indicates, or the CONTRACTOR determines, that following the standard time frame 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 no later than twenty-four (24) hours after the receipt of all necessary and relevant documentation supporting the prior authorization request. Prior authorizations shall be deemed granted for determinations not made within the twenty-four (24) hour turn-around time. In the event that the expedited authorization decision is to deny or limit services, the

CONTRACTOR shall automatically file an Appeal on behalf of the Member in accordance with Section 4.16.6.

4.12.13 Coordination and Collaboration with CYFD including children and youth in custody or under the supervision of CYFD

4.12.13.1 The CONTRACTOR shall work with CYFD and other State agencies to promote early identification of children and transition-age youth (ages 16-21) who are engaging in delinquent or high-risk factors, and/or who have experienced traumatic events, including exhibiting signs of SED or SMI.

4.12.13.2 The CONTRACTOR shall coordinate services and supports that reflect the least restrictive level of care with the CYFD Protective Services ("PS"), Behavioral Health Services ("BHS") and Juvenile Justice Services ("JJS") divisions, including discharge planning.

4.12.13.2.1 Upon request, the CONTRACTOR shall provide and/or participate in trainings regarding service availability, in collaboration with CYFD staff, to contract providers, family members, kinship supports, and youth, including but not limited to:

4.12.13.2.1.1 Non-Medicaid services and supports available, as appropriate (e.g., substance use programs, High-Fidelity Wraparound, Youth Support Services, Infant Mental Health, and Prevention Services targeted to parents and children involved with CYFD);

4.12.13.2.1.2 The referral process; and

4.12.13.2.1.3 Eligibility criteria to promote coordination and access to services. Training and information shall incorporate and be reflective of a trauma informed, youth-and family-driven and culturally and linguistically responsive approach to care.

4.12.13.3 RESERVED

4.12.13.4 The CONTRACTOR shall ensure the member's care coordinator is actively involved with the CYFD permanency placement worker (PPW) for Protective Services (PS) involved children and youth, juvenile probation officer (JPO) or juvenile facility staff for JJS involved youth, and BHS community behavioral

health clinician (CBHC) for CYFD involved children/youth, provided that CYFD informs the CONTRACTOR of the assigned CYFD lead worker.

4.12.13.5 The CONTRACTOR shall ensure that children in the custody or supervision of CYFD receive a behavioral health screening within forty-eight (48) hours of a referral to a behavioral health contract provider and receive a behavioral health assessment, access to medically necessary covered services, and care coordination as appropriate.

4.12.13.6 The CONTRACTOR shall participate in all PS, BHS, and JJS clinical staffing reviews related to the CYFD care planning process.

4.12.13.7 Upon request, the CONTRACTOR shall participate in the PS Family Centered Meetings (“FCM”), JJS Multi-Disciplinary Team (“MDT”) meetings, and/ or behavioral health team meetings which shall include family members or kinship supports, as appropriate.

4.12.13.8 The CONTRACTOR shall collaborate with CYFD for CYFD involved children and youth experiencing a transition.

4.12.13.8.1 Transitions include:

4.12.13.8.1.1 Moving from a higher LOC to a lower LOC;

4.12.13.8.1.2 Transition for member(s) moving from a residential placement or institutional facility (including psychiatric hospitals) to a community placement;

4.12.13.8.1.3 Transition for member(s) moving from an out-of-state placement to an in-state placement;

4.12.13.8.1.4 Transition for member(s) released from incarceration or detention facilities;

4.12.13.8.1.5 Transition for children entering or returning home from a foster care placement; and

4.12.13.8.1.6 Transition for member(s) turning 21 years of age.

4.12.13.8.2 The CONTACTOR shall ensure an appropriate level of care coordination to meet the needs and ensure that the child or youth is placed in the least restrictive placement.

4.12.13.8.3 The CONTRACTOR shall ensure that providers initiate discharge planning with CYFD staff in accordance with NMAC 7.20.11.23.

4.12.13.8.3.1 The CONTRACTOR shall participate with the State on a workgroup to develop and implement the Family First Prevention and Services Act (FFPSA).

4.12.13.8.4 The CONTRACTOR shall notify the assigned CYFD lead worker of the decision within twenty-four (24) hours of an authorization or denial of the continuance of stay for CYFD involved children/youth. Precipitous discharge from these placements is prohibited. The assigned care coordinator will work collaboratively with CYFD and other applicable stake holders to ensure that the discharge plan is in place prior to discharge.

4.12.13.8.5 The CONTRACTOR shall ensure care coordination of high-risk transition-age youth ages sixteen (16) to twenty-one (21) with all relevant providers and State departments currently involved in the Member's care and with the family, relevant individuals identified by the youth, and the Member's legal guardian or designated representative.

4.12.13.9 The CONTRACTOR shall promote coordination between juvenile justice facilities and the CONTRACTOR's contract providers to establish continuity of care.

4.12.13.9.1 Upon request, the CONTRACTOR shall provide training to juvenile justice facility staff and contract providers regarding service availability, the referral process, and eligibility criteria to promote coordination and access to services upon release.

4.12.13.9.2 The CONTRACTOR shall ensure assessment and provide appropriate covered services for all CYFD-referred juveniles.

4.12.13.9.3 The CONTRACTOR shall work with CYFD to provide care coordination for committed juveniles identified as having high needs as they transition from juvenile justice facilities back into the community.

4.12.13.10 RESERVED

4.12.13.11 For requests for authorization of residential treatment services for children and youth in custody or supervision of CYFD, the CONTRACTOR shall make a decision upon receipt of all necessary and relevant documentation supporting the request, and in accordance with the Prior Authorization Act of 2019 and notify the CYFD lead worker and the provider within twenty-four (24) hours of the decision.

4.12.14 Children in Tribal Custody or Under Tribal Supervision

4.12.14.1 The CONTRACTOR shall ensure that children in Tribal custody or under Tribal supervision pursuant to a Tribal court order (as such term is defined in NMSA 1978 § 32A-1-4) receive a Behavioral Health screening within twenty- four (24) hours of a referral to a Behavioral Health Contract Provider and receive a Behavioral Health assessment, Medically Necessary Covered Services and Care Coordination as appropriate.

4.12.14.2 If requested by an Indian Tribe, Nation or Pueblo located partially or wholly in New Mexico, the CONTRACTOR shall negotiate in good faith to enter into agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to children in Tribal custody or under Tribal supervision who are in need of such services. Should a Tribe, Nation or Pueblo choose not to enter into such agreements, the CONTRACTOR shall not be liable for providing Covered Services to those children.

4.12.15 Notice of Adverse Action

The CONTRACTOR must notify the requesting 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, Subpart F.

4.12.16 Critical Incident Management

4.12.16.1 The CONTRACTOR shall adhere to all State requirements for Critical Incident management and reporting. The CONTRACTOR shall develop policies and procedures to address and respond to incidents, report incidents to the

appropriate entities per required time frames and track and analyze incidents. The CONTRACTOR shall use this information to identify trends and patterns both case-specific and systemic, identify opportunities for improvement and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care.

4.12.16.1.1 The CONTRACTOR shall use this information and the data to conduct an annual evaluation of its Critical Incident Management system. The CONTRACTOR shall include the results of its evaluation as part of the CONTRACTOR'S QM/QI work plan submitted to HSD as outlined in Section 4.12.4.9 of this Agreement.

4.12.16.2 The CONTRACTOR shall require its staff and Contract Providers to report, respond to, and document Critical Incidents and the resulting follow-up activities, as specified by the CONTRACTOR. The CONTRACTOR shall also require staff and Providers to cooperate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., HSD, the Collaborative, the New Mexico Department of Health, CYFD, Adult Protective Services and law enforcement).

4.12.16.3 The CONTRACTOR shall provide appropriate training and take corrective action as needed to ensure provider compliance with Critical Incident requirements. The CONTRACTOR shall ensure that training is provided upon a provider entering into a contract, upon hire of employees, and upon enrollment in the SDBC. The CONTRACTOR shall ensure that training be provided at least annually thereafter.

4.12.16.4 The CONTRACTOR shall follow the required processes and instruct Physical Health and Behavioral Health Providers annually on the required processes for reporting critical incidents and Sentinel events as required by the agency or department that has oversight of the report, including but not limited to: HSD, Department of Health, Children, Youth and Families Department and Aging and Long-Term Services Department. For recipients of adult Behavioral Health services who are non-Medicaid recipients, all Critical Incident Reports (CIRs)

should be faxed to the State of New Mexico Interagency Behavioral Health Purchasing Collaborative at fax number 505- 476-9272.

4.12.16.5 The CONTRACTOR shall establish a Critical incident review committee as defined under 8.308.21.15 B (1) NMAC.

4.12.16.5.1 The CONTRACTOR shall ensure that the Critical Incident Review Committee meets on a monthly basis.

4.12.16.6 Upon transition of a member to another MCO, the CONTRACTOR shall identify whether the member is associated with an unresolved Critical Incident Report in the HSD Critical Incident Reporting Portal. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved critical incidents for members who were part of the CONTRACTOR'S membership at the time the incident was filed.

4.12.16.7 Upon termination of this Agreement by HSD or the CONTRACTOR, the CONTRACTOR shall submit a report of outstanding critical incidents and death investigations pending receipt of the findings from the Office of the Medical Investigator, for members who were enrolled with the CONTRACTOR prior to termination of this Agreement. HSD will provide to the CONTRACTOR, a template for the report. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved critical incidents for members who were part of the CONTRACTOR'S membership at the time the incident was filed.

4.12.16.7.1 The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting, for the outstanding critical incidents and pending death investigations associated with members who were enrolled with the CONTRACTOR prior to termination of this agreement. This requirement will apply even when members have transferred to another MCO. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved critical incidents for members who were part of the CONTRACTOR'S membership at the time the incident was filed.

4.12.17 Tracking Measures

4.12.17.1 The CONTRACTOR shall report on the tracking measures included in this Section 4.12.17 as directed by HSD.

4.12.17.2 The tracking measures included in this Section 4.12.17 are not subject to sanctions in Section 7.3.3 of this Agreement.

4.12.17.3 TM#1- Fall Risk Management

The Percentage of Medicaid Members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

4.12.17.4 TM#2- Diabetes, Short-Term Complications Admission Rate

The number of inpatient hospital admissions with ICD-10-CM principal diagnosis codes for diabetes short-term complications for Medicaid enrollees age 18 and older.

4.12.17.5 TM#3- Screening for Clinical Depression and Follow-Up Plan

The percentage of Medicaid Members age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

4.12.17.6 TM#4 - Follow-up after Hospitalization for Mental Illness

Measure: Percent of seven-day follow-up visits into community-based Behavioral Health care for child and for adult Members released from inpatient psychiatric hospitalizations stays of four or more days.

Inpatient Psychiatric Facility/Unit (IPF) – Discharges: Discharges for Members, six years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four days or more (i.e., discharge date more than three days after admission date). Includes only psychiatric units in general hospitals and freestanding psychiatric hospitals. For the purposes of tracking discharges and follow-ups, Claims data should be used.

Follow-up after Hospitalization for Mental Illness: Discharges for Members, six years of age or older at the time of discharge, who were hospitalized for treatment of mental health disorders for a continuous period of four days or more and who had at least one follow-up visit with a mental health practitioner on or after the discharge date, within seven (7) Calendar Days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient or recovery treatment.

Members who are enrolled with the MCO at the time of the Member's discharge and are eligible for Medicaid services under New Mexico's State Plan. For purposes of this calculation, use age at time of discharge. Measure should be sorted by two categories and in two Member groups:

- Number of IPF Discharges of Members six years of age to 17 years of age during the quarter;
- Number of IPF Discharges of Members 18 years of age and older during the quarter;
- Number of Members six years of age to 17 years of age who had a follow-up visit within seven days after an IPF Discharge during the quarter; and
- Number of Members 18 years of age and older who had a follow-up visit within seven days after an IPF Discharge during the quarter.

4.12.17.7 TM#5 – Immunizations for Adolescents.

Use current reporting year HEDIS technical specification for reporting. The percentage of adolescents thirteen years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and a cellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. Report rates for each vaccine and one combination rate.

4.12.17.8 TM#6 Long Acting Reversible Contraceptive (LARC)

The CONTRACTOR shall measure the use of Long-Acting Reversible Contraceptives (LARC) among Members age 15–19. The contractor shall report

LARC insertion/utilization data for this measure to the HSD on a quarterly and annual basis.

4.12.17.9 TM#7 Smoking Cessation

The CONTRACTOR shall monitor the use of smoking cessation products and counseling utilization.

4.12.17.10 TM#8 Ambulatory Care

Use current reporting year HEDIS technical specification for reporting. Utilization of outpatient visits and emergency department (ED) visits reported by all Member months for the measurement year.

4.12.17.11 TM#9 - Annual Dental Visit: Use current reporting year HEDIS technical specifications for reporting. The percentage of enrolled Members ages two (2) to twenty (20) years who had at least one (1) dental visit during the measurement year.

4.12.17.12 TM#10 – Controlling High Blood Pressure: Use current reporting year HEDIS technical specifications for reporting. The percentage of Members ages eighteen (18) to eighty-five (85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled during the measurement year.

4.13 **Patient-Centered Initiatives**

The CONTRACTOR shall comply and cooperate with all HSD patient-centered initiatives. The purpose of the patient-centered initiatives is to support HSD's commitment to improving health status, achieving superior clinical outcomes and improving service delivery, while reducing administrative burdens.

4.13.1 Patient-Centered Medical Home (PCMH)

4.13.1.1 The CONTRACTOR shall work with PCP Contract Providers to implement PCMH programs. PCMHs are not required to attain NCQA or Joint Commission

recognition but are encouraged to achieve recognition as soon as possible. PCMHs shall incorporate the following principles:

4.13.1.1.1 Every Member has a selected Primary Care Provider;

4.13.1.1.2 Care is provided by a physician-directed team that collectively cares for the Member;

4.13.1.1.3 The PCMH: (i) performs Care Coordination functions in accordance with Section 4.4 of this Agreement or (ii) is engaged with the Member's assigned care coordinator, as applicable, provided by the CONTRACTOR in arranging and coordinating services; and

4.13.1.1.4 Care is coordinated and/or integrated across all aspects of health care.

4.13.1.2 The CONTRACTOR shall support transition and ensure engagement of Primary Care practices to PCMHs by focusing on the following areas:

4.13.1.2.1 Screening/identification and targeting of PCMH participants, including, but not limited to: (i) Members with an identified disease state/condition aligned with the CONTRACTOR's proposed disease management programs; and (ii) Members identified with a higher level of need for continuity of care, such as those with a Behavioral Health diagnosis, including substance abuse that adversely effects the Member's life, co-morbid health conditions or Members receiving NF LOC;

4.13.1.2.2 Continuous, accessible, comprehensive and coordinated care using community-based resources as appropriate, enhanced access including, but not limited to, extended office hours outside of 8:00 AM to 5:00 PM (Mountain Time), open scheduling and alternative communication models, such as web-based or telephonic options;

4.13.1.2.3 Focusing care on prevention, chronic care management, reducing emergency room visits and unnecessary hospitalizations and improving care transitions;

4.13.1.2.4 Using access and quality measures (HEDIS and surveys), as defined by HSD;

4.13.1.2.5 Demonstrating improved health status and outcomes for Members as defined by HSD;

4.13.1.2.6 Using measures to analyze the delivery of patient-centered services and quality of care, over and underutilization of services, disease management strategies and outcomes of care;

4.13.1.2.7 Promoting adoption of all use of HIT and supporting integration between Primary Care and other Providers of Covered Services through Care Coordination, as well as electronic data exchange; specifically, data that may be used to support decision making and continuous quality improvement, which may include the release of CONTRACTOR authorization data as directed by HSD; and

4.13.1.2.8 Promoting integration between Primary Care and other Providers of Covered Services through Care Coordination, as well as data exchange; specifically, data that may be used to support decision making and continuous quality improvement, which may include the release of Medicaid Claims/Encounter Data, MCO Claims/Encounter Data and MCO authorization data as directed by HSD.

4.13.1.3 The CONTRACTOR shall report PCMH activities and expenditures to HSD shall be in a format and methodology specified by HSD.

4.13.1.4 Any amounts expended by the CONTRACTOR implementing or operating the PCMH initiative shall be counted as direct medical expenses as defined in Section 7.2 of this Agreement.

4.13.2 Health Homes

4.13.2.1 The CONTRACTOR shall comply and cooperate with HSD's Health Home initiative for developing Behavioral Health Homes ("BHH") and physical Health Homes ("PHH") as authorized under Section 2703 of the Patient Protection and Affordable Care Act ("PPACA").

4.13.2.2 The CONTRACTOR shall implement Health Homes in accordance with New Mexico's Medicaid State Plan and the Managed Care Policy Manual and the CareLink New Mexico Policy Manual.

4.13.2.3 The CONTRACTOR shall make best efforts to contract with all Health Home Providers designated by HSD and the CareLink New Mexico Steering Committee.

4.13.2.4 The CONTRACTOR shall refer all eligible Members who meet the CareLink New Mexico Health Home criteria and who are not participating in a Full Delegation of care coordination model to one of the CareLink NM Health Homes and document all such referrals. It shall also maintain a record of any Member choice to opt in or out of the Health Home or to select a different CareLink NM provider.

4.13.2.5 The CONTRACTOR shall ensure that the Health Homes provide Care Coordination functions for Members enrolled with the Health Home.

4.13.2.6 The CONTRACTOR shall maintain administrative responsibility and oversight of Care Coordination and reporting as required by HSD according to this Agreement.

4.13.2.7 The CONTRACTOR shall issue monthly payments to Health Home provider(s) when the Health Home provider has submitted Claims to the CONTRACTOR documenting the utilization of Health Home services by the Member per the CareLink New Mexico Provider Policy Manual. The costs associated with the Health Home are included in the CONTRACTOR's Capitation Rate.

4.13.2.7.1 The payment shall be an amount based on the CONTRACTOR's Centennial Care membership enrolled in the Health Home and billed by the Health Home provider for that month using a PMPM set by HSD.

4.13.2.7.2 The Claim payment shall be made, per Section 4.19 Claims Management.

4.13.3 <u>New Mexico’s Health Information Exchange (HIE)</u>

4.13.3.1 The CONTRACTOR shall make its Centennial Care health plan’s health information available to the HIE and use the HIE to exchange electronic health information with other Providers and health plans in accordance with applicable State and federal law.

4.13.3.2 The CONTRACTOR shall issue monthly payments to the New Mexico Health Information Collaborative (NMHIC), or its successor, as operator of the HIE.

The costs associated with the HIE or its successor are included in the CONTRACTOR's Capitation Rate.

4.13.3.2.1 The payment shall be an amount based on the CONTRACTOR's Centennial Care membership for that month using a PMPM set by HSD.

4.13.3.2.2 The payment shall be made no later than ten (10) Calendar Days, or at HSD's discretion, following the CONTRACTOR's receipt of the monthly Capitation Payment for its membership from HSD.

4.13.4 Home Visiting Pilot Program

4.13.4.1 The CONTRACTOR shall operate an evidence-based Home Visiting (HV) pilot program in two to four counties with poor performance for prenatal/postpartum care and/or poor birth outcomes, such as high rate of preterm births and high rate of low birth weight infants or other risk factors as determined by HSD. HSD will designate the counties to be served and the evidence-based HV model to be utilized. The program will be voluntary for Centennial Care Members. The CONTRACTOR shall include methods to incentivize participation.

4.13.4.2 New Mexico has an extensive home visiting network throughout the State. The CONTRACTOR shall contract with the high-fidelity HV models that are operating in the designated counties to deliver a defined set of Medicaid-reimbursable services.

4.13.4.3 The CONTRACTOR shall work collaboratively with the Early Childhood Education & Care Department (ECECD), the Department of Health (DOH) and the Children, Youth and Families Department (CYFD) to implement the program, develop workforce and provider capacity to serve the Members participating in the program, and improve prenatal and postnatal outcomes in the identified counties.

4.13.4.4 The CONTRACTOR shall provide appropriate oversight of all contracted services and monitor the program fidelity of HV model delivery based on agreed upon criteria.

4.13.4.5 Activities that may be conducted as part of the visits include, but are not limited to:

4.13.4.5.1 Screening: HV services include best practice guidelines and standards for screening services. These include screenings for pregnant mothers to help identify services or resource supports needed to prevent, assess and treat maternal problems such as high-risk pregnancy, depression, trauma, intimate partner violence and mental health and substance use disorders and may also include home and family relationship assessment; and

4.13.4.5.2 Targeted Case Management: These services include activities such as conducting a comprehensive history and assessment (in place of CNA), developing an individualized care plan, providing referrals and scheduling treatment services, linking Members to necessary community resources, monitoring and follow-up activities.

4.13.4.6 The CONTRACTOR shall be responsible for submitting the HV outcomes as determined by HSD. HSD will provide guidance on required reporting and frequency.

4.14 **Member Materials**

4.14.1 Prior Approval Process

4.14.1.1 The CONTRACTOR shall submit to HSD for review and prior written approval all materials that will be distributed to Members (referred to as Member Materials). This includes, but is not limited to, Member handbooks, provider directories, Member newsletters, Member identification (ID) cards and, upon request, any other additional, but not required, materials and information provided to Members designed to promote health and/or educate Members.

4.14.1.2 All Member Materials must be submitted to HSD in paper and electronic file media in the format prescribed by HSD. The CONTRACTOR shall submit the reading level and the methodology used to measure it concurrent with all submissions of Member Materials and include a plan that describes the CONTRACTOR's intent for the use of the Member Materials.

4.14.1.3 Member and Marketing materials shall be approved by HSD in accordance with the procedures specified in the Managed Care Policy Manual.

4.14.1.4 Prior to modifying any approved Member Material(s), the CONTRACTOR shall submit to HSD for prior written approval a detailed description of the proposed modifications in accordance with this Section.

4.14.1.5 HSD reserves the right to notify the CONTRACTOR to discontinue or modify Member Materials after approval.

4.14.2 Written Member Material Guidelines

4.14.2.1 The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of Member Materials including how the CONTRACTOR will meet the requirements in this Section. The CONTRACTOR shall, at a minimum, have policies and procedures regarding the process for developing/creating, proofing, approving, publishing and mailing the: (i) Member ID card; (ii) Member handbook; (iii) provider directory; (iv) Preferred Drug List; (v) Member newsletter; and (vi) form letters within contractual standards and time frames. The CONTRACTOR shall include a separate set of policies and procedures for each of the items listed above (i-vi).

4.14.2.2 All written Member Materials must be worded at or below a sixth (6th) grade reading level, unless otherwise approved in writing by HSD.

4.14.2.3 All written Member Materials must be clearly legible with a minimum font size of twelve (12) point with the exception of Member ID cards and unless otherwise approved in writing by HSD and must comply with all provisions in 42 C.F.R. § 438.10.

4.14.2.4 All written Member Materials must be printed with the assurance of non-discrimination.

4.14.2.5 All written Member Materials shall be available in English and the prevalent languages spoken by approximately five percent (5%) or more of the population, with the exception of Native American languages, for which there are not written forms and/or for which the State has not obtained consent from Tribal leadership to use the language. The CONTRACTOR shall certify that the translation of the information into the different languages has been reviewed by a qualified individual for accuracy. The CONTRACTOR does not need to submit the

translated Member Materials to HSD; however, the CONTRACTOR shall submit the certification that the translations have been reviewed by a qualified individual. The CONTRACTOR shall submit the certification within thirty (30) Calendar Days of HSD approval of the English version of materials. The CONTRACTOR is responsible for ensuring the translation is accurate and culturally appropriate. The State will identify the prevalent non-English languages spoken by enrollees and potential enrollees in the state and will provide the information to the CONTRACTOR.

4.14.2.6 All written Member Materials distributed shall include a language block that informs the Member that the document contains important information and directs the Member to call the CONTRACTOR to request the document in an alternative language or to have it orally translated at no expense to the Member. The language block shall be printed, at a minimum, in the non-English languages meeting the requirement in Section 4.14.2.5 of this Agreement.

4.14.2.7 The CONTRACTOR shall make all written Member Materials available in alternative formats and in a manner that takes into consideration the Member's special needs, including those who are visually impaired or have limited reading proficiency. The CONTRACTOR shall notify all Members and potential Members that information is available in alternative formats and how to access those formats at no expense to the Member.

4.14.2.8 Once a Member has requested a Member Material in an alternative format or language, the Contractor shall: (i) make a notation of the Member's preference in the system; and (ii) provide all subsequent Member Materials to the Member in such format unless the Member requests otherwise.

4.14.2.9 The CONTRACTOR shall provide written notice to Members of any material changes to written Member Materials previously sent at least thirty (30) Calendar Days before the effective date of the change.

4.14.2.10 The CONTRACTOR must comply with Section 1557 of the Patient Protection and Affordable Care Act, as codified at 45 C.F.R. § 92, with regard to

nondiscrimination on the basis of race, color, national origin, sex, age or disability in health programs or activities receiving federal financial assistance.

4.14.3 Member Handbook

4.14.3.1 The Member handbook shall be prior approved by HSD and be in a format that is easily understood. The Member handbook shall include a table of contents, HSD-approved definitions for the terms specified in 42 C.F.R. § 438.10(c)(4)(i) and defined in the Agreement or referenced in the NM Managed Care Policy Manual, Section 3.2, and at a minimum comply with the following:

4.14.3.1.1 Describe 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. Include a separate Section and/or addendum that describes the provisions and limitations (including amount, duration scope and cost-sharing) of the ABP, the qualifications and conditions for ABP exemptions, the benefit and cost-sharing differences for an ABP Exempt Member and the process by which a Member can self-identify as potentially an ABP Exempt Member and voluntarily opt-out of the ABP;

4.14.3.1.2 Include information on how to access all services, including, but not limited to, EPSDT services, dental services, non-emergency transportation services, Behavioral Health services and LTC services;

4.14.3.1.3 Include information about the PCP, including: (i) how to select/change PCP and (ii) the role of the PCP and the procedures to be followed to obtain needed services;

4.14.3.1.4 Include information about Care Coordination, including the role of care coordinators;

4.14.3.1.5 Include information on how to access services when out of State;

4.14.3.1.6 Describe how to report suspected Fraud and Abuse;

4.14.3.1.7 Describe how to access language assistance services for individuals with LEP and auxiliary aids and services, including additional information in alternative formats or languages;

4.14.3.1.8 Include information on the circumstances/situations under which a Member may be billed for services or assessed charges or fees; specifically that the provider may not bill a Member or assess charges or fees except: (i) if a Member self-refers to a specialist or other provider within the network without following CONTRACTOR procedures (e.g., without obtaining prior authorization) and the CONTRACTOR denies payment to the provider, the provider may bill the Member; (ii) if a provider fails to follow the CONTRACTOR's procedures, which results in nonpayment, the provider may not bill the Member and (iii) if a provider bills the Member for non-Covered Services or for self-referrals, he or she shall inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at time of service;

4.14.3.1.9 A statement that failure to pay for non-Covered Services will not result in a loss of Medicaid benefits;

4.14.3.1.10 RESERVED;

4.14.3.1.11 Detail procedures for obtaining benefits including, services for which prior authorization or a referral is required and the methods for obtaining both;

4.14.3.1.12 Explain any restrictions on Member's freedom of choice among Contract Providers;

4.14.3.1.13 Explain 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 C.F.R. § 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 the Member has the right to use any hospital or other setting for emergency care;

4.14.3.1.14 Provide information regarding Grievances, Appeals and Fair Hearing procedures and time frames, including all pertinent information provided in 42 C.F.R. § 438.400 through § 438.424;

4.14.3.1.15 Describe the Member's right to access a second opinion from a qualified health care professional within the network, or, if not available within the network, from a qualified health care professional outside of the network, at no cost to the Member;

4.14.3.1.16 Include information and written policies on Member rights and responsibilities, pursuant to 42 C.F.R. § 438.100 and NCQA's Standards and Guidelines for the Accreditation of MCOs;

4.14.3.1.17 Include written information concerning Advance Directives as described in 42 C.F.R. § 489 Subpart I and in accordance with 42 C.F.R. § 422.128 and the Mental Health Care Treatment Decisions Act, NMSA 1978, 24- 7B-1 et seq.;

4.14.3.1.18 Include language to clearly explain that a Native American Member may self-refer to an I/T/U for services;

4.14.3.1.19 Include information on how to contact a care coordinator and/or self-report a change in health status;

4.14.3.1.20 Include information on how to contact a Behavioral Health peer support specialist or wellness center;

4.14.3.1.21 Include Health Education and Health Literacy information as explained in Section 4.14.11 of this Agreement;

4.14.3.1.22 Include information regarding the Birthing Options Program;

4.14.3.1.23 Include information on how to request disenrollment from the CONTRACTOR's MCO;

4.14.3.1.24 Include in a prominent place on the website, how Members can access the full provider directory and instructions for how Members can request a printed copy of the provider directory;

4.14.3.1.25 Include information explaining to Members: (i) that the CONTRACTOR has an independent Ombudsman; (ii) how they may contact the Ombudsman; and (iii) the roles and responsibilities of the Ombudsman and how the Ombudsman may assist the Member;

4.14.3.1.26 Include in a prominent place on the website, how Members can access the preferred drug list and instructions for how Members can request a printed copy of the Preferred Drug List; and

4.14.3.1.27 Include the toll-free telephone number for member services, medical management and any other unit providing services directly to Members.

4.14.4 Member Rights and Responsibilities

4.14.4.1 The CONTRACTOR shall provide each Member with written information in the Member handbook that encompasses all the provisions in this Section 4.14.4. 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 Contract Providers or the State treat the Member.

4.14.4.2 The CONTRACTOR must have written policies regarding the Member's, and/or Representatives' rights including, but not limited to, the guaranteed right to:

4.14.4.2.1 Be treated with respect and with due consideration for his or her dignity and privacy;

4.14.4.2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to the his or her condition and ability to understand;

4.14.4.2.3 Make and have honored an Advance Directive consistent with State and federal laws;

4.14.4.2.4 Receive Covered Services in a nondiscriminatory fashion;

4.14.4.2.5 Participate in decisions regarding his or her health care, including the right to refuse treatment;

4.14.4.2.6 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;

4.14.4.2.7 Request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 C.F.R. § 164.524 and § 526;

4.14.4.2.8 Choose a Representative to be involved as appropriate in making care decisions;

4.14.4.2.9 Provide informed consent;

4.14.4.2.10 Voice Grievances about the care provided by the CONTRACTOR and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation;

4.14.4.2.11 Choose from among Contract Providers in accordance with the CONTRACTOR's prior authorization requirements;

4.14.4.2.12 Receive information about Covered Services and how to access Covered Services, and Contract Providers;

4.14.4.2.13 Be free from harassment by the CONTRACTOR or its Contract Providers in regard to contractual disputes between the CONTRACTOR and Providers; and

4.14.4.2.14 Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals.

4.14.4.3 The CONTRACTOR shall ensure that each Member (and/or as appropriate, Representative) is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CONTRACTOR or its Contract Providers treat the Member (and/or Representative).

4.14.4.4 Members and/or Representatives, to the extent possible, have a responsibility to:

4.14.4.4.1 Provide information that the CONTRACTOR and its Contract Providers need in order to care for the Member;

4.14.4.4.2 Follow the plans and instructions for care that they have agreed upon with their Providers; and

4.14.4.4.3 Keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.

4.14.5 Provider Directory

4.14.5.1 The CONTRACTOR shall develop and maintain a general provider directory, which must include the following for all Contract Providers: complete name and any group affiliation; specialty, as appropriate; all locations; telephone numbers; office hours; non-English languages spoken (including American Sign Language) and if the languages are used by the provider or skilled medical

interpreter; identification of Contract Providers accepting new patients (closed or open panels); website URL, as appropriate; whether the provider's office/facility has accommodations for Members with physical disabilities, including offices, exam room(s) and equipment; whether the provider has completed cultural competence training; and hospital listings, including locations of emergency settings and Post-Stabilization Services, with the name, location and telephone number of each facility/setting.

4.14.5.2 The provider directory must be indexed alphabetically and by specialty.

4.14.5.3 Provider directories shall be submitted for written approval by HSD prior to distribution to Members.

4.14.5.4 The CONTRACTOR shall maintain on its website an updated provider directory that includes all identified information above and is searchable by provider type, distance from Member's address, zip code and/or whether the provider is accepting new patients. This directory shall be updated daily and contain a disclaimer that the online provider directory is updated more frequently than the printed directory. Information on how to access this information shall be clearly stated in both the Member and provider areas of the website.

4.14.5.5 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 CONTRACTOR's provider network, including open- and closed-panel status, which must be updated regularly and made available on the Internet.

4.14.6 Preferred Drug List

4.14.6.1 The CONTRACTOR shall develop and maintain a Preferred Drug List for Members that provides the following information: which covered outpatient drugs are provided (preferred drug and non-preferred drug, as appropriate) and the tier classification for each covered outpatient drug.

4.14.7 Member Handbook and Provider Directory and Preferred Drug List Distribution

4.14.7.1 The CONTRACTOR shall comply with requirements regarding the mailing of, or sending electronically of, Member enrollment materials including Member ID cards, Member handbook and provider directory and Preferred Drug List.

4.14.7.2 The CONTRACTOR shall mail or send electronically a Member handbook within thirty (30) Calendar Days of receipt of notification of enrollment in the CONTRACTOR's MCO.

4.14.7.3 Upon request of a Member or Recipient, the CONTRACTOR shall mail or send electronically a Provider Directory, Preferred Drug List and/or Member handbook within ten (10) Calendar Days. The CONTRACTOR shall give the person requesting a provider directory, Preferred Drug List and/or Member handbook the option to get the information from the CONTRACTOR's website or to receive a printed document.

4.14.7.4 The Member handbook, provider directory and Preferred Drug List shall be updated on the CONTRACTOR's website.

4.14.7.5 Printed copies of the provider directory shall be updated monthly and the electronic version shall be updated no later than 30 Calendar days after the CONTRACTOR receives updated provider information.

4.14.7.6 The CONTRACTOR shall distribute updated information to Members on a regular basis, and the Member handbook must include information about how to find the online version of the provider directory and Preferred Drug List and how to request a printed copy.

4.14.8 Additional Information Available Upon Request

The CONTRACTOR shall provide all other information to Members as required by CMS, including but not limited to, the following information to any Member who requests such information:

4.14.8.1 Information regarding the structure and operation of the CONTRACTOR’s MCO and

4.14.8.2 Physician incentive plans, if applicable.

4.14.9 Member Identification (ID) Cards

4.14.9.1 Each Member shall be provided an identification card identifying the Member as a participant in the Centennial Care program within twenty (20) Calendar Days of notification of enrollment into the CONTRACTOR's MCO.

4.14.9.2 The CONTRACTOR shall re-issue a Member ID card within ten (10) Calendar Days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.

4.14.9.3 The ID card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all State and federal requirements and, at a minimum, shall include:

4.14.9.3.1 The CONTRACTOR's name and issuer identifier, with the company logo;

4.14.9.3.2 Phone numbers for information and/or authorizations, including for physical health, Behavioral Health and LTC services;

4.14.9.3.3 Descriptions of procedures to be followed for emergency or special services;

4.14.9.3.4 The Member's identification number;

4.14.9.3.5 The Member's name (first and last name and middle initial);

4.14.9.3.6 The Member's date of birth;

4.14.9.3.7 The Member's enrollment effective date;

4.14.9.3.8 The Member's PCP;

4.14.9.3.9 Expiration date (the Member's eligibility renewal date for the next calendar year);

4.14.9.3.10 RESERVED;

4.14.9.3.11 Whether the Member is enrolled in the ABP, indicated on the card as "ABP," or is ABP Exempt, indicated on the card as "State Plan"; and

4.14.9.3.12 The Member's State-issued Medicaid identification number, which shall be identified on the card as the "Medicaid ID".

4.14.10 Member Website

4.14.10.1 The CONTRACTOR shall have a Member portal on its website that is available to all Members, containing accurate, up-to-date information about the MCO,

services provided, the CONTRACTOR's preferred drug list, the provider directory, FAQs and contact phone numbers and e-mail addresses. Members shall have access to the Member handbook and provider directory via the website without having to log in.

4.14.10.2 Call center staff shall have access to the website and provide assistance to Members with navigating the site and locating information.

4.14.10.3 The Section of the website relating to Centennial Care shall comply with the Marketing policies and procedures and requirements for written materials described in this Agreement and all applicable State and federal laws.

4.14.11 Member Health Education

4.14.11.1 The CONTRACTOR shall develop a Health Education Plan on an annual basis. The Health Education Plan shall comply with the reporting requirements as directed by HSD.

4.14.11.2 The Health Education Plan shall include a Member education program that uses classes, individual or group sessions, videotapes, written material, media campaigns and modern technologies (e.g., mobile applications and tools). All instructional materials shall be provided in a manner and format that is easily understood and in keeping with requirements for Member Materials as prescribed in this Agreement.

4.14.11.3 The CONTRACTOR shall educate its Members on the importance of good health and how to achieve and maintain good health, including but not limited to:

4.14.11.3.1 The availability and benefits of preventive health care;

4.14.11.3.2 Targeted disease management education;

4.14.11.3.3 The benefits of completing Advance Directives;

4.14.11.3.4 The availability and benefits of Health Homes;

4.14.11.3.5 Include information about the full array of EPSDT services, the importance and availability of EPSDT services, the benefits of preventive services, federal requirements for screenings and well-child examinations and how to access services;

4.14.11.3.6 The importance of and schedules for screenings for cancer, high blood pressure and diabetes;

4.14.11.3.7 The risks associated with the use of alcohol, tobacco and other substances and available products and counseling, i.e. smoking cessation products;

4.14.11.3.8 The concepts of managed care;

4.14.11.3.9 The use of the PCP as the primary source of medical care; and

4.14.11.3.10 The role of the care coordinator and how to contact the Care Coordination unit.

4.14.11.4 The CONTRACTOR shall make materials available for review by HSD upon request.

4.14.11.5 The CONTRACTOR shall notify Members of the schedule of educational events and shall post such information on its website.

4.14.11.6 The CONTRACTOR's Health Education Plan shall also include how the CONTRACTOR will work with Community Health Workers to improve Member Health Literacy. Specifically, the CONTRACTOR shall make Community Health Workers available to Members to, among other things:

4.14.11.6.1 Offer interpretation and translation services;

4.14.11.6.2 Provide culturally appropriate Health Education and information;

4.14.11.6.3 Assist Members in navigating the managed care system;

4.14.11.6.4 Assist in obtaining information about and access to available community resources;

4.14.11.6.5 Provide informal counseling and guidance on health behaviors; and

4.14.11.6.6 Assist the Member and care coordinator in ensuring the Member receives all Medically Necessary Covered Services.

4.14.11.7 The CONTRACTOR shall ensure that Community Health Workers receive training on Centennial Care, including the integration of physical and Behavioral Health, as well as long-term services and the provisions and limitations of the ABP.

4.14.11.8 The CONTRACTOR shall submit a Health Education Plan Evaluation Report as directed by HSD.

4.14.11.9 The CONTRACTOR shall, at a minimum, distribute to Members on a quarterly basis a newsletter that is intended to educate Members on the managed care system, proper utilization of services, etc. and encourage utilization of preventive care services. HSD may require the CONTRACTOR to address a specific topic in the quarterly newsletter. The CONTRACTOR shall submit the newsletter to HSD for approval forty-five (45) Calendar Days prior to the date on which it proposes to use or distribute the newsletter.

4.15 **Member Services**

4.15.1 Member Services Call Center

4.15.1.1 The CONTRACTOR shall operate a call center with a toll-free telephone line (Member services information line) to respond to Member questions, concerns, inquiries and complaints from the Member, Representative or the Member's provider. The call center and its staff must be located and operated in the State of New Mexico. With prior approval from HSD, the CONTRACTOR may locate specially-trained call center staff in other locations outside New Mexico so long as calls can be transferred with a Warm Transfer during the hours delineated in Sections 4.15.1.6 and 4.15.1.9. With prior approval from HSD, the CONTRACTOR may also allow Major Subcontractors that are providing Covered Services to Members to operate a call center specific to those Covered Services being provided.

4.15.1.2 The CONTRACTOR shall develop Member services information line policies and procedures that address staffing, training, hours of operation, access and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation and compliance with standards.

4.15.1.3 The CONTRACTOR's call center shall have the capacity for HSD or its agent to monitor calls remotely.

4.15.1.4 The Member services information line shall be equipped to handle calls from callers with Limited English Proficiency, as well as calls from Members who are hearing impaired.

4.15.1.5 The CONTRACTOR shall have bilingual representatives based on the threshold of a prevalent non-English language specified in Section 4.14.2.5 of this Agreement.

4.15.1.6 The CONTRACTOR shall ensure that the Member services information line is staffed adequately to respond to Members' questions and meet contract-specified call center metrics at a minimum, from 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except for New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day on the actual day on which the Holiday falls.

4.15.1.7 The call center staff shall be trained to respond to Member questions in all areas, including, but not limited to, Covered Services including the ABP, the provider network and Member enrollment issues.

4.15.1.8 The call center staff shall receive ongoing training, at least quarterly, through instructor-led trainings and staff meetings. The call center staff must receive training immediately following changes to service delivery and Covered Services.

4.15.1.9 The Member services information line shall be staffed twenty-four (24) hours- a-day, seven (7) days-a-week with qualified nurses to triage urgent care and emergency calls from Members and to facilitate transfer of calls to a care coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section 4.15.1.

