HUMAN SERVICES
DEPARTMENT

State of New Mexico
Human Services Department

Amendment #8 to the Medicaid Managed Care Agreement

Among

New Mexico Human Services Department,
New Mexico Behavioral Health Purchasing Collaborative
and
HCSC Insurance Services Company, operating as
Blue Cross and Blue Shield of New Mexico

PSC 13-630-8000-0021 A8
CFDA 93.778

Table of Contents

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAID MANAGED CARE SERVICES AGREEMENT
PROFESSIONAL SERVICES CONTRACT
Amended and Restated

This amended and restated 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 HCSC Insurance Services Company AKA Blue Cross and Blue Shield of New Mexico including any successors and/or assignees ("CONTRACTOR"); and is to be effective January 1, 2018.

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 not 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, policy manuals, 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 meets 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 the Collaborative and HSD will enter into a memorandum of understanding such 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 HSD and/or the Collaborative may, in the administration of this Agreement, seek input on health care related issues from any advisory group or steering committee. HSD and/or the Collaborative may seek the input of the CONTRACTOR on issues raised by advisory groups or steering committees that may affect the CONTRACTOR. The CONTRACTOR shall make reasonable efforts to notify HSD of the CONTRACTOR's or its Major Subcontractors', Subcontractors' and Contract Providers' potential public relations issues that could affect HSD, the Collaborative, the State or the Agreement.

1.10 The CONTRACTOR shall provide the alternative benefit plan (the "ABP") in accordance with the State's Medicaid State Plan and this Agreement. Unless explicitly stated otherwise, all provisions of this Agreement shall apply to the ABP and the Other Adult Group.

1.11 The CONTRACTOR shall, by Go-Live, become a SNP or offer Medicare products in all counties agreed to by the Parties.

1.12 The CONTRACTOR's cost proposals have been generally accepted by the HSD and in accordance with Section 7.4 of the RFP, and Sections 1.6, 2.3, 2.4 of the Cost Scoring and Cost Proposal Instructions adjustments to these accepted rates will be implemented and communicated to the CONTRACTOR subsequent to the effective date of this Agreement before Go-Live. The adjustments will reflect known changes to the population and services to be covered under this Agreement effective January 1, 2014, including but not limited to, changes attributed to CMS approval of the State's 1115(a) Waiver, Medicaid expansion under the Patient Protection and Affordable Care Act, establishment of an alternative benefit plan or other material items that may impact the rate ranges such as programmatic changes. In addition, final Capitation Rates may be adjusted utilizing a budget neutral methodology so that all individual Capitation Rates are within the actuarially sound rate ranges to be developed and submitted to CMS at a later date.

1.13 The CONTRACTOR shall provide ownership and control information as related to the CONTRACTOR and any Subcontractors as required per 42 CFR § 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.

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.

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 timeframes set forth in 42 CFR § 438.408; (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.

Adverse Determination means a determination consistent with 42 C.F.R. § 438.408 by the CONTRACTOR or the CONTRACTOR's utilization review agent that the health care services furnished, or proposed to be furnished, to a Member are not medically necessary or not appropriate.

Agency-Based Community Benefit means the consolidated benefit of HCBS and personal care services 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.

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

Alternative Benefit Plan (ABP) means the services outlined in Attachment 6. The ABP lists the Covered Services available to Members in the Other Adult Group, unless the Member is ABP Exempt.

Alternative Benefit Plan Exempt (ABP Exempt) means an Other Adult Group Member who has been determined as meeting the definition and criteria of Medically Frail or 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 select between the ABP services outlined

in Attachment 6 and the Covered Services listed in Attachment 2.

Appeal means a request by a Member for review by the CONTRACTOR of a CONTRACTOR 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 CEO and/or CFO.

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

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.

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

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 MCO.

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. Amounts associated with I/T/U services are excluded from the Capitation Rates and the Capitation Rate is adjusted for the ACA Section 9010 Health Insurer Provider Fee once CONTRACTOR liabilities are known.

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 Peer Support Worker (CPSW) is an individual in recovery from mental health and/or substance use issues who has successfully completed a training program offered by HSD's Office of Peer Recovery and Engagement and who has passed the certification examination administered by the New Mexico Credentialing Board for Behavioral Health Professionals.

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

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.

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 Workers means lay members of communities who work either for pay or as volunteers in association with the local health care system in Tribal, Urban, Frontier and Rural areas and usually share ethnicity, language, socioeconomic status and life experiences with the Members they serve. Community Health Workers include, among others, community health advisors, lay health advocates, promotoras, Outreach educators, community health representatives, peer health promoters, and peer health educators.

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

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 CFR Part 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 or with funds received by HSD.

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, 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, health and other social services.

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

Comprehensive Needs Assessment (CNA): The CNA will assess the Member's physical, behavioral health, and long-term care needs; 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.