4.15.1.10 Staff providing triage/nurse advice services must be registered nurses (R.N.), physician assistants, nurse practitioners or medical doctors. At all times there must be staff on hand equipped to handle Behavioral Health crises. The primary intent of this triage is to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with a Member's PCP.

However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

4.15.1.11 The CONTRACTOR shall ensure that all calls from Members to the nurse triage/nurse advice line that require immediate attention are immediately addressed by qualified nurses or transferred to a care coordinator, whichever is most appropriate. During normal business hours, the transfer to the Care Coordination unit shall be a Warm Transfer. After normal business hours, if the CONTRACTOR cannot transfer the call to the Care Coordination unit as a Warm Transfer, the CONTRACTOR shall ensure that a care coordinator is notified about the call and returns the Member's call within thirty (30) minutes. When returning the call the care coordinator must have access to the necessary information (e.g., the Member's CCP) to resolve Member issues. The CONTRACTOR shall implement protocols, with prior approval from HSD, that describe how calls to the nurse triage/nurse advice line from Members will be handled.

4.15.1.12 The CONTRACTOR shall implement protocols, with prior approval from HSD, to ensure that calls to the Member services information line that should be transferred/referred to other CONTRACTOR staff, including, but not limited to, a Member services supervisor or a care coordinator, or to an external entity, are transferred/referred appropriately.

4.15.1.13 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action, as necessary, to ensure the accuracy of responses and appropriate phone etiquette by staff.

4.15.1.14 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency, the option to speak directly to a nurse, and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return all messages by the next Business Day.

4.15.1.15 The call center staff shall have access to electronic documentation from previous calls made by, or on behalf of, the Member to the Member services information line, nurse triage/nurse advice line and the Care Coordination department.

4.15.2 Performance Standards for Member Services Line/Queue

4.15.2.1 The CONTRACTOR shall adequately staff the Member services information line to ensure that the line and the nurse triage/nurse advice line or queue, meet the following performance standards independently on a monthly basis: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds; average wait time for assistance does not exceed two (2) minutes; and one hundred percent (100%) of voicemails returned by next Business Day.

4.15.2.2 The CONTRACTOR's call center systems shall have the capability to track call center metrics as identified above. Metrics shall be reported separately for the Member services information line and the nurse triage/nurse advice line/queue.

4.15.3 Interpreter and Translation Services

4.15.3.1 The CONTRACTOR shall provide oral interpretation services to individuals with LEP and sign language services and TDD/TTY services to individuals who are hearing impaired at no cost to the individual. The CONTRACTOR shall notify its Members and potential Members of the availability of free interpreter services, sign language and TDD/TTY services and inform them of how to access these services.

4.15.3.2 Interpreter services should be available in the form of in-person interpreters or telephonic assistance, such as the Language Line. For phone interpreters, the caller should not have to hang up or call a separate number.

4.15.3.3 The CONTRACTOR shall offer oral interpretation services to individuals with LEP regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language as set forth in Section 4.14.2.5 of this Agreement.

4.15.3.4 The CONTRACTOR shall document the offer of an interpreter and whether the individual declined or accepted the interpreter service.

4.15.3.5 The CONTRACTOR is prohibited from requiring or suggesting that Members with LEP or Members using sign language provide their own interpreters or utilize friends or family members.

4.15.4 Personal Health Records

4.15.4.1 The CONTRACTOR shall provide Members with access to electronic versions of their personal health records.

4.16 **Grievances and Appeals Systems**

4.16.1 General Requirements for Grievances & Appeals System

4.16.1.1 The CONTRACTOR shall have a Grievance and Appeal system in place for Members that includes a process related to the expressions of dissatisfaction and an Appeal process related to a CONTRACTOR Adverse Benefit Determination. A Member must first exhaust the CONTRACTOR's Grievance and Appeal system prior to requesting a State Fair Hearing. The CONTRACTOR's Ombudsman, prescribed in Section 3.3.3.17 of this Agreement, is separate and distinct from the CONTRACTOR's Grievance system and Appeals process.

4.16.1.2 In implementing these processes, the CONTRACTOR shall, at a minimum:

4.16.1.2.1 Adopt 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;

4.16.1.2.2 Provide a copy of its Grievance and Appeal policies and procedures to all Contract Providers;

4.16.1.2.3 Comply with the requirements in 42 C.F.R. § 438.406;

4.16.1.2.4 Have sufficient support staff (clerical and professional, including Behavioral Health practitioners) available to process Grievances and Appeals in accordance with HSD requirements related to an Adverse Benefit Determination affecting a Member. The CONTRACTOR shall notify HSD of the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable State and federal law, HSD rules

and regulations, and all court orders and consent decrees governing Grievance and Appeal procedures, as they become effective;

4.16.1.2.5 Ensure that the individuals who make decisions on Grievances and/or Appeals are not involved in any previous level of review or decision making; and

4.16.1.2.6 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.

4.16.2 Grievances

A Member may file a Grievance either verbally or in writing with the CONTRACTOR at any time from the date the dissatisfaction occurred. The Representative 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.

4.16.2.1 Within five (5) Business 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.

4.16.2.2 The CONTRACTOR shall complete the investigation and final resolution process for Grievances 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.

4.16.2.3 The CONTRACTOR may request an extension from HSD in accordance with 42 C.F.R. § 438.408(c). 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) Calendar Days of the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision.

4.16.2.4 The CONTRACTOR shall mail a resolution letter to the Member no later than thirty (30) Calendar Days after the initial date the Grievance was received by the

CONTRACTOR. The resolution letter must include, but not be limited to, the following:

4.16.2.4.1 All information considered in investigating the Grievance;

4.16.2.4.2 Findings and conclusions based on the investigation; and

4.16.2.4.3 The disposition of the Grievance.

4.16.3 Appeals

4.16.3.1 The CONTRACTOR shall mail a notice of Adverse Benefit Determination to the Member or provider in accordance with the procedures and time frames in 42 C.F.R. § 438.404 unless such time frame is prescribed in this Section 4.16.3.

4.16.3.2 The CONTRACTOR shall mail a notice of Adverse Benefit Determination within five (5) Calendar Days if probable Member Fraud has been verified.

4.16.3.3 The CONTRACTOR may mail a notice of Adverse Benefit Determination no later than the date of the Adverse Benefit Determination for the following:

4.16.3.3.1 The CONTRACTOR has factual information confirming the death of a Member;

4.16.3.3.2 The CONTRACTOR receives a signed written Member statement requesting service termination or giving information requiring termination of Covered Services (where the Member understands that this must be the result of supplying that information);

4.16.3.3.3 The Member has been admitted to an institution where he or she is ineligible for further services;

4.16.3.3.4 The Member's address is unknown and mail directed to him or her has no forwarding address;

4.16.3.3.5 The Member has been accepted for Medicaid services in another state or United States territory;

4.16.3.3.6 The Member's physician prescribes a change in the level of medical care;

4.16.3.3.7 An Adverse Benefit Determination is made with regard to the preadmission screening requirements for Nursing Facility admissions; and

4.16.3.3.8 In accordance with 42 C.F.R. § 483. 404(c)(1) and 42 C.F.R. § 431.211, § 431.213 and § 431.214.

4.16.3.4 A Member may file an Appeal of a CONTRACTOR's Adverse Benefit Determination either verbally or in writing within sixty (60) Calendar Days from the date on the Adverse Benefit Determination notice. The Representative or a provider acting on behalf of the Member with the Member's written consent has the right to file an Appeal of an Adverse Benefit Determination on behalf of the Member. The CONTRACTOR shall consider the Member, Representative, or estate representative of a deceased Member as parties to the Appeal.

4.16.3.5 The CONTRACTOR has thirty (30) Calendar Days from the date the initial oral or written Appeal is received by the CONTRACTOR to resolve the Appeal. The CONTRACTOR shall appoint at least one (1) person to review the Appeal; such person shall not have been involved in the initial decision.

4.16.3.6 The CONTRACTOR shall have a process in place that assures that an oral or written inquiry from the Member seeking to Appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal). Unless the Member or the provider requests an expedited resolution, an oral Appeal must be followed by a written Appeal that is signed by the Member within thirteen (13) Calendar Days; failure to file the written Appeal within thirteen (13) Calendar Days shall constitute withdrawal of the Appeal. The CONTRACTOR shall make best efforts to assist the Member, as needed, with the written Appeal.

4.16.3.7 Within five (5) Business Days of receipt of the Appeal, the CONTRACTOR shall provide the Member with written notice that the Appeal has been received and of the expected date of its resolution.

4.16.3.8 The CONTRACTOR may extend the thirty (30) Calendar Day time frame in accordance with 42 C.F.R. § 438.408(c). 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) Calendar Days of the decision to extend the time frame.

4.16.3.9 The CONTRACTOR shall comply with the special provisions for Appeals in 42 C.F.R. § 438.406(b).

4.16.3.10 Unless extended pursuant to the requirements in this Section 4.16, the CONTRACTOR shall provide written notice of resolution within the thirty (30) Calendar Days of the CONTRACTOR's receipt of the Appeal to the Member, the Member's Representative(s) and/or the provider, if the provider filed the Appeal. The written notice of the Appeal resolution shall include, but is not limited to, the information contained in 42 C.F.R. § 438.408(e), as applicable.

4.16.3.11 The CONTRACTOR may only have one level of appeal for members in 42 C.F.R. § 438.402(b).

4.16.4 Expedited Resolution of Appeals

4.16.4.1 The CONTRACTOR shall establish and maintain an expedited review process for Appeals in accordance with 42 C.F.R. § 438.410.

4.16.4.2 The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the Member.

4.16.4.3 The CONTRACTOR shall resolve the expedited Appeal within 72 hours of CONTRACTOR's receipt of the appeal, per 42 C.F.R. § 438.408(b)(3) and (d)(2).

4.16.4.4 The CONTRACTOR may extend the time frame for an expedited Appeal in accordance with 42 C.F.R. § 438.408(c). For any extension not requested by the Member, the CONTRACTOR shall make reasonable efforts to give the Member prompt oral notice of delay and within two (2) Calendar Days, give the Member with a written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a grievance if the Member disagrees with the decision to extend the time frame.

4.16.4.5 If the CONTRACTOR denies a request for expedited resolution of an Appeal, the CONTRACTOR shall transfer the Appeal to the time frame for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial and follow up within two (2) Calendar Days with a written notice.

4.16.4.6 The CONTRACTOR shall inform the Member of the limited time available for expedited reviews to present evidence and allegations in fact or law.

4.16.4.7 The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

4.16.4.8 The CONTRACTOR must ensure that punitive action is not taken against a provider who requests an expedited appeal or supports a Member's appeal.

4.16.5 Deemed Exhaustion of Appeal Process

In the event the CONTRACTOR fails to adhere to the notice and timing requirements specified in Section 4.16, the Member is deemed to have exhausted the appeal process and may request a State Fair Hearing.

4.16.6 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. For purposes of this Section 4.16.6, "expedited service authorization" is a request for urgently needed care or services.

4.16.7 If requested by the Member, the CONTRACTOR shall continue benefits while an Appeal and/or the State Fair Hearing process is pending in accordance with 42 C.F.R. § 438.420 and § 438.424.

4.16.8 State Fair Hearings for Members

4.16.8.1 A Member may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination that has been taken by the CONTRACTOR and the Member has exhausted the CONTRACTOR's internal Appeal process, within ninety (90) Calendar Days of the final decision by the CONTRACTOR. The Representative, the estate representative of a deceased Member, or a provider acting on behalf of the Member and with the Member's written consent, may request a State Fair Hearing on behalf of the Member.

4.16.8.2 The CONTRACTOR shall provide the HSD/Fair Hearings Bureau, the HSD/Medical Assistance Division, the Member and/or the Member's Representative(s) with a summary of evidence ("SOE") within seven (7) Calendar Days after receipt of a request for hearing but no later than fifteen (15)

Business Days prior to the initially scheduled hearing. The SOE must contain copies of all documentation used to make the CONTRACTOR's decision, and it must explain the reasons for the Adverse Benefit Determination and address all of the Member's concerns. The SOE must refer to all relevant State and federal statutes, rules and regulations used to make the decision. Upon request and no later than seven (7) Calendar Days after receiving the request, the CONTRACTOR shall provide the Member and/or the Member's Representative (with written consent of the Member) access to the Member's case file and provide copies of documents contained therein without charge.

4.16.8.3 The CONTRACTOR shall appear with appropriate clinical personnel at all scheduled State Fair Hearings concerning its clinical determinations to present evidence as justification for its determination regarding the disputed benefits and/or services.

4.16.8.4 The CONTRACTOR shall have its legal counsel appear at all scheduled State Fair Hearings for which the CONTRACTOR has received notification that the Member has legal counsel and when HSD provides it with not less than seven (7) Calendar Days' notice that legal representation will be required.

4.16.8.5 The CONTRACTOR shall comply with all determinations rendered as a result of State Fair Hearings. Nothing in this Section shall limit the remedies available to HSD or the federal government relating to any non-compliance by the CONTRACTOR with a State Fair Hearing determination or by the CONTRACTOR's refusal to provide disputed services.

4.16.8.6 The CONTRACTOR may initiate recovery procedures against the Member, if the Adverse Benefit Determination is upheld after a State Fair Hearing, to recoup the cost of any service required to be continued while the appeal was pending.

4.16.9 Provider Grievances and Appeals

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 provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, the CONTRACTOR shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by the CONTRACTOR. A provider shall have the right to file an Appeal with the CONTRACTOR regarding provider payment issues and/or Utilization Management decisions.

4.17 **Program Integrity**

4.17.1 General

4.17.1.1 The CONTRACTOR, Major Subcontractors, Subcontractors and Contract Providers shall have a comprehensive internal Fraud, Waste and Abuse program in accordance with 42 C.F.R. § 438.608(a)(1).

4.17.1.2 The CONTRACTOR shall cooperate with the MFEAD and other investigatory agencies in accordance with the provisions of NMSA 1978, 27- 11-1 et seq.

4.17.1.3 The CONTRACTOR shall comply with all federal and State requirements regarding Fraud, Waste and Abuse, including but not limited to, Sections 1128, 1156 and 1902(a)(68) of the Social Security Act, Section 6402(h) of PPACA, the CMS Medicaid integrity program and the Deficit Reduction Act of 2005.

4.17.1.4 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential Fraud, Waste and Abuse.

4.17.1.5 The CONTRACTOR shall establish effective lines of communication between the CONTRACTOR’s compliance officer and the CONTRACTOR’s employees to facilitate the oversight of systems that monitor service utilization and Encounters for Fraud, Waste and Abuse.

4.17.1.6 The CONTRACTOR shall cooperate fully in any activity performed by the HSD, MFEAD, Medicaid Recovery Audit Contractor (RAC), CMS and CMS Audit Medicaid Integrity Contractors (MIC). The CONTRACTOR, its Subcontractors, Major Subcontractors and Contract Providers shall, within two (2) to ten (10)

Business Days after the date of request, in accordance with NMSA 1978, § 27-11- 4(B), make available to the HSD, MFEAD, RAC, CMS or MIC 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 CONTRACTOR and its Subcontractors, Major Subcontractors and Contract Providers shall provide the HSD, MFEAD, RAC, CMS or MIC with access during normal business hours to its respective place of business and records.

4.17.1.7 The CONTRACTOR, Major Subcontractors, Subcontractors and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.17.1.7.1 Enhanced provider screening and enrollment, Section 6401;

4.17.1.7.2 Termination of provider participation, Section 6501; and

4.17.1.7.3 Provider disclosure of current or previous affiliation with excluded provider(s), Section 6401.

4.17.1.7.4 The requirements set forth in Section 4.17.1.7 shall be included in the CONTRACTOR's contracts with such Major Subcontractors, Subcontractors and Contract Providers no later than the time of such Contracts' respective renewals.

4.17.1.8 The CONTRACTOR and Major Subcontractors, Subcontractors and Contract Providers shall establish written policies and procedures for all employees, agents, or CONTRACTORS that provide detailed information regarding: (i) the New Mexico False Claims Act, NMSA 1978, 27-14-1 et seq.; (ii) the New Mexico Fraud Against the Taxpayers Act, NMSA 1978, 44-9-1 et seq.; and (iii) the Federal False Claims Act established under 31U.S.C § 3729-3733, administrative remedies for false Claims established under 31 U.S.C. 3801 et seq., including but not limited to, preventing and detecting Fraud, Waste and Abuse in federal health care programs (as defined in Social Security Act § 1128B(f)) and 42 C.F.R. § 438.608. Such policies and procedures shall clearly

state the CONTRACTOR's commitment to compliance with federal and State standards.

4.17.1.9 The CONTRACTOR and all Major subcontractors, Subcontractors and Contract Providers shall include in any employee handbook the rights of employees to be protected as "whistleblowers."

4.17.1.10 The CONTRACTOR shall make every reasonable effort to detect, recoup and prevent Overpayments made to Contract Providers in accordance with federal and State law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HSD at a regularly scheduled interval and in a format agreed to by HSD and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HSD may require an HSD-contracted Recovery Audit Contractor to review paid Claims that are over three hundred sixty (360) Calendar Days old from the MCO paid date and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.

4.17.1.11 The CONTRACTOR shall promptly notify HSD when it receives information about changes in a Member's circumstances that may affect the Member's eligibility, including Members moving out of state and the death of a Member.

4.17.1.12 The CONTRACTOR shall promptly notify HSD when it receives information about a change in a Contract Provider's circumstances that may affect the Contract Provider's eligibility for participation in Medicaid, including termination of the provider agreement with the CONTRACTOR.

4.17.1.13 The CONTRACTOR shall employ a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Contract Providers were received by Members and apply this verification method on a regular basis as specified by HSD.

4.17.2 Reporting and Investigating Suspected Fraud, Waste and Abuse

4.17.2.1 The CONTRACTOR shall cooperate with all appropriate State and federal agencies in investigating Fraud, Waste and Abuse.

4.17.2.2 The CONTRACTOR shall have methods for identifying, investigating and referring suspected Fraud cases pursuant to 42 C.F.R.s § 455.13, § 455.14 and § 455.21.

4.17.2.3 The CONTRACTOR shall report all confirmed, credible or suspected Fraud, Waste and Abuse to HSD as follows within the time frames required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and Abuse in the administration of Centennial Care shall be reported to HSD. It shall be HSD's responsibility to report verified cases to MFEAD;

4.17.2.3.2 All confirmed, credible or suspected provider Fraud, Waste and Abuse shall be immediately reported to HSD and shall include the information provided in 42 C.F.R. § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.3 All confirmed or suspected Member Fraud, Waste and Abuse shall be reported to HSD.

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) make an initial report to HSD of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HSD with monthly updates. HSD may, at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter time frame. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

4.17.2.4.1 Contact the subject of the investigation about any matters related to the investigation;

4.17.2.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

4.17.2.4.3 Accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.

4.17.2.5 The CONTRACTOR shall within the twelve-month period and within ten (10) Business Days of completing the preliminary investigation, report the results to the agency where the CONTRACTOR has determined that a potential overpayment exists.

4.17.2.6 The CONTRACTOR shall notify HSD within five (5) Business Days, via email, when a formal, written action is taken by the CONTRACTOR against a Contract Provider. Such action being defined for purposes of this Section as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is defined in the Contract Provider's agreement with the CONTACTOR; or (ii) due to concerns other than fraud, such as integrity or quality.

4.17.2.7 The CONTRACTOR shall comply with the reporting requirements in Section 4.21 of this Agreement.

4.17.2.8 The CONTRACTOR shall have a mechanism in place to suspend payments to any provider for which HSD, in accordance with 42 C.F.R. § 455.23, has determined that a credible allegation of fraud exists.

4.17.3 Compliance Plan

4.17.3.1 The CONTRACTOR shall have a written Fraud, Waste and Abuse Compliance Plan. A paper and electronic copy of the Compliance Plan shall be provided to HSD annually by July 1. HSD shall provide notice of approval, denial or modification to the CONTRACTOR within thirty (30) Calendar Days of receipt. The CONTRACTOR shall make any changes required by HSD within thirty (30) Calendar Days of a request.

4.17.3.2 The CONTRACTOR's Fraud, Waste and Abuse Compliance Plan shall:

4.17.3.2.1 Require reporting of suspected and/or confirmed Fraud, Waste and Abuse be done as required by this Agreement;

4.17.3.2.2 Outline activities proposed for the next reporting year regarding employee education of federal and State law and regulations related to Medicaid

program integrity and Fraud, Waste and Abuse to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's Fraud, Waste and Abuse Compliance Plan;

4.17.3.2.3 Outline activities proposed for the next reporting year regarding provider education of federal and State statutes and regulations related to Medicaid program integrity and Fraud/Waste/Abuse and on identifying and educating targeted Contract Providers with patterns of incorrect billing practices and/or overpayments;

4.17.3.2.4 Contain procedures designed to prevent and detect Fraud, Waste and Abuse in the administration and delivery of services under this Agreement;

4.17.3.2.5 Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, Waste and Abuse;

4.17.3.2.6 Contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting and investigating Fraud, Waste and Abuse Compliance Plan violations;

4.17.3.2.7 Ensure that no individual who reports violations by the CONTRACTOR or suspected Fraud, Waste and Abuse is retaliated against; and

4.17.3.2.8 Include work plans for conducting both announced and unannounced site visits and field audits to Contract Providers defined as high risk (Providers with cycle/auto billing activities, Providers offering DME, home health, Behavioral Health and transportation services) to ensure services are rendered and billed correctly.

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process For Overpayments

4.17.4.1.1 The CONTRACTOR shall report to HSD all instances in which the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons and the potential Overpayment amount. HSD may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.17.4.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.17.4.2 Self-Reporting

4.17.4.2.1 For all identified Overpayments and within the time frames specified in Section 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD that shall include, at a minimum: (i) provider's name; (ii) provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance Claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid Claim control number, as appropriate; (viii) description of corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) whether a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for Overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an Overpayment existed;

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the Claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the Claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund; such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC or MFEAD identifies the overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC § 8.351.2.13.

4.17.4.3.4 Failure To Self-Report and/or Refund Overpayments

4.17.4.3.4.1 The CONTRACTOR shall inform all Providers that all Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day time frame may be considered false Claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.17.2.3.1 of this Contract.

4.18 **Financial Management**

4.18.1 Initial and Ongoing Working Capital and/or Net Worth Requirements

The CONTRACTOR shall, at all times, be in compliance with the net worth requirements under applicable State insurance laws.

If the CONTRACTOR has been providing services to Medicaid Members for a period of less than three (3) months, the CONTRACTOR shall submit to HSD, at the Agreement execution, proof of the greater of the following:

Working capital in the form of cash or liquid assets, excluding revenues from Medicaid capitation equal to at least the first three (3) months of operating expenses;

initial net worth of one million five hundred thousand dollars ($1,500,000); and

Insolvency Protection (Section 4.18.2) and Surplus Requirement (Section 4.18.3) balances may be included in the above as appropriate.

4.18.2 Insolvency Protection

The CONTRACTOR shall comply with and is subject to all applicable State and federal statutes 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 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, at no cost to HSD, in a reasonable time from the date of request or as specified herein.

4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in the State of New Mexico in accordance with Section 1903(m) of the Social Security Act (amended by Section 4706 of the Balanced Budget Act of 1997), and applicable state insurance laws. The CONTRACTOR shall deposit, in the form of cash or securities or investments consistent with applicable state insurance laws, an amount equal to ninety percent (90%) of the total Capitation Payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.

4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Centennial Care program.

4.18.2.1.2 The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HSD of the deposit amount required.

4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.

4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.

4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD, the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD, to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.

4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.

4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.

4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee acceptable through which a custodial or controlled account is utilized.

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent under applicable state insurance law, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

4.18.2.3 If the Agreement is terminated, expired or not continued, the account balance shall be released by HSD to the CONTRACTOR upon receipt of proof of satisfaction of all outstanding obligations incurred under this Agreement.

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, Overpayments made to the CONTRACTOR and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed, and the CONTRACTOR is unable to pay all of its outstanding debts to health care Providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other Claims subject to applicable state insurance law.

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The 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, provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with applicable state insurance regulations and guidelines.

4.18.2.6 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.

4.18.3 Surplus Requirement

The CONTRACTOR shall maintain, at all times, in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary state regulator and restricted funds of deposits controlled by HSD (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five-hundred thousand dollars ($1,500,000), ten percent (10%) of total liabilities or two percent (2%) of the annualized amount of the CONTRACTOR's prepaid revenues. In the

event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

4.18.4 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR's discretion, provided requirements outlined in Section 4.18.2.1 of this Agreement have been satisfied.

4.18.5 Inspection and Audit of Financial Records

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 or its designee and provide all financial records required by HSD or its designee so that they may inspect and audit the CONTRACTOR's financial records at least annually or at HSD's discretion.

4.18.6 Fidelity Bond

4.18.6.1 The CONTRACTOR shall maintain, in force, a fidelity bond in the amount of at least one million dollars ($1,000,000).

4.18.6.2 The CONTRACTOR shall secure and maintain during the life of this Agreement a blanket fidelity bond from a company doing business in the State of New Mexico on all personnel in its employment. The bond shall be issued in the amount of at least one million dollars ($1,000,000) per occurrence. Said bond shall protect HSD from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CONTRACTOR or its Subcontractors or Major Subcontractors.

4.18.6.3 The CONTRACTOR shall submit proof of coverage to HSD within sixty (60) Calendar Days after the execution of this Agreement or date designated by HSD.

4.18.7 Insurance

4.18.7.1 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:

4.18.7.1.1 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;

4.18.7.1.2 Workers' compensation as required by State and/or federal regulations;

4.18.7.1.3 Unemployment insurance as required by State and/or federal regulations;

4.18.7.1.4 Adequate protections against financial loss due to outlier (catastrophic) cases and Member utilization that is greater than expected. The CONTRACTOR shall submit to HSD such written documentation, as is necessary, to show the existence of this protection, which includes reinsurance as specified in Section 4.18.10 of this Agreement;

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

4.18.7.1.6 Health insurance for employees as further set forth in Section 7.30 of this Agreement.

4.18.7.2 The CONTRACTOR shall provide HSD with documentation, at least annually, that the above specified insurance has been obtained, and the CONTRACTOR's Subcontractors and Major Subcontractors shall provide the same documentation to the CONTRACTOR.

4.18.8 Financial Stability

4.18.8.1 Throughout the term of this Agreement, the CONTRACTOR shall:

4.18.8.1.1 Comply with and be subject to all applicable state and federal statutes and regulations, including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and present to HSD any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time from the date of the request or as specified herein; and

4.18.8.1.2 Immediately notify HSD when the CONTRACTOR has reason to consider insolvency or otherwise has reason to believe it or any Subcontractor or Major Subcontractors, is other than financially sound and stable, or when financial difficulties are significant enough for the Chief Executive Officer or Chief Financial Officer to notify the CONTRACTOR's board of the potential for insolvency.

4.18.8.2 The CONTRACTOR shall be responsible for sound financial management of its MCO.

4.18.8.3 The CONTRACTOR shall comply with financial viability standards/performance guidelines and cooperate with HSD reviews of the ratios and financial viability standards listed below. Failure to maintain the Current Ratio (Section 4.18.8.3.1) and financial viability standards will be considered a material breach of this Agreement.

4.18.8.3.1 Current Ratio: Current assets divided by current liabilities must be greater than or equal to 1.00. Current assets may include Insolvency Protection (Section 4.18.2) and Surplus Requirements (Section 4.18.3) balances as appropriate.

4.18.8.3.2 Defensive Interval: Must be greater than or equal to thirty (30) Calendar Days.

Defensive Interval =
(Cash + Current Investments) /
((Operating Expense – Non-Cash Expense) /
(Period Being Measured in Days))

Non-Cash expense is any expense not paid for in cash, such as depreciation.

4.18.8.4 If the CONTRACTOR fails to maintain either the current ratio or defensive interval, then the CONTRACTOR shall submit a written plan to reestablish a positive working capital balance for approval by HSD.

4.18.8.5 HSD may take action it deems appropriate, including termination of this Agreement, if: (i) the CONTRACTOR does not propose a plan to reestablish

compliance-stated ratios in Section (4.18.8.3.1 and 4.18.8.3.2) within a reasonable period of time; (ii) the CONTRACTOR violates a DCAP; or (iii) HSD determines that the compliance with the stated ratios cannot be corrected within a reasonable time.

4.18.9 Performance Bond

4.18.9.1 The CONTRACTOR shall maintain in force a performance bond in the initial amount of one hundred percent (100%) of the first month of Capitation Payment as determined by HSD and, thereafter, in the amount set forth in Section 4.18.9.3 of this Agreement.

4.18.9.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.9.1.1.1 through 4.18.9.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative to 4.18.9.1.1.

4.18.9.1.1.1 Cash Deposits.

4.18.9.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit Insurance Corporation (FDIC) or equivalent federally insured deposit.

4.18.9.1.1.3 Surety Bond issued by a surety or insurance company licensed to do business in New Mexico,

4.18.9.1.1.4 Certificate of Deposit.

4.18.9.1.1.5 Investment account with a financial institute licensed to do business in the State of New Mexico.

4.18.9.2 The performance bond must be restricted to the CONTRACTOR's Centennial Care program.

4.18.9.3 If the performance bond falls below ninety percent (90%) of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD, the CONTRACTOR has thirty (30) Calendar Days to comply with the requirements of this Section and provide proof of the increased bond amount.

4.18.9.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in a material default of or

failing to materially perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

4.18.9.5 The CONTRACTOR is prohibited from using a parental guarantee to fulfill the requirements of the Performance Bond.

4.18.9.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

4.18.9.7 The CONTRACTOR may not change the amount, duration or scope of the performance bond without prior written approval from HSD.

4.18.9.8 The CONTRACTOR is prohibited from leveraging the bond for another loan or creating other creditors from using this bond as security.

4.18.9.9 Failure to maintain the performance bond as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

4.18.9.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

4.18.10 Reinsurance

4.18.10.1 The CONTRACTOR shall have and maintain a minimum of one-million dollars ($1,000,000) per occurrence or per Member per incurred year, in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HSD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance.

4.18.10.2 HSD reserves the right to revisit reinsurance annually and to modify the reinsurance threshold amount, to be determined by HSD, if, upon review of financial and Encounter Data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by HSD.

4.18.10.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.10 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that

it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR must submit the pricing details of the reinsurance agreement, including the covered period, to HSD for approval.

4.18.11 Third-Party Liability

4.18.11.1 The CONTRACTOR shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and notify the agency's third-party liability vendor of any third-party creditable coverage discovered. Specifically, the CONTRACTOR:

4.18.11.1.1 Is responsible for identification of third-party coverage of Members and coordination of benefits with applicable third-parties and shall comply with NMAC 8.302.3.12;

4.18.11.1.2 Shall inform HSD monthly regarding any member who has other health coverage;

4.18.11.1.3 Shall provide monthly documentation to HSD, Third-Party Liability Unit enabling HSD to pursue its right under federal and State law, regulations and rules; documentation shall include payment information, collection and/or recoveries for services provided to enrolled Members as required by HSD; and

4.18.11.1.4 Has the sole right of collection to recover from a third-party resource or from a provider who has been overpaid due to a third-party resource for twelve (12) months from the date the CONTRACTOR first pays the Claim to initiate recovery and attempt to recover any third-party resources available to Medicaid Members, for all services provided by the CONTRACTOR pursuant to this Agreement or any other Agreement for Medicaid services between the CONTRACTOR and HSD. Without mitigating any rights the CONTRACTOR's provider has pursuant to federal and state law and regulations, the CONTRACTOR:

4.18.11.1.4.1 Agrees HSD has the sole right of collection from a third- party resource which the CONTRACTOR has failed to identify within twelve (12) months from the date the CONTRACTOR first pays the Claim;

4.18.11.1.4.2 Agrees HSD has the sole right of recovery from the CONTRACTOR or a CONTRACTOR's provider who has been overpaid due to the combined payments of the CONTRACTOR and a third-party resource when the CONTRACTOR has not made a recovery within twelve (12) months from the date the CONTRACTOR first pays the Claim;

4.18.11.1.4.3 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has identified a third-party resource but failed to initiate recovery within the twelve (12) month period;

4.18.11.1.4.4 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR's provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the Claim; and may permit payments to be made in accordance with state regulations; and

4.18.11.1.4.5 The exception to this twelve (12) month period is for cases in which a capitation has been recouped from the CONTRACTOR pursuant to Article 6.2.4, whereupon the CONTRACTOR shall retain the sole right of recovery for all paid Claims related to Members and months that were recouped.

4.18.11.2 Medicaid shall be the payer of last resort for Covered Services in accordance with federal regulations. The CONTRACTOR has the same rights to recovery of the full value of services as HSD and shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost void and/or recover any such liability from the third party. The CONTRACTOR shall develop and implement policies and procedures to meet its obligations regarding third-party liability when the third party (e.g., LTC insurance) pays a cash benefit to the Member, regardless of services used, or does not allow the Member to assign his or her benefits.

4.18.11.3 If third-party liability (TPL) exists for part or all of the services provided by the CONTRACTOR to a Member, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

4.18.11.4 If the CONTRACTOR has determined that third-party liability exists for part or all of the services provided to a Member by a Major Subcontractor or referral Provider and the third party is reasonably expected to make payment within one-hundred-twenty (120) Calendar Days, the CONTRACTOR may pay the Major Subcontractor or referral Provider only the amount, if any, by which the Major Subcontractor's allowable Claim exceeds the amount of the anticipated third-party payment; or, the CONTRACTOR may pay the Major Subcontractor or Provider only the amount, if any, by which the Major Subcontractor's or Provider's allowable Claim exceeds the amount of TPL.

4.18.11.5 The CONTRACTOR may not withhold payment for services provided to a Member if third-party liability or the amount of liability cannot be determined or if payment shall not be available within a reasonable time, beyond one-hundred-twenty (120) Calendar Days from the date of receipt.

4.18.11.6 If the probable existence of TPL has been established at the time the Claim is filed, the CONTRACTOR must reject the Claim and return it to the provider for a determination of the amount of any TPL.

4.18.11.7 Claims for EPSDT shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

4.18.11.8 The CONTRACTOR shall deny payment on a Claim that has been denied by a third-party payer when the reason for denial is the provider's or enrollee's failure to follow prescribed procedures, including but not limited to failure to obtain prior authorization, timely filing, etc.

4.18.11.9 The CONTRACTOR shall treat funds recovered from third parties as reductions to Claims payments. The CONTRACTOR shall report all TPL collection amounts to HSD in accordance with federal guidelines and as directed by HSD.

4.18.11.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.11, third-party resources shall not include subrogation resources

provided; however, the CONTRACTOR shall be required to seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. The amount of any subrogation recoveries collected by the CONTRACTOR outside of the Claims processing system shall be treated by the CONTRACTOR as offsets to medical expenses for purposes of reporting.

4.18.11.11 Cost sharing and medical care credit responsibilities shall not be considered TPL.

4.18.11.12 The CONTRACTOR shall provide TPL data to any provider having a Claim denied by the CONTRACTOR based upon TPL.

4.18.11.13 The CONTRACTOR shall provide to HSD any third-party resource information necessary in a format and media described by HSD and shall cooperate in any manner necessary, as requested by HSD, with HSD and/or a cost recovery vendor at such time that HSD acquires said services.

4.18.11.14 HSD may require an HSD-contracted TPL vendor to review paid Claims that are over three-hundred-sixty (360) Calendar Days old and pursue TPL (excluding subrogation) for those Claims that do not indicate recovery amounts in the CONTRACTOR's reported Encounter Data.

4.18.11.15 If the CONTRACTOR operates or administers any non-Medicaid MCO, health plan or other lines of business, the CONTRACTOR shall assist HSD with the identification of Members with access to other insurance.

4.18.11.16 The CONTRACTOR shall demonstrate, upon request, to HSD that reasonable effort has been made to seek, collect and/or report third-party recoveries. HSD shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

4.18.11.17 HSD shall be solely responsible for estate recovery activities and shall retain any and all funds recovered through these activities.

4.18.12 Medical Care Credit

4.18.12.1 The CONTRACTOR shall have policies and procedures to ensure that, where applicable, Members residing in residential facilities pay their medical care credit.

4.18.12.2 HSD will notify the CONTRACTOR of any applicable medical care credit amounts for Members via the eligibility/enrollment file.

4.18.12.3 The CONTRACTOR shall delegate collection of medical care credit to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable medical care credit amount.

4.18.12.4 The CONTRACTOR shall submit medical care credit information associated with Claim payments to Providers in its Encounter Data submission.

4.18.12.5 HSD shall reconcile medical care credit amounts in accordance with Section 6.9.4 of this Agreement.

4.18.13 Payments by HSD

The CONTRACTOR shall accept payments remitted by HSD in accordance with Section 6 of this Agreement as payment in full for all services required pursuant to this Agreement.

4.18.14 Reporting

4.18.14.1 The CONTRACTOR shall submit quarterly and annual insurance filings and financial statements that are specific to the operations of the CONTRACTOR's New Mexico operations rather than a parent or umbrella organization as directed by HSD.

4.18.14.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis as directed by HSD.

4.18.14.3 The CONTRACTOR shall submit reports on medical care credit information on a date of service basis as directed by HSD.

4.18.14.4 The CONTRACTOR shall provide an annual audited financial report to HSD, conducted in accordance with generally accepted accounting and auditing principles, as directed by HSD.

4.19 **Claims Management**

4.19.1 The CONTRACTOR and any of its Major Subcontractors or Providers paying their own Claims are required to maintain Claims-processing capabilities to include, but not be limited to:

4.19.1.1 Accepting NPI and HIPAA-compliant formats for electronic Claims submission;

4.19.1.2 Assigning unique identifiers for all Claims received from Providers and ensuring that any adjustments or voids either carry some part of that original TCN in the adjustment/void TCN or carry a related TCN field so that the original can always be linked to any adjustments and voids;

4.19.1.3 Standardizing protocols for the transfer of Claims information between the CONTRACTOR and its Major Subcontractors and Providers, audit trail activities and the communication of data transfer totals and dates;

4.19.1.4 Date-stamping all Claims in a manner that will allow determination of the calendar date of receipt;

4.19.1.5 Running a payment cycle to include all submitted Claims to date at least weekly;

4.19.1.6 Paying Clean Claims in a timely manner as follows:

4.19.1.6.1 For Claims from I/T/Us, day activity Providers, assisted living Providers, Nursing Facilities and home care agencies, including Community Benefit Providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt;

4.19.1.6.2 For all other Claims, ninety percent (90%) of all Clean Claims must be adjudicated within thirty (30) Calendar Days of receipt and ninety-nine percent (99%) of all Clean Claims must be adjudicated within ninety (90) Calendar Days of receipt;

4.19.1.7 Paying interest as required in Paragraph (1) of subsection 8.308.20.9 (E) of NMAC;

4.19.1.8 The CONTRACTOR may be at risk for any payments made to a non-Medicaid enrolled provider or registered provider. The CONTRACTOR is required to ensure that all Providers reflected on the Claim are enrolled or registered as an HSD Medicaid provider for the dates of service on the Claim and that the provider type assigned by HSD is appropriate for the service(s) being billed. If the provider is enrolled but the CONTRACTOR is not affiliated, that Claim will

trigger a Provider Notification record sent to HSD's fiscal agent within 24 hours of the Claims payment;

4.19.1.9 The CONTRACTOR may be at risk for any payments made in advance of Claims adjudication (i.e., forward funding) not substantiated by Claims for those services;

4.19.1.10 Meeting both State and federal standards for processing Claims, except as provided for in this Agreement;

4.19.1.11 Generating remittance advice and/or electronic response files to Providers for all Claims submissions;

4.19.1.12 Participating on a committee or committees with HSD to discuss and resolve systems and data-related issues, as required by HSD;

4.19.1.13 Accepting from Providers and Major Subcontractors only national HIPAA-compliant standard codes and editing to ensure that the standard measure of units is billed and paid for;

4.19.1.14 Editing Claims, regardless of whether paid directly by the CONTRACTOR, Subcontractor, or by a Major Subcontractor, 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 services and that services are billed in a manner consistent with HSD-defined editing criteria and national coding standards;

4.19.1.15 Meeting all TPL requirements described in Section 4.18.11 of this Agreement;

4.19.1.16 Using the third party liability (TPL) file provided by HSD to coordinate benefits with other payers;

4.19.1.17 Capturing and reporting all TPL, interest, copayment or other financial adjustments on all Claims, using HSD defined editing criteria and HIPAA standard Claim adjustment reason codes and remark codes to identify the payments and adjustments;

4.19.1.18 Developing and maintaining an NPI HIPAA-compliant electronic billing system for all Providers or Major Subcontractors submitting bills directly to the CONTRACTOR or Subcontractor;

4.19.1.19 Accepting and accurately paying Medicare Claims coming either as Medicare Claims sent to the CONTRACTOR from Contract Providers or as Medicaid crossover Claims submitted by the coordination of benefits agreement ("COBA") contractor; ensuring the following:

4.19.1.19.1 All information on the Medicare or crossover Claim must be accepted, adjudicated and stored in the CONTRACTOR's system; including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules;

4.19.1.19.2 Any Medicare Claims paid by a SNP or a Medicare Advantage Plan for which there is no Medicaid obligation (no coinsurance or deductible) must be adjudicated and stored complete with all Claim adjustment reason codes explaining the difference between the Provider's billed charges and the CONTRACTOR's allowed and paid amounts;

4.19.1.19.3 The CONTRACTOR shall adjudicate all Claims ensuring Medicaid is the payer of last resort as it relates to third-party coverage liability through an insurer; and

4.19.1.19.4 The CONTRACTOR shall have a coordination of benefits agreement with Medicare and participate in the automated Claims crossover process effective January 1, 2019;

4.19.1.20 Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicare Claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in Section 4.19.2, including but not limited to:

4.19.1.20.1 Services provided under subcapitation payment arrangements;

4.19.1.20.2 Services provided as part of a bundled rate; and

4.19.1.20.3 Services performed by CONTRACTOR staff, even where no payment is made or identified for those services, such as Care Coordination activities;

4.19.1.21 Adhering to federal and State timely filing requirements;

4.19.1.22 Configuring the CONTRACTOR's own system to meet HSD's editing criteria;

4.19.1.23 Submitting information to the State's all payers Claim database at a time and in a format prescribed by HSD;

4.19.1.24 Effective with implementation of the State's new MMIS Replacement system (MMIS-R), all Claims, regardless of the type of Claim or provider, will come from Providers or Major Subcontractors directly into the State's System Integrator and will be transmitted to the CONTRACTOR for adjudication. CONTRACTORS must ensure that as of the effective date of the MMIS-R, the CONTRACTOR shall:

4.19.1.24.1 Adjudicate all Claims received within the same timeliness and accuracy requirements specified in this contract;

4.19.1.24.2 Submit Claims to the System Integrator under the CONTRACTOR's provider number as MCO Administration or MCO Care Coordination for any services directly administered by the CONTRACTOR, similar to how those services are submitted as Encounters prior to the MMIS-R;

4.19.1.24.3 Reject and redirect any Claims submitted by Providers directly to the CONTRACTOR that have not come through the System Integrator;

4.19.1.24.4 Require in its contracts with any Major Subcontractors that all services to Members be submitted on standardized electronic Claims submitted through the System Integrator; regardless of the payment method;

4.19.1.24.5 Transmit any COBA Claims to the Systems Integrator, if transmitted directly to the CONTRACTOR;

4.19.1.24.6 Generate electronic remittances to Providers and any Major Subcontractors, even if the Claims are not paid directly, but rather, through a per diem or other payment arrangement;

4.19.1.24.7 Communicate back to the Systems Integrator all Electronic Data Interchange (EDI) response files and all remittance files (HIPAA 835) which will, in turn, update the Claims information with the adjudicated information and pass along to the Providers;

4.19.1.24.8 Include in 835 files all Claims processed, including paid, denied, suspended and any provider-submitted adjustment or void Claims. The 835 shall

include all data elements required to fully explain the CONTRACTOR's adjudication, ensuring that the following data elements are present, where applicable:

- Any TPL, including Medicare payment amounts;
- All Claim Adjustment codes (CAS) applied to the Claim and Claim lines by any other payor, as well as by the Contractor;
- Any copay, interest or other financial adjustments; and
- For any subcapitated services, the payment amount for individual Claims on the 835 will be $0 and the CONTRACTOR will be expected to report separately its monthly contracted costs for those services and include on the Claim an amount that would have been paid if the services were not subcontracted;

4.19.1.24.9 For any Claims for which the CONTRACTOR initiates adjustment or void, the CONTRACTOR shall submit the results of that action on an 835 submitted to the System Integrator ensuring that the original Claim number being adjusted or voided is included; and

4.19.1.24.10 Reconcile with HSD any Claims received by the Systems Integrator for which status has not been received via 835 or EDI response files according to the method and timeline specified by HSD.

4.19.2 Encounter Requirements

4.19.2.1 HSD maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness and quality of all Claims adjudicated by the CONTRACTOR. If the CONTRACTOR elects to contract with a Subcontractor, the CONTRACTOR must ensure that the Subcontractor complies with all Claims and Encounter requirements. Until such time that HSD notifies the CONTRACTOR that the MMIS-R is being implemented, the CONTRACTOR must submit all Encounter Data for all services performed to HSD. The CONTRACTOR is responsible for the quality, accuracy and timeliness of all Encounter Data submitted to HSD. HSD shall communicate directly with the CONTRACTOR any requirements and/or deficiencies regarding completeness,

quality, accuracy and timeliness of Encounter Data and not with any third party contractor. Failure to submit accurate and complete Encounter Data will result in financial penalties determined by HSD based upon the error, and/or the repetitive nature of the error and/or the frequency of the errors, as described in Section 7.3 of this Agreement.

4.19.2.2 With respect to Encounter submission, the CONTRACTOR shall:

4.19.2.2.1 Provide Encounter Data to HSD by electronic file transmission using the HIPAA 837 balancing rules and NCPDP formats according to HIPAA transaction and code sets and operating rules using HSD approved, standard protocols;

4.19.2.2.2 Comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to Subcontractors and Major Subcontractors);

4.19.2.2.3 Submit to HSD all Encounters in accordance with the HIPAA Technical Review Guides, New Mexico's Medicaid MCO Companion Guides, any HIPAA operating rules that may be issued, New Mexico's procedures for successful submission for files to the translator operated by New Mexico's Medicaid fiscal agent and any specific information included in the MCO Systems Manual;

4.19.2.2.4 Make changes or corrections to any systems, processes or data transmission formats, as needed, to comply with HSD data quality standards as originally defined or subsequently amended;

4.19.2.2.5 Within five (5) Business Days of the end of a payment cycle, the CONTRACTOR shall generate Encounter Data files for that payment cycle from its Claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the Encounter Data files may be merged and submitted within five (5) Business Days of the end of the last payment cycle during the calendar week;

4.19.2.2.6 Submit to HSD Encounters for all adjustment/void Claims of previously reported Encounters according to the same timeliness standards as required of paid/denied original Claims applied to the adjustment date. Adjustment and voids of previously paid Claims must be identified as such according to instructions in the HIPAA Technical Review Guides and New Mexico's Medicaid MCO Companion Guides, including the HSD Transaction Control Number (TCN) of the previously paid Encounter that the adjustment/void modifies;

4.19.2.2.7 Submit to HSD Encounters for any Medicare Claims for a Member sent to the CONTRACTOR from the CONTRACTOR's Providers, as well as Medicaid crossover Claims submitted by the COBA contractor or provider; ensuring the following: (i) all information on the Medicare or Medicaid crossover Claim must be submitted as an Encounter to HSD, including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules.

Instructions for the submission of Medicare Encounters will be included in New Mexico's Medicaid MCO Companion Guides and the MCO Systems Manual; and (ii) any Medicaid crossover Claim where the CONTRACTOR either paid the Medicaid obligation, or there was no payment made on the Medicaid obligation, must be sent to HSD as a Medicaid crossover Encounter;

4.19.2.2.8 Have a formal monitoring and reporting system to reconcile submission and resubmission of Encounter Data between the CONTRACTOR and HSD to ensure timeliness of submissions, resubmissions and corrections and the overall completeness and accuracy of data;

4.19.2.2.9 Have a formal monitoring and reporting system to reconcile submissions and resubmissions of Encounter Data between the CONTRACTOR and the Subcontractors, Major Subcontractors, or Providers who pay their own

Claims to assure timeliness, completeness and accuracy of their submission of Encounter Data to the CONTRACTOR;

4.19.2.2.10 Meet HSD Encounter timeliness requirements by submitting to HSD at least ninety percent (90%) of its Claims, paid originals and adjustments within thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accordance with the specifications included in HIPAA Technical Review Guides, the New Mexico Medicaid MCO Companion Guide and the MCO Systems Manual, regardless of whether the Encounter is from a Subcontractor or Major Subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. The CONTRACTOR may not withhold submission of Encounters for any reason;

4.19.2.2.11 Have written contractual requirements of Major 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. All Major Subcontractors or Providers that pay their own claims must submit the actual amount paid to the provider as an encounter to the CONTRACTOR and the CONTRACTOR, in turn, must submit this same amount paid to the provider (not the Major Subcontractor or PBM cost) on its encounter submission to HSD.

4.19.2.2.12 Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per adjudication invoice type (Inpatient and Inpatient crossovers and pharmacy Encounters are adjudicated at the header level; all others are adjudicated at the line level), calculated for a quarter’s worth of submissions. HSD will monitor the CONTRACTOR corrections to denied Encounters for services covered under this Agreement by random sampling performed quarterly and over the term of the Agreement. The methodology for the error rates will be determined by HSD. Seventy-five percent (75%) of the denied Encounters

for services covered under this Agreement included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial;

4.19.2.2.13 The CONTRACTOR shall submit a quarterly report of the number of paid Claims by adjudication type (Inpatient and Inpatient crossovers and pharmacy Encounters are adjudicated at the header level, all others are adjudicated at the line level) by date of payment and date of service as directed by HSD. This report will be compared to Encounter Data to evaluate the completeness of data submitted. A variance between the CONTRACTOR's report and the record of Encounters received cannot exceed five percent (5%) for months of payment greater than ninety (90) Calendar Days. The methodology for the variances will be determined by HSD;

4.19.2.2.14 Systematically edit Encounters prior to submission to prevent or decrease submission of duplicate Encounters and other types of Encounter errors. HSD will share the edits it uses in Encounter adjudication for use by the CONTRACTOR to perform its own edits to ensure optimum accuracy and completeness. The CONTRACTOR may withhold Encounters it has identified with errors through this process in order to make corrections to its system or have the Claim adjusted. However, a paid Claim with known errors must be submitted as an Encounter if, at the end of ninety (90) Calendar Days from that Claims' payment cycle, the error has not been corrected. The CONTRACTOR shall make corrections needed to resolve the error and resubmit the Encounters at such time that the error is resolved;

4.19.2.2.15 Where the CONTRACTOR has entered into subcapitated reimbursement arrangements with Contract Providers, the CONTRACTOR shall require submission of all utilization or Encounter Data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicare Claims, as a condition of the Capitation Payment and shall make

every effort to enforce this contract provision to ensure timely receipt of complete and accurate data; and

4.19.2.2.16 The CONTRACTOR shall conduct an analysis of its submitted and accepted Encounter Data and its financial reports within the Financial Reporting Package.

4.19.2.3 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 MCOs, and those required by CMS or HSD for use in managed care. HSD 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. The transition to HIPAA codes and requirements does not relieve the CONTRACTOR of timely submission of Encounter Data.

4.19.2.4 The CONTRACTOR shall submit all Encounter Data elements noted as "required" in the HIPAA Technical Review Guides and New Mexico's Medicaid Companion Guides with specific attention to the following financial information that will be used to ensure accuracy of Claims payment and to set future Capitation Rates:

4.19.2.4.1 Actual CONTRACTOR paid amount on all Claims/lines paid by the CONTRACTOR, Subcontractor, or Major Subcontractor;

4.19.2.4.2 A CONTRACTOR paid amount equivalent for any Claims/lines that do not have an actual CONTRACTOR paid amount, with a pricing process code that indicates that the amount shown is an assigned equivalent amount rather than an actually paid amount (e.g., subcapitated Providers/Members);

4.19.2.4.3 Claim Adjustment reason codes (CAS codes) with remark codes, as needed, to designate the reasons any Claim/line is not paid (e.g., bundling);

4.19.2.4.4 Any payments by any third party payer, copayments from the Member, or adjustments to the Claim/line's pricing reported with the appropriate Claim adjustment reason and remark codes; and

4.19.2.4.5 Payment to IHS, FQHC and RHC Providers using institutional Claim formats and including the Encounter rate on one line of the Claim, but including all services rendered as part of that Encounter.

4.19.2.5 Any services provided to Members directly by CONTRACTOR staff (Care Coordination, assessments, etc.) must be submitted to HSD as Encounter Data using agreed upon coding and meeting all HIPAA transaction standards.

4.19.2.6 Any incentive payments to Providers must be reported to HSD as Encounter Data using agreed upon coding and meeting all HIPAA transaction standards.

4.19.2.7 The CONTRACTOR shall populate the dispensed as written field in all pharmacy Encounter Data submissions.

4.19.2.8 The CONTRACTOR shall provide all Encounters that include dates of service for all prenatal and postpartum visits for both FFS and bundled payment arrangements.

4.19.3 Effective with implementation of the MMIS-R, The CONTRACTOR will no longer submit Encounters to HSD; all MCO Claims will be captured in the State's data warehouse from the Providers' submissions and will be updated to reflect final 'Encounter' status based on the 835 and EDI response files received from the MCOs through the System Integrator.

4.19.3.1 The quarterly report of the number of paid Claims by adjudication type will no longer be required as all Claims and adjudication results will be captured directly by HSD.

4.19.3.2 The CONTRACTOR will be Responsible for responding to Data Validation studies that HSD will perform from the CONTRACTOR's Claims (Encounters) stored in the Data Warehouse. These data validation studies will not mimic FFS Claims edits, but will evaluate 'Encounter' timeliness, appropriateness and completeness.

4.19.3.3 The CONTRACTOR will be responsible for reconciling any Claims received by HSD for which no paid, denied or suspended status has been returned by the CONTRACTOR on an 835 or EDI response file.

4.19.3.4 The CONTRACTOR will be responsible for adjusting or voiding any Claims identified by HSD as inappropriately paid and sanctions will be imposed for any Claims that violate timeliness and/or completeness requirements.

4.20 **Information Systems**

4.20.1 General System Hardware, Software and Information Systems Requirements

4.20.1.1 The CONTRACTOR shall maintain system hardware, software and information systems (IS) resources sufficient to provide the capability to:

4.20.1.1.1 Accept, transmit, maintain and store electronic data and enrollment roster files;

4.20.1.1.2 Accept, transmit, process, maintain and report specific information necessary to the administration of the State's Centennial Care programs, 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;

4.20.1.1.3 Comply with the most current federal standards for encryption of any data that is transmitted via the internet by the CONTRACTOR or its Subcontractors, Major Subcontractors and Contract Providers;

4.20.1.1.4 Conduct automated Claims processing with current National Provider Identification (NPI) Number for health care Providers and FEIN/SSN numbers for atypical Providers in HIPAA compliant formats;

4.20.1.1.5 Accept and maintain the State's ten (10) digit Member Medicaid identification number to be used for all communication to HSD and be cross-walked to the CONTRACTOR's assigned universal Member number, which is used by the Member and Providers for identification, eligibility verification and Claims adjudication by the CONTRACTOR and all Subcontractors and Major Subcontractors;

4.20.1.1.6 Monitor and transmit electronic Encounter Data to HSD according to Encounter Data submission standards, prior to implementation of MMIS-R;

4.20.1.1.7 Transmit electronic remittance (835) and EDI response files to HSD's System Integrator upon implementation of MMIS-R;

4.20.1.1.8 Monitor the completeness of the data being received to detect Providers or Major Subcontractors who are transmitting partial or no records;

4.20.1.1.9 Transmit data securely and electronically;

4.20.1.1.10 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;

4.20.1.1.11 Receive data elements associated with identifying Members who are receiving ongoing services or from another contractor and using, where possible, the formats that HSD uses to transmit similar information to a MCO;

4.20.1.1.12 Transmit to HSD or another contractor, data elements associated with Members who have been receiving ongoing services within the CONTRACTOR's MCO; and

4.20.1.1.13 Have an automated access system for Providers to obtain Member enrollment information that includes the cross-reference capability of the system to the Member's ten (10) digit Medicaid identification number designated by HSD to the Member's Social Security number as a means of identifying the Member's most current benefits, such as providing the Member's category of eligibility.

4.20.1.2 The CONTRACTOR shall submit all reports electronically to HSD's FTP site, unless directed otherwise by HSD. HSD shall provide the CONTRACTOR with access to the FTP site.

4.20.1.3 The CONTRACTOR shall transmit to and receive from HSD all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by HSD, so long as HSD direction does not conflict with State or federal law.

4.20.1.4 The CONTRACTOR's systems shall conform to future federal and/or HSD specific standards for data exchange within the time frame stipulated by federal authorities or HSD. The CONTRACTOR shall partner with HSD in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

4.20.1.5 The CONTRACTOR shall participate in and, as may be directed, implement any Health Information Exchange or Electronic Health Record initiatives undertaken by HSD or other entities.

4.20.1.6 The CONTRACTOR shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems and shall provide these documents to HSD upon request.

4.20.1.7 Provider Network Information Requirements

The CONTRACTOR's provider network capabilities shall include the following, in order to fulfill the provider certification and enrollment functions described in Section 4.8.14 of this Agreement, as further described in the MCO Systems Manual:

4.20.1.7.1 Accepting a provider master file from HSD that identifies all Medicaid enrolled Providers;

4.20.1.7.2 Transmitting a provider network file to New Mexico Medicaid's fiscal agent that identifies by NPI any provider enrolled with New Mexico Medicaid who is in the CONTRACTOR's provider network. Out of network providers are not to be included on this file. The CONTRACTOR shall include the date on which the provider's status as a network provider is effective and when the provider is no longer included in their network, the CONTRACTOR shall include the date the network status ended. The CONTRACTOR shall send this file monthly, due no later than the tenth day

of each month, reflecting the network providers for the previous month. This requirement may be modified or deleted with the implementation of MMIS-R. The CONTRACTOR shall adhere to all federal requirements related to the enrollment, identification and reporting of billing, rendering, furnishing, ordering, referring, prescribing, attending and other Providers, as applicable;

4.20.1.7.3 RESERVED;

4.20.1.7.4 Accepting a provider confirmation update file from New Mexico Medicaid that contains any newly active Contract Providers or changes to Contract Providers that lists, at a minimum, the provider's NPI or FEIN/SSN, the provider's Medicaid ID, servicing location zip code, provider type, specialty, and dates of enrollment/termination;

4.20.1.7.5 RESERVED;

4.20.1.7.6 Recording each provider listed on the New Mexico Medicaid provider update confirmation file and the full provider confirmation file in the CONTRACTOR's system with the Medicaid provider ID, the assigned provider type, specialty (if applicable), and dates of enrollment/termination and using this data to edit Claims and ensure that the appropriate provider taxonomy and provider servicing location zip code is assigned to Encounter Claims;

4.20.1.7.7 Maintain an online provider directory for Members as specified in Section 4.14.5 of this Agreement; and

4.20.1.7.8 Upon implementation of MMIS-R, the CONTRACTOR agrees to accept a single provider master file from HSD that has all enrolled Providers. This file will be updated on a daily basis with any changes and published monthly as a full file.

4.20.2 Member Information Requirements

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

4.20.2.2 The CONTRACTOR shall receive, process and update enrollment files sent daily by HSD.

4.20.2.3 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

4.20.2.4 The CONTRACTOR shall be capable of uniquely identifying a distinct Member across multiple populations and systems within its span of control.

4.20.2.5 The CONTRACTOR shall be able to identify potential duplicate records for a single Member and, upon confirmation of said duplicate record by HSD, resolve the duplication such that the enrollment, service utilization and customer interaction histories of the duplicate records are linked or merged.

4.20.2.6 The CONTRACTOR shall:

4.20.2.6.1 Provide a means for Providers and Major Subcontractors to verify Member eligibility and enrollment status twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) Calendar Days a year;

4.20.2.6.2 Ensure that current and updated eligibility information received from HSD is available to all Providers via the CONTRACTOR's eligibility verification system and all Subcontractors' eligibility verification systems within twenty-four (24) hours of receipt of any and all enrollment files from HSD;

4.20.2.6.3 Assign as the key Medicaid Member ID number, the RECIP-MCD- CARD-ID-NO that is sent on the enrollment roster file and capture and store the Medicare ID, SSN and pseudo-SSN if they are included on the enrollment roster file for use in 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;

4.20.2.6.4 Meet federal CMS and HIPAA standards for release of Member information (applies to Subcontractors, Major Subcontractors and Providers as well). Standards are specified in the MCO Systems Manual and at 42 C.F.R. § 431.306(b);

4.20.2.6.5 Maintain accurate Member eligibility and demographic data to include but not be limited to, category of eligibility, Care Coordination level, NF LOC and setting of care, Community Benefit status, copayment maximum, copayment spent amount, Medicare status, Health Home status, Behavioral Health needs, age, sex, race, residence county, parent/non parent status, Native American status, institutional status and disability status on its system's database consistent with HSD requirements. This requirement also applies to any Subcontractor who maintains a copy of the Member enrollment files for the purpose of distributing eligibility or enrollment information to Providers for verifying Member eligibility;

4.20.2.6.6 Upon learning of third party coverage that was previously unknown, notify HSD within fifteen (15) Calendar Days, according to the reporting process outlined in the MCO Systems Manual;

4.20.2.6.7 Exclude the Member's social security number from the Member's ID card;

4.20.2.6.8 Have system functionality to manage different financial fields identified as annual maximum out-of-pocket amounts, benefit maximums and copayment amounts for different services and for Members with different copayment requirements, including effective dates of the financial fields, as they could change over time; and

4.20.2.6.9 Transmit to HSD a daily update file that contains Member information specific to nursing facility level of care, Community Benefit status, Care Coordination level, Health Home status, PCP assignment, disability status and identifying information as specified in the MCO Systems Manual.

4.20.3 System and Information Security and Access Management Requirements

4.20.3.1 The CONTRACTOR's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

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

4.20.3.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified appropriate staff.

4.20.3.2 The CONTRACTOR shall make system information available to duly authorized representatives of HSD and other State and federal agencies to evaluate, through inspections, and to audits, or other means, the quality, appropriateness and timeliness of services performed.

4.20.3.3 The CONTRACTOR's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits by the CONTRACTOR and the results of these tests shall be made available to HSD upon request.

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

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

4.20.3.4.2 Have the date and identification "stamp" displayed on any online inquiry;

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

4.20.3.4.4 Be supported by listings, transaction reports, update reports, transaction logs or error logs;

4.20.3.4.5 Facilitate auditing of individual records as well as batch audits; and

4.20.3.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than seven (7) years and shall be retrievable within forty-eight (48) hours.

4.20.3.5 The CONTRACTOR's systems shall have inherent functionality that prevents the alteration of finalized records.

4.20.3.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The

CONTRACTOR shall provide HSD with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.

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

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

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

4.20.3.10 The CONTRACTOR shall ensure that remote access users of its systems can only access said systems through two-factor user authentication and via methods such as Virtual Private Network (VPN).

4.20.3.11 The CONTRACTOR shall comply with recognized industry standards governing security of State and federal automated data processing systems and information processing. At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided to HSD prior to Go-Live. The risk assessment shall also be made available to appropriate State and federal agencies upon request.

4.20.4 Systems Availability, Performance and Problem Management Requirement

4.20.4.1 The CONTRACTOR shall ensure that critical Member and provider Internet and/or telephone-based functions and information, including, but not limited to, Member eligibility and enrollment systems, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods

of scheduled system unavailability agreed upon by HSD and the CONTRACTOR.

4.20.4.2 The CONTRACTOR shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m. (Mountain Time), Monday through Friday.

4.20.4.3 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and Claims processing systems shall have functionality restored within seventy-two (72) hours of the failure's or disaster's occurrence.

4.20.4.4 In the event of a problem with system availability that exceeds four (4) hours, the CONTRACTOR shall notify HSD immediately and provide HSD, within five (5) Business Days, with full written documentation that includes a Corrective Action Plan describing how the CONTRACTOR will prevent the problem from occurring again.

4.20.5 Business Continuity and Disaster Recovery (BC-DR) Plan

4.20.5.1 Regardless of the architecture of its systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that has been reviewed and approved in writing by HSD.

4.20.5.2 At a minimum, the CONTRACTOR's BC-DR plan shall address the following scenarios:

4.20.5.2.1 The central computer installation and resident software are destroyed or damaged;

4.20.5.2.2 System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;

4.20.5.2.3 System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system; and

4.20.5.2.4 System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of

transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability.

4.20.5.2.5 The CONTRACTOR's system is functional but has been compromised by unauthorized access which has led to a security incident or breach; or a vulnerability is detected which could lead to a potential incident of protected health information (PHI) that pertains to this agreement.

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

4.20.5.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures and provide the results of this testing to HSD upon request.

4.21 **Reporting Requirements**

4.21.1 General Requirements

4.21.1.1 The CONTRACTOR shall comply with all the reporting requirements established by HSD including all Delivery System Improvement Performance Target (DSIPT) reports.

4.21.1.2 The CONTRACTOR shall adhere to HSD defined standards and templates for all reports and reporting requirements. HSD shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables and technical assistance as required. HSD may, at its discretion, change the content, format or frequency of reports.

4.21.1.3 As directed by HSD, the CONTRACTOR shall submit reports to the Collaborative and other State agencies.

4.21.1.4 As appropriate, report templates may include specific information related to Behavioral Health services and utilization.

4.21.1.5 HSD's requirements regarding report packages (i.e. instructions, template and review tool) for reports, report content and frequency of submission are subject to change at any time during the term of the Agreement.

4.21.1.5.1 The CONTRACTOR shall comply with all report package (i.e., instructions, template) revisions specified in writing by HSD, after HSD has discussed such revisions with the CONTRACTOR. HSD shall notify the CONTRACTOR, in writing, of report package revisions to existing required report content, at least fourteen (14) Calendar Days prior to implementing the report package revisions. The CONTRACTOR shall only be held harmless on the first submission of the revised report, after revisions are implemented by HSD, if HSD fails to meet this notification requirement. However, the CONTRACTOR is not otherwise relieved of any penalties for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report (i.e., template and instructions) revised by HSD to include a revision in data requirements or definitions will not be subject to penalty for accuracy. For minor formatting and schedule changes, the CONTRACTOR will implement as directed by HSD. Minor formatting and schedule changes shall include, but are not be limited to, items such as addition of rows in a template, unlocking certain template cells and changes in titles.

4.21.1.5.2 HSD shall notify the CONTRACTOR, in writing, of new report packages at least forty-five (45) Calendar Days prior to implementing the new report package, excluding DSIPT reports.

4.21.1.6 The CONTRACTOR shall submit reports that are complete, timely, accurate and in the specified format, as required by HSD. The submission of reports that are incomplete, late, inaccurate or not in specified format constitutes a “Failure to Report”. “Timely submission” shall mean that a complete and accurate report, in the specified format, was submitted on or before the date it was due. HSD, in its sole discretion, shall determine if a report is late, inaccurate, incomplete or in an unspecified format. “Failure to Report” may result in monetary penalties in accordance with Section 7.3 of this Agreement.

The CONTRACTOR shall not be penalized if an error in a previously submitted report is identified by the CONTRACTOR and reported to HSD prior to HSD’s

identification of the error. Corrected reports in this type of situation will be submitted to HSD in a time frame determined by HSD after consulting with the CONTRACTOR. In such a situation, failure to comply with the agreed upon time frames for correction and resubmission may result in monetary penalties in accordance with Section 7.3 of this Agreement.

4.21.1.7 The CONTRACTOR shall review, as part of its continuous improvement activities, timeliness and accuracy of reports submitted to HSD to identify instances and patterns of non-compliance. The CONTRACTOR shall perform an analysis identifying any patterns or issues of non-compliance and shall implement quality improvement activities to improve overall performance and compliance.

4.21.1.8 HSD may, at its discretion, require the CONTRACTOR to submit additional reports, both ad hoc and recurring.

4.21.1.9 If HSD requests any revisions to reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format directed by HSD.

4.21.1.10 HSD reserves the right to request reports more frequently during the Transition Period in order to monitor implementation of Centennial Care.

4.21.1.11 The CONTRACTOR shall submit all reports to HSD, unless indicated otherwise in this Agreement, according to the schedule below or as otherwise directed by HSD. "Failure to Report" may result in monetary penalties in accordance with Section 7.3 of this Agreement.

DELIVERABLE	DUE DATE
Weekly Reports	Wednesday of the following week
Monthly Reports	Fifteenth (15th) Calendar Day of the following month
Quarterly Reports	Thirtieth (30th) Calendar Day of the following month*
Semi-Annual Reports	January 31 and July 31 of the Agreement year
Annual Report	As directed by HSD
Ad Hoc Reports	Time frame as determined by HSD at time of the request.
DSIPT Reports	As Directed by HSD

*Quarterly financial reports are due Sixty (60) Calendar Days from the end of the first quarter, the remaining quarterly financial reports are due Forty-Five (45) Calendar Days from the end of the respective quarter.

4.21.1.12 If a report due date falls on a weekend or a State of New Mexico scheduled holiday, receipt of the report the next Business Day is acceptable.

4.21.1.13 Extensions to report submission dates will be considered by HSD after the CONTRACTOR has contacted the HSD designated point of contact via email at least twenty-four (24) hours in advance of the report due date. Extensions for submission of reports should be under rare and unusual circumstances. If HSD grants an extension and the report is complete, accurate, in the specified format and submitted on or before the extended deadline, the report will not be subject to penalty. Failure to request an extension at least twenty-four (24) hours prior to the report due date is considered a "Failure to Report" and may result in monetary penalties in accordance with Section 7.3 of this Agreement.

4.21.1.14 When a report is rejected because it constitutes a "Failure to Report", the CONTRACTOR shall resubmit the report as soon as possible once notification of the rejection is received. The length of time in Business Days it takes the CONTRACTOR to resubmit rejected reports may result in monetary penalties in accordance with items #7 and #11 of Section 7.3.3.6.7 of this Agreement. If the CONTRACTOR cures the deficiency identified by HSD and resubmits an accurate report, in the specified format, within five (5) Business Days from receipt of written notification of the basis of such failure, the CONTRACTOR will only be subject to a report rejection penalty of $5,000 and not the $1,000 daily monetary penalty. This one-time cure period shall apply only to the initial rejection of any report and not to subsequent rejections of the same report. If the CONTRACTOR does not cure the deficiency within five (5) Business Days of receipt of written notification, HSD may impose monetary penalties for Failure to Report, in addition to the $5,000 rejection penalty. Any monetary penalties imposed in addition to the $5,000 report rejection penalty may begin to accrue

the day after the report rejection notice is uploaded to the DMZ and ending the day before the report is resubmitted to the DMZ.

4.21.1.15 The CONTRACTOR shall submit all reports electronically to HSD's FTP site, unless directed otherwise by HSD. HSD shall provide the CONTRACTOR with access to the FTP site. The email generated by the FTP upload will be used as the time stamp for the submission of the report(s).

4.21.1.16 HSD shall provide an acknowledgement of receipt of the report to the CONTRACTOR within fifteen (15) Business Days from receipt of the report.

4.21.1.17 A number of reports as identified by HSD require CONTRACTOR certification. The Authorized Certifier, or an equivalent position, as delegated by the CONTRACTOR and approved by HSD, shall review the accuracy of language, analysis and data in each report prior to submitting the report to HSD. The Authorized Certifier shall include a signed attestation each time the report is submitted. The attestation must include a certification, based on best knowledge, information and belief, as to the accuracy, completeness and truthfulness of the data in the report. Reports will be deemed incomplete if an attestation is not included.

4.22 **Obligations Relating to Member Personal Responsibility Initiatives**

4.22.1 Member Incentives

4.22.1.1 General Expectations

4.22.1.1.1 The CONTRACTOR shall assign at least one Centennial Care Committee representative to work with the other Centennial Care Rewards Committee representatives to continue the Centennial Rewards program.

4.22.1.1.2 The CONTRACTOR shall contract directly with the Centennial Rewards Program vendor approved by HSD to provide incentives to Members for healthy behaviors and to provide other services as assigned by HSD.

4.22.1.1.3 Amounts expended to administer the Member rewards program shall be deemed as administrative expenses and amounts expended on the value of

the rewards themselves shall be deemed as direct services for purposes of the medical expense ratio (see Section 7.2 of this Agreement).

4.22.1.2 Specific Requirements

4.22.1.2.1 The activities and behaviors proposed to be rewarded with incentives should promote good health, Health Literacy and continuity of care for all Members and shall be prior approved by HSD. Changes to the rewards and redemption options will be approved by HSD.

4.22.1.2.2 The following reward activities are under consideration for the Member Incentive program:

- Annual dental visit for children;
- Annual dental visit for adults;
- Well-child PCP visit (age 0-15 months);
- Well-child PCP visit (age 3-6 years);
- Adolescent well-care visit;
- Childhood immunizations;
- Adult PCP visit;
- Perinatal (1st trimester, ongoing prenatal and postpartum visits);
- Breast cancer screening;
- Diabetes management (HbA1c, nephropathy and diabetic retinopathy);
- Medication management for asthma;
- Medication management for bipolar disorder;
- Medication management for schizophrenia;
- Medication management for hypertension;
- Medication management for depression;
- Follow-up after hospitalization for mental illness;
- New Member Health Risk Assessment Completion;
- Step-Up Wellness Challenge;
- Drink Water Wellness Challenge; and
- Just Move Wellness Challenge.

4.22.1.2.3 Members shall earn points for each healthy behavior based on a schedule approved by HSD. Points may be redeemed for healthy items available through a catalog or for member premium payments. Points may be redeemed for HSD-approved items available through a catalog or other options as directed by HSD.

4.22.1.2.4 The points in the Member's account shall be available to the Member if the Member enrolls in a different MCO.

4.22.1.3 RESERVED

4.22.1.4 Data Sharing and Reporting

4.22.1.4.1 Subject to HSD approval, the CONTRACTOR will work with the Centennial Rewards Program vendor to follow established processes for capturing and storing the data necessary to award points for participation in qualified activities and programs. The CONTRACTOR is required to follow the data schedules established collaboratively by the MCOs and the Centennial Rewards Program vendor for providing required data.

4.22.1.4.2 The points for qualified activities and programs may be tracked based on Claim submissions.

4.22.1.4.3 The points for Member rewards may be tracked and accumulated based on an alternative process, subject to agreement by all the MCOs and prior approval by HSD. In no instance shall the methodology proposed fail to provide the points to the Members in less than forty-five (45) Calendar Days from payment of the associated Claim or receipt by the MCO or a written request for a non-Claim based reward.

4.22.1.4.4 The CONTRACTOR shall design and operate an automated system to communicate information on the points available for each Member to the vendor retained by the Centennial Care MCOs to administer the provider catalog fulfillment process.

4.22.2 PCP Lock Ins

The CONTRACTOR shall monitor the potential for abuse or overuse of services and require that a Member visit a certain PCP when the CONTRACTOR has identified

continuing utilization of unnecessary services. 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 every quarter. The Member shall be removed from PCP lock in when the CONTRACTOR has determined that the utilization problems have been resolved and that recurrence of the problems is judged to be improbable. HSD shall be notified of all lock in removals.

4.22.3 Pharmacy Lock Ins

The CONTRACTOR monitors the potential for abuse or overuse of services and requires that a Member visit a certain pharmacy provider when Member compliance or drug-seeking behavior is suspected. Prior to placing the Member on pharmacy lock in, the CONTRACTOR shall inform the Member and/or his or 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 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 shall be notified of all lock in removals.

5 HSD's Responsibilities

5.1 **HSD shall:**

5.1.1 Establish and maintain Member eligibility and enrollment information and transfer eligibility and enrollment information to the CONTRACTOR 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.

Each Party shall notify the other of possible errors or problems as soon as reasonably possible;

5.1.2 Support implementation deadlines by providing technical information at the required level of specificity in a timely fashion;

5.1.3 Provide the CONTRACTOR with enrollment information concerning each Member enrolled with the CONTRACTOR, including the Member's name, social security number, address, telephone number, date of birth, gender, the availability of third-party coverage, rate category and the State-assigned identification number;

5.1.4 Compensate the CONTRACTOR as specified in Section 6 of this Agreement;

5.1.5 Provide a mechanism for Fair Hearings to review denials and utilization decisions made by the CONTRACTOR;

5.1.6 Conduct review and monitoring activities, as needed, to meet CMS, SAMHSA or other federal requirements for State oversight responsibilities;

5.1.7 Monitor the effectiveness of the CONTRACTOR's QM/QI programs;

5.1.8 Review the CONTRACTOR's Grievance files, as necessary;

5.1.9 Provide Members with specific information about services, benefits, MCOs from which to choose and Member enrollment;

5.1.10 Provide the content, format and schedule for the CONTRACTOR's report submissions;

5.1.11 Provide the CONTRACTOR with specifications related to data reporting requirements;

5.1.12 Ensure that no requirement or specification established or provided by HSD under this Section conflicts with requirements or specifications established pursuant to HIPAA and the regulations promulgated there under. All requirements and specifications established or provided by HSD under this Section shall comply with the requirements of Section 5.2 of this Agreement; and

5.1.13 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 bears no responsibility for the cause of the delay.

5.2 HSD and/or its fiscal agent shall implement electronic data standards for transactions related to managed health care. In the event that HSD and/or its fiscal agent requests that the CONTRACTOR, or its Subcontractors or Major 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 Section 7.7 of this Agreement.

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

5.4 To the extent the CONTRACTOR is unable to perform any obligation or meet any deadline under this Agreement because of the failure of HSD to perform its specific responsibilities under the Agreement; the CONTRACTOR's performance shall be excused or delayed, as appropriate. The CONTRACTOR shall provide HSD 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 has failed to meet, as well as the reason HSD's failure impacts the CONTRACTOR's ability to meet its performance obligations under the Agreement.

5.5 Within three (3) Business Days of becoming aware of any Claim or information that may impact the CONTRACTOR or the services to be performed by the CONTRACTOR under this Agreement, HSD shall provide the CONTRACTOR with written notice of such Claim or information.

6 Payments to CONTRACTOR

6.1 General Requirements

6.1.1 The Parties understand and agree that the compensation and payment reimbursement for services delivered under this Agreement are dependent upon federal and State funding and regulatory approvals.

6.1.2 HSD shall compensate the CONTRACTOR for work performed under this Agreement based on the Capitation Rates shown on the rate sheets for the Contract Period. The CONTRACTOR shall accept payments remitted by HSD as payment in full for all services required pursuant to this Agreement.

6.1.3 HSD shall make monthly Capitation Payments to the CONTRACTOR for all Members enrolled with the CONTRACTOR on or before the second Friday of each month. HSD shall not make partial month or daily Capitation Payments.

6.1.4 The CONTRACTOR shall comply with all requirements stated in NMAC 8.308.20. HSD shall make payments under capitated risk contracts that are developed in accordance with 42 C.F.R. § 438.4. All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound and approved as such by the CMS.

6.1.4.1 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's offer of all Capitation Rates and related risk-sharing arrangements is contingent on both certifications by HSD'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 reserves the right to modify these Capitation Rates. HSD's decision to modify the Capitation Rates under the circumstances described above is binding on the CONTRACTOR.

6.1.5 To the extent, it is determined by the appropriate taxing authority, excluding the fee imposed by Section 9010 of the ACA (Health Insurance Providers Fee), that the performance of this Agreement by the CONTRACTOR is subject to taxation, the Capitation Payments paid by HSD to the CONTRACTOR under this Agreement shall

include such tax(es) and no additional amount shall be due from HSD. Therefore, the amount paid by HSD 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. HSD shall pay a monthly Capitated Payment amount to the CONTRACTOR for the provision of the managed care benefit package. Section 6.4 of this Agreement addresses the payment associated with the Health Insurance Providers Fee under Section 9010 of the ACA.

6.1.6 Capitation rates determined through discussion between the Parties are considered confidential.

6.1.7 Members shall be held harmless against any liability for debts of a CONTRACTOR that are incurred within the Agreement in providing Covered Services to the Medicaid Member.

6.2 **Payments for Services**

6.2.1 HSD shall make a full monthly Capitation Payment to the CONTRACTOR for the month in which the Member is enrolled with the CONTRACTOR. The CONTRACTOR shall be responsible for Covered Services (Attachment 2) provided to the Member in any month for which HSD paid the CONTRACTOR for the Member's care under the terms of this Agreement.

6.2.2 The CONTRACTOR is at risk of incurring losses if its expenses for providing the Covered Services and performing the requirements of the Agreement exceed its Capitation Payment. HSD 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 underwriting gain subject to the limitations set forth in Section 7.2 of this Agreement. HSD makes no guarantee of underwriting gain to the CONTRACTOR.

6.2.3 The CONTRACTOR remains ultimately liable to HSD for the services rendered under the terms of this Agreement. The CONTRACTOR is required to obtain reinsurance as outlined in Section 4.18.10 and shall provide a copy of its reinsurance agreement to HSD annually, beginning with the effective date of this Agreement.

6.2.4 If a Member loses eligibility for any reason and is reinstated as eligible by HSD 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.

6.2.5 Retro Capitation Payments may not be issued for Members for the same coverage month in which FFS Claims have already been paid by Medicaid, except in special situations determined by HSD. When retro Capitation Payments are not issued for a particular month, the Member will remain enrolled with FFS for that month.

6.2.6 HSD shall have the discretion to recoup Capitation Payments made by HSD pursuant to the time periods governed by this Agreement for the following:

6.2.6.1 Members incorrectly enrolled with more than one CONTRACTOR;

6.2.6.2 Members who die prior to the enrollment month for which a Capitation Payment was made; and/or

6.2.6.3 Members whom HSD later determines were not eligible for Medicaid during the enrollment month for which Capitation Payment was made. HSD acknowledges and agrees that in the event of any recoupment pursuant to this Section, the CONTRACTOR shall have the right to recoup from Providers or other persons to whom CONTRACTOR has made payment during this period of time; however, the CONTRACTOR may not recoup payments for any Value Added Services provided. Any payments that are recouped from Providers or other persons must be reflected in the Encounter Data as outlined in Section 4.19.2; and

6.2.6.4 Members with a length of stay in an IMD that exceeds 15 Calendar Days within the Calendar Month as specified in Section 4.5.15.

6.2.7 HSD shall have the discretion to recoup Capitation Payments for a non-Dual Rate Cohort and reissue a Dual Rate Cohort for Members who are retroactively determined to have Medicare coverage and do not exceed the time period that the CONTRACTOR can retroactively adjust Claims payment to Providers for those services for which Medicare would be the primary payer.