Covered Services means those physical, Behavioral Health and Long-Term Care services listed in Attachment 2 or the ABP services listed in Attachment 6 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 incarcerated individuals, incarcerated individuals who are about to be released, individuals in the community who are on probation or have some ongoing relationship with the criminal justice system and individuals serving a jail sentence in 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.

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.

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.

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

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means the federally required Early and Periodic Screening, Diagnosis and Treatment program. as defined in section 1905(r) of the Social Security Act and 42 C.F.R. Part 441, Subpart B for Members under the age of twenty-one (21). It includes comprehensive periodic and inter-periodic screening and diagnostic services to determine physical and Behavioral Health needs as well as the provision of all Medically Necessary Services listed in section 1902(a) of the Social Security Act even if the service is not available under the State's Medicaid 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 medical or Behavioral Health condition manifesting itself through acute symptoms of sufficient severity (including severe 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 Members' 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 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 claim adjudicated by the CONTRACTOR or any of its Major Subcontractors and Subcontractors for a Member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by the CONTRACTOR or any of its Major Subcontractors 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 for goods and/or services rendered to its Members. Such information includes whether claims were paid or denied and any capitated and subcapitated arrangements.

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 their contractors furnish to Medicaid beneficiaries.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review, other EQR-related activities as set forth in § 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 be given the opportunity to confront the evidence against them and have their evidence considered by an impartial finder of fact 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.

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 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 anticipated to be January 1, 2014.

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.

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 actual 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, as defined in section 2703 of PPACA, 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 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.

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, 42 U.S.C. 160, et seq.

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

Health Risk Assessment (HRA): 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.

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

IADL means instrumental activities of daily living.

ICF/MR/DD means an individual with mental retardation or developmental disabilities with an intermediate care facilities level of care.

Independent Consumer Supports System (ICSS) means a system that operates independently from the Centennial Care MCOs established by HSD that assists Members in understanding and navigating the managed care environment and in the resolution of problems regarding services, coverage, 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 Centennial Care Covered Services as set forth in Attachment 2, but are medically appropriate and cost effective substitutes.

Institution for Mental Disease (IMD) shall have the same definition as found in 42 CFR §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, their full Medicaid benefits are reinstated.

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

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 beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary 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.

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 Other Adult Group Member 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; (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 Services means clinical and rehabilitative physical, mental or Behavioral Health services 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, and Behavioral Health care needs of the Member; (iii) are provided within professionally accepted standards of practice and national guidelines; (iv) are required to meet the physical, and Behavioral Health 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 project.

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.

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

NCPDP means the National Council of Prescription Drug Programs.

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 contract with the CONTRACTOR.

Non-Medicaid Contractor means the entity contracting with the Collaborative to provide Behavioral Health services with the use of non-Medicaid funds.

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 are not included on a PDL.

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

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

Other Adult Group means the new category of Medicaid eligibility authorized in the Patient Protection and Affordable Care Act and effective on January 1, 2014, 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 4.18.13; (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 complaint formats.

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

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).

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

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 that are provided after a Member is stabilized in order 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.

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.

Primary Care means all health care services 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 practitioner furnishes them.

Primary Care Physician or Primary Care Provider (PCP) means, for purposes of this Agreement, 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 all of the Centennial Care MCOs, 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 10 of this document, or the equivalent classes of drugs in other therapeutic classification systems.

QM/QI means quality management and quality improvement.

RAC means the Medicaid Recovery Audit Contractor.

Rate Cohort 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.

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 August 31, 2012 RFP No. 13-630-8000-0001.

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: (1) a Member is enrolled with the CONTRACTOR and has not previously been enrolled with the CONTRACTOR in the Centennial Care Program; or (2) a Member that was previously enrolled with the CONTRACTOR whose period of ineligibility or disenrollment exceeds three (3) or more months. The Retroactive Period includes the full month in which enrollment notification is received by the CONTRACTOR. The Retroactive Period does not include (1) newborns, as described in the enrollment Section 4.2 of this Agreement, and does not include (2) Members who are established with the CONTRACTOR and whose subsequent disenrollment and retroactive re-enrollment result in no gap in coverage by CONTRACTOR.

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 of New Mexico 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.

Short Term Medicaid for Incarcerated Individuals (STMII) means the Covered Services available to inmates, while the inmate'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 Medicaid reimbursement.

SMI means serious mental illness.

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

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.

TDD/TTY (telecommunications device for the deaf)/telephone typewriter, or teletypewriter) are electronic 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 Definition: The Treat First Model is 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 a four therapeutic encounters.

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. § 479a located wholly or partially in the State of New Mexico.

Tribal 638 Facility means a facility operated by a Native American/Indian Tribe 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.

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 benefit or an in lieu of service or setting.

Value-Based Purchasing (VBP) means payment arrangements with providers that motivate movement away from fee-for-service reimbursement and toward payment methodologies that reward value or outcomes, including but not limited to such as Primary Care incentives, performance-based contracts, risk contracts, bundled/episode payments, shared savings and shared risk and global capitation payments or any other payment arrangement that HSD approves as a value based purchasing.