6.2.8 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 payments made to Providers for the delivery of Covered Services outlined in this Agreement. The CONTRACTOR who retains the Capitation Payment shall reimburse in a timely manner any Providers from whom payments were recouped by the prior CONTRACTOR.

6.2.9 In the event of an error that causes Capitation Payment(s) to the CONTRACTOR in excess of amounts specified in the contract, the CONTRACTOR must report to HSD any incorrect payments within sixty (60) Calendar Days of identification. The CONTRACTOR shall reimburse HSD within thirty (30) Calendar Days of written notice of such error for the full amount of the payment. 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) Calendar Day following the notice. Any process that automates the recoupment procedures will be discussed in advance by HSD and the CONTRACTOR and be 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 Section 7.11 of this Agreement.

6.2.10 Members shall be held harmless against any liability for debts of the CONTRACTOR that were incurred within the Agreement in providing health care to the Members, excluding any Member's liability for applicable premiums, copayment or Member's liability for an overpayment resulting from benefits paid pending the results of a Fair Hearing.

6.3 **Reimbursement to CONTRACTOR for I/T/U Services**

6.3.1 HSD will pay the CONTRACTOR, on a quarterly basis, for the costs of services provided at I/T/Us. This payment shall be separate from the Capitation Rates and be based upon Encounter Data provided by the CONTRACTOR to HSD that have been accepted and have cleared all systems edits in the MMIS.

6.3.2 The CONTRACTOR shall have up to two (2) years from an I/T/U Claim's first date of service to submit to HSD. I/T/U Claims not submitted within two (2) years of the first date of service are not eligible for reimbursement by HSD.

6.3.3 The CONTRACTOR shall submit all Encounters for I/T/U payments.

6.3.4 The CONTRACTOR shall report expenditures on a date of service basis for I/T/U payment amounts.

6.4 **ACA Section 9010 Health Insurance Providers Fee**

6.4.1 HSD agrees to reimburse the CONTRACTOR for the Health Insurance Providers Fee under Section 9010 of the ACA, including the impact of income tax, assessments and premium tax applicable to the CONTRACTOR's liability for the New Mexico Medicaid program.

6.4.2 The CONTRACTOR is required to provide HSD with all necessary documentation, as determined by HSD, related to the CONTRACTOR's Health Insurance Providers Fee liability, including related income tax, assessments and premium tax.

6.4.3 HSD will make payment to the CONTRACTOR after the receipt of the final documentation outlined in Section 6.4.2 and within the calendar year that the fee is imposed on the CONTRACTOR.

6.5 **Capitation Rates**

The Capitation Payments made by HSD to the CONTRACTOR are based on the Capitated Rates for the Members enrolled with the CONTRACTOR. The Rate Cohorts designate the Covered Services and/or population characteristics (age/gender/geography) of the Capitation Rate. During the term of this Agreement, HSD reserves the right to modify or change the number assigned to the Rate Cohorts described in this Section, if necessary, due to HSDs MMIS requirements.

6.5.1 <u>Physical Health</u>

6.5.1.1 The Capitation Rates for the physical health program are represented by Rate Cohorts 001 through 012 and include acute care Covered Services outlined in Attachment 2 (Covered Services). Behavioral Health services for the population enrolled in the Physical Health Rate Cohorts are covered by the Behavioral Health Rate Cohorts (see Section 6.5.4).

6.5.1.2 Physical health Capitation Rates are subject to risk-adjustment, described in Section 6.5.5. Members enrolled in Rate Cohorts 001 and 006 (newborns) and

Rate Cohort 011 (pregnant women) are excluded from risk-adjustment. Certain Covered Services may also be excluded from risk-adjustment as outlined in Section 6.5.1.3.

6.5.1.3 HSD may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the risk-adjusted Capitation Rates for Covered Services not subject to risk-adjustment including, but not limited to, specialty pharmacy treatment cost for Hepatitis C.

6.5.1.4 During the term of this Agreement HSD reserves the right to modify the structure, type or number of add-on PMPM amounts and shall notify the CONTRACTOR about the change at least ninety (90) days prior to the effective date change.

6.5.1.5 HSD will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rate and any add-on PMPM rates by Rate Cohort on an annual basis or when Capitation Rates are revised during the annual contract term.

6.5.2 Other Adult Group

6.5.2.1 The Capitation Rates for the Other Adult Group program are represented by Rate Cohorts 110 through 122, excluding Rate Cohort 113 and include acute care Covered Services outlined in Attachment 2 (Covered Services) and/or Attachment 5 (Alternative Benefit Plan Covered Services). Behavioral Health services for the population enrolled in the Other Adult Group Rate Cohorts are covered by the Behavioral Health Rate Cohorts (see Section 6.5.4).

6.5.2.2 Other Adult Group Capitation Rates, except Behavioral Health services, are subject to risk-adjustment, described in Section 6.5.5. Certain Covered Services may also be excluded from risk-adjustment as outlined in Section 6.5.2.3.

6.5.2.3 HSD may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the risk-adjusted Capitation Rates for Covered Services not subject to risk-adjustment including, but not limited to, specialty pharmacy treatment cost for Hepatitis C and the Agency-Based or Self- Directed Community Benefit.

6.5.2.4 During the term of this Agreement, HSD reserves the right to modify the structure, type or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least ninety (90) days prior to the effective date of the change.

6.5.2.5 HSD will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rates and any add-on PMPM rate amounts by Rate Cohort on an annual basis or when Capitation Rates are revised during the annual contract term.

6.5.3 Long-Term Services and Supports (LTSS)

6.5.3.1 Blended Rates

6.5.3.1.1 The Capitation Rates for the LTSS population include blended Capitation Payments for Members who are assigned to a Nursing Facility or Agency-Based Community Benefit setting of care. Rate Cohorts 300, 310, 320 represent the blended Rate Cohorts for Dual Eligible Members and Rate Cohorts 302, 312 and 322 represent the blended Rate Cohorts for Medicaid only Members.

6.5.3.1.2 The LTSS Capitation Rates outlined in Section 6.5.3.1.1 are developed separately for Members with a Nursing Facility setting of care and Members with an Agency-Based Community Benefit setting of care for acute and Long-Term Care services outlined in Attachment 2 (Covered Services). On an annual basis HSD shall evaluate the CONTRACTOR's proportion of enrollment in the Nursing Facility and Agency-Based Community Benefit settings of care and make a determination of the proportion of Nursing Facility and Agency-Based Community Benefit Members for the upcoming contract period. This proportion will be used to blend the Nursing Facility and Agency-Based Community Benefit Capitation Rates to derive the blended Capitation Rates paid by HSD to the CONTRACTOR.

6.5.3.1.3 HSD, at its discretion, may reevaluate the proportion of the CONTRACTOR's Members with Nursing Facility and Agency-Based Community Benefit setting of care assumed in the blended Capitation Rates

at any time during this Agreement to determine if a revision to the blended Capitated Rates are necessary. HSD shall limit changes to the blended Capitation Rates on a prospective basis.

6.5.3.1.4 The Capitation Rates for the blended LTSS cohorts are "net" of medical care credit. The Capitation Rates used for the Nursing Facility setting of care population are developed on a "gross" basis and reduced for the estimated average monthly amount of medical care credit.

6.5.3.1.4.1 The blended Capitation Payments are subject to medical care credit reconciliation outlined in Section 6.9.

6.5.3.1.5 HSD may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the Medicaid only blended Capitation Rates (Rate Cohorts 302, 312, 322) for services including, but not limited to, specialty pharmacy treatment cost for Hepatitis C.

6.5.3.1.6 During the term of this Agreement, HSD reserves the right to modify the structure, type or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least ninety (90) days prior to the effective date change.

6.5.3.2 Self-Directed

6.5.3.2.1 The Capitation Rates for Self-Directed Community Benefit Members include acute and Self-Directed Community Benefit services outlined in Attachment 2 (Covered Services). Self-Directed Community Benefit Capitation Rates are identified by Rate Cohort 301 for Dual Eligible Members and Rate Cohort 303 for Medicaid only Members.

6.5.3.2.2 The Self-Directed Community Benefit component of the Capitation Rate is based on the projected annual Self-Directed Community Benefit budget and historical budget utilization for Members enrolled with the CONTRACTOR. On an annual basis, HSD shall evaluate the Self-Directed Community Benefit component for Members enrolled with the CONTRACTOR, their annual budgets and budget utilization to develop a prospective Long-Term

Care service cost. The aggregate of the Self-Directed Community Benefit component for all Members enrolled with the CONTRACTOR will be the basis for the Self-Directed Community Benefit component of the Self-Directed Community Benefit Rate Cohorts.

6.5.3.2.3 HSD, at its discretion, may reevaluate the annual budget amounts and budget utilization for Members enrolled with the CONTRACTOR any time during the term of this Agreement. If HSD determines an adjustment to the Capitation Rate is necessary, HSD shall adjust the Self-Directed Community Benefit Capitation Rates on a prospective basis only.

6.5.3.2.4 HSD may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the Medicaid only Self-Directed Community Benefit (Rate Cohort 303) for Covered Services including, but not limited to, specialty pharmacy treatment cost for Hepatitis C.

6.5.3.2.5 During the term of this Agreement, HSD reserves the right to modify the structure, type or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least ninety (90) days prior to the effective date change.

6.5.3.3 Healthy Dual

6.5.3.3.1 The Healthy Dual Capitation Rate includes Covered Services outlined in Attachment 2. Medicare is the primary payer for Medicare Covered Services. The Capitation Rate includes Medicaid liability for Medicare deductible and co-insurance and any Medicaid Covered Services outlined in Attachment 2 that are not covered by Medicare. The Healthy Dual Rate Cohort is 304.

6.5.3.3.2 During the term of this Agreement, the CONTRACTOR may determine that a Member meets the NF LOC and may transition the Member into a Nursing Facility or the Agency-Based Community Benefit. If the CONTRACTOR determines the effective date for the NF LOC after the first day of the month and prior to the last five (5) Business Days of the month, the Healthy Dual

Capitation Payment for the month remains in effect. HSD will change the Capitation Payment to the applicable blended Rate Cohort the month following the effective date of the NF LOC.

6.5.4 Behavioral Health

6.5.4.1 The Behavioral Health Capitation Rates include all populations (physical health, LTSS and Other Adult Group) for Covered Services identified in Attachment 2. Behavioral Health Capitation Rates are represented by Rate Cohorts 201 through 208.

6.5.4.2 The CONTRACTOR shall ensure that all of the funding, through the Capitation Payments, is made available for Behavioral Health services.

6.5.4.3 Behavioral Health Capitation Rates are not subject to risk adjustment outlined in Section 6.5.5.

6.5.4.4 HSD shall adjust the CONTRACTOR's Behavioral Health Capitation Rates to reflect the CareLink NM Health Home PMPM payment for Members who enroll in the CareLink NM Health Home. Capitation Rate adjustments will occur quarterly and include a reconciliation of the prior quarter's assumed enrollment with actual enrollment, as well as an estimated enrollment and impact on the Capitation Rate for the prospective quarter.

6.5.4.5 HSD shall provide the CONTRACTOR with documentation supporting the prior quarter reconciliation and future period estimates.

6.5.5 Risk Adjustment to Capitation Rates

6.5.5.1 HSD develops risk-adjusted Capitation Rates for the Physical Health and Other Adult Group as outlined in Sections 6.5.1 and 6.5.2. Add-on PMPMs described in Sections 6.5.1.3 and 6.5.2.3 are excluded from risk adjustment.

6.5.5.2 The risk-adjusted rate model shall meet the requirements of the CMS Medicaid Managed Care Final Rule and follow guidance established by the Actuarial Standards of Practice.

6.5.5.3 HSD will use medical and pharmacy Encounter Data submitted by the CONTRACTOR to develop risk-adjusted results. The CONTRACTOR is responsible for submitting timely, accurate and complete Encounter data.

6.5.5.4 As part of annual Capitation Rate determination or reevaluation, HSD will provide the CONTRACTOR the risk-adjusted rate methodology, the raw risk scores for the Members enrolled with the CONTRACTOR, prevalence tables and risk-adjusted rate scores.

6.5.5.5 HSD, at its discretion, may reevaluate the CONTRACTOR'S enrollment used to develop the risk scores at any time during this Agreement and may modify risk-adjusted Capitation Rates on a prospective basis.

6.5.5.6 HSD reserves the right to modify the risk-adjusted rate model / methodology during the term of this Agreement.

6.5.5.7 HSD reserves the right to modify the populations covered under risk adjustment payment rates during the term of this Agreement.

6.5.5.8 HSD will notify the CONTRACTOR of any changes to the risk-adjusted rate model / methodology or populations included in the risk adjustment at least three (3) months before the effective date of the change.

6.5.5.9 Following CMS guidelines, HSD will apply the risk-adjusted rate methodology in a budget neutral manner. In the case in which a material change must be made to the risk-adjusted rate results, prospectively or retrospectively, the Capitation Rates paid to the CONTRACTOR will be adjusted on a budget neutral basis.

6.6 **Capitation Rates Adjustments**

6.6.1 The Capitation Rates awarded with this Agreement shall be effective for the term of this Agreement and not subject to renegotiation during the Contract period. HSD may, at its option, review the Capitation Rates to determine if an adjustment is needed for reasons including, but not limited to, the following:

- 1115(a) Waiver changes;
- New or amended federal or State statutes or regulations are implemented;
- Judicial decisions;
- Program changes;
- Legislative changes; and
- Actuarial assumptions, including those described in Section 6.5.

The CONTRACTOR is responsible to notify HSD of program and/or expenditure changes initiated by the CONTRACTOR during the contract period that may result in material changes to the current or future expenses for the CONTRACTOR. These may include but are not limited to Contract Provider terminations.

6.6.2 In the event that HSD initiates change affecting Capitated Rates and Capitation Payments for managed care during the term of this Agreement, HSD 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 unless otherwise specifically defined.

6.6.2.1 Upon notice of a change affecting Capitation Rates, the CONTRACTOR may initiate discussions for a modification of the Agreement concerning changes in Capitation Rates. Such changes and any resulting discussions and modifications shall be limited to the change in Capitation Rates for managed care and program changes and shall not subject the entire contract to being reopened.

6.6.2.2 If the CONTRACTOR does not request discussion for a modification of the Agreement concerning the change in Capitation Rates within fifteen (15) Calendar Days of the notice from HSD, then the change shall be implemented and become effective, subject to the continued Actuarial Soundness of the Capitation Rates.

6.6.3 Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the CONTRACTOR must do no work on that part after the effective date of the loss of program authority. The state must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the CONTRACTOR works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the CONTRACTOR will not be paid for that work. If the state paid the CONTRACTOR in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to

be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the CONTRACTOR worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the CONTRACTOR, the CONTRACTOR may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.7 **Centennial Rewards Annual Evaluation**

On an annual basis, HSD shall evaluate the actual cost of the Centennial Rewards program versus the amount assumed in the Capitation Rates. In the event that actual costs are significantly lower or higher than included in the Capitation Rates, HSD may recoup or adjust payment accordingly.

6.8 **Retroactive Period Reconciliation**

6.8.1 Retroactive Period means the time between the notification date by HSD to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR, but the eligibility date is effective before the CONTRACTOR is notified of enrollment. The retroactive period includes instances where the CONTRACTOR is notified by HSD that the Member is enrolled after the first day of the month for the current or prior months. The retroactive period does not include newborns as described in the enrollment Section of this Agreement. The Retroactive Period includes the full month in which enrollment notification is received by the CONTRACTOR. The retroactive period does not include (1) newborn cohorts identified as Rate Cohorts 001 and 006 and also described in the enrollment Section of this Agreement; and (2) Members who are established with the CONTRACTOR and whose subsequent disenrollment and retroactive reenrollment result in no gap in coverage by the CONTRACTOR.

6.8.2 The CONTRACTOR is required to reimburse Providers for the medical expenses incurred by the Member during the Retroactive Period. The duration and expenditures

associated with the Retroactive Period may fluctuate for each Member and are not considered in the development of the prospective Capitation Rates.

6.8.3 HSD shall reconcile the difference between the Covered Service expenses incurred by the CONTRACTOR during the Retroactive Period supported by accepted Encounter data and the payment made by HSD to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2.8.2.

6.8.4 HSD shall reconcile the medical care credit amounts at least annually or more frequently at HSD's discretion during the term of this Agreement. The result of the reconciliation may result in recoupment from or payment to the CONTRACTOR. The reconciliation process is outlined in Attachment 7.

6.9 **Medical Care Credit Reconciliation**

6.9.1 Capitation Rates for the LTSS blended Rate Cohorts are "net" of medical care credit as outlined in Section 6.5.3.1.4.

6.9.2 The CONTRACTOR shall delegate the collection of medical care credit to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable medical care credit amount.

6.9.3 The CONTRACTOR shall submit, via Encounter data submission, medical care credit information associated with Claim payments.

6.9.4 HSD shall reconcile the difference between the actual amount of medical care credit of the Members enrolled with the CONTRACTOR and the amounts assumed in the Capitated Rates.

6.9.5 HSD shall reconcile the medical care credit amounts at least annually, or more frequently at HSD's discretion, during the term of this Agreement. The result of the reconciliation may result in recoupment from or payment to the CONTRACTOR. The reconciliation process is outlined in Attachment 7.

6.10 **Community Benefit Reconciliation**

6.10.1 RESERVED

6.10.2 The CONTRACTOR shall adhere to the NF LOC and Setting of Care timelines outlined in the Systems Manual.

6.10.3 HSD will not retroactively adjust payments from physical health or healthy dual Rate Cohort to a LTC Rate Cohort. It is the CONTRACTOR's responsibility to ensure timely submission of correct Setting of Care for the Member. Notwithstanding the foregoing, if the CONTRACTOR has made good faith efforts to complete the CNA and the CONTRACTOR demonstrates through Encounter Data that it has continued to provide the LTC benefits after expiration of the NF LOC determination, then retroactive payment adjustments to the appropriate LTC Cohort may be made.

6.11 **Hepatitis C Drug Reconciliation**

6.11.1 The CONTRACTOR receives an add-on PMPM payment by Rate Cohort, outlined in Section 6.5, in the Capitated Rates for assumed utilization and cost associated with specialty drug treatment for Hepatitis C. The utilization, cost and the number of Members by cohort assumed to seek treatment is communicated to the CONTRACTOR annually and included in the rate signature sheets.

6.11.2 HSD and the CONTRACTOR shall reconcile the difference between the pharmacy expenses for FDA-approved specialty drugs utilized for the treatment of Hepatitis C incurred by the CONTRACTOR and the value included in the Capitation Rates.

6.11.3 The process for the Hepatitis C reconciliation is outlined in Attachment 7, and the specialty drug list, as part of the reconciliation, will be provided to each CONTRACTOR by HSD.

6.11.4 The CONTRACTOR is requested to provide HSD with the effective date and value of any supplemental rebates or discounts received from the manufacturers or through the CONTRACTORS pharmacy benefit manager for Hepatitis C specialty medications.

6.11.4.1 In the event that the CONTRACTOR produces information the CONTRACTOR wants HSD to treat as confidential, in response to 6.11.4, the CONTRACTOR shall clearly mark such information as confidential. HSD shall, to the extent

consistent with the State and federal laws and regulations including, but not limited to, NMSA 14-2-1, hold such information in a confidential manner.

6.11.5 If the CONTRACTOR cannot provide, or refuses to provide, the information outlined in Section 6.11.4, then the CONTRACTOR accepts that HSD will utilize an assumed supplemental rebate or discount amount to reduce the reported payment in the Encounter Data for purposes of the reconciliation.

6.11.6 HSD shall reconcile the Hepatitis C drug amounts at least annually, or more frequently at HSD's discretion during the term of this Agreement. The result of the reconciliation may result in recoupment from or payment to the CONTRACTOR. The reconciliation process is outlined in Attachment 7.

6.12 **Delivery System Improvement Performance Targets (DSIPTs)**

6.12.1 HSD shall impose performance penalties of one-and-a-half percent (1.5%), net of premium taxes, New Mexico Medical Insurance Pool assessments and New Mexico Health Insurance Exchange assessments, of HSD's Capitation Payments, including one-time lump sum payments if DSIPTs are not met. Capitation Payments are based on the full capitation cycle which, generally, runs the first Monday after the first Friday of each month throughout the term of the Agreement.

6.12.2 The DSIPTs are outlined in Attachment 3.

6.12.3 The CONTRACTOR's DSIPTs will be evaluated following the performance target period and necessary time for claims runout; results shall be provided by HSD to the CONTRACTOR after the evaluation period. The evaluation shall be calculated by summing all earned points, dividing the sum by one hundred (100) points and converting to a percentage (performance penalty percentage). Points will only be awarded if the CONTRACTOR meets the performance targets as prescribed in Attachment 3 and 3.A.

6.12.4 If the CONTRACTOR does not meet the DSIPTs, the CONTRACTOR may propose that the performance penalty amounts be spent on system improvement activities for provider network development and enhancement activities that will directly benefit Members. The CONTRACTOR shall submit proposals to HSD for approval within

forty-five (45) Calendar Days of notification of HSD's determination that the DSIPT(s) were not met.

7 Terms and Conditions

7.1 Limitation of Cost

In no event shall Capitation Payment 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 HSD pay twice for the provision of services.

7.2 Underwriting Gain Limitation and Medical Loss Ratio

7.2.1 The CONTRACTOR is permitted to retain one-hundred percent (100%) of any underwriting gain generated under this Agreement up to three percent (3.0%) of net capitation revenue generated annually as defined in Section 7.2.2 of this Agreement. The CONTRACTOR shall share fifty percent (50%) of any underwriting gain generated in excess of three percent (3.0%) with HSD. HSD shall measure the annual underwriting gain based on the Medicaid Financial Reporting Package. The measurement will be performed as outlined in Section 7.2.2 of this Agreement.

7.2.2 For purposes of this Section, “underwriting gain” is defined as the net income before State and federal taxes for the Medicaid line of business on an annual basis. Penalties related to the Delivery System Improvement Performance Targets and other monetary damages will not be considered reductions to revenue and/or countable expenses in the calculation of the limitation on underwriting gain.

7.2.2.1 Medicaid line of business Net Capitation Revenue:
Prospective capitation premium, excluding IHS supplemental revenue, less Premium Tax, less NMMIP and HIX Assessments during the annual period.

7.2.2.2 Medicaid line of business Total Medical Expense:
Medical Expense (net of reinsurance and TPL post payment recoveries) incurred during the annual period, less IHS expenditures and less expenses for Care

Coordination services deemed to be administrative per Section 7.2.8.6 of this Agreement.

7.2.2.2.1 In Lieu of Services or Settings:

In Lieu of Services or Settings may be considered a Medical Expense if approval has been received by the CONTRACTOR from HSD, in accordance with Contract Section 4.5.14. In Lieu of Services or Settings are alternative services, or services in settings that are not Centennial Care Covered Services as set forth in Attachment 2, but are medically appropriate and cost-effective substitutes. However, the CONTRACTOR may not require a Member to use In Lieu of Services or Settings arrangements as a substitute for Centennial Care Covered Services but may offer and cover such services or settings, if approved by HSD, as a means of ensuring that appropriate care is provided in a cost-effective manner.

7.2.2.3 Medicaid Administration:

Administrative expense (outlined in Section 7.2.7 of this Agreement) incurred during the annual period including expenses for Care Coordination services deemed to be administrative per Section 7.2.8.6 of this Agreement less Premium Tax less NMMIP and HIX Assessments during the annual period.

7.2.2.4 Underwriting Gain:

Net Capitation Revenue less Medicaid line of business Total Net Medical Expense less Administrative expenses, equals underwriting gain.

7.2.3 HSD has established the underwriting gain limit and sharing outlined in Section 7.2.1 of this Agreement; however, HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

7.2.4 HSD will utilize the annual Medicaid Financial Reporting Package following the close of the calendar year to calculate the underwriting gain. If underwriting gain in excess of three percent (3.0%) is realized, HSD will recoup the amount for the excess underwriting gain share outlined in Section 7.2.1 of this Agreement.

7.2.5 HSD reserves the right to examine the allocation methodologies utilized for any non-direct expenditure by the CONTRACTOR as it relates to any expenditure including, but not limited to, administrative expense.

7.2.6 HSD reserves the right to modify the measurement of underwriting gain based on review of allocation methodologies.

7.2.7 Administrative Expense Reporting

7.2.7.1 Determinations shall be made using the following list as administrative expenses and/or costs; all other expenses shall be considered paid for by the CONTRACTOR for direct services to Medicaid Members. Administrative expenses and/or costs do not include premium tax and the NMMIP and HIX assessments, which are neither administrative nor direct medical expenses. The following are considered administrative expenses and/or costs:

7.2.7.1.1 Network development and contracting;

7.2.7.1.2 Direct provider contracting;

7.2.7.1.3 Credentialing and re-credentialing;

7.2.7.1.4 Information systems;

7.2.7.1.5 Health Information Technology;

7.2.7.1.6 Health Information Exchange;

7.2.7.1.7 Encounter Data collection and submission;

7.2.7.1.8 Claims processing for select CONTRACTORS;

7.2.7.1.9 Member Advisory Board and Native American Advisory Board meetings;

7.2.7.1.10 Member services;

7.2.7.1.11 Training and education for Providers and Members;

7.2.7.1.12 Financial reporting;

7.2.7.1.13 Licenses;

7.2.7.1.14 Taxes, excluding premium tax, NMMIP and HIX assessments and PPACA-related insurer fees;

7.2.7.1.15 Plant expenses;

7.2.7.1.16 Staff travel;

7.2.7.1.17 Legal and risk management;

7.2.7.1.18 Recruiting and staff training;

7.2.7.1.19 Salaries and benefits to MCO staff;

7.2.7.1.20 Non-medical supplies;

7.2.7.1.21 Purchased service, non-medical, excluding Member and attendant travel, meals and lodging costs, reinsurance expense and risks delegated to third parties with HSD's approval;

7.2.7.1.22 Depreciation and amortization;

7.2.7.1.23 Audits;

7.2.7.1.24 Grievances and Appeal System;

7.2.7.1.25 Capital outlay;

7.2.7.1.26 Reporting and data requirements;

7.2.7.1.27 Compliance;

7.2.7.1.28 Surveys;

7.2.7.1.29 Quality assurance;

7.2.7.1.30 Quality improvement/quality management;

7.2.7.1.31 Marketing;

7.2.7.1.32 Damages/penalties;

7.2.7.1.33 Project ECHO multi-disciplinary team;

7.2.7.1.34 Electronic Visit Verification (EVV);

7.2.7.1.35 Housing Specialist;

7.2.7.1.36 Justice-Involved Liaison;

7.2.7.1.37 Member Incentives (Non-Incentive costs); and

7.2.7.1.38 Administrative Fee Paid to the CONTRACTOR'S Pharmacy Benefit Manager.

7.2.7.2 The CONTRACTOR shall submit a detailed explanation of administrative agreements with parent organizations on an annual basis in a template to be prescribed by HSD that may include, but is not limited to, allocation methodology, full-time equivalents, salary, benefits and general administrative overhead.

7.2.8 Care Coordination Expenses

7.2.8.1 The CONTRACTOR shall provide Care Coordination services in accordance with Section 4.4 of this Agreement.

7.2.8.2 For purposes of this Agreement, the following Care Coordination functions will be deemed medical services:

7.2.8.2.1 Comprehensive Needs Assessment;

7.2.8.2.2 Face-to-face meetings between the care coordinator and the Member;

7.2.8.2.3 Telephonic meetings between the care coordinator and the Member;

7.2.8.2.4 Case management;

7.2.8.2.5 Discharge consultation;

7.2.8.2.6 CCP development and updates;

7.2.8.2.7 Health Education provided to the Member;

7.2.8.2.8 Disease management provided to the Member; and

7.2.8.2.9 Costs associated with Community Health Workers.

7.2.8.3 The CONTRACTOR shall submit Member Care Coordination activities through Encounter Data.

7.2.8.4 For purposes of this Agreement, the following Care Coordination functions will be deemed administrative services:

7.2.8.4.1 Health Risk Assessments (HRAs);

7.2.8.4.2 Data runs;

7.2.8.4.3 Referrals; and

7.2.8.4.4 Case assignation and scheduling.

7.2.9 HSD shall issue its final calculation, in writing, within one-hundred-eighty (180) Calendar Days after the close of the calendar year or termination of this Agreement. To the extent that the CONTRACTOR fails to meet the requirements set forth herein, HSD shall, at the time it issues its final calculation, advise the CONTRACTOR of this deficiency and require the CONTRACTOR to remit the overpayment to HSD, or its designee, or otherwise advise the CONTRACTOR as to how the overpayment shall be treated for purposes of compliance with this Section. If the CONTRACTOR disputes HSD's final calculation, it must advise HSD 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's receipt of the CONTRACTOR's dispute. If the Parties cannot informally resolve the matter, the CONTRACTOR may exercise its rights under Section 7.11 of this Agreement.

7.2.10 Medical Expense Ratio

The CONTRACTOR shall spend no less than eighty-six percent (86%) of net Medicaid line of business Net Capitation Revenue on direct medical expenses on an annual basis. HSD reserves the right, in accordance with and subject to the terms of this Agreement, to reduce or increase the minimum allowable for direct medical services over the term of this Agreement provided that any such change: (i) shall only apply prospectively; (ii) shall exclude any retroactive increase to allowable direct medical services; and (iii) shall comply with federal and State law. The medical loss ratio calculation and definitions for its calculation are separate from the underwriting gain limitation outlined in Section 7.2.1-7.2.2.4.

7.2.10.1 For the purposes of this requirement, the medical loss ratio calculation standards shall be consistent with 42 C.F.R. § 438.8. The CONTRACTOR shall submit annually to HSD a medical loss ratio (MLR) report in the specified format, as required by HSD. This report shall be consistent with the requirements in 42 CFR 438.3(m) and will include, for each reporting year, taxes, licensing and regulatory fees, and a comparison of the information reported with the CONTRACTOR'S audited financial reports, specific to the Medicaid contract. Key components of the medical loss ratio calculation are outlined below:

7.2.10.1.1 Numerator: Sum of the CONTRACTOR's incurred Claims, activities that improve health care quality and fraud prevention activities. The expenditures for fraud prevention activities will not be included in the numerator until CMS adopts a standard for the private market at 45 C.F.R. § 158.

7.2.10.1.2 Denominator: The adjusted premium revenue, which is premium revenue less the CONTRACTOR's federal, state, local taxes and licensing and regulatory fees.

7.2.10.1.3 Aggregation Method: The CONTRACTOR shall calculate the medical loss ratio for the medical loss ratio contract period for Other Adult Group and Non-Other Adult Group populations.

7.2.10.1.4 Credibility Adjustment: A credibility adjustment factor will be applied to the CONTRACTOR's medical loss ratio if experience is deemed to be partially credible. The credibility adjustment factors and standards for credibility will be published by CMS for the medical loss ratio reporting year. In the event that CMS has not issued Medicaid credibility adjustment factors for the applicable medical loss ratio reporting year, the CONTRACTOR will apply the credibility adjustment factors issued by CMS for the private market.

7.2.10.2 The CONTRACTOR shall submit its medical loss ratio calculation report by the last Business Day in July following the contract year. HSD will notify the CONTRACTOR if it disputes the information and the CONTRACTOR shall work timely and collaboratively with HSD to resolve the matter.

7.3 **Failure to Meet Agreement Requirements**

7.3.1 General

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent, Subcontractor, or Major Subcontractor, fails to comply with this Agreement, HSD may impose, at HSD's discretion sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3.

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as administrative expenses subject to Section 7.2.8 of this Agreement.

7.3.1.3 HSD retains the right to apply progressively strict sanctions against the CONTRACTOR, for failure to perform in any of the Agreement areas.

7.3.1.4 Any sanction, including the withholding of Capitation Payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.

7.3.1.5 HSD may impose any other administrative, contractual or legal remedies available under federal or State law for the CONTRACTOR's noncompliance under this Agreement.

7.3.1.6 HSD will give the Collaborative written notice whenever it imposes or lifts a sanction for one of the violations listed herein that relates to Behavioral Health.

7.3.1.7 HSD 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) Calendar Days after HSD imposes or lifts a sanction and must specify the affected CONTRACTOR, the kind of sanction and the reason for HSD's decision to impose or lift the sanction.

7.3.1.8 HSD at its discretion may direct the CONTRACTOR to expend any portion of monetary penalties for provider network development and enhancement activities that will directly benefit Medicaid beneficiaries.

7.3.2 Corrective Action Plans

7.3.2.1 If HSD determines that the CONTRACTOR is not in compliance with one or more requirements in this Agreement, HSD may issue a notice of deficiency, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HSD Directed Corrective Action Plan (DCAP)). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that sanctions are also necessary.

7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.

7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HSD within fourteen (14) Calendar Days of receipt of a noncompliance notice from HSD. CAPs are subject to review and approval by HSD.

7.3.2.4 If HSD imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days to respond to HSD.

7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the time frame specified in the CAP/DCAP, HSD may impose additional sanctions.

7.3.2.6 If HSD staff is required to spend ten (10) hours or more per week monitoring a CAP(s) or DCAP(s), HSD will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party, either designated by HSD or approved by HSD, to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

7.3.3 Sanctions

7.3.3.1 HSD may impose any or all of the non-monetary sanctions and monetary penalties based on determination of noncompliance as described in this Section to the extent authorized by federal and State law. Nothing in this Section prohibits HSD from imposing additional sanctions under State law that address areas of non-compliance specified in Section 7.3.3.2, as well as additional areas of non-compliance.

7.3.3.2 Federal Basis for imposition of sanctions

HSD may impose non-monetary or monetary intermediate sanctions as specified in Sections 7.3.3.3, 7.3.3.4 and 7.3.3.5, if HSD determines the CONTRACTOR acted or failed to act in the following ways.

7.3.3.2.1 Fails substantially to provide Medically Necessary services that the CONTRACTOR is required to provide, under law or under this Agreement, to a Member covered under the Agreement.

7.3.3.2.2 Imposes and/or collect Member’s premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

7.3.3.2.3 Acts to discriminate among Members on the basis of their health status or need for Covered Services. This includes CONTRACTOR-initiated transfers or refusal to re-enroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future Covered Services.

7.3.3.2.4 Misrepresents or falsifies information that it furnishes to CMS or to the State.

7.3.3.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member or provider.

7.3.3.2.6 Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210.

7.3.3.2.7 Distributes, directly or indirectly, through any Major Subcontractor, Subcontractor, or Contract Provider, Marketing or Member Materials that have not been approved by the State or that contain false or materially misleading information.

7.3.3.2.8 Violates any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations.

7.3.3.3 Non-monetary intermediate sanctions may include:

7.3.3.3.1 For determinations made under Section 7.3.3.2.8, suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.3.2 For determinations made under Section 7.3.3.2.8, suspension of new enrollment with the CONTRACTOR;

7.3.3.3.3 For determinations made under Section 7.3.3.2.8, notification to Members of their right to terminate enrollment with the CONTRACTOR, without cause, as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.3.4 Disenrollment of Members by HSD;

7.3.3.3.5 For determinations made under Section 7.3.3.2.8, suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HSD is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.3.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.3.7 Appointment of temporary management or any portion thereof for an MCO as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.3.8 Additional sanctions permitted under federal or State statute or regulations that address areas of noncompliance.

7.3.3.4 Termination of the MCO Agreement

HSD may terminate the Agreement per Section 7.6 and enroll the CONTRACTOR's Members in other MCOs or provide their Covered Services through other options in the State plan, if HSD determines that the CONTRACTOR has failed to carry out the substantive terms of the Agreement or has failed to meet applicable requirements of Section 1932 or 1903(m) of the Social Security Act. Prior to termination of the Agreement, HSD will provide a pre-termination hearing in accordance with 42 C.F.R. § 438.710.

7.3.3.5 Civil Monetary Penalties, as provided in 42 C.F.R. § 438.702(a), may be assessed as follows:

7.3.3.5.1 $25,000 for each determination under Sections 7.3.3.2.1, 7.3.3.2.5, 7.3.3.2.6, or 7.3.3.2.7;

7.3.3.5.2 $100,000 for each determination under Sections 7.3.3.2.3 or 7.3.3.2.4;

7.3.3.5.3 $15,000 for each Member, HSD determines was not enrolled because of a discriminatory practice under Section 7.3.3.2.3; and

7.3.3.5.4 $25,000 or double the amount of the excess charges, whichever is greater, for determinations under Section 7.3.3.2.2. HSD will deduct the amount of the overcharge from the penalty and return the overcharge amount to the Member.

7.3.3.6 Other Monetary penalties may include:

7.3.3.6.1 Actual damages incurred by HSD and/or Members resulting from the CONTRACTOR' s non-performance of obligations under this Agreement;

7.3.3.6.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties 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. HSD may

withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.6.3 When HSD determines the CONTRACTOR has a deficiency in a specific area that is not improving, HSD may take certain actions to include the provision of trainings, webinars and/or on-site technical assistance until the issue is resolved. Such actions may result in a fee of up to $5,000 per day. The CONTRACTOR will be required to provide a dedicated workspace during the time that HSD staff is on-site;

7.3.3.6.4 Monetary penalties for non-compliance of this Agreement that may potentially involve risk or harm to Members or the integrity of the Centennial Care program up to five percent (5%) of the CONTRACTOR's Medicaid Capitation Payment for each month in which the penalty is assessed;

7.3.3.6.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below; and

7.3.3.6.6 HSD reserves the right to assess a general monetary penalty of five-hundred dollars ($500) per occurrence with any notice of deficiency as outlined below:

7.3.3.6.7 Other Monetary Penalties

	PROGRAM ISSUES	PENALTY
1.	Failure to comply with Claims processing as described in Section 4.19 of this Agreement.	Two percent (2%) of the monthly Capitation Payment per month, for each month that the HSD determines that the CONTRACTOR is not in compliance with the requirements of Section 4.19 of this Agreement.
2.	Failure to comply with Encounter submission as described in Section 4.19 of this Agreement.	Monetary penalties up to two percent (2%) of the CONTRACTOR’s Medicaid Capitation Payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.

	PROGRAM ISSUES	PENALTY
3.	Failure to comply with the time frames for a Comprehensive Needs Assessment for Care Coordination level two (2) and level three (3).	$1,000 per Member in which the CONTRACTOR fails to comply with the time frames for that Member.
4.	Failure to complete or comply with CAPs/DCAPs.	0.12% of the monthly Capitation Payment per Calendar Day for each day the CAP/DCAP is not completed or complied with as required.
5.	Failure to obtain approval of Member Materials as required by Section 4.14.1 of this Agreement.	$5,000 per day for each Calendar Day that HSD determines the CONTRACTOR has provided Member Material that has not been approved by HSD. The $5,000 per day damage amounts will double every ten (10) Calendar days.
6.	Failure to comply with the time frame for responding to Grievances and Appeals required in Section 4.16 of this Agreement.	$1,000 per occurrence in which the CONTRACTOR fails to comply with the time frames.
7.	For every report that meets the definition for "Failure to Report" in accordance with Section 4.21 of this Agreement.	$5,000 per report, per occurrence. With the exception of the cure period: $1,000 per report, per Calendar Day. The $1,000 per day damage amounts will double every ten (10) Calendar days.
8.	Failure to submit timely Summary of Evidence in accordance with Section 4.16 of this Agreement.	$1,000 per occurrence.
9.	Failure to have legal counsel appear in accordance with Section 4.16 of this Agreement.	$10,000 per occurrence.
10.	Failure to meet targets for the performance measures described in Section 4.12.8 of this Agreement.	A monetary penalty based on two percent (2%) of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

	PROGRAM ISSUES	PENALTY
11.	HSD can modify and assess any monetary penalty if the CONTRACTOR engages in a pattern of behavior that constitutes a violation of this Agreement, or may potentially involve a risk of harm to Members or to the integrity of Centennial Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete Care Coordination activities by the time frames specified within this Agreement; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the CONTRACTOR up to three times and the report still meets the definition of for "Failure to Report" in accordance with Section 4.21 of this Agreement; etc.	Monetary penalties up to five percent (5.0%) of the CONTRACTOR's Medicaid Capitation Payment for each month in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity of the infraction, taking into consideration factors reasonably related to the nature and severity of the infraction.

7.3.4 Payment of Monetary Penalties

7.3.4.1 HSD shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly Capitation Payment. The collection of monetary penalties by HSD shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HSD will be immediately returned to the CONTRACTOR.

7.3.4.2 Monetary penalties as described in Section 7.3.4 of this Agreement are assessed by HSD to the CONTRACTOR and not to Major Subcontractors, Subcontractors, or Contract Providers. The CONTRACTOR shall be responsible to HSD for such monetary penalties.

7.3.5 Waiver of Sanctions

HSD may waive the application of sanctions (including monetary penalties) at its discretion if HSD determines that such waiver is in the best interests of the Centennial

Care program and its Members. Such waiver shall not constitute an ongoing waiver of sanctions or penalties.

7.3.6 Federal Sanctions

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

7.4 Agreement Term

7.4.1 This Agreement, including any amendments and any changes made by notice to adjust the capitation rates, shall be effective upon signature of all parties and will terminate on December 31, 2023. Thereafter, HSD reserves the right to renew this Agreement for an additional one-year period(s), not to exceed 8 years for the total contract period.

7.4.2 HSD reserves the right to extend this Agreement for an additional period or periods of time consistent with extensions of the 1115(a) Waiver; provided that HSD notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement will be made effective through an amendment to the Agreement.

At the option of HSD, the CONTRACTOR agrees to continue services under this Agreement when HSD determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this Section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) Calendar Days written notice shall be given by HSD before this option is exercised.

7.5 Applicable Laws and Regulations

CONTRACTOR agrees to comply with all applicable federal and State statutes, rules and regulations, policies, consent decrees, executive orders and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

7.5.1 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. 7401 et seq.);

7.5.2 Title IV and VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) as implemented by regulations at 45 C.F.R. § 80;

7.5.3 Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. § 84;

7.5.4 Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance, as implemented by regulations at 45 C.F.R. § 91;

7.5.5 Titles II and III of the Americans with Disabilities Act, 42 U.SC. 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R.s § 35 and § 36;

7.5.6 Title IX of the Education Amendments of 1972 regarding education programs and activities;

7.5.7 Equal Employment Opportunity (EEO) provisions;

7.5.8 Byrd Anti-Lobbying Amendment;

7.5.9 Indian Child Welfare Act (ICWA), 25 U.S.C. 1901 et seq., and the Indian Health Care Improvement Act;

7.5.10 Patient Protection and Affordable Care Act (PPACA);

7.5.11 New Mexico Human Rights Act (NMSA 1978, 28-1-1 et seq.);

7.5.12 The 1115(a) Waiver and all special terms and conditions agreed to with CMS that relate to the Waiver; and

7.5.13 Any and all consent decrees, court orders, legally binding agreements, federal program improvement plans and contracts related to Behavioral Health services entered into by the State.

7.6 **Termination**

In the event of termination, it is agreed that neither Party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the

course of this Agreement. For terminations pursuant to Sections 7.6.1, 7.6.2, 7.6.3, 7.6.4, or 7.6.6, HSD will assume responsibility for informing all affected Members of the reasons for their termination from the CONTRACTOR's MCO.

7.6.1 Termination Under Mutual Agreement

Under mutual agreement, HSD and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of HSD and the CONTRACTOR. Both Parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination and extent to which performance of work under this Agreement is terminated.

7.6.2 Termination by HSD for Cause

7.6.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

7.6.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

7.6.2.1.2 The CONTRACTOR renders only partial performance of any term or provision of the Agreement; or

7.6.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

7.6.2.2 For purposes of Section 7.6, Subsections 7.6.2.1.1 through 7.6.2.1.3 of this Agreement shall hereinafter be referred to as "Breach."

7.6.2.3 In the event of a Breach by the CONTRACTOR, HSD shall have available any one or more of the following remedies in addition to, or in lieu of, any other remedies set out in this Agreement or available in law or equity:

7.6.2.3.1 Recover actual damages, including incidental and consequential damages and any other remedy available at law or equity;

7.6.2.3.2 Require that the CONTRACTOR prepare a plan to correct the cited deficiencies immediately, unless some longer time is allowed by HSD and implement this plan;

7.6.2.3.3 Recover any and/or all liquidated damages provided in Section 7.3 of this Agreement; and

7.6.2.3.4 Declare a default and terminate this Agreement.

7.6.2.4 In the event of a conflict between any other Agreement provisions and Section 7.6.2.3 of this Agreement, Section 7.6.2.3 of this Agreement shall control.

7.6.2.5 In the event of Breach by the CONTRACTOR, HSD shall provide the CONTRACTOR written notice of the Breach and thirty (30) Calendar Days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then HSD shall have available any and all remedies described herein and available at law.

7.6.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

7.6.3 Termination for Unavailability of Funds

In the event that federal and/or State funds to finance this Agreement become unavailable, HSD may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date for uncompensated work performed on or after Go-Live. Availability of funds shall be determined solely by HSD. HSD's decision as to whether sufficient funds are available shall be accepted by the CONTRACTOR and shall be final.

7.6.4 Termination for CONTRACTOR Financial Inviability, Insolvency or Bankruptcy

7.6.4.1 If HSD reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services under this Agreement in the manner required by HSD, HSD may terminate this Agreement in whole or in part immediately or in stages. Said termination shall not be deemed a Breach by either Party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described in this Agreement in the manner required by HSD if the

CONTRACTOR cannot demonstrate to HSD's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 4.18.1 of this Agreement.

7.6.4.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a Subcontractor, Major Subcontractor or Provider or the insolvency of said Subcontractor, Major Subcontractor or Provider, the CONTRACTOR shall immediately advise HSD.

7.6.5 Termination by HSD for Convenience

HSD may terminate this Agreement for convenience and without cause upon one hundred eighty (180) Calendar Days written notice. Said termination shall not be a Breach of the Agreement by HSD, and HSD shall not be responsible to the CONTRACTOR or any other party for any costs, expenses or damages occasioned by said termination, e.g., without penalty.

7.6.6 Termination Related to the 1115(a) Waiver

7.6.6.1 The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of New Mexico by CMS. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement.

7.6.6.2 In the event that there is a required modification, change or interpretation in State or federal law or the 1115(a) Waiver terms, because of court order, HSD may terminate this Agreement.

7.6.6.3 A termination under Section 7.6.6 of this Agreement shall not be a breach of this Agreement by HSD, and HSD shall not be responsible to the CONTRACTOR or any other party for any costs, expenses or damages occasioned by said termination.

7.6.6.4 In the event of a conflict between this Section 7.6.6 of this Agreement and any other term in this Agreement, Section 7.6.6 of this Agreement shall control.

7.6.7 Termination by the CONTRACTOR

7.6.7.1 The CONTRACTOR may terminate this Agreement, on at least ninety (90) Calendar Days prior written notice, in the event HSD fails to pay any amount due the CONTRACTOR hereunder within thirty (30) Calendar Days of the date such payments are due.

7.6.8 Termination Procedures

7.6.8.1 The Party initiating the termination shall render written notice of termination to the other Party by certified mail, return receipt requested or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination and the date on which such termination shall become effective.

7.6.8.2 Upon termination or expiration, HSD shall pay the CONTRACTOR all amounts due for service from Go-Live through the effective date of such termination. HSD will withhold twenty-five percent (25%) of the full last monthly capitation cycle for the contract period plus the average of any penalties and recoupments/sanctions for the past two years. This withheld amount may also include any payments due from HSD to the CONTRACTOR for items subject to reconciliations, I/T/U payment reconciliation and the Health Insurer Provider Fee until all transition requirements are completed and approved by HSD. HSD may deduct from amounts otherwise payable to the CONTRACTOR monies determined to be due by HSD from the CONTRACTOR. Any amounts in dispute at the time of termination shall be placed by HSD in an interest-bearing escrow account with an escrow agent mutually agreed to by HSD and the CONTRACTOR.

7.6.8.3 Upon receipt of notice of termination, and subject to the provisions of this Section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

7.6.8.3.1 Not incur additional financial obligations for materials, services or facilities under this Agreement, without prior written approval of HSD;

7.6.8.3.2 Terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as HSD may direct for orderly completion and transition or as required to prevent the CONTRACTOR from being in breach of its existing contractual obligations;

7.6.8.3.3 At the point of termination, assign to HSD in the manner and extent directed by HSD all the rights, title and interest of the CONTRACTOR in the subcontracts, in which case, HSD shall have the right, in its discretion, to settle or pay any of the Claims arising out of the termination of such agreements and subcontracts;

7.6.8.3.4 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

7.6.8.3.5 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement that is in possession of the CONTRACTOR and in which HSD has or may acquire an interest;

7.6.8.3.6 In the event the Agreement is terminated by HSD, continue to serve or arrange for provision of services to the Members in the CONTRACTOR's MCO for up to forty-five (45) Calendar Days from the Agreement Termination Date or until the Members can be transferred to another MCO, whichever is longer. During this transition period, HSD shall continue to make payments as specified in Section 6 of this Agreement;

7.6.8.3.7 Promptly make available to HSD, or its designated entity, any and all records, whether medical, behavioral, related to LTC services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided, at no expense, to HSD or its designated entity;

7.6.8.3.8 Promptly supply all information necessary to HSD, or its designated entity, for reimbursement of any outstanding Claims at the time of termination;

7.6.8.3.9 HSD will provide a termination plan template to the CONTRACTOR. The CONTRACTOR's completed termination plan shall be submitted to HSD within thirty (30) Calendar Days of receipt, for HSD's review and written

approval . This plan shall, at a minimum, contain the provisions in Sections 7.6.8.3.10 through 7.6.8.3.16 below. The CONTRACTOR shall agree to make revisions to the plan, as necessary, in order to obtain approval by HSD. Failure to submit a termination plan and obtain written approval of the termination plan by HSD shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly Capitation Payment;

7.6.8.3.10 Agree to maintain Claims processing functions as necessary for a minimum of twenty-four (24) months in order to complete adjudication of all Claims;

7.6.8.3.11 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the Appeal process as described in Section 4.16.3 of this Agreement;

7.6.8.3.12 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

7.6.8.3.13 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of Members from coverage under this Agreement to coverage under any new arrangement developed by HSD;

7.6.8.3.14 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until HSD provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled;

7.6.8.3.15 The CONTRACTOR shall be responsible to HSD for liquidated damages arising out of the CONTRACTOR's breach of this Agreement; and

7.6.8.3.16 Upon expiration or termination of this Agreement, submit reports to HSD every thirty (30) Calendar Days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to HSD describing how the CONTRACTOR has completed its continuing obligations. HSD shall, within twenty (20)

Calendar Days of receipt of this report, advise, in writing, whether HSD agrees that the CONTRACTOR has fulfilled its continuing obligations. If HSD finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then HSD shall require the CONTRACTOR to submit a revised final report. HSD shall, in writing, notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of HSD that the CONTRACTOR has fulfilled its continuing obligations.

7.6.8.4 In the event that HSD terminates the Agreement for cause, in full or in part, HSD may procure services similar to those terminated and the CONTRACTOR shall be liable to HSD 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 HSD for administrative costs incurred by HSD in procuring such similar services. The rights and remedies of HSD 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.

7.6.8.5 Any payments advanced to the CONTRACTOR for coverage of Members for periods after the date of termination shall be promptly returned to HSD. If termination of this Agreement 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 HSD 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.

7.7 **Agreement Modification/Amendments**

7.7.1 Mutual Agreement

This Agreement may be amended at any time by mutual agreement of the Parties, except for rates, which may be amended in accordance with Section 6.6. The

amendment must be in writing and signed by individuals with authority to bind the Parties.

7.7.2 Changes in Law or Appropriation(s)

If federal or State statutes, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed or changes in federal or State appropriation(s) or other circumstances require a change in the way HSD manages its Medicaid program, this Agreement shall be subject to modification by amendment. Such election shall be effected by HSD sending written notice to the CONTRACTOR. HSD's decision as to the requirement for change in the scope of the Medicaid program shall be final and binding.

7.7.3 Modification Process

7.7.3.1 If HSD seeks modification to the Agreement, it shall provide notice to the CONTRACTOR that specifies those modifications, which may include the rates, or other terms and conditions.

7.7.3.2 The CONTRACTOR must respond to HSD's notice of proposed modification within ten (10) Business Days of receipt unless otherwise provided by HSD. If the CONTRACTOR fails to respond, HSD shall consider the proposed modification(s) acceptable to the CONTRACTOR and shall implement the proposed modification(s) as soon as practicable. Upon receipt of the CONTRACTOR's response to the proposed modifications, HSD may enter into negotiations with the CONTRACTOR to arrive at mutually agreeable amendments. In the event that HSD determines that the Parties will be unable to reach agreement on mutually satisfactory modifications, HSD will provide written notice to the CONTRACTOR of its intent to terminate this Agreement or not to extend the Agreement beyond the current term.

7.7.4 CMS Approval of the State's1115(a) Waiver

In the event that approval of the State's 1115(a) Waiver is contingent upon amendment of this Agreement, the CONTRACTOR agrees to make any necessary amendments to obtain such waiver approval, provided, however, that the CONTRACTOR shall not be required to agree whether the modification is a

substantial change to the business arrangement anticipated by the CONTRACTOR in executing this Agreement. Failure of the Parties to agree upon Capitation 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 of providing the Covered Services herein that is caused by CMS in granting the waiver shall be negotiated and mutually agreed to between the Parties. The results of the negotiation shall be made in writing and incorporated into this Agreement.

7.7.5 CMS Approval of Amendments

Amendments, modifications and changes to this Agreement are subject to the approval of CMS.

7.7.6 Required Compliance with Amendment and Modification Procedures

No different or additional services, work or products will be authorized or performed except as authorized by this Section. No waiver of any term, covenant or condition of this Agreement will be valid unless executed in compliance with this Section. The CONTRACTOR will not be entitled to payments for any services, work or products that are not authorized by a properly executed amendment or modification.

7.8 Intellectual Property and Copyright

7.8.1 Infringement and Misappropriation

7.8.1.1 The CONTRACTOR warrants that all materials provided by the CONTRACTOR will not infringe or misappropriate any right of, and will be free of any Claim of, any third person or entity based on copyright, patent, trade secret or other intellectual property rights.

7.8.1.2 The CONTRACTOR will, at its expense, defend with counsel approved by HSD, indemnify and hold harmless HSD, its employees, officers, directors, CONTRACTORS and agents from and against any losses, liabilities, damages, penalties, costs and fees from any Claim or action against HSD that is based on a Claim of breach of the warranty set forth in Section 7.8.1.1 of this Agreement. HSD will promptly notify the CONTRACTOR, in writing, of the Claim, provide

the CONTRACTOR a copy of all information received by HSD with respect to the Claim and cooperate with the CONTRACTOR in defending or settling the Claim. HSD will not unreasonably withhold, delay or condition approval of counsel selected by the CONTRACTOR.

7.8.1.3 If materials are held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted, or if a proceeding appears to the CONTRACTOR to be likely to be brought, the CONTRACTOR will, at its own expense, either:

7.8.1.3.1 Procure for HSD the right to continue using the materials; or

7.8.1.3.2 Modify or replace the materials to comply with this Agreement and to not violate any intellectual property rights.

7.8.2 Exceptions

7.8.2.1 The CONTRACTOR is not responsible for any Claimed breaches of the warranties set forth in Section 7.8.1, above, to the extent caused by:

7.8.2.1.1 Modifications made to the item in question by anyone other than the CONTRACTOR or its Subcontractors, or modifications made by HSD or its CONTRACTORS working at HSD's direction or in accordance with the specifications;

7.8.2.1.2 The combination, operation or use of the item with other terms if the CONTRACTOR did not supply or approve for use with the item; or

7.8.2.1.3 HSD's failure to use any new or corrected versions of the item made available by the CONTRACTOR.

7.8.3 Ownership and Licenses

7.8.3.1 The Parties agree that any materials, including, without limitation, the Custom Software developed by the CONTRACTOR for the State, will be the exclusive property of HSD.

7.8.3.2 HSD will own all right, title and interest in and to its Confidential Information and the materials provided by the CONTRACTOR, including without limitation the Custom Software and associated documentation. For purposes of this Section, the materials will not include the CONTRACTOR's Proprietary Software or

Third Party Software. The CONTRACTOR will take all actions necessary and transfer ownership of the materials to HSD, including, without limitation, the Custom Software and associated documentation prior to the termination of this Agreement.

7.8.3.3 The CONTRACTOR will furnish such material, upon request of HSD, in accordance with applicable State law. All materials, in whole and in part, will be deemed works made for hire of HSD for all purposes of copyright law, and the copyright will belong solely to HSD. To the extent that any materials do not qualify as a work made for hire under applicable law, and to the extent that the materials include items subject to copyright, patent, trade secret or other proprietary right protection, the CONTRACTOR agrees to assign, and hereby assigns, all right, title and interest in and to the materials, including, without limitation, all copyrights, inventions, patents, trade secrets and other proprietary rights therein (including renewals thereof) to HSD.

7.8.3.4 The CONTRACTOR will, at HSD's expense, assist HSD or its nominee to obtain copyrights, trademarks or patents for all such materials in the United States and any other countries. The CONTRACTOR agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign copyrights and patents, and to transfer, or cause to transfer, to HSD all the right, title and interest in and to such materials. The CONTRACTOR also agrees not to assert any moral rights under applicable copyright law with regard to such materials.

7.8.3.5 License Rights

HSD will have a royalty-free and non-exclusive license to access the CONTRACTOR's Proprietary Software and associated documentation during the term of this Agreement. HSD will also have ownership and unlimited rights to use, disclose, duplicate or publish all information and data developed, derived, documented or furnished by the CONTRACTOR under or resulting from this Agreement. Such data will include all results, technical information and materials developed for and/or obtained by HSD from the CONTRACTOR in the

performance of the services hereunder, including but not limited to, all reports, surveys, plans, charts, recordings (video and/or audio), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda and documents (whether finished or unfinished) that result from, or are prepared in conjunction with, this Agreement.

7.8.3.6 Proprietary Notices

The CONTRACTOR will reproduce and include HSD's copyright and other proprietary notices and product identifications provided by the CONTRACTOR on such copies, in whole or in part, or on any form of the materials.

7.8.3.7 State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate State and federal agencies will have a royalty-free, nonexclusive and irrevocable license to reproduce, publish, translate or otherwise use, and to authorize others to use, for federal government purposes, all materials, the Custom Software and modifications thereof, and associated documentation designed, developed or installed with federal financial participation under this Agreement, including but not limited to those materials covered by copyright, all software source and object code, instructions, files and documentation.

7.9 **Appropriations**

7.9.1 The terms of this Agreement are contingent upon sufficient appropriations or authorizations being made by the New Mexico Legislature, CMS or the U.S. Congress for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the New Mexico Legislature, CMS or the U.S. Congress, this Agreement shall be subject to termination or amendment. Subject to the provisions of Section 7.9 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 the CONTRACTOR affected pursuant to this Section 7.9 shall be negotiated, reduced to writing and signed by the Parties in accordance with Section

7.7 of this Agreement and any other applicable State or federal statutes, rules or regulations.

7.9.2 To the extent CMS, legislation or congressional action impacts the amount of appropriation available for performance under this Agreement, HSD has the right to amend the CONTRACTOR's scope of work, at its discretion, which shall be effected by HSD sending written notice to the CONTRACTOR. Any changes to the scope of work and compensation to the CONTRACTOR affected pursuant to this Section 7.9 shall be negotiated, reduced to writing and signed by the Parties in accordance with Section 7.7 of this Agreement and any other applicable State or federal statutes, rules or regulations.

7.10 **Governing Law**

This Agreement shall be governed by the statutes 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.

7.11 **Disputes**

7.11.1 The entire agreement shall consist of: (i) this Agreement, including all attachments and any amendments; (ii) the RFPs, HSD's written clarifications to the RFPs and CONTRACTOR's responses to RFP questions, where not inconsistent with the terms of this Agreement or its amendments; and (iii) the CONTRACTOR's additional responses to the RFPs, where not inconsistent with the terms of this Agreement or its amendments, all of which are incorporated herein or by reference.

7.11.2 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:

7.11.2.1 Amendments to the Agreement in reverse chronological order followed by;

7.11.2.2 The Agreements, including all attachments followed by; and

7.11.2.3 The Request for Proposals, including attachments thereto and HSD's written responses to written questions and HSD's written clarifications, and the

CONTRACTOR's response to the Request for Proposals, 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).

7.11.3 Dispute Procedures for Other than Contract Termination

7.11.3.1 Except for termination of this Agreement, any dispute concerning remedies, sanctions and/or damages imposed under Section 7.3 of this Agreement shall be reported, in writing, to the MAD Director within thirty (30) Calendar Days of the date the CONTRACTOR receives notice of the sanction. The decision of the MAD Director regarding the dispute shall be delivered to the disputing party, in writing, within sixty (60) Calendar Days of the date the MAD Director receives the written dispute. The decision shall be final and conclusive unless, within thirty (30) Calendar Days from the date the decision is received, a written appeal is filed with the Secretary of HSD.

7.11.3.2 Any other dispute concerning performance of the Agreement shall be reported, in writing to the 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 MAD Director shall be delivered to the Parties in writing within sixty (60) Calendar Days and shall be final and conclusive unless, within thirty (30) Calendar Days from the date of the decision, either Party files with the Secretary of HSD a written appeal of the decision of the MAD Director.

7.11.3.3 Failure to file a timely appeal shall be deemed acceptance of the MAD Director's decision and waiver of any further Claim.

7.11.3.4 In any appeal under this Section, the CONTRACTOR and HSD shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Secretary of HSD or his or her designee. The appeal is an informal hearing that shall not be recorded or transcribed and is not subject to formal rules of evidence or procedure.

7.11.3.5 The Secretary of HSD, or his or her designee, shall acknowledge receipt of the appeal within thirty (30) Calendar Days and shall schedule and hold an informal hearing within one hundred twenty (120) Calendar Days of receipt of the appeal. The Secretary of HSD, or their designee, shall review the issues and evidence presented and issue a determination, in writing, within thirty (30) Calendar Days of the informal hearing that shall conclude the administrative process available to the Parties. These timeframes shall be followed unless otherwise agreed to by the Parties in writing or extended by the Secretary of HSD for good cause. Either Party may appeal to the District Court; however, the appeal will be subject to a record rather than de novo review.

7.11.3.6 Pending decision by the Secretary of HSD, both Parties shall proceed diligently with performance of this Agreement in accordance with the terms of this Agreement.

7.11.3.7 Failure to initiate or participate in any part of this process shall be deemed waiver of any Claim.

7.11.4 Dispute Procedures for Contract Termination

7.11.4.1 In the event HSD seeks to terminate this Agreement, the CONTRACTOR may appeal the termination to the Secretary of HSD within ten (10) Business Days of receiving the HSD's termination notice.

7.11.4.2 The Secretary of HSD will conduct a formal hearing on the termination within thirty (30) Calendar Days after receipt of the written appeal. Either Party may appeal to the District Court; however, the appeal will be subject to a record rather than de novo review.

7.12 Status of CONTRACTOR and CONTRACTOR's Personnel

7.12.1 Status of CONTRACTOR

7.12.1.1 The CONTRACTOR is an independent contractor performing professional services for HSD and is not an employee of the State of New Mexico. The CONTRACTOR shall not accrue leave, retirement, insurance, bonding, use State vehicles or any other benefits afforded to State employees. The CONTRACTOR

acknowledges that all sums received hereunder are reportable by the CONTRACTOR for tax purposes.

7.12.1.2 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 the terms of this Agreement.

7.12.1.3 The CONTRACTOR shall not purport to bind HSD, its officers, directors, employees or the State of New Mexico, to any obligation not expressly authorized herein, unless HSD has expressly given the CONTRACTOR the authority to do so, in writing.

7.12.2 No Third-Party Beneficiaries

Only the Parties to this Agreement, and their successors in interest and assigns, have any rights or remedies under, or by reason of, this Agreement.

7.12.3 Conduct of the CONTRACTOR's Personnel and Subcontractors

7.12.3.1 While performing the services required under this Agreement, the CONTRACTOR's personnel and Subcontractors must:

7.12.3.1.1 Comply with applicable federal and State statutes, rules, regulations and program guidelines and HSD's requests regarding personal and professional conduct; and

7.12.3.1.2 Otherwise conduct themselves in a business-like and professional manner.

7.12.3.2 Notwithstanding Section 3.3 of this Agreement, if HSD determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with this Agreement, HSD may provide the CONTRACTOR with notice and documentation concerning such conduct. Upon receipt of such notice, the CONTRACTOR shall promptly investigate the matter and take appropriate action, which may include:

7.12.3.2.1 Removing the employee or Subcontractor;

7.12.3.2.2 Providing HSD with written notice of such removal; and

7.12.3.2.3 Replacing the employee or Subcontractor with a similarly qualified individual acceptable to HSD.

7.12.3.3 The CONTRACTOR agrees that anyone employed or retained by the CONTRACTOR to fulfill the terms of this Agreement remains under the CONTRACTOR's sole direction and control.

7.12.3.4 The CONTRACTOR must have policies regarding disciplinary action for all employees who have failed to comply with federal and/or State statutes and the CONTRACTOR's standards of conduct, policies and procedures and requirements under this Agreement. The CONTRACTOR must have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

7.13 **Assignment**

With the exception of provider agreements 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 HSD.

7.14 **Major Subcontractors and Subcontractors**

7.14.1 Prohibited Subcontracting Relationships

7.14.1.1 The CONTRACTOR shall not subcontract the provision of Behavioral Health services to a managed, risk-bearing Behavioral Health organization.

7.14.1.2 The CONTRACTOR shall not subcontract Member Services to any other entity.

7.14.1.3 The CONTRACTOR may subcontract Utilization Management to another entity upon prior approval of HSD. Under such an arrangement, Utilization Management must be transparent and seamless to the Members.

7.14.2 Subcontract Relationships and Delegation

7.14.2.1 If the CONTRACTOR delegates responsibilities to a Major Subcontractor, Subcontractor or Preferred Vendor, the CONTRACTOR shall ensure that the

subcontracting relationship and subcontracting document(s) comply with federal requirements, including, but not limited to, compliance with the applicable provisions of 42 C.F.R. § 438.230(b) through (c):

7.14.2.1.1 The CONTRACTOR shall evaluate and certify to HSD that the delegated entity has the ability to perform the activities to be delegated;

7.14.2.1.2 The CONTRACTOR shall require that the delegation be in writing and specify the delegated activities and report responsibilities and provide for revoking delegation or imposing other sanctions if the delegated entity's performance is inadequate;

7.14.2.1.3 The CONTRACTOR shall monitor the delegated entity's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and State MCO statutes and regulations;

7.14.2.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the delegated entity shall take corrective action as necessary. When a CONTRACTOR identifies one or more areas of non-compliance with the delegated entity, the CONTRACTOR shall notify HSD within ten (10) Calendar Days of identification; and

7.14.2.1.5 If the subcontract is with a Major Subcontractor, for purposes of providing or securing the provision of Covered Services to Members, the CONTRACTOR shall ensure that all requirements described in Section 4.9 of this Agreement are included in the subcontract and/or a separate provider agreement executed by the appropriate Parties.

7.14.2.2 The CONTRACTOR shall have and implement policies and procedures to ensure that the delegated entity meets all standards of performance mandated by HSD for the Centennial Care program. 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.

7.14.2.3 The CONTRACTOR shall have and implement policies and procedures for the oversight of the performance of the subcontracted functions.

7.14.2.4 The CONTRACTOR shall maintain policies and procedures for verifying that the credentials of all its Contract Providers, Major Subcontractors, Subcontractors, Preferred Vendors and Sole Source Providers meet applicable standards as stated in this Agreement, including all Attachments.

7.14.2.5 The CONTRACTOR must provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) about its Grievance and Appeals system to all Major Subcontractors and Subcontractors at the time they enter into mutual contract.

7.14.2.6 The CONTRACTOR must conduct an annual evaluation of its delegated entities that includes the review of policies and procedures, an audit of applicable files or records, and implementation of a corrective action plan, if warranted. The CONTRACTOR shall provide HSD a copy of all annual evaluation results and applicable supporting documents by January 30 following the year of evaluation. If a delegated entity is under a corrective action plan, the CONTRACTOR must conduct the annual review on-site.

7.14.2.7 The CONTRACTOR must notify HSD, and the Collaborative to the extent Behavioral Health services are involved, if any of the delegated entities are under a CAP and provide regular updates, as directed by HSD, until the CAP is closed.

7.14.2.8 HSD maintains the right to review all transactions from a delegated entity to the CONTRACTOR at any time.

7.14.3 Legal Responsibility

7.14.3.1 The CONTRACTOR is solely responsible for fulfillment of this Agreement. HSD shall make payments only to the CONTRACTOR.

7.14.3.2 In the event that any Major Subcontractor is incapable of performing the service contracted for by the CONTRACTOR, the CONTRACTOR shall assume responsibility for providing the services that the Major Subcontractor is incapable of performing. Upon HSD's request, the CONTRACTOR shall provide any Covered Services directly until the CONTRACTOR identifies and contracts with a Provider to provide such services.

7.14.3.3 In the event that any Subcontractor is incapable of performing any functions contracted for by the CONTRACTOR, the CONTRACTOR shall assume

responsibility for the functions the Subcontractor is incapable of performing. Upon HSD's request, the CONTRACTOR shall perform any functions, until the CONTRACTOR identifies and contracts with an appropriate Subcontractor.

7.14.4 Prior Approval

7.14.4.1 The CONTRACTOR shall give HSD prior notice with regard to its intent to subcontract certain significant contract requirements, as specified herein or in writing by HSD, including, but not limited to, credentialing and Claims processing. HSD reserves the right to disallow a proposed subcontracting arrangement if the proposed Subcontractor has been formally restricted from participating in a federal entitlement program (e.g., Medicare, Medicaid) for other good cause or as otherwise determined by HSD.

7.14.4.2 The CONTRACTOR shall give HSD prior notice with regard to its intent to subcontract Covered Services to a Major Subcontractor, as specified herein or in writing by HSD, including, but not limit to, DME and transportation services. HSD reserves the right to disallow a proposed subcontracting arrangement if the proposed Major Subcontractor has been formally restricted from participating in a federal entitlement program (e.g., Medicare, Medicaid) for other good cause or as otherwise determined by HSD.

7.14.4.3 All subcontracts, revisions and terminations thereto shall be approved in advance in writing by HSD. The CONTRACTOR shall not assign, transfer or delegate any key functions to a Subcontractor or Major Subcontractor without the explicit prior written approval of HSD. The CONTRACTOR shall revise subcontracts as directed by HSD. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to HSD within thirty (30) Calendar Days of execution. This written prior approval requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's operations to HSD for prior review and approval.

7.14.5 Minimum Requirements for Subcontracts

The CONTRACTOR's subcontracts shall include the following:

7.14.5.1 The requirements in Section 4.9 of this Agreement, as applicable;

7.14.5.2 The relationship between the CONTRACTOR and the Subcontractor or Major Subcontractor including if the Subcontractor or Major Subcontractor is a subsidiary of the CONTRACTOR or within the CONTRACTOR's corporate organization;

7.14.5.3 The responsibilities of the CONTRACTOR and the Subcontractor or Major Subcontractor;

7.14.5.4 The frequency of reporting (if applicable) to the CONTRACTOR;

7.14.5.5 The process by which the CONTRACTOR evaluates the Subcontractor or Major Subcontractor;

7.14.5.6 Certification language as described in Section 7.23.3 of this Agreement;

7.14.5.7 Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 1857 (h)), Section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 C.F.R. § 15);

7.14.5.8 The requirements for submission of Encounter Data, as applicable;

7.14.5.9 The remedies, including the revocation of the delegation, available to the CONTRACTOR if the delegate does not fulfill its obligations; and

7.14.5.10 That Major Subcontractors and 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 Major Subcontractor or Subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the CONTRACTOR and Major Subcontractor or Subcontractor agreement for authorized services rendered prior to the termination of the agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members.

7.14.6 Disclosure Requirements

As required by 45 C.F.R. § 76, or other applicable federal regulations, the CONTRACTOR shall require each proposed first-tier Subcontractor or Major

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, Major 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 HSD when it requests Subcontractor or Major Subcontractor approval from HSD pursuant to Section 7.14.4. If the Subcontractor, Major Subcontractor or its principals, is debarred, suspended or proposed for debarment by any federal department or agency, HSD may refuse to approve the use of the Subcontractor or Major Subcontractor.

7.14.7 Notice of Subcontractor or Major Subcontractor Termination

7.14.7.1 When a subcontract related to the provision of services or Subcontractor function is being terminated, the CONTRACTOR shall give at least thirty (30) Calendar Days prior written notice of the termination to HSD.

7.14.7.2 If the CONTRACTOR changes Subcontractors for a specific subcontracted function during the term of this Agreement, the CONTRACTOR shall pay an independent monitor, as selected by HSD, to determine whether the new Subcontractor is ready to perform the subcontracted function. The CONTRACTOR shall not make any payments to the new Subcontractor until the Subcontractor has been determined ready.

7.14.8 Cooperation with Other CONTRACTORS

HSD, the Collaborative, or 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 HSD or the State in all such cases.

7.15 **Release**

7.15.1 Upon final payment of the amounts due under this Agreement, unless the CONTRACTOR objects, in writing, to such payment within one-hundred-eighty (180) Calendar Days, the CONTRACTOR shall release HSD, its 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.

7.15.2 Payment to the CONTRACTOR by HSD shall not constitute final release of the CONTRACTOR. Should audit or inspection of the CONTRACTOR's records or the CONTRACTOR's Member Grievances subsequently reveal outstanding CONTRACTOR liabilities or obligations, the CONTRACTOR shall remain liable to HSD for such obligations. Any payments by HSD to the CONTRACTOR shall be subject to any appropriate recoupment by the State.

Notice of any post-termination audit or investigation of complaint by HSD shall be provided to the CONTRACTOR, and such audit or investigation shall be initiated in accordance with CMS requirements. HSD 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 or applicable regulations. Any payments by HSD to the CONTRACTOR shall be subject to any appropriate recoupment by the State in accordance with the provisions of Section 7.15.2 of this Agreement.

7.16 **Records and Audit**

7.16.1 Maintenance of Medical Records

The CONTRACTOR shall maintain and shall require its Subcontractors, Major Subcontractors and Contract Providers to maintain appropriate records in accordance with federal and State statutes and regulations relating to the CONTRACTOR's performance under this Agreement. Records include but are not limited to, all Covered Services provided to Members. A separate medical record shall be maintained for each Member on paper and/or in electronic format in a manner that is legible, current and organized and shall be produced timely as directed by HSD.

Medical records must permit effective and confidential patient care and quality review.

7.16.2 Financial Records

7.16.2.1 The CONTRACTOR agrees to maintain and require its Major Subcontractors, Subcontractors and Contract Providers to maintain records, books, documents and information that are adequate to ensure that services are provided and payments are made in accordance with the requirements of this Agreement, including Encounter Data and audited financial reports, information relating to adequate provision against the risk of insolvency, the medical loss ratio report in Section 7.2, and the annual report on overpayments, and including applicable federal and State requirements (e.g., 45 C.F.R. § 74.53).

7.16.2.2 The CONTRACTOR shall retain, and require its Major Subcontractors, Subcontractors and Contract Providers to retain, records identified in Section 7.16.2.1 of this Agreement for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.16.3 Grievance and/or Appeal Files

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

7.16.3.2 The CONTRACTOR will have procedures for ensuring 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 Member's Representative(s) and/or the provider, the date the Grievance and/or Appeal is resolved, the resolution and notices of final decision to the Member, the Member's Representative(s) and/or provider and all other pertinent information.

7.16.3.3 Documentation regarding the Grievance and/or Appeal shall be made available to the Member, if requested.

7.16.3.4 The CONTRACTOR shall provide the Provider complaint and appeal files upon HSD's request.

7.16.4 Program Integrity Related Records, Books and Documents

7.16.4.1 The CONTRACTOR agrees to maintain and require its Major Subcontractors and Subcontractors to maintain, records, books, documents and information on ownership and control, as required in 42 C.F.R. § 455.104 and prohibited affiliations, as specified in 42 C.F.R. § 438.610.

7.16.4.2 The records, books, documents and information in Section 7.16.4.1 shall be maintained for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.16.5 Provider Network Records, Books and Documents

7.16.5.1 The CONTRACTOR agrees to maintain and require its Contract Providers to maintain, records, books, documents and information related to the adequacy of the provider network as specified in Section 4.8.1 of this Agreement and 42 C.F.R. § 438.207.

7.16.5.2 The records, books, documents and information in Section 7.16.5.1 shall be maintained for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.16.6 Access to Records, Books and Documents

7.16.6.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its Subcontractors, Major Subcontractors and Contract Providers to provide the officials and entities identified in this Section with reasonable and adequate access to any records that are related to the scope of work performed under this Agreement within two (2) to ten (10) Business Days, NMSA 1978, § 27-11-4(B).

7.16.6.2 The CONTRACTOR and its Subcontractors and Major Subcontractors must provide the access described in this Section upon HSD's request. This request may be for, but is not limited to, the following purposes:

7.16.6.2.1 Examination;

7.16.6.2.2 Audit;

7.16.6.2.3 Investigation;

7.16.6.2.4 Agreement administration; or

7.16.6.2.5 The making of copies, excerpts, or transcripts.

7.16.6.3 The access required must be provided to the following officials and/or entities:

7.16.6.3.1 The United States Department of Health and Human Services or its designee;

7.16.6.3.2 The Comptroller General of the United States or its designee;

7.16.6.3.3 HSD personnel or its designee;

7.16.6.3.4 HSD's Office of Inspector General;

7.16.6.3.5 The Collaborative personnel or designee;

7.16.6.3.6 MFEAD or its designee;

7.16.6.3.7 Any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of HSD;

7.16.6.3.8 The Office of the State Auditor or its designee;

7.16.6.3.9 A State or federal law enforcement agency;

7.16.6.3.10 A special or general investigating committee of the New Mexico Legislature or its designee; and

7.16.6.3.11 Any other State or federal entity identified by HSD, or any other entity engaged by HSD.

7.16.6.4 The CONTRACTOR agrees to provide the access described wherever the CONTRACTOR maintains such books, records and supporting documentation. The CONTRACTOR further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment or other conveniences deemed necessary to fulfill the purposes described in this Section. The CONTRACTOR

will require its Subcontractors, Major Subcontractors and Contract Providers to provide comparable access and accommodations.

7.16.6.5 Upon request, the CONTRACTOR must provide copies of the information described in this Section free of charge to HSD and the entities described in this Section.

7.17 **Indemnification**

7.17.1 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, Subcontractors or Major 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 that 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 7.17.1 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 or any of its officers, employees or agents.

7.17.2 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 that the State may sustain, incur or be required to pay: (i) 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 (ii) 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, Major 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, except the 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 or Major Subcontractor under this Agreement is brought against the CONTRACTOR, the CONTRACTOR shall, as soon as practicable but no later than two (2) 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.

7.17.3 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 the CONTRACTOR's erroneous or negligent acts or omissions, including the following:

7.17.3.1 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, Subcontractors or Major 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 in writing to the performance of such acts; and

7.17.3.2 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.

7.17.4 The provisions of this Section 7.17 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 the CONTRACTOR's legal rights to pursue indemnity actions and/or disputed Claims arising from allegations involving the actions of the State and the CONTRACTOR.

7.17.5 The CONTRACTOR, including its Subcontractors and Major 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 or Major 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 copayments under HSD's policy. In no case, shall HSD and/or Members be liable for any debts of the CONTRACTOR.

7.17.6 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.

7.17.7 HSD shall notify the CONTRACTOR of any Claim, loss, damage, suit or action as soon as HSD reasonably believes that such Claim, loss, damage, suit or action may give rise to a right to indemnification under this Section. The failure of HSD, however, to deliver such notice shall not relieve the CONTRACTOR of its obligation to indemnify HSD under this Section. Prior to entering into any settlement for which it may seek indemnification under this Section, HSD 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. HSD shall permit the CONTRACTOR, at the CONTRACTOR's

option and expense, to assume the defense of such asserted Claim(s) using counsel acceptable to HSD and to settle or otherwise dispose of the same, by and with the consent of HSD, such consent shall not be unreasonably withheld. Failure to give prompt notice as provided herein shall not relieve the 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.

7.18 **Liability**

7.18.1 The CONTRACTOR shall be wholly at risk for all Covered Services. No additional payment shall be made by HSD, nor shall any payment be collected from a Member, except for copayments authorized by HSD or State statutes or regulations.

7.18.2 The CONTRACTOR is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Agreement. HSD 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.

7.18.3 The CONTRACTOR, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Agreement.

7.19 **Rights to Property**

All equipment and other property provided or reimbursed to the CONTRACTOR by HSD is the property of HSD and shall be turned over to HSD 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.

7.20 **Erroneous Issuance of Payment or Benefits**

In the event of an error that causes payment(s) to the CONTRACTOR to be issued by HSD, HSD shall deduct amounts from future Capitation Payments after thirty (30) Calendar Days of written notice of such error.

7.21 **Excusable Delays**

7.21.1 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, court order or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder nor grounds for termination of the Agreement.

7.21.2 Suspensions under Force Majeure shall require the Party seeking suspension to give notification to the other Parties 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 any 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) Calendar Days, whichever is shorter, and such Party shall be granted an extension of time for performance equal to the period of suspension.

7.21.3 In addition, the CONTRACTOR shall be excused from performance hereunder for insufficient payment by HSD provided the CONTRACTOR notifies HSD in writing of its intent to suspend performance, and HSD is unable to remedy the monetary shortfall within forty-five (45) Calendar Days.

7.22 **Prohibition of Bribes, Gratuities and Kickbacks**

7.22.1 Pursuant to the State of New Mexico statutes and regulations, the receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

7.22.2 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.

7.22.3 HSD 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 or 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.

7.23 **Lobbying**

7.23.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 C.F.R. § 93 and 31 U.S.C. § 1352. This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement imposed under 31 U.S.C. § 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.

7.23.2 The CONTRACTOR shall disclose any lobbying activities using non-federal funds, in accordance with 45 C.F.R. § 93.

7.23.3 The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-

grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

7.24 **Conflict of Interest**

7.24.1 The CONTRACTOR 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 and 42 C.F.R. § 438.58. Without in any way limiting the generality of the foregoing, the CONTRACTOR specifically represents and warrants that:

7.24.1.1 In accordance with NMSA 1978, § 10-16-4.3, the CONTRACTOR does not employ, has not employed and will not employ during the term of this Agreement any HSD employee while such employee was or is employed by HSD and participating directly or indirectly in HSD's contracting process;

7.24.1.2 This Agreement complies with NMSA 1978, § 10-16-7(A) because:

7.24.1.2.1 The CONTRACTOR is not a public officer or employee of the State of New Mexico;

7.24.1.2.2 The CONTRACTOR is not a Member of the family of a public officer or employee of the State of New Mexico;

7.24.1.2.3 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

7.24.1.2.4 If the CONTRACTOR is a public officer or employee of the State of New Mexico, a Member of the family of a public officer, employee of the State of New Mexico or an employee of the State who has a substantial interest, public notice was given, as required, by NMSA 1978, § 10-16-7(A), and this Agreement was awarded pursuant to a competitive process.