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
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
CFR—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
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
EPSDT—Early and Periodic Screening, Diagnosis, 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
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 10
ICD-9— International Classification of Diseases 9
ICF/MR/DD— Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disabilities
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
MMIS—Medicaid Management Information System
MST—Multi-Systematic Therapy
NCPDP—National Council of Prescription Drug Programs
NCQA—National Committee for Quality Assurance
NFLOC—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
NPI—National Provider Identifier
NQMC—National Quality Measures Clearinghouse
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
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
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
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
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
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 expected Centennial Care program 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 achieve New Mexico NCQA accreditation within two (2) years from Go-Live.

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, breach, or noncompliance of Contract requirements as described in Section 7.6 of this Agreement.

3.1.2 Readiness

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 timeframes specified by HSD.

3.1.2.3 Based on the results of the review activities, HSD will issue a letter of findings and, if needed, will request a CAP or 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 timeframes 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 With the execution of this amended and restated Agreement, the CONTRACTOR shall enter into a Transition Management Agreement with HSD. The CONTRACTOR agrees to comply with all of the requirements within the Transition Management Agreement. The parties to this Agreement are bound by the terms of the Transition Management Agreement. A fully executed Transition Management Agreement is attached to this executed Agreement as Exhibit B.

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 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 (7) 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 (5) years of combined experience in mental health and substance abuse services. 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 (5) years of experience administering managed long-term care programs. On a case-by-case basis, equivalent experience in administering long-term care 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 Four (4) full-time staff persons to work directly with I/T/Us, including billing and provider issues. 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.

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. The CONTRACTOR shall establish and fill this position no later than April 1, 2015.

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 timeframes 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 BHPC and local Behavioral Health collaboratives.

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

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. Parts 422, 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 (oral, 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 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. Such provision does not apply to Value Added Services offered in accordance with this Agreement;

3.4.6.6 Using gifts or other incentives 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 government, or a similar entity.

3.4.7 The CONTRACTOR shall take reasonable steps to prevent Contract Providers, Subcontractors, Major Subcontractors, agents, consultants, or any other party affiliated with the CONTRACTOR from committing the acts described herein. The CONTRACTOR shall be held liable only if it knew or should have known a party acting on its behalf was committing the acts described above in Section 3.4.6 and did not take timely corrective action.

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

3.4.9 Marketing Timeframes

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 Native Americans;

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 services 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.

3.5.3 Reserved.

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 Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver.

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 1st business day in October following the execution of the contract.

4.1.1.3 HSD shall send eligibility recertification lists to the CONTRACTOR monthly 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.

4.1.1.4 The CONTRACTOR may delegate care coordination functions with prior approval from HSD. The CONTRACTOR shall comply with 7.14 of this Agreement for all delegated activities.

4.1.2 Level of Care Determinations for Not Otherwise Medicaid Eligible Individuals

4.1.2.1 The CONTRACTOR shall conduct a nursing facility level of care evaluation for individuals who are Not Otherwise Medicaid Eligible and who, through a preliminary screening conducted by HSD or its designee, are found to have indicators that may warrant a nursing facility level of care.

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: 1) the member's condition has not changed, and 2) the member had a prior year NF LOC approval.

4.2 Enrollment

4.2.1 General

HSD shall enroll individuals determined eligible for Centennial Care. Enrollment in an 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 for Medicaid in the State of New Mexico and receiving services as of October 1, 2013, must select a Centennial Care MCO by December 1, 2013, unless excluded from mandatory enrollment in Centennial Care. Recipients required to enroll in Centennial Care who do not select an MCO by December 1, 2013 will be auto assigned to an MCO in accordance with Section 4.2.4 of this Agreement. Recipients required to enroll in Centennial Care who become eligible after October 1, 2013 but before January 1, 2014 must select an MCO at the time of applying for Medicaid eligibility.

4.2.3 New Medicaid Recipients.

4.2.3.1 Individuals determined eligible for Centennial Care on or after January 1, 2014, and who did not select or were not assigned to an MCO in accordance with Section 4.2.2 of this Agreement, must select an MCO at the time of applying for Medicaid eligibility. Recipients who fail to select an MCO at such time will be auto-assigned to an MCO in accordance with Section 4.2.4 of this Agreement.

4.2.3.2 Effective November 1, 2018, HSD will cease member enrollment for an MCO not awarded a Centennial Care 2.0 contract.

4.2.4 Auto-Assignment

4.2.4.1 HSD will auto-assign a Recipient to an MCO in specified circumstances, including but not limited to (i) the Recipient does not select an 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).

4.2.4.2 The auto-assignment process will consider the following:

4.2.4.2.1 If the Recipient was previously enrolled with an MCO and lost eligibility for a period of six (6) months or less, the Recipient will be re-enrolled with that MCO;

4.2.4.2.2 If the Recipient has family members in an MCO, the Recipient will be enrolled in that MCO;

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

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

4.2.4.3 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 ninety (90) Calendar Days 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 and is not considered in the retroactive period at the time of delivery.