7.24.1.3 In accordance with NMSA 1978, § 10-16-8(A):

7.24.1.3.1 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

7.24.1.3.2 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 or the Collaborative making this Agreement.

7.24.1.4 This Agreement complies with NMSA 1978, § 10-16-9(A) because:

7.24.1.4.1 The CONTRACTOR is not a legislator;

7.24.1.4.2 The CONTRACTOR is not a Member of a legislator's family;

7.24.1.4.3 The CONTRACTOR is not a business in which a legislator or a legislator's family has a substantial interest; or

7.24.1.4.4 If the CONTRACTOR is a legislator, a Member of a legislator's family or a business in which a legislator or legislator's family has a substantial interest, disclosure has been made as required by NMSA 1978, § 10-16-9(A), 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, NMSA 1978, 13-1-28 et seq.

7.24.1.5 In accordance with NMSA 1978, § 10-16-13, 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.

7.24.1.6 In accordance with NMSA 1978, § 10-16-3 and 10-16-13.3, 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.

7.24.2 The CONTRACTOR's representation and warranties in Section 7.24.1 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 Section 7.24.1 of this Agreement were erroneous on the effective date of this Agreement or have become erroneous by

reason of new or changed circumstances. If it is later determined that the CONTRACTOR's representations and warranties in Section 7.24.1 of this Agreement 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.

7.25 **Health Insurance Portability and Accountability Act ("HIPAA") Compliance**

7.25.1 The CONTRACTOR must comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the CONTRACTOR's management information system (MIS) complies with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. The CONTRACTOR must comply with HIPAA electronic data interchange (EDI) requirements.

7.25.2 The CONTRACTOR must comply with HIPAA notification requirements, including those set forth in the HITECH Act, 45 C.F.R. § 164.410, and related regulations. The CONTRACTOR must notify HSD of all breaches or potential breaches of unencrypted protected health information, as such protected health information pertains to the Related Agreement and any amendments thereto, and as defined by the HITECH Act, without unreasonable delay. If, in HSD's determination, the CONTRACTOR has not provided notice in the manner or format prescribed by the HITECH Act, and its related regulation, then HSD may require the CONTRACTOR to provide such notice.

7.25.2.1 In addition to the requirements identified in 7.25.2, the CONTRACTOR must notify HSD no later than five (5) Calendar days after discovery of the breach or potential breach to include the date and circumstances of the breach or potential breach and the number of Members who might be affected. CONTRACTOR shall continue to keep HSD updated as directed by HSD.

7.25.3 Unless otherwise required by federal or State statutes or regulations, any ambiguity or inconsistency between the provisions of the Contract and the Business Associate

Agreement, attached hereto as Exhibit A and incorporated herein, shall be resolved in favor of the Contract.

7.26 **Disclosure and Confidentiality of Information**

7.26.1 Confidentiality

7.26.1.1 The CONTRACTOR, its employees, agents, Subcontractors, Major Subcontractors, consultants or advisors must treat all information that is obtained through Providers performance of the services under this Agreement, including, but not limited to, information relating to Members, potential recipients of HSD and the Collaborative programs, as Confidential Information to the extent that confidential treatment is provided under State and federal law, rules and regulations.

7.26.1.2 The CONTRACTOR is responsible for understanding the degree to which information obtained through the performance of this Agreement is confidential under State and federal law, rules and regulations.

7.26.1.3 The CONTRACTOR and all Subcontractors, Major Subcontractors, consultants, advisors or agents shall not use any information obtained through performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement.

7.26.1.4 Within sixty (60) Calendar Days of the effective date of this Agreement, the CONTRACTOR shall develop and provide to HSD for review and approval written policies and procedures for the protection of all records and all other documents deemed confidential under this Agreement.

7.26.1.5 Any disclosure or transfer of Confidential Information by the CONTRACTOR, including information required by HSD and/or the Collaborative, will be in accordance with applicable law. If the CONTRACTOR receives a request for information deemed confidential under this Agreement, the CONTRACTOR will immediately notify HSD of such request and will make reasonable efforts to protect the information from public disclosure.

7.26.1.6 In addition to the requirements expressly stated in this Section, the CONTRACTOR must comply with 42 C.F.R. § 438.224, any policy, rule or reasonable requirement of HSD that relates to the safeguarding or disclosure of information relating to Members, the CONTRACTOR's operations or the CONTRACTOR's performance of this Agreement.

7.26.1.7 In the event of the expiration of this Agreement, or termination thereof for any reason, all Confidential Information disclosed to and all copies thereof made by the CONTRACTOR must be returned to HSD or, at HSD's option, erased or destroyed. The CONTRACTOR must provide HSD certificates evidencing such destruction.

7.26.1.8 The CONTRACTOR's contracts with practitioners and other Providers shall explicitly state expectations about the confidentiality of HSD's Confidential Information and Member records.

7.26.1.9 The CONTRACTOR shall afford Members and/or Representatives the opportunity to approve or deny the release of identifiable personal information by the CONTRACTOR to a person or entity outside of the CONTRACTOR, except to duly authorized Subcontractors, Major Subcontractors, Providers or review organizations, or when such release is required by law, regulation or quality standards.

7.26.1.10 The obligations of this Section must not restrict any disclosure by the CONTRACTOR pursuant to any applicable law, or under any court or government agency, provided the CONTRACTOR must give prompt notice to HSD of such order.

7.26.2 Disclosure of HSD's Confidential Information

7.26.2.1 The CONTRACTOR shall immediately report to HSD any and all unauthorized disclosures or uses of Confidential Information of which it or its Subcontractors, Major Subcontractors, Providers, consultants or agents is aware or has knowledge. The CONTRACTOR acknowledges that any publication or disclosure of Confidential Information to others may cause immediate and irreparable harm to HSD and may constitute a violation of State or federal

statutes. If the CONTRACTOR, its Subcontractors, Major Subcontractors, Providers, consultants or agents should publish or disclose Confidential Information to others without authorization, HSD will immediately be entitled to injunctive relief, or any other remedies to which it is entitled, under law or equity. HSD will have the right to recover from the CONTRACTOR all damages and liabilities caused by, or arising from, the CONTRACTOR's, its Subcontractors', Major Subcontractors', Providers', representatives', consultants' or agents' failure to protect Confidential Information. The CONTRACTOR will defend with counsel approved by HSD, indemnify and hold harmless HSD from all damages, costs, liabilities and expenses caused by or arising from the CONTRACTOR's, or its Subcontractors', Major Subcontractors' Providers', representatives', consultants' or agents' failure to protect Confidential Information. HSD will not unreasonably withhold approval of counsel selected by the CONTRACTOR.

7.26.2.2 The CONTRACTOR will require its Subcontractors, Major Subcontractor, Providers, consultants and agents to comply with the terms of this Section.

7.26.3 Member Records

7.26.3.1 The CONTRACTOR must comply with the requirements of State and federal statutes, including the HIPAA requirements set forth in this Agreement, regarding the transfer of Member records.

7.26.3.2 The CONTRACTOR shall have an appropriate system in effect to protect substance abuse Member records from inappropriate disclosure in accordance with 42 U.S.C. § 300x-53(b) and 45 C.F.R. § 96.13(e).

7.26.3.3 If this Agreement is terminated, HSD may require the transfer of Member records, upon written notice to the CONTRACTOR, to another entity, as consistent with federal and State statutes and applicable releases.

7.26.3.4 The term "Member record" for this Section means only those administrative, enrollment, case management and other such records maintained by the CONTRACTOR and is not intended to include patient records maintained by participating Contract Providers.

7.26.4 Requests for Public Information

7.26.4.1 When the CONTRACTOR produces reports or other forms of information that the CONTRACTOR believes consist of proprietary or otherwise Confidential Information, the CONTRACTOR must clearly mark such information as Confidential Information or provide written notice to HSD that it considers the information confidential.

7.26.4.2 If HSD receives a request, filed in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, 14-2-1 et seq. ("IPRA") seeking information that has been identified by the CONTRACTOR as proprietary or otherwise confidential, HSD will deliver a copy of the IPRA request to the CONTRACTOR.

7.26.5 Unauthorized Acts

7.26.5.1 Each Party agrees to:

7.26.5.1.1 Notify the other Parties promptly of any unauthorized possession, use, knowledge or attempt thereof, by any person or entity that may become known to it, of any Confidential Information or any information identified as confidential or proprietary;

7.26.5.1.2 Promptly furnish to the other Parties full details of the unauthorized possession, use, knowledge, or attempt thereof and use reasonable efforts to assist the other Parties in investigating or preventing the reoccurrence of any unauthorized possession, use, knowledge or attempt thereof of Confidential Information;

7.26.5.1.3 Cooperate with the other Parties in any litigation and investigation against third parties deemed necessary by such Party to protect its proprietary rights; and

7.26.5.1.4 Promptly prevent a recurrence of any such unauthorized possession, use or knowledge of such information.

7.26.6 Information Security

7.26.6.1 The CONTRACTOR and all its Subcontractors, Major Subcontractors, Providers, consultants, representatives, Providers and agents must comply with

all applicable statutes, rules and regulations regarding information security, including, without limitation, the following:

7.26.6.1.1 Health and Human Services Enterprise Information Security Standards and Guidelines;

7.26.6.1.2 HIPAA;

7.26.6.1.3 HITECH Act; and

7.26.6.1.4 NMAC 1.12.20 et seq.

7.27 **Cooperation Regarding Fraud**

7.27.1 The CONTRACTOR shall make an initial report to HSD and the Collaborative to the extent the activities relate to Behavioral Health, within 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 HSD and submit any applicable evidence in support of its findings. If HSD decides to refer the matter to the MFEAD or another State or federal investigative agency, HSD will notify the CONTRACTOR within ten (10) Business Days of making the referral. The CONTRACTOR shall cooperate fully with any and all requests from MFEAD or other State or federal investigative agency for additional documentation or other types of collaboration in accordance with applicable law.

7.27.2 The CONTRACTOR shall cooperate fully in any investigation by the MFEAD, or other State or federal agency, as well as any subsequent legal action that may result from such investigation. The CONTRACTOR and its Subcontractors, Major Subcontractors and Contract Providers shall within two (2) to ten (10) Business Days after the date of request, in accordance with NMSA 1978, § 27-11- 4(B), make available to the MFEAD or other State or federal agency conducting an investigation, any and all administrative, financial and medical records relating to the delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, the MFEAD or other State or federal agency shall be allowed to have access during normal business hours to the place of business and all records of

the CONTRACTOR and its Subcontractors, Major Subcontractors and Providers, except under special circumstances when after hour's access shall be allowed. Special circumstances shall be determined by the MFEAD or other State or federal agency.

7.27.3 The CONTRACTOR shall disclose to HSD, the Collaborative, MFEAD and any other State or federal agency charged with overseeing the Centennial Care program, full and complete information regarding ownership, significant financial transactions or financial transactions relating to or affecting the Centennial Care program between the CONTRACTOR and persons related to the CONTRACTOR convicted of criminal activity related to Medicaid, Medicare or the federal Title XX programs.

7.27.4 The CONTRACTOR shall refer any actual or potential conflict of interest to MFEAD. The CONTRACTOR also shall refer to MFEAD any instance where a financial or material benefit is given by any representative, agent or employee of the CONTRACTOR to HSD, or any other Party with direct responsibility for this Agreement. In addition, the CONTRACTOR shall notify MFEAD 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 HSD in a capacity relating to the Centennial Care program or any other Party with direct responsibility for this Agreement.

7.27.5 Any recoupment received from the CONTRACTOR by HSD pursuant to the provisions of Section 7.3 of this Agreement herein shall not preclude the Collaborative, MFEAD or any other State or federal agency from exercising its right to criminal prosecution, civil prosecution or any applicable civil penalties, administrative fines or other remedies. Any Medicaid funds identified in any action by MFEAD or other prosecutorial agency, whether the action is civil or criminal, shall be returned to HSD. The funds shall not be retained by the CONTRACTOR. The amount returned to HSD shall be determined according to the adjudicated Claims retained from the time the suspension of payment was initiated.

7.27.6 Upon request to the CONTRACTOR, MFEAD or any other State or federal agency shall be provided with copies of all Grievances and resolutions affecting Members.

7.27.7 Should the CONTRACTOR know about or become aware of any investigation being conducted by MFEAD or another State or federal agency, the CONTRACTOR, and

its representatives, agents and employees, shall maintain the confidentiality of this information.

7.27.8 The CONTRACTOR shall have in place and enforce policies and procedures to educate Members of the existence of, and role of, MFEAD.

7.27.9 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.

7.27.10 All documents submitted by the CONTRACTOR to HSD and/or the Collaborative, 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.

7.27.11 Referrals For Credible Allegations Of Fraud

7.27.11.1 The CONTRACTOR shall report to HSD suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HSD's direction in identifying and reporting cases of credible allegations of Fraud. HSD shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HSD's directions to the CONTRACTOR may include, but is not limited to:

7.27.11.1.1 At HSD's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part, as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD's notice, the CONTRACTOR: (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pended Claims or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all

money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD's notice;

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law;

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD;

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider;

7.27.11.1.4.2 The dismissal of all charges and/or Claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.27.11.1.4.3 For other good cause as determined solely by HSD; and

7.27.11.1.5 The CONTRACTOR shall continue the suspension of payments, in whole or in part, until further notified, in writing, by HSD to release suspended funds. The CONTRACTOR shall release funds, as directed, within fourteen (14) Business Days of the date of release authorization.

7.27.11.2 Should HSD require the CONTRACTOR’s assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

7.27.12 Recovery for Fraud/False Claims

7.27.12.1 Should MFEAD or HSD pursue what it alleges are false and/or fraudulent Claims as permitted under law and identified by the CONTRACTOR against a

provider, any recovery (either by the provider making payment, collection on a judgment or restitution) shall be divided as follows:

7.27.12.1.1 HSD shall recoup and remit to CMS the federal share, if applicable;

7.27.12.1.2 HSD shall retain the non-federal share and be reimbursed for any and all costs associated with any program integrity or similar audit that results in the identification and/or recovery of false and/or fraudulent Claims and for HSD's professional and associated costs for transitioning recipients, when applicable; and

7.27.12.1.3 For any remaining amount of the non-federal share, HSD shall remit to the CONTRACTOR for:

7.27.12.1.3.1 Aggregate Recovery in excess of $25,000.00 but less than $100,000.00, forty percent (40%) of the non-federal share;

7.27.12.1.3.2 Aggregate recovery in excess of $100,000.00 but less than $250,000.00, thirty percent (30%) of the non-federal share; or

7.27.12.1.3.3 Aggregate recovery in excess of $250,000.00, twenty-five percent (25%) of the non-federal share.

7.27.12.1.4 HSD and the CONTRACTOR shall work together in good faith to come to a mutually agreeable process for any remittance due the CONTRACTOR and how that remittance will be treated for purposes of the medical loss ratio.

7.27.12.1.5 HSD shall provide the CONTRACTOR with quarterly reports regarding any recovery for which the CONTRACTOR may be entitled to a remittance.

7.27.13 The CONTRACTOR is not entitled to any recovery under this subsection when MFEAD and/or HSD independently identifies and pursues false Claims and/or fraudulent Claims.

7.28 **Waivers**

7.28.1 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.

7.28.2 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.

7.29 **Suspension, Debarment and Other Responsibility Matters**

7.29.1 Pursuant to either 7 C.F.R. § 3017 or 45 C.F.R. § 76, as applicable, 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 and except as otherwise disclosed in writing by the CONTRACTOR to HSD prior to the execution of this Agreement: (i) are not debarred, suspended, proposed for debarment or declared ineligible for the award of contracts by any federal department or agency; (ii) have not, within a three (3) 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; (iii) 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 Section 7.29; (iv) 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 (v) 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 shall not employ or have any relationship or affiliation with an individual or entity that has been excluded from participation in health care programs pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1320a- 7 and other applicable federal

statutes and regulations. The CONTRACTOR shall not be an entity that must be excluded pursuant to 42 C.F.R. § 438.610 and § 438.808(b).

7.29.2 The CONTRACTOR's certification in Section 7.29.1 is a material representation of fact upon which HSD and the Collaborative relied when this Agreement was entered into by the Parties. The CONTRACTOR shall provide immediate written notice to HSD and the Collaborative, if, at any time during the term of this Agreement, the CONTRACTOR learns that its certification in Section 7.29.1 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 Section 7.29.1 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 HSD and the Collaborative, HSD and the Collaborative may terminate the Agreement.

7.30 **New Mexico Employees' Health Coverage**

7.30.1 If the CONTRACTOR has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least twenty (20) hours per week over a six (6) month period during the term of this Agreement, the CONTRACTOR certifies, by signing this Agreement, to have in place, and agree to maintain for the term of this Agreement, health insurance for those employees and offer that health insurance to those employees.

7.30.2 The CONTRACTOR agrees to maintain a record of the number of employees who have:

7.30.2.1 Accepted health insurance;

7.30.2.2 Declined health insurance due to other health insurance coverage already in place; or

7.30.2.3 Declined health insurance for other reasons.

7.30.3 These records are subject to review and audit by a representative of the State.

7.31 **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 the Parties to continue performance of the Agreement in the spirit it was written in the event they identify any possible errors or problems associated with the performance of their respective obligations under this Agreement.

7.32 **Entire Agreement/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.

7.33 **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.

7.34 **Workers' Compensation**

The CONTRACTOR agrees to comply with State statutes and rules applicable to workers' compensation benefits for its employees.

7.35 **Severability**

If any provision of this Agreement is construed to be illegal, invalid or unenforceable, such interpretation and/or determination will not affect the legality or validity of any other provisions. The illegal, invalid or unenforceable provision will be deemed stricken and deleted to the same extent and effect as if never incorporated into this Agreement, with all other provisions remaining in full force and effect.

7.36 **Technical Assistance**

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by HSD or the Collaborative.

7.37 **Use of Data**

HSD and the Collaborative shall have unlimited, but not exclusive, rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented or furnished by the CONTRACTOR resulting from this Agreement. However, HSD and the Collaborative shall not disclose proprietary information that is afforded confidential status by State or federal law.

7.38 **Titles/Headings**

Titles of paragraphs or Section headings used in this Agreement are for the purpose of facilitating use or reference only and shall not be considered in the interpretation of this Agreement.

7.39 **Attorneys' Fees**

In the event that any Party deems it necessary to take legal action to enforce any provision of this Agreement and HSD or the Collaborative prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorneys' fees and the cost of all State litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

7.40 **Authority**

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

7.41 **State Contract Administrator**

The Contract Administrator shall be designated by HSD. HSD 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 HSD and the Collaborative to represent the State in all matters related to this Agreement except those reserved to other State personnel by this Agreement. Notwithstanding the foregoing, 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.

7.42 **Survival of Terms**

Termination or expiration of this Agreement for any reason will not release any Party from any liabilities or obligations set forth in this Agreement that:

7.42.1 The Parties have expressly agreed shall survive any such termination or expiration; or

7.42.2 Remain to be performed or, by their nature, would be intended to be applicable following any such termination or expiration.

7.43 **Calculation of Time**

Any time period herein calculated by reference to “days” means Calendar Days unless further defined and provided; however, if the last day for a given act falls on a Saturday, Sunday or a holiday scheduled by the State of New Mexico, the day for such act shall be the first day following that is not a Saturday, Sunday or such scheduled holiday.

7.44 **No Implied Authority**

7.44.1 The authority delegated to the CONTRACTOR by HSD and the Collaborative is limited to the terms of this Agreement. The CONTRACTOR may not rely upon implied authority and specifically is not delegated authority under this Agreement to:

7.44.1.1 Make public policy;

7.44.1.2 Promulgate, amend or disregard administrative regulations or program policy decisions made by the State and federal agencies responsible for administration of HSD's or the Collaborative' s programs; or

7.44.1.3 Unilaterally communicate or negotiate with any federal or State agency or the New Mexico State Legislature on behalf of HSD or the Collaborative regarding HSD's or the Collaborative' s programs.

7.44.2 The CONTRACTOR is required to cooperate, to the fullest extent possible, to assist HSD and the Collaborative in communications and negotiations with State and federal governments and agencies as directed by HSD.

7.45 **No Waiver of Sovereign Immunity**

The Parties expressly agree that no provision of this Agreement is in any way intended to constitute a waiver by the State of any immunities from suit or from liability that the State of New Mexico may have by operation of law.

7.46 **NOTICE**

7.46.1 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.

7.46.2 All notices required to be given to the State under this Agreement shall be sent to the following, or his or her designee:

Nicole Comeaux, Director
Medical Assistance Division
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or

Paul Ritzma, Chief Legal Counsel
Office of General Counsel
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348

7.46.3 All notices required to be given to CONTRACTOR under this Agreement shall be sent to the following, or his or her designee:

Jean Wilms
Interim Plan President & Chief Executive Officer
Western Sky Community Care, Inc.
5300 Homestead Rd NE
Albuquerque, NM 87110

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of signature by all parties.

CONTRACTOR

By: DocuSigned by: Jean Wilms A091182E8F95481... Date: 10/8/2021

Jean Wilms, WSCC Interim Plan President & Chief Executive Officer

STATE OF NEW MEXICO

By: DocuSigned by: David Scrase 9DBE7D7D1B53422... Date: 10/22/2021

David Scrase, Cabinet Secretary
Human Services Department

By: DocuSigned by: Danny Sandoval B60DFEE7DE10413... Date: 10/8/2021

Danny Sandoval, CFO
Human Services Department

THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

By: DocuSigned by: David Scrase 9DBE7D7D1B53422... Date: 10/22/2021

David Scrase, Cabinet Secretary
Human Services Department

By: DocuSigned by: David Scrase 9DBE7D7D1B53422... Date: 10/22/2021

David Scrase, Acting Cabinet Secretary
Department of Health

By: DocuSigned by: Barbara Vigil D14A45E63250460... Date: 10/29/2021

Barbara Vigil, Cabinet Secretary Designee
Children, Youth and Families Department

Approved as to Form and Legal Sufficiency:

By: DocuSigned by: 5709D277B0FC4AA... Date: 10/19/2021

Paul Ritzma, Chief Legal Counsel
Human Services Department

DS

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

BTIN ID Number: 03-247670-00-1

By: DocuSigned by: Ann Marie Lucero A1E23200AE974AA... Date: 10/29/2021

Attachment 1: Deliverable Requirements

General

This is a preliminary list of deliverables. The CONTRACTOR and HSD shall agree to the appropriate deliverables, deliverable formats, submissions and approval time frames (unless otherwise specified in this Agreement) and technical assistance as required. Deliverables shall be submitted to HSD unless otherwise specified.

HSD will review and/or approve some or all deliverables during the readiness review and/or during operations. As specified by HSD, material modifications to certain deliverables must be reviewed and approved by HSD.

Deliverable Items

Agreement Section Reference	Deliverable	Due Date
1.11	Copy of D-SNP application to CMS or current D-SNP agreement with CMS in good standing	By March 1, 2018
3.3.3	Listing of Key Personnel (including resumes)	By April 15, 2018
3.3.4.1.9	Policies and procedures that have been mutually agreed upon with the Non-Medicaid Contractor regarding information sharing, billing procedures and participation in non-Medicaid initiatives	TBD
3.3.5	Staff training plan and evaluation plan	March 30, 2018
3.4.1	Policies and Procedures regarding distribution and development of Marketing Materials	March 15, 2018
3.5.1.1/3.5.1.2/ 3.5.1.4	Cultural Competency/Sensitivity Plan that includes Policies and Procedures to ensure Covered Services are provided in a Culturally Competent manner and Plan for interpretive services/written materials for Members	March 30, 2018
3.5.2	Initial organizational self-assessment of culturally and linguistically competent-related activities	March 30, 2018

Agreement Section Reference	Deliverable	Due Date
4.1.2.2/4.4.5.7.1	Tools, procedures and policies for conducting NF LOC determinations to ensure timeliness and compliance with system interfaces and submissions for NF LOC and setting of care (SOC)	May 1, 2018
4.2.10.2	Policies and procedures for mass transfer	March 30, 2018
4.4.2.5	HRA tool	March 30, 2018
4.4.5.4/4.4.5.5	Comprehensive Needs Assessment tool	March 30, 2018
4.4.8.1	Policies and procedures for ongoing identification of Members who may be eligible for higher levels of Care Coordination	March 30, 2018
4.4.10.1.7	Policies and procedures for identifying, responding to and resolving service gaps pursuant to a care plan in a timely manner	March 30, 2018
4.4.10.5	Policies and procedures regarding care coordinator involvement in discharge planning from hospitals or institutional settings	March 30, 2018
4.4.12.3/ 4.4.12.16	Policies and procedures regarding qualifications, experience and training of Members of the Care Coordination team, including training plan for newly hired care coordinators	March 30, 2018
4.4.12.8	Care Coordination staffing plan	March 30, 2018
4.4.12.14	Policies and procedures for distributing notices to Members regarding Care Coordination changes	March 30, 2018
4.4.13.3	Policies and procedures regarding electronic case management system for Care Coordination	March 30, 2018
4.4.14	Policies and procedures to ensure compliance with EVV requirements	March 30, 2018
4.4.15/4.6.3/ 4.6.4	Policies and procedures to ensure compliance with Self-Directed Community Benefits (SDCB) requirements by Members and their Providers; and MCO oversight of their FMA contractor and contracted or employed support brokers.	March 30, 2018

Agreement Section Reference	Deliverable	Due Date
4.4.16.1.1	Policies and procedures to ensure that Members are contacted in a timely manner in accordance with the time frames prescribed in this Agreement	March 30, 2018
4.4.17	Policies and procedures regarding individuals transitioning from Qualified Health Plans on the Health Insurance Exchange.	March 30, 2018
4.5.4.3	Policies and procedures regarding emergency and non-emergency use of services in outpatient settings	March 30, 2018
4.5.6	Policies and procedures regarding Advance Directives	March 30, 2018
4.5.8.1	Policies and procedures for educating Members on their rights to family planning services	March 30, 2018
4.6.3.2	Policies and procedures regarding the roles and responsibilities of care coordinators and support brokers	March 30, 2018
4.8.1.1	Policies and procedures regarding compliance with State requirements for provider networks	March 15, 2018
4.8.1.2	Annual provider network and development management plan	March 30, 2018
4.8.2.1	Policies and procedures regarding provider recruitment, retention and termination	March 15, 2018
4.8.3	Mechanisms to monitor provider activities to ensure compliance with the CONTRACTOR's and State's policies	March 15, 2018
4.8.6	Policies and procedures regarding the process for Member selection of PCPs and requests for change	March 15, 2018
4.8.7	Certification of provider network	Ongoing
4.8.7.1	Policies and Procedures to ensure that Members and Contract Providers understand how to access services and prior authorization requirements	March 30, 2018
4.8.14.1.1	Policies and Procedures regarding credentialing and recredentialing of Providers	March 15, 2018

Agreement Section Reference	Deliverable	Due Date
4.8.14.1.11	Policies and Procedures to ensure that Providers have appropriate licenses and certifications	March 15, 2018
4.8.16.1.3	Policies and Procedures to comply with federal and State security and procedure guidelines for Telemedicine	March 30, 2018
4.9.1.1	Templates/sample contracts for each type of Contract Provider	March 15, 2018
4.10.6	Physician Incentive Plan, if applicable	March 30, 2018
4.11.1	Provider handbook	March 30, 2018
4.11.2.2	Policies and Procedures for the provider service call center line	March 15, 2018
4.11.3	Screenshots of provider website portal	March 30, 2018
4.11.3.3	Policies and Procedures to ensure provider website is updated and accurate	March 30, 2018
4.11.5.1	Provider Training and Outreach Plan	March 30, 2018
4.11.5.2	Policies and Procedures to implement Provider Training and Outreach Plan	March 15, 2018
4.12.4.1	QM/QI annual program description (including annual work plan)	April 20, 2018
4.12.5.3.1	Policies and procedures for conducting Member surveys	April 20, 2018
4.12.7	Practice guidelines	April 20, 2018
4.12.9.2.4	Disease management plan and description	April 20, 2018

Agreement Section Reference	Deliverable	Due Date
4.12.10.4	Annual UM edits	April 20, 2018
4.12.10.5	Annual UM program description	April 20, 2018
4.12.10.7	UM clinical criteria	April 20, 2018
4.12.10.16	Policies and procedures regarding extended prior authorizations for Covered Services provided to address chronic conditions that require care on an ongoing basis	April 20, 2018
4.12.16.1	Policies and procedures to address, respond to and report Critical Incidents	April 20, 2018
4.14.2.1	Policies and procedures regarding the development and distribution of Member Materials	March 15, 2018
4.14.3.1	Member handbook	March 30, 2018
4.14.4.2	Policies and procedures regarding Members' and Representatives' rights	March 15, 2018
4.14.5.3	Provider directory	Ongoing
4.14.8	Sample Member ID card	March 15, 2018
4.14.9	Screenshots of Member website portal	March 30, 2018
4.14.10	Health Education Plan	March 30, 2018
4.15.1.2	Policies and procedures regarding the Member service call center line	March 15, 2018
4.16.1.2.1	Policies and procedures regarding Member Grievances and Appeals	March 30, 2018

Agreement Section Reference	Deliverable	Due Date
4.16.8	Policies and procedures regarding provider Grievances and Appeals	March 30, 2018
4.17.1.8	Policies and procedures regarding Program Integrity	April 20, 2018
4.17.3	Annual Fraud and Abuse compliance plan	April 20, 2018
4.18.13.2	Policies and procedures regarding TPL responsibilities	April 20, 2018
4.18.14.1	Policies and procedures, where applicable, regarding medical care credit payments for Members residing in residential facilities	TBD
4.20.5	Business Continuity and Disaster Recovery Plan (BC-DR)	March 30, 2018
7.12.4	Policies and procedures regarding disciplinary action for all employees who fail to comply with federal and State statutes, and the CONTRACTOR's standards of conduct policies and procedure requirements under this Agreement	April 20, 2018
7.26.1.4	Policies and procedures for protection of records and all other documents deemed confidential	April 20, 2018

Attachment 2: Centennial Care Covered Services

Non-Community Benefit Services Included Under Centennial Care
Accredited Residential SUD Treatment Centers (Adult)
Accredited Residential Treatment Center Services
Applied Behavior Analysis (ABA)
Adult Psychological Rehabilitation Services
Ambulatory Surgical Center Services
Anesthesia Services
Assertive Community Treatment Services
Bariatric Surgery[1]
Behavior Management Skills Development Services
Behavioral Health Professional Services: outpatient Behavioral Health and substance abuse services
Case Management
Chronic Care Management services
Community Interveners for the Deaf and Blind
Comprehensive Community Support Services
Crisis Services including telephone, clinic, mobile, and stabilization centers
Crisis Triage Centers including residential
Day Treatment Services
Dental Services
Diagnostic Imaging and Therapeutic Radiology Services
Dialysis Services
Durable Medical Equipment and Supplies
Emergency Services (including emergency room visits and psychiatric ER)
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[2]
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services
Family Planning
Family Peer Support Services
Family Support (Behavioral Health)
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations

[1] No limitation on number of surgeries, as long as medical necessity is met.

[2] Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.

Non-Community Benefit Services Included Under Centennial Care
Home Health Services (limitations apply)
Hospice Services
Hospital Inpatient (including Detoxification services)
Hospital Outpatient
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
Institutions for Mental Disease (IMD) for SUD only
Intensive Outpatient Program Services
IV Outpatient Services
Laboratory Services
Medication Assisted Treatment for Opioid Dependence
Midwife Services
Multi-Systemic Therapy Services
Non-Accredited Residential Treatment Centers and Group Homes
Nursing Facility Services
Nutritional Services
Occupational Services
Outpatient Hospital based Psychiatric Services and Partial Hospitalization
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
Outpatient Health Care Professional Services
Peer Support Services
Pharmacy Services
Physical Health Services
Physical Therapy
Physician Visits
Podiatry Services
Pregnancy Termination Procedures
Preventive Services
Prosthetics and Orthotics
Psychosocial Rehabilitation Services
Radiology Facilities
Recovery Services (Behavioral Health)
Rehabilitation Option Services
Rehabilitation Services Providers
Reproductive Health Services
Respite (Behavioral Health) (annual limits may apply but may be exceeded based on the member's health and safety needs)
Rural Health Clinics Services
School-Based Services
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services

Non-Community Benefit Services Included Under Centennial Care
Speech and Language Therapy
Supportive Housing (limitations apply)
Swing Bed Hospital Services
Telemedicine Services
Tobacco Cessation treatment and services (may include counseling, prescription medications, and products).
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Transitional Care Management services
Treatment Foster Care I
Treatment Foster Care II
Vision Care Services

Agency-Based Community Benefit Services Included Under Centennial Care
Adult Day Health
Assisted Living
Behavior Support Consultation
Community Transition Services
Emergency Response
Employment Supports
Environmental Modifications ($5,000 limit every five years)
Home Health Aide
Nutritional Counseling
Personal Care Services (Consumer Directed and Consumer Delegated)
Private Duty Nursing for Adults
Respite (annual limits may apply)
Skilled Maintenance Therapy Services

Self-Directed Community Benefit Services Included Under Centennial Care
Behavior Support Consultation
Customized Community Support
Emergency Response
Employment Supports
Environmental Modifications ($5,000 limit every 5 years)

Self-Directed Community Benefit Services Included Under Centennial Care
Home Health Aide
Self-Directed Personal Care (formerly Homemaker)
Start-Up Goods (For member electing SDCB on or after January 1, 2019, one-time limit of $2000)
Nutritional Counseling
Private Duty Nursing for Adults
Related Goods (annual limits may apply)
Respite (annual limits may apply)
Skilled Maintenance Therapy Services
Specialized Therapies (annual limits may apply)
Transportation (non-medical) (annual limits may apply)

Attachment 3: Delivery System Improvement Performance Targets (DSIPTs)

DSIPTs for Centennial Care 2.0

DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Behavioral Health Visit with a Behavioral Health Provider	The CONTRACTOR shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health Services provided by a Behavioral Health provider. CY20 will be a baseline year for this DSIPT. The CONTRACTOR shall submit CY20 data to HSD by April 1, 2021 to establish the baseline for the CY21 increase. The CONTRACTOR shall provide quarterly reports to HSD with the number of unique Members receiving Behavioral Health services by a Behavioral Health provider and an analysis of trends observed. The quarterly reports are due to HSD thirty (30) Calendar Days after the end of each quarter.	25
Behavioral Health Visit with a Non-Behavioral Health Provider	The CONTRACTOR shall increase the number of unduplicated Medicaid Managed Care members receiving Behavioral Health services by a Non-Behavioral Health provider. CY20 will be a baseline year for this DSIPT. The CONTRACTOR shall submit CY20 data to HSD by April 1, 2021 to establish the baseline for the CY21 increase. The CONTRACTOR shall provide quarterly reports to HSD with the number of unique Members receiving Behavioral Health services by a Non-Behavioral Health provider and an analysis of trends observed. The quarterly reports are due to HSD thirty (30) Calendar Days after the end of each quarter.	25

DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Telemedicine	The CONTRACTOR shall increase the number of unique Members with a Telemedicine visit by twenty percent (20%) in Rural, Frontier, and Urban areas for Physical Health Specialists and Behavioral Health Specialists. The CONTRACTOR shall use the end of Calendar Year (CY) 2019 as the baseline for CY 2020. The baseline for each upcoming calendar year will be the total number of unique members with a Telemedicine visit at the end of the previous calendar year. • Members with Telemedicine visits conducted at I/T/Us are included. • Project ECHO is not considered "Telemedicine" for the purposes of this DSIPT, nor is routine Telemedicine, such as interpretations of radiologic exams by a radiologist at a remote site. • Telemedicine may include virtual visits or e-visits and asynchronous/store-and-forward Telemedicine. If the CONTRACTOR achieves a minimum of five percent (5%) of total membership with Telemedicine visits, as of November 30th each year, then the CONTRACTOR must maintain that same 5% percentage at the end of each Calendar Year in order to meet this target. • The CONTRACTOR shall obtain the Medicaid enrollment data from HSD's website: https://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx The CONTRACTOR shall provide quarterly reports to HSD with the number of unique Members served through Telemedicine visits and an analysis of trends observed. The quarterly reports are due to HSD thirty (30) Calendar Days after the end of each quarter.	25
Value-Based Purchasing	The CONTRACTOR must implement a Value-Based Purchasing (VBP) Strategy that addresses how the CONTRACTOR will meet VBP requirements in the following three (3) component areas. See Attachment 3.A.	25

Centennial Care Contract Attachment [3.A]

Value Based Purchasing (VBP) Delivery System Improvement Performance Targets:

CONTRACTOR'S VBP Program and Requirements

To support Centennial Care's VBP goals, the CONTRACTOR must implement a VBP Program that addresses 4.10.6 and how the CONTRACTOR will meet VBP requirements in the following three (3) component areas.

1. VBP Required Components

The VBP portion of the CONTRACTOR's DSIPT is worth 25 points but will be calculated on a 30-point achievement scale. The VBP portion of the CONTRACTOR's DSIPT consists of two (2) required components.

1. Total Points = 30 for meeting all components of VBP requirements.
2. Point Deductions:
    a. Ten (10) points for each level of provider payments target not achieved; and
    b. Two (2) point deduction for each additional requirement that the contractor fails to meet. Refer to Table 1 for additional requirements for each Level of VBP.

2. VBP Strategy

As noted above, the CONTRACTOR must develop a VBP Strategy. The VBP strategy must include a detailed work plan outlining all interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the contract period. The VBP Strategy for the contract period was submitted to HSD in January 2019. In subsequent years the CONTRACTOR shall develop a VBP Annual Plan that must include a detailed work plan outlining all the interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the contract year, prior period experience, and changes to the VBP Strategy. The CONTRACTOR's VBP Annual Plan shall be submitted to HSD annually by April 1.

3. VBP Quarterly Report

The CONTRACTOR must submit all required quarterly VBP Reports on the template provided by HSD and shall submit narrative updates of all VBP barriers, solutions, successes, status, supportive data and other pertinent information to the VBP. Quarterly reports are due sixty (60) Calendar Days from the end of the first quarter, the remaining quarterly reports are due forty-five (45) Calendar Days after the respective quarter close (or next Business Day if it falls on a weekend or holiday)

1st Quarter: May 30th 2nd Quarter: August 15th

3rd Quarter: November 15th 4th Quarter: February 15th

VBP reporting requirements will be developed by HSD and will be provided to the CONTRACTOR sixty (60) Business Days prior to the contract period. HSD reserves the right to modify the reporting requirements for each contract period.

Percentage of Provider Payments as a Component of a VBP Payment Arrangement

The CONTRACTOR must meet minimum targets for three levels of VBP arrangements. Failure to meet minimum targets will result in deductions to the points available. Percentage of provider payments are defined as Claims paid to a provider who is actively contracted under one of the three levels of VBP arrangements as defined in Table 1 below. For reporting purposes, the CONTRACTOR may exclude provider payment for dually-eligible Members, with the exception of those VBP arrangements that are with long- term care or Nursing Facility Providers, from the calculation. The CONTRACTOR must include payments to Behavioral Health Community Providers in calculating the percentage of overall spend in its VBP arrangements. For purposes of calculating VBP percentages for Community Benefit Providers and Nursing Facilities, the MCO may include dual-eligible Members within those calculations.

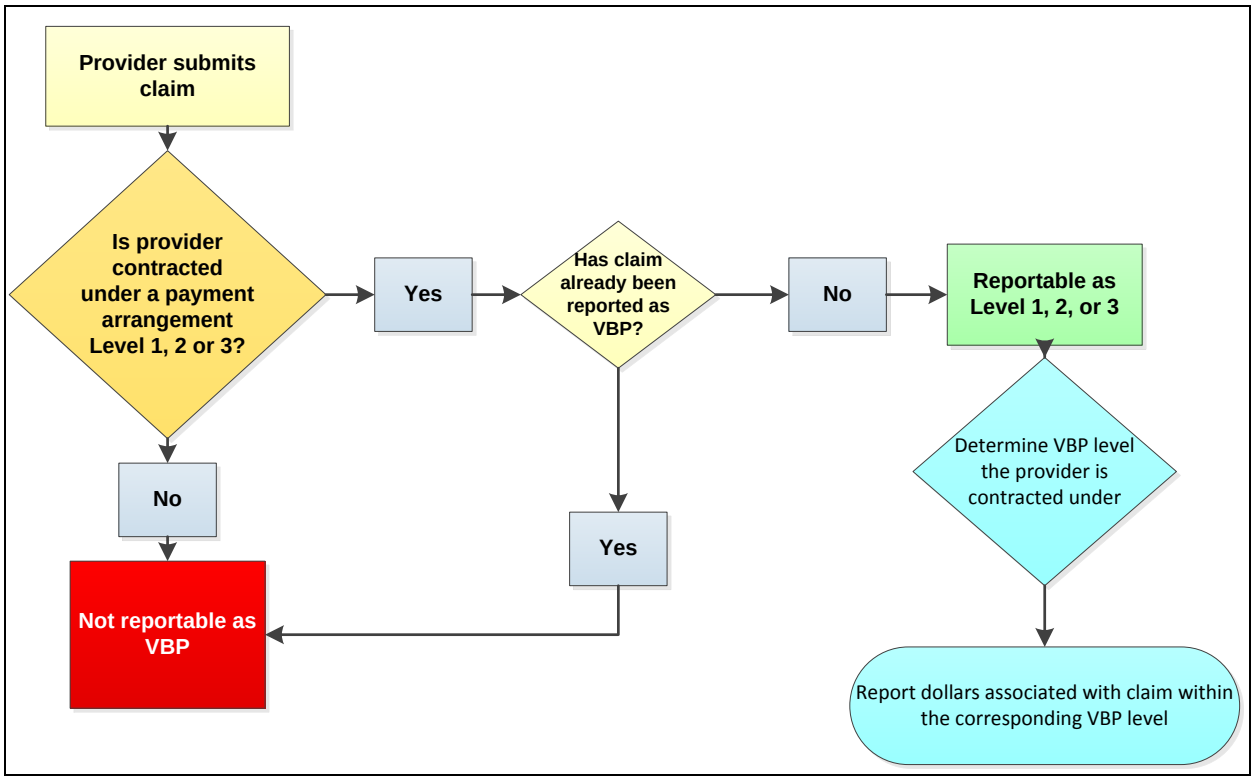
To meet the targets, the CONTRACTOR must have met the percentages established in Table 1 in all three levels, with the following exceptions:

- CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level three (3) for lower percentages in Level two (2) and higher percentages in Level one (1) as the overall minimum percentage targets (total for Level 1-3) are met for the contract year; and
- CONTRACTORS with disproportionate membership within the LTSS program may, at HSD's discretion, submit a plan to HSD for approval that substitutes a higher percentage in Level two (2) for a lower percentage in Level three (3).