4.2.6 Non-Discrimination

The CONTRACTOR shall accept Recipients in accordance with 42 CFR § 438.206 and 42 CFR § 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 enrollment in the CONTRACTOR's MCO.

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 at least ninety (90) Calendar Days prior notice.

4.2.9 Enrollment Period

4.2.9.1 *Changing MCOs During the Ninety (90) Calendar Day Change Period.* After enrolling in the CONTRACTOR's MCO (whether as the result of selection or auto assignment), Members shall have one (1) opportunity anytime during the ninety (90) Calendar Day 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 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 at the time of the Member's redetermination. 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 ninety (90) Calendar Day 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 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.

4.2.10.2 The CONTRACTOR shall develop policies and procedures for a mass transfer of Members either to another MCO or into the CONTRACTOR's 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 the CONTRACTOR's Members from the CONTRACTOR to another MCO is required.

4.2.11 Enrollment Data

4.2.11.1 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 Disenrollment

4.3.1 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, or because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, seriously impairs the MCO's ability to furnish services to either this particular Member or other Members).

4.3.2 Member Disenrollment Initiated by Member

4.3.2.1 A Member has the opportunity to change MCOs during the first ninety (90) Calendar Days of a twelve (12) month period. After exercising change rights, the Member shall remain with the CONTRACTOR until his or her twelve (12) month period expires.

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, even during a lock-in period (see Section 4.22 of this Agreement). 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 If HSD imposes 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 disenrollment opportunity during the 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, not all related services are 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 Where a Member's LTSS residential or employment supports provider is leaving the CONTRACTOR's Network, a Member may switch MCOs at any time within ninety (90) Calendar Days from the date of notice of the provider departure from the CONTRACTOR. If a requested transfer cannot be arranged within ninety (90) Calendar Days, 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 switch 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 dealing with 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.

4.4 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, due to the Member's enrollment in a Health Home:

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 care coordination levels in accordance with standards in Section 4.4.3 of this Agreement;

4.4.1.2.3 Perform comprehensive needs assessments (including level of care) for those Members who meet the conditions in Section 4.4.5 of this Agreement; complete the Community Benefit and Services Questionnaire (CBSQ) Community Benefits Member Agreement (CBMA) to inform member of community benefits;

4.4.1.2.4 Determine the Members' physical, Behavioral Health, 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 on-going 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 Members' 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. Parts 160 and 164 and 42 C.F.R. Part 2.

4.4.1.5 Each Member has the right to refuse to participate in care coordination. In the event a Member refuses, it shall be documented in the Member's file.

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.

4.4.2 Health Risk Assessment (HRA)

4.4.2.1 The CONTRACTOR shall conduct the HSD standardized Health Risk Assessment (HRA) on all members who are (1) newly enrolled in Centennial Care and (2) who are not in CCL2 or CCL3 and who have a change in health condition that requires a higher level of care coordination, 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 to Centennial Care 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 Reserved

4.4.2.4.1 Reserved

4.4.2.4.2 Reserved

4.4.2.5 The CONTRACTOR shall use the HSD standardized HRA as well as any available 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.

4.4.2.5.1 Reserved

4.4.2.5.2 Reserved

4.4.2.5.3 Reserved

4.4.2.5.4 Reserved

4.4.2.5.5 Reserved

4.4.2.5.6 Reserved

4.4.2.5.7 Reserved

4.4.2.5.8 Reserved

4.4.2.6 Reserved

4.4.2.6.1 Reserved

4.4.2.6.2 Reserved

4.4.2.6.3 Reserved

4.4.2.6.4 Reserved

4.4.2.6.5 Reserved

4.4.2.7 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 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.

4.4.2.7.1 After these attempts have been made, and documented, the member is categorized "Unreachable" and the CONTRACTOR will continue attempts to reach the member, as directed by HSD.

4.4.2.7.2 Members who have been reached by the CONTRACTOR, but who have not completed a required HRA: A member may be categorized as "difficult to engage" (DTE), if reached at least once, with an additional two attempts to contact documented by the CONTRACTOR. The CONTRACTOR will continue attempts to complete the HRA as directed by HSD.

4.4.3 Assignment to Care Coordination Levels

4.4.3.1 The HRA shall determine if a Member requires a comprehensive needs assessment 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 timeframe during which the Member can expect to be contacted by the care coordination unit or individual care coordinator to complete the comprehensive needs assessment (based on the care coordination level assigned).