4. VBP Percentage Calculation Methodology

For purposes of calculating the VBP percentage minimums in Tables 1-3, a Claim may be counted a maximum of once and is considered a VBP Claim only if the billing provider is contracted with the CONTRACTOR under one of the three types of payment arrangements defined in Table 1. Calculation methodology is outlined in the following diagram:

Diagram 1 – Counting Claims when calculating VBP percentages:



VBP Minimum Percentage of Provider Payments Requirements

The following outlines the minimum percentage of provider Claims that must be associated with a VBP payment arrangement for each Contract Year.

Table 1 – VBP Level Minimum Requirements:

Aggregate VBP Targets			
Contract Year 1 (Jan 1 – Dec 31, 2019)	**Contract Year 2** (Jan 1 – Dec 31, 2020)	**Contract Year 3** (Jan 1 – Dec 31, 2021)	**Contract Year 4** (Jan 1 – Dec 31, 2022)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%**	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HSD reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.***	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%** ***HSD reserves the right to modify the percentage in Year 4 increasing 5% from Contract Period 3.***
Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract period three.			

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 1 – Minimum Requirements			
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
8%	**10%**	**11%**	**12%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed***	• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed***	• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long -Term Care Providers including nursing facilities. ***All included provider requirements must exceed***

Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.)

1. Must include a mix of Physical Health, Behavioral Health, Long-Term Care and nursing facility Providers.

2. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.

VBP Level 1 Definitions:

1. Traditional PH Providers are Providers whose primary services are not Behavioral Health, Long-Term Care or nursing facilities. Traditional PH Providers include FQHCs, hospitals etc.

2. Small provider is defined as practices with 1,000 or less assigned/attributed Members or as determined by HSD prior to the start of the contract period.

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 2 – Minimum Requirements			
Level 2: Fee schedule based, upside-only shared savings-- available when outcome/quality scores meet agreed-upon targets (may include downside risk).			
Contract Year 1	**Contract Year 2**	**Contract Year 3**	**Contract Year 4**
11%	**13%**	**14%**	**15%**
• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Actively build readiness for Long-Term Care Providers including nursing facilities.	• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Actively build readiness for Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers with at least 2 small Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavioral health services. • Long-Term Care Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***
Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.) 1. Must include two or more bundled payments for episodes of care. 2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**. 3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.			

VBP Level 2 – Minimum Requirements

VBP Level 2 Definitions:

1. **Actively build** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTSS and Nursing Facility Providers in Level 2 by Contract Year 3.

2. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top 10 to 20 highest of contracted hospitals and serve at least 100 Members annually.

3. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR'S delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment of Care Coordination needs and Care Coordination assignment and linkage.

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 3 – Minimum Requirements

Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.

Contract Year 1	Contract Year 2	Contract Year 3	Contract Year 4
5%	**7%**	**8%**	**9%**
• Traditional PH Providers. • Implement a CONTRACTOR led BH provider level workgroup that works with BH Providers to design full risk model (see definitions).	• Traditional PH Providers. • Develop Level 3 BH Provider contract model that includes providers who are primarily BH and/or integrated provider systems who offer a continuum of specialty behavior health services. • Implement a CONTRACTOR led Long-Term Care Providers including nursing facilities provider level workgroup to design full-risk model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional PH Providers. • BH Providers whose primary services are BH and/or integrated providers who offer a continuum of specialty behavior health services. • Actively build Long-Term Care Providers including nursing facilities full-risk contracting model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• 8% with traditional PH Provider. • 1% with Providers who are primarily BH and/or integrated providers who offer a continuum of specialty behavior health services. • Long-Term Care Providers including nursing facilities over prior year. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

VBP Level 3 – Minimum Requirements
VBP Level 3 – Minimum Requirements

Additional Requirements: (CONTRACTOR is subject to a 2-point deduction for each Additional Requirement that is not met during a contract year.)

1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
2. At least 5% of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**.
3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services including total cost of care on a quarterly basis.

VBP Level 3 Definitions:

1. **Implement a Contractor led BH provider Level workgroup** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Behavioral Health Providers in Level 3 by Contract Year 3.
2. **Implement a Long-Term Care including nursing facilities provider level workgroup to design full-risk model** is defined as a CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Long-Term Care including nursing facilities Providers in Level 3 by Contract Year 4.
3. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top 10 to 20 highest of contracted hospitals and serve at least 100 Members annually.
4. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR'S delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment for Care Coordination needs and Care Coordination assignment and linkage.

Full Delegation of Care Coordination within Level 3 VBP arrangements are tied to Level 3 full risk Providers and with Health Homes.

Attachment 4: Safety-Net Care Pool Hospitals

HOSPITAL NAME	COUNTY
Alta Vista Regional Medical Center	San Miguel
Artesia General Hospital	Eddy
Carlsbad Medical Center	Eddy
Cibola General Hospital	Cibola
Dan C. Trigg	Quay
Eastern New Mexico Medical Center	Chaves
Espanola Hospital	Rio Arriba
Gerald Champion Medical Center	Otero
Gila Regional Medical Center	Grant
Guadalupe Hospital	Guadalupe
Holy Cross Hospital	Taos
Lea Regional Hospital	Lea
Lincoln County Medical Center	Lincoln
Los Alamos Medical Center	Los Alamos
Memorial Medical Center	Dona Ana

Mimbres Memorial Hospital	Luna
Miners Colfax Medical Center	Colfax
Mountain View Regional Medical Center	Dona Ana
Nor-Lea General Hospital	Lea
Plains Regional Medical Center	Curry
Rehoboth McKinley Christian Hospital	McKinley
Roosevelt General Hospital	Roosevelt
Lovelace Regional Hospital-Roswell	Chaves
San Juan Regional Medical Center	San Juan
Sierra Vista Hospital	Sierra
Socorro General Hospital	Socorro
CHRISTUS – St. Vincent Regional Medical Center	Santa Fe
Union County General Hospital	Union
The University of New Mexico Hospital	Bernalillo

Attachment 5: Alternative Benefit Plan Covered Services

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation[3]
Applied Behavioral Analysis (ABA)
Bariatric surgery[4]
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiovascular rehabilitation[5]
Chemotherapy
Chronic Care Management services
Dental services[6]
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
Dialysis
Diagnostic imaging
Disease management
Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[7]
Electroconvulsive therapy
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19-20
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
Family planning and reproductive health services and devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices[8]
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing[9]

[3] Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.

[4] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight BMI and health status.

[5] Limited to short-term therapy (two consecutive months) per cardiac event.

[6] The ABP covers dental services for adults in accordance with 8.310.2 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.

[7] Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.

[8] Sterilization reversal is not covered. Infertility treatment is not covered.

[9] Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.

Alternative Benefit Plan Services Included Under Centennial Care
Habilitative and rehabilitative services, including physical, speech and occupational therapy[10]
Hearing screening as part of a routine health exam[11]
Holter monitors and cardiac event monitors
Home health care, skilled nursing and intravenous services[12]
Hospice care services
Immunizations[13]
Inpatient physical and behavioral health hospital/medical services and surgical care[14]
Inpatient rehabilitative services/facilities[15]
Internal prosthetics
IV infusions
Lab tests, x-ray services and pathology
Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care
Medication assisted therapy for opioid addiction
Non-emergency transportation when necessary to secure covered medical services
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
Organ and tissue transplants[16]
Osteoporosis diagnosis, treatment and management
Outpatient surgery
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions[17]
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings[18]
Physician visits
Podiatry and routine foot care[19]
Prescription medicines
Primary Care to treat illness/injury and chronic disease management

[10] Limited to short-term therapy (two consecutive months) per condition.
[11] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20. The ABP does not cover audiology services.
[12] Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.
[13] Includes ACIP-recommended vaccines.
[14] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.
[15] Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the recipient is the eventual return home.
[16] Transplants are limited to two per lifetime.
[17] Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.
[18] Includes US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.
[19] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

Alternative Benefit Plan Services Included Under Centennial Care
Pulmonary therapy[20]
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing[21]
Sleep studies[22]
Specialist visits
Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[23]
Telemedicine services
Tobacco Cessation treatment and services (may include counseling, prescription medications, and products).
Transitional Care Management services
Urgent care services/facilities
Vision care for eye injury or disease[24]
Vision hardware (eyeglasses or contact lenses)[25]

[20] Limited to short-term therapy (two consecutive months) per condition.

[21] Subject to the 100-visit home health limit when provided through a home health agency.

[22] Limited to diagnostic sleep studies performed by certified providers/facilities.

[23] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and respite Services.

[24] Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.

[25] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients age 19-20 following a periodicity schedule.

Attachment 6: Providers with Distance Requirements

A. Behavioral Health

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)
6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agency (CSA)
8. Community Mental Health Centers (CMHC)
9. Indian Health Service and Tribal 638s providing Behavioral Health services
10. Outpatient Provider Agencies
11. Agencies providing Behavioral Management Services (BMS)
12. Agencies providing Day Treatment Services
13. Agencies providing Assertive Community Treatment (ACT)
14. Agencies providing Multi-Systemic Therapy (MST)
15. Agencies providing Intensive Outpatient Services
16. Methadone Clinics
17. FQHCs providing Behavioral Health Services
18. Rural Health Clinics providing Behavioral Health services
19. Psychiatrists
20. Psychologists (including Prescribing Psychologists)
21. Suboxone certified MDs
22. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS & CNP with Psychiatric Certification, Independent Practices or Groups

B. Physical Health

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. RHC
10. Hematology/Oncology
11. I/T/U
12. Neurology
13. Neurosurgeon
14. OB-GYN
15. Orthopedics

16. Pediatrics
17. Physician Assistant
18. Podiatry
19. Rheumatology
20. Surgeons
21. Urology

C. Long-Term Care

1. Assisted Living Facilities
2. Personal Care Service Agencies (PCS) - delegated
3. Personal Care Service Agencies (PCS) - directed
4. Nursing Facilities

D. Hospitals

1. General Hospitals
2. Inpatient Psychiatric Hospitals

E. Transportation

Attachment 7: Reconciliations and Risk Corridor Evaluation Methodologies

The following outlines the methodologies, including data and other information, for the evaluation of the following:

1. Retroactive Period Reconciliation (Section 6.8)
2. Medical Care Credit Reconciliation (Section 6.9)
3. Community Benefit Reconciliation (Section 6.10)
4. Hepatitis C Risk Corridor Reconciliation (Section 6.11)

The reconciliations outlined in this Attachment utilize Encounter Data submitted by the CONTRACTOR and accepted by HSD's MMIS system. In some circumstances, additional information may be required of the CONTRACTOR and this information may be incorporated into the evaluation. Additional information includes, but is not limited to, reinsurance expense and recoveries, pharmacy rebates, pharmacy supplemental rebates or exclusivity pricing. As required in Section 4.19, the CONTRACTOR is required to submit timely and accurate Encounter Data.

Retroactive Period Reconciliation

1. HSD shall reconcile the medical expenditures related to the Retroactive Period for each Contract year period (January 1 to December 31 of each Contract year). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HSD's notification date to the CONTRACTOR outlined in Sections 4.2.8 and 6.8. As outlined in Section 6.8.1 newborns identified by Rate Cohorts 001 and 006 are excluded from the Retroactive Period reconciliation.
2. The reconciliation for the Retroactive Period is limited to the Covered Services medical expenses defined in Attachment 2. The following expenses are excluded from the reconciliation:
   a. Indian Health Services / Tribal 638 Providers reimbursed through the supplemental process described in Section 6.3;
   b. Value Added Services;
   c. CONTRACTOR administrative expense;

d. CONTRACTOR Care Coordination expense (medical or administrative);
e. CONTRACTOR Centennial Rewards expense (reward or administrative);
f. Health Insurance Exchange payments; and
g. Project ECHO payments.

3. The retroactive reconciliation will be calculated using the following information:
   a. Payments made by HSD to the Contractor for Members in the Retroactive Period;
   b. Medical expenses outlined in Retroactive Period Reconciliation item #2 and defined as covered medical expenses incurred by Members during the retroactive period and paid by the CONTRACTOR less:
      i. Pharmacy rebates, including supplemental rebates for specialty medications such as Hepatitis C;
      ii. Applicable Member cost sharing; and
      iii. Net reinsurance expense (reinsurance premium less reinsurance recoveries).
4. HSD will permit the CONTRACTOR to retain five percent (5%) of the net medical expense for administrative costs (net medical expense multiplied by 5.0%).
5. HSD shall adjust the final reconciliation for applicable premium tax.
6. Net medical expense plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR to determine the value of recoupment from or payment to the CONTRACTOR.
7. HSD shall provide the CONTRACTOR with detailed Member level data for revenue and Encounter expenses as well as impacts of pharmacy rebates, Member cost sharing and net reinsurance expense upon completion of the reconciliation calculations.
8. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
9. Evaluation Periods
   a. Interim Evaluation

   HSD will perform an initial evaluation of the reconciliation between July and September in the year following the end of the contract period being measured when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the interim evaluation, and at HSDs

discretion may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns about the capitation, Encounter Data or other factors included in the interim reconciliation. The CONTRACTOR is responsible for communicating any issues that may impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

b. Final Evaluation

HSD will perform a final evaluation of the reconciliation between July and September in the second year following the end of the Contract period being measured when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within 30 Business Days following receipt of the information and provide HSD with any concerns about the capitation, Encounter Data or other factors included in the final reconciliation; otherwise, the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

10. Retroactive Changes to the Data Following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HSD then HSD is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

Medical Care Credit Reconciliation

1. HSD shall evaluate the difference between the actual and assumed medical care credit amounts included in the LTSS blended capitation rates described in Section 6.5.3.1.4 and Section 6.9.

2. HSD shall evaluate the actual medical care credit amounts reflected in the CONTRACTOR'S payments from the CONTRACTORS' submitted and accepted Encounter Data versus the amount included in the LTSS blended payment rates. The difference between the amounts will result in either a recoupment by HSD from the CONTRACTOR or a payment by HSD to the CONTRACTOR.
3. Evaluation Periods
   a. Interim Evaluation

   HSD will perform an initial evaluation of the medical care credit between July and September in the year following the end of the contract period being measured when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the interim evaluation, and at HSD's discretion, may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns about the capitation, Encounter Data or other factors included in the interim reconciliation. The CONTRACTOR is responsible for communicating any issues that may impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

   b. Final Evaluation

   HSD will perform a final evaluation of the reconciliation and/or risk corridor between July and September in the second year following the end of the contract period being measured when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns about the capitation, Encounter Data or other factors included in the final reconciliation otherwise the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

4. Retroactive Changes to the Data Following the Final Evaluation
   In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HSD, then HSD is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

Community Benefit Reconciliation

The community benefit reconciliation process evaluates the LTSS Capitation Payments made by HSD to the CONTRACTOR based on the determination of the NF LOC and community benefit SOC by the CONTRACTOR. The NF LOC and SOC triggers a LTSS Capitation Payment. Members who are determined by the CONTRACTOR to meet the NF LOC and access the community benefit are expected to require long term and frequent use of community benefit services. LTSS Capitation Payments for Members who are designated by the CONTRACTOR to meet the NF LOC and SOC, and do not use community benefit services within the first three months of the LTSS Capitation Payment, will be identified for adjustment described in the following:

1. HSD shall evaluate the LTSS Capitation Payments for Members who are NF LOC with a community benefit SOC. The LTSS Capitation Payment and the utilization of community benefit services for each Member will be evaluated on an annual basis for each Contract Period (the period between January 1 and December 31), referred to as the Reconciliation Evaluation Period. The Community Benefit reconciliation process described below will identify LTSS Capitation Payments paid by HSD to the CONTRACTOR that were not appropriate based on a lack of community benefit service utilization by the Member. These LTSS Capitation Payments will be adjusted by HSD through the MMIS capitation process, recouping the LTSS Capitation Payment and issuing a different Capitation Rate for the correct Rate Cohort.
2. The data sources for the reconciliation include Capitation Payments for LTSS Rate Cohorts 300-322, with a SOC indicating community benefit outlined below. Rate Cohort 304, healthy duals, will be excluded from this evaluation. HSD makes Capitation Payments prospectively

to the CONTRACTOR; therefore, if a Member is assigned a LTSS Rate Cohort the effective date for evaluating community benefit utilization is the first and last day of the month the LTSS Capitation Payment is effective. Due to Centennial Care Member transfers that occurred prior to and during CY14, the SOC selected for the community benefit could include the following:

Centennial Care Settings of Care

- ADB = Agency Directed Benefit
- ANW = Agency Non-Waiver
- SDB = Self-Directed Benefit
- SNW = Self-Directed Non-Waiver

Pre-Centennial Care Settings of Care

- PCO = Personal Care Option (pre-Centennial Care)
- DEW = Disabled and Elderly Waiver (pre-Centennial Care)
- MIV = Mi Via/self-direction (pre-Centennial Care)
- Null = if any LTSS Members are selected and have an empty setting of care, their Encounter Data service utilization will be evaluated to determine the appropriate SOC.

3. The LTSS Capitation Payment data evaluated will include three months prior to the Reconciliation Evaluation Period because the LTSS Capitation Payment may begin prior to the Reconciliation Evaluation Period. The periods prior to the Reconciliation Evaluation Period **will not** be identified for recoupment.
4. The LTSS Capitation Payment data will include any LTSS Capitation Payments that occurred in the retroactive period. Although the reconciliation will evaluate the retroactive period, these periods **will not** be identified for recoupment, since they are reconciled under the Retroactive Reconciliation process.
5. HSD will select all agency-based and self-directed community benefit services from the CONTRACTORS submitted and accepted Encounter Data. Any Encounter Data records that have been denied will not be considered. Community benefit services are defined in Table 1 for agency-based and Table 2 for self-directed community benefit services.

6. The community benefit services in the Encounter Data will be classified into the two following types of community benefit services:
    - Community benefit – environmental modification.
    - Community benefit – all other services that are not environmental modifications.

7. HSD will evaluate the LTSS Capitation Payment and Encounter Data for incurred periods during the month of capitation and identify community benefit service utilization. A Member must use a community benefit service within the first three months from the effective coverage date for the LTSS Capitation Payment. The reconciliation will apply the following rules to determine which periods will be identified for adjustment.
    a. If a community benefit service is not used within the first three months then the LTSS Capitation Payments will be identified for recoupment between the first LTSS Capitation Payment and the month prior to the utilization of a community benefit service. This evaluation process will restart following the month a community benefit service is utilized.
    b. Members who utilize a community benefit service within the first three months of the LTSS Capitation Payment and are then admitted to an inpatient facility (acute, skilled nursing, rehabilitation or psychiatric), nursing facility or Hospice facility, for more than 20 consecutive days in each of the three months following the utilization of community benefits, will not be identified for adjustment because the gap in the utilization of the community benefit is due to a long term facility admission.
        i. LTSS Capitation Payments will be identified for adjustment if the facility admission is less than 20 consecutive days and a community benefit service is not utilized. This evaluation process will restart following the month a community benefit service is found to be utilized. If the only community benefit service utilized is an environmental modification, then HSD will consider the NF LOC, SOC and LTSS Capitation Payment inappropriate and identify the LTSS Capitation Payment for adjustment.
    c. If a community benefit service, other than an environmental modification, is eventually utilized, HSD will identify the period between the first LTSS Capitation Payment and the

month prior to the non-environmental modification in which the community benefit service was utilized for adjustment.

i. If the Member experiences a loss of eligibility that results in a gap of community benefit services, the community benefit reconciliation evaluation will restart and apply the process outline above beginning with the first month of the LTSS Capitation Payment following the gap in eligibility.

d. If community benefit services are not present for the duration of the reconciliation evaluation period, the entire period will be flagged for recoupment.

8. Evaluation Periods

a. Interim Evaluation

As described in the prior Sections, the period(s) identified as an adjustment to LTSS Capitation Payments will be identified by HSD for the CONTRACTOR to review. HSD will provide each CONTRACTOR the LTSS Capitation Payments and community benefit Encounter Data used in the evaluation by Member. The files will be posted to HSD's secure file transfer site, where the CONTRACTOR can download and inspect the files. The CONTRACTOR has thirty (30) Business Days, between the notification by HSD to the CONTRACTOR of the files availability to raise data issues or concerns to HSD. Following this period HSD will schedule and perform the Capitation Payment adjustment process.

The LTSS and corresponding Behavioral Health Capitation Payment will be recouped and replaced with the correct Rate Cohort based on the Member's category of eligibility (COE), age and gender as applicable. The Member's setting of care span will also be updated by HSD to accurately reflect utilization or non-utilization of community benefit service(s) to the Member's setting of care information.

HSD will perform an initial evaluation of the community benefit reconciliation between July and September, in the year following the end of the contract period being measured, when the evaluation includes Capitation Payment and accepted Encounter Data. The CONTRACTOR is responsible for communicating any issues that may impact the information that HSD uses to perform the interim evaluation by no later than the last

Business Day of May, prior to the measurement of the reconciliation. HSD will provide the CONTRACTOR with the results of the interim evaluation, and at HSD's discretion, may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns about the capitation, Encounter Data or other factors included in the interim reconciliation.

b. Final Evaluation

HSD will perform a final evaluation of the community benefit reconciliation between July and September, in the second year following the end of the contract period being measured, when the evaluation includes Capitation Payment and accepted Encounter Data. The CONTRACTOR is responsible for communicating any issues that impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May, prior to the measurement of the reconciliation. HSD will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and should provide HSD with any concerns about the capitation, Encounter Data or other factors included in the final reconciliation; otherwise, the results are considered final.

9. Retroactive Changes to the Data Following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HSD, then HSD is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

Table 1 – Agency-Based Community Benefit Services

Agency-based community benefit is defined as the billing codes outlined in the following table and a billing provider type = "363".

Service Description	Billing Code	Unit
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Personal Care Consumer Directed	99509	Hour

Service Description	Billing Code	Unit
Personal Care Consumer Delegated	T1019	15 minutes
Personal Care Directed training	S5110	15 minutes
Personal Care Directed Administrative Fee	G9006	1 unit + 1 month
Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes
Respite RN	T1002 U1	15 minutes
Private Duty Nursing for Adults – LPN	T1003 U1	15 min
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes

Table 2– Self-Directed Community Benefit Services

The billing provider name "TNT" and the procedure codes listed in the following table will be selected to identify the self-directed community benefit services.

SDCB Service Description	Billing Code	Unit
Self-Directed PCS	99509	Hour
Home Health Aide	S9122	Hour
Employment Supports (includes Job Coach)	T2019	15 minutes
Job Developer (per job that is developed for Member)	T2019	Each
Customized Community Supports (adult day rehab)	S5100	15 minutes
Physical Therapy	G00151	15 minutes
Occupational Therapy	G0152	15 minutes
Speech/Language Pathology	G0153	15 minutes
Behavior Support Consultation	H2019	15 minutes
Private Duty Nursing – Adults — RN	T1002	15 minutes
Private Duty Nursing – Adults — LPN	T1003	15 minutes
Nutritional Counseling	S9470	Hour
Acupuncture	97810	15 minutes
Biofeedback	90901	Visit
Chiropractic	98940	Visit
Cognitive Rehab Therapy	97532	15 minutes
Hippotherapy	S8940	Visit
Massage Therapy	97124	15 minutes
Naprapathy	S8990	Visit
Native American Healers	S9445	Session
Play Therapy	H2032	15 minutes
Respite Standard (not provided by RN, LPN or HHA)	T1005	15 minutes
Respite RN	T1005	15 minutes
Respite LPN	T1005	15 minutes
Respite Home Health Aide	T1005	15 minutes
Emergency Response (monthly fee)	S5161	Each Emergency
Response (testing and maintenance)	S5160	Each Environmental
Modifications	S5165	Each

SDCB Service Description	Billing Code	Unit
Transportation Time	T2007	Hour
Transportation Trip	T2003	Each
Transportation Mile	T2049	Per Mile
Transportation Commercial Carrier Pass	T2004	Each
Coaching/Education for Parents, Spouse or Others (not available for paid caregivers)	T1999	Each
Coaching/Education for Parents, Spouse or Others-Classes only (not available for paid caregivers)	T1999	Each
Coaching/Education for Parents, Spouse or Others-Conferences and Seminars (not available for paid caregivers)	T1999	Each
Technology for Safety and Independence	T1999	Each Cell
Phone Service (including data/GPS)	T1999	Each Cell
Phone and Related Equipment	T1999	Each
Cell Phone/Landline	T1999	Each
Internet Service	T1999	Each
Landline Service	T1999	Each
Internet/Cell Phone	T1999	Each
Internet/landline	T1999	Each
Fax Machine	T1999	Each
Computer	T1999	Each
Office Supplies	T1999	Each
Printer	T1999	Each
Health-Related Equipment and Supplies	T1999	Each
Adaptive Equipment and Related Supplies	T1999	Each
Exercise Equipment and Related Items	T1999	Each
Nutritional Supplements	T1999	Each
Over the Counter Medications	T1999	Each
Household Related Goods	T1999	Each
Appliances for Independence	T1999	Each
Adaptive Furniture	T1999	Each
Fees and Memberships	T1999	Each

Hepatitis C Risk Corridor

1. HSD shall evaluate the risk corridor for Hepatitis C for each Contract year period (January 1 to December 31). The CONTRACTOR and HSD shall share in excess gains or losses generated under this Agreement as follows:

Corridor	Gain/Loss Limits		Share of Gain/Loss	
	Lower	Upper	CONTRACTOR	HSD
0.0% to 3.0% loss/gain	0.0%	3.0%	100%	0%
3.0% to 6.0% loss/gain	3.0%	6.0%	25%	75%
6.0% + loss/gain	6.0%	100.0%	10%	90%

2. The risk corridor evaluation is limited to the covered pharmacy cost associated with Hepatitis C treatment defined as the FDA-approved drug list maintained and communicated to the CONTRACTOR by HSD for each annual contract period (January 1 to December 31). Pharmacy expenditures not identified and included in the drug list will not be countable expenses in the calculation of the risk corridor.
3. The risk corridor excludes Contractor Member months and pharmacy Encounter Data in the Retroactive Period.
4. HSD will utilize the following to evaluate the risk corridor:
   a. Capitated rate add-on PMPM, described in Section 6.5, by Rate Cohort;
   b. Member months by Rate Cohort for the evaluation period per HSD's Capitation Payments to the CONTRACTOR;
   c. Encounter data submitted by the CONTRACTOR and accepted by HSD for the Hepatitis C drugs defined on the FDA-approved drug list communicated to the CONTACTOR;
   d. Applicable rebates or discounts described in Sections 6.14.4 and 6.14.5;
   e. Applicable Member cost sharing, and
   f. Applicable premium tax.
5. Upon completion of the risk corridor evaluation, HSD shall provide the CONTRACTOR with Member level data for Member months, capitation, Encounter expenses, as well as impacts of pharmacy rebates or discounts and Member cost sharing.
6. HSD has established the risk corridor but makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

7. Evaluation Periods

   a. Interim Evaluation

   HSD will perform an initial evaluation of the reconciliation and/or risk corridor between July and September, in the year following the end of the contract period being measured, when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the interim evaluation and at HSDs discretion may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns regarding the source data or other factors included in the interim reconciliation. The CONTRACTOR is responsible for communicating any issues that may impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

   b. Final Evaluation

   HSD will perform a final evaluation of the reconciliation and/or risk corridor between July and September, in the second year following the end of the contract period being measured, when the evaluation includes Capitation Payment and accepted Encounter Data. HSD will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HSD within thirty (30) Business Days following receipt of the information and provide HSD with any concerns regarding the source data or other factors included in the final reconciliation; otherwise, the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information that HSD uses to perform the interim evaluation by no later than the last Business Day of May.

8. Retroactive Changes to the Data Following the Final Evaluation

   In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HSD, then HSD is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

Attachment 8: List of Psychotropic Drugs and Medications

GENERAL DESCRIPTION	THERAPEUTIC CLASS (MCOs must use their comparable therapeutic classes)	PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names are in parentheses)				
Anti-Anxiety Medications (non-benzodiazepines)	H2F	Buspirone (BuSpar)				
Antidepressants	H2F, H2S, H2U, H7B, H7C, H7D, H7E, H20, H8P, H8T, H8Z **Antipsychotics** H2G, H7P, H7R, H7S, H7U, H7O, H7Z	Amitriptyline (Elavil)	Amoxapine (Asendin)	Bupropion (Wellbutrin)	Citalopram (Celexa)	Clomipramine (Anafranil)
		Desipramine (Norpramin)	Desvenlafaxine (Pristiq)	Duloxetine (Cymbalta)	Doxepin (Sinequan)	Escitalopram (Lexapro)
		Fluoxetine (Prozac, Sarafem)	Fluoxetine & Olanzapine (Symbyax)	Fluvoxamine (Luvox)	Imipramine (Tofranil)	Maprotiline (Ludiomil)
		Mirtazapine (Remeron)	Nefazodone (Serzone)	Nortriptyline (Pamelor)	Paroxetine (Paxil, Pexeva)	Protriptyline (Vivactil)
		Sertraline (Zoloft)	Trazodone (Desyrel, Oleptro)	Trimipramine (Surmontil)	Venlafaxine (Effexor)	Vilazodone (Viibryd)
		Vortioxetine (Brintellix)				
Monoamine Oxidase Inhibitors	H2H, H7J	Isocarboxazid (Marplan)	Phenelzine (Nardil)	Tranylcypromine (Parnate)		Selegiline (Emsam)
Anti-Mania Medications	H2M	Lithium carbonate		Lithium citrate		
Phenothiazines, Other Major Tranquilizers and Antipsychotics, including Second Generation	H2G, H7T, H7X, H8W, H7P, H7R, H7S, H7U, H7O, H7Z	Aripiprazole (Abilify)	Asenapine (Saphris)	Brexiprazole (Rexulti)	Cariprazine (Vraylar)	
		Chlorpromazine (Thorazine)	Clozapine (Clozaril)	Droperidol (Inapsie)	Fluphenazine	
		Haloperidol (Haldol)	Iloperidone (Fanapt)	Lozapine (Loxitane)	Lurasidone (Latuda)	
		Molindone (Moban)	Olanzapine (Zyprexa)	Paliperidone (Invega)	Fluoxetine & Olanzapine (Symbyax)	
		Perphenazine (Trilafon)	Pimozide (Orap)	Prochlorperazine (Compro)	Quetiapine (Seroquel)	
		Risperidone (Risperdal)	Thioridazine	Thiothixene (Navane)		
		Trifluorperazine	Ziprasidone (Geodon)	Brexpiprazole (Rexulti)		

GENERAL DESCRIPTION	THERAPEUTIC CLASS (MCOs must use their comparable therapeutic classes)	PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names are in parentheses)			
Anticonvulsant Mood Stabilizers	H4B	Carbamazepine (Tegretol)	Divalproex sodium (Depakote)	Lamotrigine (Lamictal)	Valproic acid
		Oxarbazepine (Trileptal)	Topiramate (adjunct) (Topamax)	Gabapentin (Neurontin) *for use in alcohol use disorder	
ADHD Treatments	H7Y, A4B, J5B, H2V, H8M	Atomoxetine (Strattera)	Clonidine (Catapres)	Amphetamine	Amphetamine/ Dextroamphetamine (Adderall)
		Methylphenidate (Concerta, Ritalin)	Guanfacine (Intuniv)	Dexmethylphenidate (Focalin)	Dextroamphetamine (Dexedrine)
		Lisdexamfetamine (Vyvanse)	Methamphetamine (Desoxyn)		
Long Acting Injectable Antipsychotics	H7T, H7X, H7O, H2G	Risperidone IM (Risperidal Consta)	Paliperidone Palmitate IM (Invega Sustenna)	Paliperidone Palmitate ER IM (Invega Trinza)	Aripiprazole IM (Abilify Maintena)
		Aripiprazole Lauroxil IM (Aristada)	Olanzapine IM (Zypreza Relprevv)	Haloperidol Decanoate IM (Haldol Decanoate)	Fluphenazine Decanoate IM (Prolixin)
Medication Assisted Treatment for substance use disorders	H3W, H3T, C0D, H33	Buprenorphine/Naloxone (Suboxone)	Naltrexone (Vivtrol)	Acamprosate (Campral)	Disulfiram (Antabuse)
		Lofexidine (Lucemyra)			
Other	Select drugs in the following HIC3 categories: P3A, J7B, H6A	Liothyronine (Cytomel) *for augmentation in severe depression	Prazosin (Minipress) *for PTSD	Pramipexole (Mirapex) *for augmentation in severe depression	

Attachment 9: CAHPS Supplemental Questions

NCQA Tracking Number	Child Questions	Response Categories Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always)	If Required by State Medicaid Agency, which one?	NCQA Decision
990032	In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these doctors or other health providers?	1) Yes 2) No	New Mexico	Approve
990033	In the last 6 months, who helped to coordinate your child's care?	1) Someone from your child's health plan 2) Someone from your child's doctor's office or clinic 3) Someone from another organization 4) A friend or family Member 5) You	New Mexico	Approve
990010	How satisfied are you with the help you got to coordinate your child's care in the last 6 months?	1) Very dissatisfied 2) Dissatisfied 3) Neither dissatisfied nor satisfied 4) Satisfied 5) Very satisfied	New Mexico	Approve

NCQA Tracking Number	Adult Questions	Response Categories Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always)	If Required by State Medicaid Agency, which one?	NCQA Decision
990034	In the last 6 months, did anyone from your health plan, doctor's office, or clinic help coordinate your care among these doctors or other health providers?	1) Yes 2) No	New Mexico	Approve
990035	In the last 6 months, who helped to coordinate your care?	1) Someone from your health plan 2) Someone from your doctor's office or clinic 3) Someone from another organization 4) A friend or family Member 5) You	New Mexico	Approve
99008	How satisfied are you with the help you received to coordinate your care in the last 6 months?	1) Very dissatisfied 2) Dissatisfied 3) Neither dissatisfied nor satisfied 4) Satisfied 5) Very satisfied	New Mexico	Approve
990036	In the last 6 months, have you received any material from your health plan about good health and how to stay healthy?	1) Yes 2) No	New Mexico	Approve
990037	In the last 6 months, have you received any material from your health plan about Care Coordination and how to contact the Care Coordination unit?	1) Yes 2) No	New Mexico	Approve
990038	Did your Care Coordinator sit down with you and create a Plan of Care?	1) Yes 2) No	New Mexico	Approve

NCQA Tracking Number	Adult Questions	Response Categories Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always)	If Required by State Medicaid Agency, which one?	NCQA Decision
990009	Are you satisfied that your care plan talks about the help you need to stay healthy and remain in your home?	1) Very dissatisfied 2) Dissatisfied 3) Neither dissatisfied nor satisfied 4) Satisfied 5) Very satisfied	New Mexico	Approve
000237	FRM1	A fall is when your body goes to the ground without being pushed. In the past 6 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?	Yes No [I had no visits in the past 6 months]	Approve
000238	FRM2	Did you fall in the past 6 months?	Yes No	Approve
000239	FRM3	In the past 6 months, have you had a problem with balance or walking?	Yes No	Approve
000240	FRM4	Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking? Some things they might do include: Suggest that you use a cane or walker. Check your blood pressure lying or standing. Suggest that you do an exercise or physical therapy program. Suggest a vision or hearing testing.	Yes No [I had no visits in the past 6 months]	Approve

Attachment 10: SUPPORT Act Requirements

The CONTRACTOR is required to implement the requirements of the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the "SUPPORT for Patients and Communities Act" into policy and procedures for all contracted Medicaid services statewide. Managed Care Organizations must comply with the requirements in Section 1902 of the Social Security Act (42 U.S.C. 1396a) as amended.

OPIOID CLAIMS REVIEW

(I) A real-time prospective drug utilization review of the sort defined in section 1927(g)(2)(A) of the Social Security Act, for each prescription that identifies potential problems at point of sale to engage both patients and prescribers about possible opioid abuse and overdose risk prior to the prescription being dispensed to the patients.

(II) An automated claim review process as a retrospective drug utilization review of the sort defined in section 1927(g)(2)(B) of the Social Security Act, that provides for additional examination of claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.

(III) Both the prospective and the retrospective drug utilization review will be consistent with medical practice patterns in New Mexico to help meet the health care needs of the Medicaid patient population in the state. The Centers for Medicare & Medicaid Services encourage states to utilize, for example, the 2016 Centers for Disease Control and Prevention Guideline for primary care practitioners on prescribing opioids in outpatient settings for chronic pain.

(IV) CLAIMS REVIEW REQUIREMENTS

1. **Safety Edits Including Early, Duplicate, and Quantity Limits**: Limitations in both prospective and retrospective drug utilization review should include restrictions on duplicate fills, early fills, and drug quantity limitations.

2. **Maximum Daily Morphine Milligram Equivalents Safety Edits:** Both the prospective and retrospective drug utilization review safety edits must include a morphine milligram equivalents threshold amount such as the level that is recommended in the 2016 Centers for Disease Control Guideline referenced in section (III) above.

3. **Concurrent Utilization Alerts**: Both the prospective and retrospective drug utilization review safety edits must be able to provide alerts for concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics, as well as potential complications resulting from other medications concurrently being prescribed with opioids.

4. **Care Coordination:** All safety edits will activate Care Coordination for the deliberate organization of patient care activities between all participants involved in the patient's care to facilitate the appropriate delivery of health care services.

(V) **EXEMPTIONS** - The drug review and utilization requirements under this subsection shall not apply with respect to an individual who is receiving hospice or palliative care or treatment for cancer; or is a resident of a long-term care facility, a facility described in section 1905(d) of the Social Security Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

(VI) **OPIOID THERAPY EDITS** - Opioid pharmacy claims that exceed the maximum morphine milligram equivalents per day, as determined by the state, will be flagged and may be denied. If the prescriber deems that it is medically necessary for the recipient to exceed the maximum morphine milligram equivalents per day limit, the prescriber must complete the *Drug Prior Authorization Request* form and fax the completed signed form requesting to increase the maximum prescribed morphine milligram equivalents limit to the prior authorization unit of the recipient's assigned benefit plan for clinical review. If a recipient presents a new prescription to the pharmacy that exceeds a previously approved morphine milligram equivalents limit, this is considered an additional request requiring the prescriber to again submit for prior authorization. Subsequent requests by a prescriber to increase a morphine milligram equivalents limit will require the prescriber to submit a new request.

When the pharmacist cannot reach a prescriber or when the prior authorization departments are closed, the pharmacist, using his/her professional judgement, may deem the filling of the prescription for these edits to be an "emergency." In these emergency cases, the pharmacist must document "Emergency Prescription" in writing on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and can override the pharmacy claim at point-of-sale by contacting the health plan's pharmacy help desk.

The CONTRACTOR will offer education and training to all providers on new opioid provisions to help minimize workflow disruption and to ensure that beneficiaries have continuity of care. Prior authorization may be necessary to avoid abrupt opioid withdrawal for patients that need to taper off high doses of opioids to minimize potential symptoms of withdrawal and manage their treatment regimen, while encouraging pain treatment using non-pharmacologic therapies and non-opioid medications when appropriate.

(VII) **PROGRAM TO MONITOR ANTIPSYCHOTIC MEDICATIONS BY CHILDREN** - The CONTRACTOR shall develop and implement a program to monitor and manage the appropriate use of antipsychotic medications by children and submits quarterly to the Human Services Department any information as may be

required on activities carried out under a monitoring program for individuals not more than the age of 18 years, specifically for children in foster care.

(VIII) **FRAUD AND ABUSE IDENTIFICATION** —The CONTRACTOR shall develop and implement a process that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs to individuals, and pharmacies dispensing drugs to individuals.

(IX) **DRUG UTILIZATION REVIEW ACTIVITIES AND REQUIREMENTS** — Beginning not later than October 1, 2019, the CONTRACTOR will comply with the applicable provisions of section 438.3(s)(2) of title 42, Code of Federal Regulations, section 483.3(s)(4) of such title, and section 483.3(s)(5) of such title, as such provisions were in effect on March 31, 2018."