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 2 and Level 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 2 or level 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;

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; and/or

4.4.3.5.13 Is Medically Frail.

4.4.4 Requirements for Members Not Assigned to Care Coordination Level 2 or Level 3

4.4.4.1 Members who are not assigned to Care Coordination Level 2 or Level 3 shall receive, at a minimum, the following:

4.4.4.1.1 Review of predictive modeling software, claims and utilization data at least quarterly to determine if the Member has 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:

4.4.4.1.2 Reserved

4.4.5 Comprehensive Needs Assessment for Care Coordination Level 2 and Level 3

4.4.5.1 The CONTRACTOR shall perform an in-person, in-home comprehensive needs assessment on all Members identified for care coordination level 2 or level 3-at the Member's primary residence. The visit may occur in 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 comprehensive needs assessment within fourteen (14) Calendar Days

4.4.5.2.2 Complete the comprehensive needs assessment 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 Members who have been reached by the CONTRACTOR, but who have not completed a required CNA: A member may be categorized as "difficult to engage" (DTE), if reached at least once, with an additional two attempts to contact documented by the CONTRACTOR. The CONTRACTOR will continue attempts to complete the CNA as directed by HSD.

4.4.5.3.2 Reserved

4.4.5.3.3 Reserved

4.4.5.3.4 Reserved

4.4.5.3.5 Reserved; and

4.4.5.3.6 Reserved

4.4.5.4 In performing comprehensive needs assessments, the CONTRACTOR shall use a tool that has been previously 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 comprehensive needs assessment 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.

4.4.5.5.3 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: 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 in the Other Adult Group and enrolled in the 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 and cost-sharing 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.

4.4.5.6 The comprehensive needs assessment shall be conducted at least annually and as the care coordinator deems necessary due to a request from Member, provider or family member or as a result of change in health status.

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 a nursing facility level of care evaluation. The CONTRACTOR shall use the New Mexico Medicaid Nursing Facility Level of Care Criteria and Instructions to determine nursing facility level of care eligibility for all Members.

4.4.5.7.2 For Members in the Other Adult Group who meet nursing facility level of care and are enrolled in the ABP, notify the Member that he/she may be ABP Exempt, explain the benefit and cost-sharing 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.

4.4.6 Requirements for Care Coordination Level 2

4.4.6.1 Based on the comprehensive needs assessment, the CONTRACTOR shall assign care coordination level 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; and/or

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.

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 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 One in-person, in-home visit shall occur 150-180 Calendar Days from the most recent CNA;

4.4.6.3.7 Two telephonic contacts shall occur (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;

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

4.4.7 Requirements for Care Coordination Level 3

4.4.7.1 Based on the comprehensive needs assessment, the CONTRACTOR shall assign to care coordination level 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 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 3.

4.4.7.3 Care coordinators for Members in care coordination level 3 shall provide and/or arrange for the following care coordination services:

4.4.7.3.1 Care coordination services listed in Sections 4.4.6.3.1-4.4.6.3.4 of this Agreement;

4.4.7.3.2 Semi-annual comprehensive needs assessment (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 One in-person, in-home visit shall occur 60-90 Calendar Days from the most recent CNA;

4.4.7.3.4 Four telephonic contacts shall occur (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;

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
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

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 persons identified through notification of hospital admission, the CONTRACTOR shall work with the hospital discharge planner to determine what services may be needed upon discharge and shall complete all applicable screening and/or intake processes as necessary to facilitate timely transition to the most integrated and cost effective care delivery setting appropriate for the Member's needs.

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 2 and 3.

4.4.9.2 The CONTRACTOR shall develop and authorize the CCP within fourteen (14) Business Days of completion of the comprehensive needs assessment, unless the member is in a health home and/or using the Treat First model of care.

4.4.9.3 For Members in care coordination levels 2 and 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 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, 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 expensive 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, 4.4.7.3.3, 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 Comprehensive Needs Assessment;

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 reassessment of a Member's needs, the care coordination team shall update the Member's CCP as appropriate, and the CONTRACTOR shall authorize and initiate services in the updated CCP.

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.

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

4.4.10.1.9 Maintain appropriate on-going 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's becoming aware that the Member's functional or medical status has changed in a way that may affect a level of care determination;

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 lead or supervising care coordinator for determination;

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;

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 CFR 483.100-138;

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; and

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

4.4.10.2 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 or 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 needed 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 shall participate as appropriate in the institutional setting's care planning process and discharge planning processes and advocate for the Member, and shall be responsible for coordination of the Member's physical health, Behavioral Health, and Long-Term Care needs, which shall include coordination with the institutional setting as necessary to facilitate access to physical health and/or Behavioral Health services needed by the Member and to help ensure the proper management of the Member's acute and/or chronic physical health or Behavioral Health conditions, including Covered Services.

4.4.10.5 The CONTRACTOR shall develop policies and procedures to ensure that care coordinators are actively involved in discharge planning when a Member is

hospitalized or placed in an institutional facility. The CONTRACTOR shall define circumstances that require that hospitalized Members receive an in-person visit to complete a needs reassessment and an update to the Member's CCP as needed.