(X) Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act Summary:
https://www.congress.gov/bill/115th-congress/house-bill/6
Text: https://www.congress.gov/bill/115th-congress/house-bill/6/text#toc-HA3B1D9BB0B5F45B0BCF9A81C0707A4AB

Attachment 11: Directed Payments

Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
Health Care Quality Surcharge (HCQS)	January 1, 2020	Nursing Facilities per the following classifications: I: Less than 60 beds II: 60 or more beds and less than 90,000 annual Medicaid bed days III: 60 or more beds and 90,000 or more annual Medicaid bed days	A uniform dollar increase to Nursing Facility per diem rates for the market basket index (MBI) factor and per diem add-on for each respective class of Nursing Facility as defined in New Mexico statute, §7-41-4 and §7-41-6. Quality payments to Nursing Facilities for achieving performance targets across four measures. Achievement is validated by HSD's data vendor and the MCOs distribute the earned amounts to each Nursing Facility on a quarterly basis as specified by HSD.	Monthly Capitation (Per Diem and MBI) and Quarterly Separate Payment Term (Quality)	Per encounter for per diem and MBI factor Quarterly for quality
Nursing Facility Value-Based Purchasing (NF VBP) Payment Arrangement	January 1, 2020	Nursing Facilities that meet the following criteria: a Medicaid certified facility with Medicaid utilization, contracted with at least one MCO, submits Minimum Data Sets (MDS) to HSD's data vendor, and has a signed data use agreement with the data vendor.	$4,500,000 will be available to Nursing Facilities in foundational, secondary, and per diem add-on payments based on Medicaid bed days and quality scores. Achievement of these payments is calculated by HSD and its data vendor.	Monthly Capitation	Quarterly payments based on quality scorecards issued by HSD's data vendor. The MCO is to make payment in accordance with the contract terms between the MCO and the nursing facility.
University of New Mexico Medical Group (UNMMG) Uniform Percent Increase	January 1, 2020	The University of New Mexico Health Sciences Center clinical delivery system including: UNM Medical Group, UNM Sandoval Regional Medical Center, UNM Hospitals, and associated clinics and programs	Uniform percentage increase of approximately 96% of contracted rates between the practice plans and the MCOs.	Quarterly Separate Payment Term based on HSD's analysis of utilization data from the MCOs.	As directed by HSD upon the MCOs' receipt of payment from HSD.
Community Tribal Hospital	January 1, 2020	Community hospitals that serve a disproportionate share of Native American enrollees as measured relative to their total Medicaid utilization: Cibola General Hospital Lincoln County Medical Center Lovelace UNM Rehabilitation Hospital	Uniform percentage increase of approximately 13.0% to contracted rates between the class of covered hospitals and the MCOs for inpatient and outpatient hospital services	Monthly Capitation	Per encounter

Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		Rehoboth McKinley Christian Health San Juan Regional Medical Center San Juan Regional Rehab Hospital UNM Sandoval Regional Medical Center			
University of New Mexico Hospital (UNMH) Uniform Percentage Increase and Quality Payments	January 1, 2020	The eligible class of providers is defined as a hospital that, pursuant to a lease agreement, has assumed a New Mexico county's perpetual contractual obligation to the United States government, through the Indian Health Service, to provide guaranteed access to care for Native Americans.	Rate increase for inpatient and outpatient hospital services with a portion at-risk for meeting specified performance metrics. Specifically, the rate increase will equal $90 million over the course of the contract year with $9 million based on quality performance, which equates to an estimated 46% increase in current rates and total payments equal to approximately 87% of the average commercial rate.	Quarterly Separate Payment Term based on HSD's review of utilization. HSD reviews UNMH's performance on the specified quality metrics for the rating period and distributes one separate payment for this component of the directed payment.	As directed by HSD upon the MCOs' receipt of payment for the utilization increase. MCOs are to distribute the earned quality-related funds no later than April 30 following the rating period.
For-Profit and Government Owned Hospitals	January 1, 2020	For-Profit/Investor Owned and Government Owned Hospitals as identified by HSD.	Uniform percentage increase of approximately 2.0% to contracted rates between the class of covered hospitals and the MCOs for inpatient and outpatient hospital services.	Monthly Capitation	Per encounter
Not-For-Profit (NFP) Hospital Uniform Percent Increase	January 1, 2020	The uniform percentage increase applies to not-for-profit community hospitals as follows: Artesia General Hospital Dr. Dan C. Trigg Espanola Hospital Gerald Champion Regional Medical Center Holy Cross Hospital Lincoln County Medical Center	Uniform percentage increase of approximately 3.80% to contracted rates between the class of covered hospitals and the Medicaid Managed Care Organizations (MCOs) for inpatient and outpatient hospital services.	Monthly Capitation	Per encounter

Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		Plains Regional Medical Center – Clovis Presbyterian Hospital Presbyterian Hospital Santa Fe Medical Center Rehoboth McKinley Christian Hospital San Juan Regional Medical Center San Juan Regional Rehab Hospital Socorro General Hospital St. Vincent Hospital			
Safety Net Care Hospital Minimum Fee Schedule	January 1, 2020	Safety Net Care Pool (SNCP) hospitals defined in Attachment E of the Centennial Care 2.0 1115 demonstration.	Minimum fee schedule based on State plan approved rates for inpatient and outpatient services.	Capitation	Per encounter
Hospital Access Program	January 1, 2020	SNCP hospitals defined in Attachment E of the Centennial Care 2.0 1115 demonstration.	A uniform dollar increase of contracted rates for SNCP providers and the MCOs.	Quarterly Separate Payment Term based on HSD's calculation of amounts owed to each hospital.	As directed by HSD upon the MCOs' receipt of payment from HSD.
Trauma Hospital	July 1, 2020	Level 1 UNM Hospital Level 2 None Level 3 Carlsbad Medical Center CHRISTUS St. Vincent Regional Medical Center Eastern New Mexico Medical Center Gerald Champion Regional Medical Center Mountain View Regional Medical Center San Juan Regional Medical Center Level 4 Miners' Colfax Medical Center	A uniform percentage increase for Trauma hospital services for each respective class of Trauma hospitals for trauma hospital services under the managed care contract for utilization. Level 1 - 0.9% Level 2 - N/A Level 3 - 13.3% Level 4 - 37.0%	Capitation	Per encounter

Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		Nor-Lea General Hospital Sierra Vista Hospital Union County General Hospital Memorial Medical Center Gila Regional Medical Center			

- Contractors must comply with Section 4.10.11 Directed Payments
- The effective dates of the directed payments are contingent on CMS approval and subject to annual renewal unless otherwise noted.
- For directed payments operationalized through a Separate Payment Term, the amount of the payment each quarter will be based on emerging utilization data. The CONTRACTOR is required to submit utilization and paid amounts by procedure code, rate cohort and month in which the service occurred for each quarter. Each subsequent quarter will include a look-back period to account for claims lag.
- For directed payments operationalized through capitation, HSD may request ad hoc reporting to verify compliance and will take action on any provider complaints on the respective directed payment.
- HSD will also rely on sanctions and penalties for non-compliance as specified in Section 7.3.3 Sanctions

Attachment 12: Non-Risk Arrangements

This attachment sets forth the services under the CONTRACT that are under a non-risk arrangement, in accordance with 42 CFR 447.362.

Non-Risk Arrangement	Services subject to the non-risk arrangement	Frequency of payment from HSD to the CONTRACTOR based on reported utilization
1. COVID-19 Vaccines & Vaccine Administration	COVID-19 Vaccines & Vaccine Administration	Quarterly
2. COVID-19 Nursing Facility Rate Increase	Diagnosis codes U07.1 or U07.2 on the claim to specifically identify COVID-19 positive members.	Once for period of April 1, 2020 through June 30, 2020 payment to providers equal to a thirty percent (30%) increase to the providers' high NF rate.

1. COVID-19 Vaccines and Vaccine Administration

The CONTRACTOR shall allow up to one year from date of service for the filing of COVID-19 vaccine related claims, in accordance with the New Mexico Human Services Department (HSD) Administrative order dated February 22, 2021. The CONTRACTOR shall provide guidance to their contracted providers on the billing direction outlined below.

A. COVID-19 Vaccines & Vaccine Administration Coverage

Retroactive to December 1, 2020 and for the duration of the 100% Federal Medical Assistance Percentage (FMAP) of COVID-19 vaccine administration authorized by the American Rescue Plan Act (ARPA), HSD will provide reimbursement for the 2019 Novel Coronavirus (COVID-19) vaccine and vaccine administration for all eligible individuals.

The initial supply of this vaccine has been purchased and supplied by the Federal Government. HSD will implement reimbursement for the COVID-19 vaccine administration following the Medicare guidelines.

When the federally purchased supply of the COVID-19 vaccine is no longer available, HSD will provide reimbursement for the COVID-19 vaccine for Medicaid eligible individuals enrolled in Centennial Care through a non-risk arrangement with the CONTRACTOR. Additionally, HSD is expanding this benefit for individuals eligible under the Medicaid Category of Eligibility (COE) 301, Pregnancy related services.

Please see the links below for additional information:
CMS toolkit for COVID-19 Vaccine guidance:
https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf

CDC requirements:
https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

B. Billing Requirements:

This section provides guidance on how to bill for COVID-19 vaccine administration, the related procedure and professional service codes, and the reimbursement rates. The billing guidance will apply for any CDC recommended dose. This guidance is applicable when the COVID-19 vaccine is administered in a clinic, pharmacy, or offsite setting. All providers noted below must follow the guidance in Section D- Provider agreements.

- **Providers who bill on a UB-04 claim form:**

a. **Federally Qualified Health Centers (FQHCs):**

Billing on a UB-04 claim form, FQHCs should use physical health revenue code 0529 -Free-Standing Clinic-Other Free-Standing Clinic and append the associated HCPCS COVID-19 vaccine administration procedure code. Reimbursement will be made at the encounter rate.

b. **IHS and Tribal 638 Facilities:**

Billing on a UB-04 claim form, with revenue code 0519-Clinic and append the associated HCPCS COVID-19 vaccine administration procedure code. Reimbursement will be made at the OMB rate.

c. **Rural Health Clinics (RHCs) and Hospital Based Rural Health Clinics (HBRHCs):**

Billing on a UB-04 claim form, RHCs should use revenue code 0521-Free Standing Rural Health Clinic and HBRHCs should use revenue code 0510-Clinic and append the associated HCPCS COVID-19 vaccine administration procedure code. Reimbursement will be made at the encounter rate.

d. **All others billing on a UB-04 claim form:**

Billing on a UB-04 claim form, use revenue code 0779 (PREVENTIVE CARE SVCS-OTHER PREVENTIVE CARE SVCS) and append the associated HCPCS COVID-19 vaccine administration procedure code identifying the vaccine. Reimbursement will be made at the fee schedule rate. The revenue code and the HCPCS code must be on the claim line to avoid claim and/or claim line denials and ensure accurate payment.

- **Professional Practitioners and other Providers:**

Billing on a CMS-1500 claim form, enter the associated HCPCS COVID-19 vaccine administration procedure code. Reimbursement will be made at the fee schedule rate.

- **Pharmacy Providers:**

The United States Health and Human Service (HHS) authorized qualified pharmacy technicians and state-authorized pharmacy interns acting under the supervision of a qualified pharmacist to administer FDA-authorized or FDA-licensed COVID-19 vaccinations to persons aged 3 or older. See

requirements at: https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf

For detailed Pharmacy Point of Sale (POS) billing guidance, please see the National Council for Prescription Drug Programs (NCPDP) guidance at the following link: NCPDP-Emergency-Preparedness-Guidance-COVID-19-Vaccines.pdf

- For Medical Billing on a CMS-1500 claim form, use the HCPCS COVID-19 vaccine administration procedure code. Reimbursement will be made at the fee schedule rate.

- For POS Pharmacy Billing: This would be billed in a similar way as other vaccine administration.

  COVID-19 vaccine must be billed with $0.01 (one cent) and the following fields need to be filled in:

Field#	NCPDP Field Name	Value
438-E3	Incentive Amount Submitted	Reimbursement based on Medicare methodology
440-E5	Professional Service Code	MA = Medication Administration

- Providers submitting claims for the COVID-19 vaccine paid for by the federal government through funding authorized by the Coronavirus Aid, Relief and Economic Security (CARES) act, or paid for by any program supplying Providers with no associated cost (zero cost) COVID-19 vaccine, shall submit claims with either $0.01 in the Ingredient Cost Submitted field (NCPDP field 409-D9) or the combination of $0.00 in the Ingredient Cost Submitted field (NCPDP field 409-D9) and a value of "15" in the Basis of Cost Determination field (NCPDP field 423-DN).
- When submitting administration claims for a COVID-19 vaccine that requires multiple doses, pharmacies must submit the following information to indicate whether they are submitting an initial/restarter dose or the final dose in the regimen.
  Field #
  420-DK [Submission Clarification Code] Value = 02 (for Initial/Restarter Dose)
  420-DK [Submission Clarification Code] Value = 06 (for Final Dose)

C. COVID-19 Vaccine Administration Reimbursement:

HSD will follow all Medicare payment guidance and rates for COVID-19 vaccines and vaccine administration including the changes outlined below. Going forward, HSD will not issue additional amendments outlining changes to the Medicare rates or FDA approval for additional ages authorized to receive the COVID-19 vaccine, but instead the CONTRACTOR shall use the link below which contains the most current CMS guidance, codes, and rates for COVID-19 vaccines and vaccine administration.

For COVID-19 vaccine administration services furnished before March 15, 2021, the Medicare payment rate for a single-dose vaccine or for the final dose in a series was $28.39. For a COVID-19 vaccine requiring a series of two or more doses, the payment rate was $16.94 for the initial dose(s) in the series and $28.39 for the final dose in the series.

On March 15, 2021, CMS updated the Medicare payment rates for COVID-19 vaccine administration. Effective for services furnished on or after March 15, 2021, the new Medicare payment rate for administering a COVID-19 vaccine is approximately $40 to administer each dose of a COVID-19 vaccine. This means that starting on March 15, 2021, for single dose COVID-19

vaccines, Medicare pays approximately $40 for its administration. Starting on March 15, 2021, for COVID-19 vaccines requiring multiple doses, Medicare pays approximately $40 for each dose in the series. All providers will receive reimbursement for each administration of the COVID-19 vaccine, whether billed at the Medicare rate, encounter rate, or OMB rate.

The Medicare rates recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine.

Please see the most current CMS guidance, codes, and rates at:
https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment

Any claims for COVID-19 vaccine administration reimbursed at rates other than those outlined above will be reprocessed by the CONTRACTOR and paid to reflect the updated Medicare rates. Providers are encouraged to resubmit any claims which were initially denied for missing or incorrect information.

D. Provider agreements:

To receive free supplies of the COVID-19 vaccine(s), pharmacies, retail clinics and providers planning on administering COVID-19 vaccines must sign an agreement with the U.S. government and adhere to storage and recordkeeping requirements, including recording the administration of the vaccine to patients in their systems within 24 hours, and to public health data systems as soon as practical and within 72 hours. COVID-19 vaccines are covered regardless of whether the vaccine is delivered by an in-network or out-of-network provider. Providers will need to request access to the New Mexico Department of Health (NM DOH) Vaccine Provider Portal to meet the CMS requirements. Information and access to the NM DOH Vaccine Provider Portal can be located at: https://cv.nmhealth.org/providers/vaccines/

Please see the link below for CDC requirements:
https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf.

E. Operational and Reporting Requirements

The COVID-19 vaccine and vaccine administration reimbursement will be operationalized as a non-risk arrangement. HSD will make separate payments to the CONTRACTOR based on the applicable utilization for COVID-19 vaccine and vaccine administration as reported by the CONTRACTOR.

HSD will make these payments to the CONTRACTOR on a quarterly basis. The amount of the quarterly payment to the CONTRACTOR will be based on the distribution of claims. For each quarter HSD will evaluate the claims data to determine the quarterly distribution and update the payment for the CONTRACTOR.

These non-risk payments made from HSD to the CONTRACTOR will be excluded from the CONTRACTOR's Medical Loss Ratio and Underwriting Gain calculations outlined in Section 7.2. The CONTRACTOR shall report the non-risk payment revenue and the medical expenses

associated with the vaccine and the vaccine administration in the "Analysis" worksheet in the applicable program financial reporting package by cohort for each quarter.

VI. Reporting of COVID-19 vaccine and vaccine administration reimbursement

The CONTRACTOR shall submit utilization and paid amounts by provider group, rate cohort and date of service as prescribed below. The CONTRACTOR shall submit utilization and paid amounts as prescribed in Table 1. This data will be refreshed quarterly and will be the source for the quarterly payment amounts. Data is due each quarter. The CONTRACTOR shall submit the data via the DMZ no later than ten (10) business days after the last business day of the prior quarter**.**

Acceptable File Formats:

- Delimited text file (*.txt or *.csv)
- Microsoft Access (*.accdb)

Requirements:

- Table 1 illustrates the data required and information about how the field should be formatted and Table 2 provides an example of the data output.
- The report should include incurred and paid claims with dates of service within the specified period.
- Denied or voided claims should be excluded.
- Rate cohort assignment must be based on the cohort assignment for the member as of the incurred date of the claim.

Table 1. Medical Data File Fields

Field Name	Field Information	Format
Date of Service	The date of service must be formatted as 4-character year, 2-character month and 2-character day. "YYYYMMDD"	Text
Billing Provider NPI	1234567890	Text
Vaccine Procedure Code	The procedure code for the vaccine that was administered (e.g. 91300)	Text
Vaccine Administration Code	The procedure code for the administration of the vaccine (e.g. 0001A)	Text
Rate Cohort	This should be the rate cohort assigned by HSD to the member for the month the service was incurred. If a member cohort is changed retroactively by HSD the report should reflect the cohort assigned as of the date of the report. Acceptable values align with Financial Reporting Package Rate Cohorts: 001, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 300A, 300B, 300C, 301, 302A, 302B, 302C, 303, 304, 310, 312, 320, 322, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122 (113 does not exist)	Text
Units	The claim count associated with the vaccine administered	Number
Paid Amount	Amount paid by the CONTRACTOR	Number

Table 2 – Medical Data File Example

Date of Service	Billing Provider NPI	Vaccine Procedure Code	Vaccine Administration Code	Rate Cohort	Units	Paid Amount
20210401	1234567890	91300	0001A	002	46	$779.24
20210401	1234567890	91300	0002A	003	92	$2,725.44
20210401	1234567890	91301	0011A	009	81	$1,372.14

Table 3. Pharmacy Data File Fields

Field Name	Field Information	Format
Date of Service	The date of service must be formatted as 4-character year, 2-character month and 2-character day. "YYYYMMDD"	Text
Billing Provider NPI	1234567890	Text
Labeler Product ID (NDC)	National Drug Code (NDC) using NDC10 or NDC11 12345-6789-0 12345-6789-01	Text
Submission Clarification Code (SCC)	SCC Value = 02 (for Initial/Restarter Dose) SCC Value = 06 (for Final Dose)	Text
Rate Cohort	This should be the rate cohort assigned by HSD to the member for the month the service was incurred. If a member cohort is changed retroactively by HSD the report should reflect the cohort assigned as of the date of the report. Acceptable values align with Financial Reporting Package Rate Cohorts: 001, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 300A, 300B, 300C, 301, 302A, 302B, 302C, 303, 304, 310, 312, 320, 322, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122 (113 does not exist)	Text
Units	The claim count associated with the vaccine administered	Number
Incentive Amount Submitted (i.e. Vaccine Administration Fee)	Amount paid by the CONTRACTOR only for the cost of the vaccine administration fee. Please make sure that no costs are included for the $0.01 Ingredient Cost Submitted.	Number

Table 4. - Pharmacy Data File Example

Date of Service	Billing Provider NPI	NDC	SCC	Rate Cohort	Units	Incentive Amount Submitted
20210401	1234567890	59267-1000-01	02	002	1	$40.00

2. COVID-19 Nursing Facility Rate Increase

Skilled Nursing Facilities (SNF) and Nursing Facilities (NF) will transition COVID-19 positive members into an isolated ward/wing of the facility. This approach will result in a significant increase in overhead costs related to the COVID-19 positive members, including but not limited to disinfecting procedures, increased clinical and maintenance staffing, and additional personal protective equipment (PPE).

HSD has received approval from CMS through an Emergency SPA (SPA # 20-0009) to temporarily increase provider reimbursement to reflect these additional expenses. This SPA authorizes payment to providers equal to a thirty percent (30%) increase to the providers' high NF rate.

The CONTRACTOR shall temporarily increase reimbursement for COVID-19 positive members located in a Medicaid enrolled SNF/NF to equal the increased rate authorized under fee-for-service (FFS), effective April 1, 2020 through June 30, 2020.

The CONTRACTOR shall provide direction and training to the SNF/NFs on the temporary rate increase and the requirement for reporting Diagnosis codes U07.1 or U07.2 on the claim to specifically identify COVID-19 positive members. Submitting this information on a claim will result in identifying dates of service claims that are eligible for the temporary increase. The CONTRACTOR shall include the U07.1 or U07.2 code on the encounter to HSD for tracking and rate development.

The CONTRACTOR shall track patients admitted under Medicare coverage whose benefits revert to Medicaid coverage. The CONTRACTOR shall also track members who have both Medicare and Medicaid to ensure appropriate processing of claims when the Medicare benefit has been exhausted and ensure appropriate processing of Medicaid crossover claims.

All care delivered to COVID-19 positive patients by network and out-of-network SNFs/NFs will be at the skilled/acute level and will be paid at the reimbursement rate authorized in the Emergency SPA (SPA # 20-0009). HSD will not deny claims for Medicaid members admitted to a SNF/NF under a Full Medicaid category of eligibility (COE) other than institutional care (IC). SNF/NFs do not receive a NF LOC determination when Medicaid members are admitted under skilled/acute care. The rate increase will be calculated on the FFS HNF reimbursement rate and not on the CONTRACTOR's negotiated HNF rate. Therefore, if the CONTRACTOR's negotiated rate is at or above the HNF FFS reimbursement rate authorized in the Emergency SPA, no further increase in reimbursement is required.

Operational and Reporting Requirements
This SNF/NF reimbursement increase will be operationalized as a non-risk arrangement. HSD will make separate payments to the CONTRACTOR based on the applicable NF utilization for COVID-19 positive patients as reported by the CONTRACTOR.

These non-risk payments made from HSD to the CONTRACTOR will be excluded from the CONTRACTOR's Medical Loss Ratio and Underwriting Gain calculations outlined in Section 7.2.

Reporting of NF Paid Claims for COVID-19 Positive Patients
The CONTRACTOR shall submit utilization and paid amounts by provider group, rate cohort and month in which the service occurred for each month and as prescribed below.

Acceptable File Formats:

- Delimited text file (*.txt or *.csv)
- Microsoft Access (*.accdb)

Requirements:

- Table 1 illustrates the data required and information about how the field should be formatted and Table 2 provides an example of the data output.
- The report should include incurred and paid claims with dates of service within the specified period.
- Denied or voided claims should be excluded.
- Rate cohort assignment must be based on the cohort assignment for the member as of the incurred date of the claim.
- Data should be limited to NF and SNF providers that are enrolled with New Mexico Medicaid for the reported data period.

Table 1. Data File Fields

Field Name	Field Information	Format
Month of Service	The date of service must be formatted as 4-character year and 2-character month. "YYYYMM"	Text
Billing Provider NPI	1234567890	Text
Rate Cohort	This should be the rate cohort assigned by HSD to the member for the month the service was incurred. If a member cohort is changed retroactively by HSD the report should reflect the cohort assigned as of the date of the report. Acceptable values align with Financial Reporting Package Rate Cohorts: 001, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 300A, 300B, 300C, 301, 302A, 302B, 302C, 303, 304, 310, 312, 320, 322, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122 (113 does not exist)	Text
Days	Number of days associated with the submitted services	Number
Paid Amount	Amount paid by the CONTRACTOR	Number

Table 2 - Data File Example

Month of Service	Billing Provider NPI	Rate Cohort	Paid Claims	Paid Amount
202004	1234567890	002	46	$4,462.92
202004	1234567890	003	92	$4,781.24
202004	1234567890	009	81	$7,128.00

COVID-19 Testing in Nursing Facilities

HSD will reimburse fee-for-service Medicaid enrolled SNF/NFs for specimen collection for all Medicaid recipients performed by SNF/NF staff. The COVID-19 tests performed in SNF/NFs shall not require the recipient to be symptomatic nor do they require a provider referral. COVID-19 tests are required to be delivered to and processed at TriCore Reference Laboratories. HSD will reimburse TriCore Reference Laboratories directly for the services. The CONTRACTOR shall use the HSD directed codes for COVID-19 tests performed in nursing facilities.

Exhibit A
HIPAA Business Associate Agreement

This Business Associate Agreement ("BAA") is entered into between the New Mexico Human Services Department ("Department"), the New Mexico Behavioral Health Purchasing Collaborative (the "Collaborative") and Western Sky Community Care, Inc., hereinafter referred to as "Business Associate", (the "Parties") in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), including the Standards of the Privacy of Individually Identifiable Health Information and the Security Standards at 45 C.F.R.s § 160, § 162 and § 164, as amended and other relevant laws, including subsequently adopted provisions applicable to use and disclosure of confidential information and applicable agency guidance.

BUSINESS ASSOCIATE, by this PSC 18-630-8000-0035, ("the Related Agreement") has agreed to provide services to, or on behalf of, the HSD which may involve the disclosure by the Department to the Business Associate (referred to in PSC 18-630-8000-0035 as "Contractor") of Protected Health Information. This BAA is intended to supplement and to supersede all prior Business Associate agreements between the parties and to restate the respective obligations of the Department and the Contractor as set forth in PSC 18-630-8000-0035 and is hereby incorporated therein.

THE PARTIES acknowledge HIPAA, the HITECH Act and the U.S. Department of Health and Human Services final rule, effective March 26, 2003, modifying HIPAA and the Privacy and Security Rules ("the HIPAA Omnibus Rule") require that Department and Business Associates enter into a written agreement to establish the permitted and required uses and disclosures of Protected Health Information by the Business Associate, which Department may disclose to the Business Associate, or which may be created, received, maintained, or transmitted for a function or activity by the Business Associate on behalf of the Department during the term of their Related Agreement and after termination.

1. Definition of Terms

a. Breach. "Breach" has the meaning assigned to the term breach under 42 U.S.C. §17921(1) [HITECH Act § 13400 (1)] and 45 C.F.R. § 164.402, as amended.

b. Business Associate. "Business Associate", herein being the same entity as the Contractor in the same or Related Agreement, shall have the same meaning as defined under the HIPAA standards as defined below, including, without limitation, the Contractor acting in the capacity of a Business Associate as defined in 45 C.F.R. § 160.103, as amended.

c. Department. "Department" shall mean in this agreement the State of New Mexico Human Services Department.

d. Individual. "Individual" shall have the same meaning as in 45 C.F.R. §160.103 and shall include a person who qualifies as an authorized personal representative in accordance with 45 C.F.R. §164.502 (g).

e. HIPAA Standards. "HIPAA Standards" shall mean the privacy, security and breach notification provisions applicable to a Business Associate as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009 and the regulations and policy guidance, as each may be amended over time, including without limitation:

i. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information in 45 C.F.R. § 160 and Part 164, Subparts A and E, as amended.

ii. Breach Notification Rule. "Breach Notification" shall mean the Notification in the case of Breach of Unsecured Protected Health Information, 45 C.F.R. § 164, Subparts A and D.

iii. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R.s § 160, § 162 and § 164, Subparts A and C, including the following:

a) Security Standards. "Security Standards" hereinafter shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.306.

b) Administrative Safeguards. "Administrative Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.308.

c) Physical Safeguards. "Physical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.310.

d) Technical Safeguards. "Technical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.312.

f. Policies and Procedures and Documentation Requirements. "Policies and Procedures and Documentation Requirements" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.316.

g. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as in 45 C.F.R. §160.103, limited to the information created, maintained, transmitted or received by the Business Associate, its agents or Subcontractors from, or on behalf of the Department.

h. Required By Law. "Required By Law" shall have the same meaning as in 45 C.F.R. §164.103.

i. Secretary. "Secretary" shall mean the Secretary of the U. S. Department of Health and Human Services, or his or her designee.

j. Covered Entity. "Covered Entity" shall have the meaning as the term "covered entity" defined at 45 C.F.R. §160.103 and in reference to the party to this BAA, shall mean the State of New Mexico Human Services Department.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Standards. All terms used and all statutory and regulatory references shall be as currently in effect or as subsequently amended.

2. Obligations and Activities of Business Associate

a. General Rule of PHI Use and Disclosure. The Business Associate may use or disclose PHI it creates for, receives from, maintains or transmits on behalf of, the Department to perform functions, activities or services for, or on behalf of, the Department in accordance with the specifications set forth in this BAA and in this PSC 18-630-8000-

0035, provided that such use or disclosure would not violate the HIPAA Standards if done by the Department; or as Required By Law.

i. Any disclosures made by the Business Associate of PHI must be made in accordance with HIPAA Standards and other applicable laws.

ii. Notwithstanding any other provision herein to the contrary, the Business Associate shall limit uses and disclosures of PHI to the "minimum necessary," as set forth in the HIPAA Standards.

iii. The Business Associate agrees to use or disclose only a "limited data set" of PHI as defined in the HIPAA Standards while conducting the authorized activities herein and as delineated in PSC 18-630-8000-0035, except where a "limited data set" is not practicable in order to accomplish those activities.

iv. Except as otherwise limited by this BAA or PSC 18-630-8000-0035, the Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

v. Except as otherwise limited by this BAA or PSC 18-630-8000-0035, Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that the disclosures are Required By Law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

vi. The Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 C.F.R. § 164.502(j).

vii. The Business Associate may use PHI to provide Data Aggregation services to the Department as permitted by the HIPAA Standards.

b. Safeguards. The Business Associate agrees to implement and use appropriate Security, Administrative, Physical and Technical Safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 to prevent use or disclosure of PHI other than as required by law or as provided for by this BAA or PSC 18-630-8000-0035. The Business Associate

shall identify in writing upon request from the Department, the Administrative, Physical and Technical Safeguards that it uses to prevent impermissible uses or disclosures of PHI.

c. Restricted Uses and Disclosures. The Business Associate shall not use or further disclose PHI other than as permitted or required by this BAA or PSC 18-630-8000-0035, the HIPAA Standards, or otherwise as permitted or required by law. The Business Associate shall not disclose PHI in a manner that would violate any restriction which has been communicated to the Business Associate.
   i. The Business Associate shall not directly or indirectly receive remuneration in exchange for any of the PHI, unless a valid authorization has been provided to the Business Associate that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the PHI of that individual, except as provided for under the exceptions listed in 45 C.F.R. §164.502 (a)(5)(ii)(B)(2).
   ii. Unless approved by the Department, the Business Associate shall not directly or indirectly perform Marketing to individuals using PHI.

d. Agents and Subcontractors. The Business Associate shall ensure that any agents or Subcontractors that create, receive, maintain or transmit PHI on behalf of the Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and shall make that agreement available to the Department upon request. Upon the Business Associate's contracting with an agent or Subcontractor for the sharing of PHI under the Related Agreement and this BAA, the Business Associate shall provide the Department written notice of any such executed agreement.

e. Availability of Information to Individuals and the Department. The Business Associate shall provide, at the Department's request, and in a reasonable time and manner, access to PHI in a Designated Record Set (including an electronic version, if required) to the Department or, if requested by an Individual, to an Individual or the Individual's designee, in order to meet the requirements under 45 C.F.R. § 164.524.

f. Amendment of PHI. In accordance with 45 C.F.R. § 164.526, the Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Department

directs or agrees to, at the request of the Department or an Individual, to fulfill the Department's obligations to amend PHI pursuant to the HIPAA Standards.

g. Internal Practices. The Business Associate agrees to make internal practices, books and records, including policies, procedures and PHI relating to the use and disclosure of PHI, received from, or created or received by the Business Associate, on behalf of the Department, available to the Secretary, for purposes of the Secretary's determining the Department's compliance with the HIPAA Standards.

h. PHI Disclosures Recordkeeping. The Business Associate agrees to document such disclosures of PHI and information related to such disclosures, as necessary, to satisfy the Department's obligation under 45 C.F.R. § 164.528. The Business Associate shall provide such information in the time and manner reasonably designated by the Department.

i. PHI Disclosures Accounting. The Business Associate agrees to provide to the Department or an Individual, no later than thirty (30) days of receipt of a request, information collected in accordance with Section 2 (h) of this Agreement.

j. Security Rule Provisions. As required by 42 U.S.C. § 17931 (a) [HITECH Act Section 13401(a)] , the following Sections, as they are made applicable to business associates under the HIPAA Standards, shall also apply to the Business Associate: 1) Administrative Safeguards; 2) Physical Safeguards; 3) Technical Safeguards; 4) Policies and Procedures and Documentation Requirements; and 5) Security Standards. Additionally, the Business Associate shall either implement or properly document the reasons for non-implementation of all safeguards in the above cited Sections that are designated as "addressable" as such are made applicable to Business Associates pursuant to the HIPAA Standards.

k. Civil and Criminal Penalties. The Business Associate agrees that it will comply with the HIPAA Standards, as applicable to the Business Associates, and acknowledges that it may be subject to civil and criminal penalties for its failure to do so.

l. Performance of Covered Entity's Obligations. To the extent the Business Associate is to carry out the Department's obligations under the HIPAA Standards, the Business

Associate shall comply with the requirements of the HIPAA Standards that apply to the Department in the performance of such obligations.

3. Business Associate Obligations for Notification, Risk Assessment and Mitigation

During the term of this BAA or PSC 18-630-8000-0035, the Business Associate shall be required to perform the following pursuant to the Breach Notification Rule regarding Breach Notification, Risk Assessment and Mitigation:

a. Notification

i. The Business Associate agrees to report to the Department Contract Manager or HIPAA Privacy and Security Officer any use or disclosure of PHI that is the subject of the Related Agreement or this BAA not provided for by this BAA or PSC 18-630-8000-0035, and HIPAA Standards, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, as soon as it (or any employee or agent) becomes aware of the Breach, and, in no, case later than five (5) Calendar Days after it (or any employee or agent) becomes aware of the Breach, except when a government official determines that a notification would impede a criminal investigation or cause damage to national security.

ii. Business Associate shall provide the Department with the names of the individuals whose unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 C.F.R. § 164.404(c), and, if requested by the Department, provide information necessary for the Department to investigate promptly the impermissible use or disclosure. The Business Associate shall continue to provide to the Department information concerning the Breach as it becomes available to it, and shall also provide such assistance and further information as is reasonably requested by the Department.

b. Risk Assessment

i. When the Business Associate determines whether an impermissible acquisition, use or disclosure of PHI, that is the subject of the Related Agreement or this BAA, by an employee or agent, poses a low probability of the PHI being compromised, it shall

document its assessment of risk in accordance with 45 C.F.R. § 164.402 (in definition of "Breach", 2) based on at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the protected health information or to whom the disclosure was made; (iii) whether the protected health information was actually acquired or viewed; and (iv) the extent to which the risk to the protected health information has been mitigated. Such assessment shall include: 1) the name of the person(s) making the assessment; 2) a brief summary of the facts; and 3) a brief statement of the reasons documenting the determination of risk of the PHI being compromised. When requested by the Department, the Business Associate shall make its risk assessments of PHI that is the subject of the Related Agreement or this BAA available to the Department.

ii. If the Department determines that an impermissible acquisition, access, use or disclosure of PHI, for which one of the Business Associate's employees or agents was responsible, constitutes a notice to affected individuals of such Breach, and if requested by the Department, the Business Associate shall provide notice to the affected individuals whose PHI was the subject of the Breach. When requested to provide notice, the Business Associate shall provide notice in accordance with 45 C.F.R. § 164.401 et seq. The cost of notice and related remedies shall be borne by Business Associate. The notice to affected individuals shall be provided without unreasonable delay and in no case later than sixty (60) Calendar Days after discovery of the breach of the PHI.

c. Mitigation

i. In addition to the above duties in this Section, the Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI, by the Business Associate, in violation of the requirements of this Agreement, the Related Agreement or the HIPAA Standards. The Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by the

Department, the Business Associate shall make its mitigation and corrective action plans available to the Department.

ii. The notice to affected individuals shall be written in plain language and shall include, to the extent possible: 1) a brief description of the Breach; 2) a description of the types of Unsecured PHI that were involved in the Breach; 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach; 4) a brief description of what the Business Associate and the Department are doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches; and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 C.F.R. §164.404(c).

d. Notification to Clients

i. Business Associates shall notify individuals of Breaches as specified in 45 C.F.R. §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of a State or jurisdiction, the Business Associate shall notify prominent media outlets serving such location(s), following the requirements set forth in 45 C.F.R. § 164.406.

4. Obligations of the Department to Inform Business Associate of Privacy Practices and Restrictions

a. The Department shall notify the Business Associate of any limitation(s) in the Department's Notice of Privacy Practices, implemented in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.

b. The Department shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. The Department shall notify the Business Associate of any restriction in the use or disclosure of PHI that the Department has agreed to, in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. The Department shall not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule, if done by the Department.

5. Term and Termination

a. Term. This BAA terminates concurrently with PSC 18-630-8000-0035, except that obligations of the Business Associate under this BAA related to final disposition of PHI in this Section 5, shall survive until resolved, as set forth immediately below.

b. Disposition of PHI upon Termination. Upon termination of this PSC 18-630-8000-0035 and BAA for any reason, the Business Associate shall return or destroy all PHI in its possession and shall retain no copies of the PHI. In the event that the Business Associate determines that returning or destroying the PHI is not feasible, the Business Associate shall provide to the Department notification of the conditions that make return or destruction of PHI not feasible. Upon mutual agreement of the Parties that return or destruction of the PHI is infeasible, the Business Associate shall agree, and require that its agents, affiliates, subsidiaries and Subcontractors agree, to the extension of all protections, limitations and restrictions required of Business Associate hereunder, for so long as the Business Associate maintains the PHI.

c. If the Business Associate breaches any material term of this BAA, the Department may either:

i. Provide an opportunity for the Business Associate to cure the breach and the Department may terminate this PSC 18-630-8000-0035 and BAA without liability or penalty in accordance with Article 4, Termination, of PSC 18-630-8000-0035, if the Business Associate does not cure the breach within the time specified by the Department; or,

ii. Immediately terminate this PSC 18-630-8000-0035 without liability or penalty, if the Department determines that cure is not reasonably possible; or,

iii. If neither termination nor cure are feasible, the Department shall report the breach of the Related Agreement and BAA to the Secretary.

The Department has the right to seek to cure any breach of this BAA by the Business Associate, and this right, regardless of whether the Business Associate cures such breach, does not lessen any right or remedy available to the Department at law, in equity, or under this BAA or

PSC 18-630-8000-0035, nor does it lessen the Business Associate's responsibility for such breach of this BAA or its duty to cure such breach of this BAA.

6. Penalties and Training

The Business Associate understands and acknowledges that violations of this BAA or PSC 18-630-8000-0035 may result in notification, by the Department, to law enforcement officials and regulatory, accreditation and licensure organizations. If requested by the Department, the Business Associate shall participate in training regarding use, confidentiality and security of PHI.

7. Miscellaneous

a. Interpretation. Any ambiguity in this BAA, or any inconsistency between the provisions of this BAA or PSC 18-630-8000-0035, shall be resolved to permit the Department to comply with the HIPAA Standards.

b. The Business Associate's Compliance with HIPAA. The Department makes no warranty or representation that compliance by the Business Associate with this BAA or the HIPAA Standards will be adequate or satisfactory for the Business Associate's own purposes or that any information in the Business Associate's possession or control, or transmitted or received by the Business Associate, is or will be secure from unauthorized use or disclosure. The Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI that is the subject of the Related Agreement or this BAA.

c. Change in Law. In the event there are subsequent changes or clarifications of statutes, regulations or rules relating to this BAA or PSC 18-630-8000-0035, the Department shall notify Business Associate of any actions it reasonably deems necessary to comply with such changes and the Business Associate shall promptly take such actions. In the event there is a change in federal or state laws, rules or regulations, or in the interpretation of any such laws, rules, regulations or general instructions, which may render any of the material terms of this BAA unlawful or unenforceable, or which materially affects any financial arrangement contained in this BAA, the parties shall attempt amendment of this

BAA to accommodate such changes or interpretations. If the parties are unable to agree, or if amendment is not possible, the parties may terminate the BAA and PSC 18-630-8000-0035 pursuant to its termination provisions.

d. No Third-Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Department, the Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

e. Assistance in Litigation or Administrative Proceedings. The Business Associate shall make itself and any agents, affiliates, subsidiaries, Subcontractors or workforce Members assisting the Business Associate in the fulfillment of its obligations under this BAA and PSC 18-630-8000-0035, available to the Department, at no cost to the Department, to testify as witnesses or otherwise in the event that litigation or an administrative proceeding is commenced against the Department or its employees, based upon Claimed violation of the HIPAA standards or other laws relating to security and privacy, where such Claimed violation is alleged to arise from the Business Associate's performance under this BAA or PSC 18-630-8000-0035, except where the Business Associate or its agents, affiliates, subsidiaries, Subcontractors or employees are named adverse parties.

f. Additional Obligations. The Department and the Business Associate agree that, to the extent not incorporated or referenced in any Business Associate Agreement between them, other requirements applicable to either or both that are required by the HIPAA Standards, those requirements are incorporated herein by reference.

g. Any ambiguity or inconsistency between the provisions of this BAA and PSC 18-630-8000-0035 shall be resolved in favor of PSC 18-630-8000-0035.