4.4.10.6 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:

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

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

4.4.10.6.3 Member's satisfaction with services and care;

4.4.10.6.4 Member's upcoming appointments;

4.4.10.6.5 Member's mood and emotional well-being;

4.4.10.6.6 Member's falls and any resulting injuries;

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

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

4.4.10.6.9 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 2 and 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, PCMHs, Health Homes, CSAs, Community Health Workers, 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.

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 directed by HSD. To the

extent CONTRACTOR uses I/T/Us, PCMHs, Health Homes, CSAs, Community Health Workers and Centers Independent Living to perform care coordination functions, such entities may be included in the ratios included in the following subsections:

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 Members who participate in the Self-Directed Community Benefit:

4.4.12.5.3.1 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level two (2), 1:100;

4.4.12.5.3.2 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level three (3), 1:75; and

4.4.12.5.3.3 For Members under age of twenty-one (21) who participate in the Self-Directed Community Benefit 1:40.

4.4.12.5.4 Care coordination for Members who participate in the Self-Directed Community Benefit:

4.4.12.5.4.1 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level 2, 1:100;

4.4.12.5.4.2 For Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination level 3, 1:75; and

4.4.12.5.4.3 For Members under age of twenty-one (21) who participate in the Self-Directed Community Benefit 1:40.

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 plans to employ; (ii) the ratio of care coordinators to Members; (iii) the CONTRACTOR's plans to maintain ratios in accordance with the maximum ratios in Section 4.4.12.5 of this Agreement; (iv) an explanation of the methodology for determining such ratios; (vi) 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 Members 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 caseloads that must be adjusted due to the size or intensity of the individual care coordinator's caseload.

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 care coordinator changes are made, whether initiated by the Member or the CONTRACTOR. 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 for non-Covered Services.

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 all individual findings 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 Comprehensive needs assessments 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; and

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

4.4.13.1.15 Members receiving the Community Benefit in HCBS settings, as defined in 42 CFR §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.

4.4.13.3 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 timeframes 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

4.4.14.1 The CONTRACTOR, together with the other Centennial Care MCOs, shall contract with a vendor to implement a statewide electronic visit verification (EVV) system to monitor Member receipt and utilization of the Community Benefit. The EVV system shall include appropriate technology that enables functionality in all areas of the State including rural areas. The CONTRACTOR is responsible for issuing devices to its contracted providers, as needed, and shall ensure that all contracted personal care service providers are participating in the EVV system unless granted an exception as approved in writing by HSD. The CONTRACTOR shall ensure, in the development of such system, the following minimal functionality, including the ability to:

4.4.14.1.1 Log the arrival and departure of individual provider staff person or self-direction provider;

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

4.4.14.1.3 Verify the identity of the individual provider providing the service to the Member;

4.4.14.1.4 Match services provided to a Member with services authorized in the Member's Individualized Plan of Care (IPoC);

4.4.14.1.5 Ensure that the provider delivering the service is authorized to deliver such services;

4.4.14.1.6 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;

4.4.14.1.7 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;

4.4.14.1.8 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

4.4.14.1.9 Reconcile paid Claims with service authorizations.

4.4.14.2 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the IPoC, 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.

4.4.14.3 The CONTRACTOR shall submit reports on its electronic visit verification system as directed by HSD.

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). 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 comprehensive needs assessment;

4.4.15.1.2 PASRR;

4.4.15.1.3 MDS;

4.4.15.1.4 Reserved.

4.4.15.1.5 Provider referral including hospitals and RTCs;

4.4.15.1.6 Ombudsman referral;

4.4.15.1.7 Family member referral;

4.4.15.1.8 Change in medical status;

4.4.15.1.9 Member self-referral;

4.4.15.1.10 Community reintegration allocation received;

4.4.15.1.11 State agency referral; and/or

4.4.15.1.12 Incarceration or detention facility referral.

4.4.15.2 For those Members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate

the development of and complete 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 Selection of providers in the community;

4.4.15.2.3 Housing needs;

4.4.15.2.4 Financial needs;

4.4.15.2.5 Interpersonal skills; and

4.4.15.2.6 Safety.

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 members with special circumstances;

4.4.15.4.3 Transition for members moving from a higher level of care to a lower level of care;

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

4.4.15.4.5 Transition for members changing MCOs while hospitalized;

4.4.15.4.6 Transition for members changing MCOs during major organ and tissue transplantation services;

4.4.15.4.7 Transition for members changing MCOs while receiving outpatient treatment for significant medical conditions; and/or

4.4.15.4.8 Transition for members changing MCOs.

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 timeframes and processes and tools, to

identify needs.

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

4.4.16.1.3 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.

4.4.16.1.4 If a Member enrolls in the CONTRACTOR's MCO from another MCO, the CONTRACTOR shall immediately contact the Member's previous MCO and request the transfer of "transition of care data" as specified by HSD. If the CONTRACTOR is contacted by another MCO requesting "transition of care data" for a Member who has transferred from the CONTRACTOR to the requesting MCO (as verified by the CONTRACTOR), the CONTRACTOR shall provide such data in the timeframe and format specified by HSD.

4.4.16.1.5 For Members transferring from another MCO, the CONTRACTOR shall obtain relevant information and data from the transferring MCO in order to facilitate continuity of care.

4.4.16.1.6 If the CONTRACTOR becomes aware that a Member will be transferring to another MCO, the CONTRACTOR (including, but not limited to the Member's care coordinator or care coordination team) shall, in accordance with protocols established by HSD, work with the other MCO in facilitating a seamless transition for that Member.

4.4.16.1.7 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 except for applicable cost sharing.

4.4.16.1.8 During the Transition Period, for Medically Necessary Covered Services, including services previously authorized by HSD in a Member's Behavioral Health treatment or service plan and/or H C B S care plan (including Individualized Plan of Care (IPoC), being provided by a Non-Contract Provider, the CONTRACTOR shall provide continuation of such services for up to one-hundred eighty (180) Calendar Days or until the Member may be reasonably transferred without disruption to a Contract Provider, whichever is less. The CONTRACTOR may require prior authorization for continuation of services beyond thirty (30) Calendar Days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a Non-Contract Provider.

4.4.16.1.9 During Steady State, for Medically Necessary Covered Services, provided by a Contract Provider, the CONTRACTOR shall provide continuation of

such services from that provider but may require prior authorization for continuation of such services from that provider beyond thirty (30) Calendar Days. The CONTRACTOR may initiate a provider change only as otherwise specified in this Agreement.

4.4.16.1.10 Reserved.

4.4.16.2 Transition of Care Requirements for Pregnant Women

4.4.16.2.1 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.

4.4.16.2.2 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.

4.4.16.2.3 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.

4.4.16.2.4 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 4.4.16.2.

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.

4.5 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 CFR §438.206 through §438.210.

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 to all Other Adult Group Members 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 Other Adult Group Members are eligible to receive defined services that are Medically Necessary in the ABP if they are not ABP Exempt. Other Adult Group Members who are ABP Exempt may choose to receive the ABP outlined in Attachment 6 or the Covered Services outlined in Attachment 2. For the avoidance of doubt, Other Adult Group 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 section 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 Other Adult Group 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. Other Adult Group 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 Other Adult Group Member does not self-identify as being ABP Exempt but the CONTRACTOR determines that the Other Adult Group 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 and cost-sharing 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 CFR Parts 438, 440, and 456 as it relates to the Mental Health Parity law and requirements established by HSD.

4.5.2 Medically Necessary Services

4.5.2.1 The CONTRACTOR shall provide Medically Necessary Services consistent with 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;

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. Parts 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 21 years of age.

4.5.2.1.5 Services shall be available (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;

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 its UM protocols.

4.5.6.3 The CONTRACTOR shall ensure that Members are offered the opportunity to prepare an Advance Directive and that, 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 the CONTRACTOR's policies and procedures with respect to the implementation of such rights including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;

4.5.6.4.2 Documentation exists in the Member's medical record and CCP , as applicable, whether or not the Member has executed an Advanced Directive;

4.5.6.4.3 Discrimination against Members is prohibited in the provision of care or in any other manner discriminating against a Member based on whether the Member has executed an Advance Directive;

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 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 4.6.1.8. 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 comprehensive needs assessment.

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 comprehensive needs assessment.

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 4.6.1.8.1 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 CFR 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;

and

4.5.8.1.2 Birth control pills and devices (including Plan B).

4.5.8.1.3 Explain 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.

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 Member Cost Sharing

4.5.11.1 The CONTRACTOR will implement copayments as directed by HSD.

4.5.11.2 Reserved

4.5.11.3 Reserved

4.5.11.4 Reserved

4.5.12 Reserved

4.5.12.1 Reserved

4.5.12.2 Reserved

4.5.12.3 Reserved

4.5.13 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.

4.5.14 The CONTRACTOR shall not impose any enrollment fee, premium or similar charge and

no deduction, copayment, cost sharing or similar charge to members who are Native American and 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).

4.5.15 In Lieu of Services or Settings

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. 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.

4.5.15.1 The CONTRACTOR must obtain approval in writing from HSD prior to offering or paying claims for in lieu of services.

4.5.15.2 The CONTRACTOR shall ensure that the in lieu of service is a cost effective substitute for the Centennial Care Covered Service and shall provide support of the services cost effectiveness to HSD.

4.5.15.3 HSD may not consider the costs of the in lieu of service(s) in the CONTRACTOR'S Capitation Rate if the in lieu of service is not approved by HSD, is not cost effective, or the CONTRACTOR fails to provide supporting documentation to HSD.

4.5.16 Institutions for Mental Diseases (IMD)

To address access issues for short term acute psychiatric and substance abuse disorder needs, a short-term stay (up to 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 service and the CONTRACTOR must meet the requirements outlined in section 4.5.16

4.5.16.1 The utilization of an IMD for members between 21 and 64 years old is limited to 15 Calendar Days in a Calendar Month. The 15 Calendar Days may be consecutive or cumulative in a Calendar Month.

4.5.16.2 It is the responsibility of the CONTRACTOR to ensure that the 15 Calendar Day limit is not exceeded.

4.5.16.2.1 If HSD approves the IMD as an in lieu of service and retrospectively finds that that the CONTRACTOR has allowed a stay of more than 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 15 total Calendar Days occurs.

4.5.16.3 If HSD approves the in lieu of service as outlined in 4.5.15 and the CONTRACTOR fails to limit the stay to 15 Calendar Days, the HSD will only consider the first 15 Calendar Days in the development of prospective Capitation Rate as outlined in Section 6 and disregard costs associated with days in excess of 15 Calendar Days.

4.5.17 Justice-Involved Utilization of State Transitioned Healthcare (JUST Health)

4.5.17.1 The MCOs are responsible for Medicaid-covered inpatient or outpatient services provided to their members during the timeframe preceding any member's effective date as an inmate. This means that a member may be detained or incarcerated for up to 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.

4.5.17.2 An individual is considered an inmate (meaning that they have been incarcerated over 30 consecutive days), the MCO 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.

4.5.17.3 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.

4.5.17.4 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.

4.5.17.5 Just Health individuals are not defined as inmates after 30 consecutive days of incarceration/detention. Because Capitation Payments will not cease during the first 30 days of a member's incarceration/detention, and since those Capitation Payments will not be recouped by HSD, the MCO retains its responsibilities to pay for Medicaid-covered inpatient and outpatient services provided prior to the suspension of Medicaid benefits. The inpatient or outpatient services must be covered by Medicaid and provided by a network provider outside of the

correctional or detention facility where the member is housed. Medication Assisted Therapy (MAT) services are an exception to the requirement that outpatient services be provided outside of the correctional or detention center. MAT services may be administered, to a Medicaid enrolled individual who has been incarcerated for less than 30 days, in the facility of incarceration by a Medicaid enrolled provider who is certified to perform the service.

4.5.17.6 When a member is incarcerated, the CONTRACTOR remains responsible for any Medicaid-covered inpatient or outpatient services provided to the member in the time period in which capitation payments have been paid to the CONTRACTOR. The inpatient and outpatient services must be covered by Medicaid and provided outside of the facility of incarceration by a network provider of the member's MCO (prior authorization may be required for some services). Medication Assisted Therapy (MAT) services are an exception to the requirement that outpatient services be provided outside of the correctional or detention center. In the time period in which capitation payments have been paid to the CONTRACTOR, MAT services may be administered to a Medicaid enrolled member in the facility of incarceration by a Medicaid enrolled provider who is certified to perform the service.

4.6 Self-Directed Community Benefit (SDCB)

4.6.1 General

4.6.1.1 The CONTRACTOR shall offer the Self-Directed Community Benefit (SDCB) to (i) non-Other Adult Group Members who meet nursing facility level of care and are determined through a comprehensive needs assessment/reassessment to need the Community Benefit and (ii) ABP Exempt Members who select the Covered Services in Attachment 2 who meet nursing facility level of care and are determined through a comprehensive needs assessment/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 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 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 Reserved.

4.6.1.5 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.

4.6.1.6 The CONTRACTOR shall have a contract effective with the FMA for each of the periods covered by this Agreement and shall not terminate their agreement with the FMA during the term of this Agreement without engaging in mediation and/or mitigation strategies as approved by HSD.

4.6.1.7 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.

4.6.1.8 Existing Self-Directed Community Benefit Members

4.6.1.8.1 Members who are enrolled in Centennial Care effective January 1, 2014 and who had approved self-directed budgets prior to December 31, 2013 that exceed the cost limitation in section 4.5.7.5 will be "grandfathered" and their prior approved self-directed budget will become their annual cost limitation subject to section 4.6.1.8.2.

4.6.1.8.2 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 comprehensive needs assessment and CCP development process.

4.6.1.8.3 The CONTRACTOR is prohibited from imposing reimbursement modifications to existing providers for grandfathered clients.

4.6.1.8.4 HSD will provide the CONTRACTOR with information to identify grandfathered Members.

4.6.1.9 New Self-Directed Community Benefit Members

4.6.1.9.1 Members who were not enrolled as self-directed or did not have an approved self-directed budget that exceeds 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.

4.6.1.9.2 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.

4.6.2 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 Member and employer of records 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 and 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 Supports 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 a 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.

4.6.4 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 and 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 timeframes for authorization of the Self-Directed Community Benefit;

4.6.4.2.5 Requirements and processes, including timeframes, 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 Reserved.

4.6.5.2 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.

4.6.5.3 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 Reserved.

4.6.7.4 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.

4.6.7.5 The CONTRACTOR shall evaluate the rates selected by the Member for SDCB services for reasonableness.

4.6.7.6 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 legal 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 provider providing 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 Abuse prevention and reporting;

4.6.9.2.8 Performing administrative tasks such as reviewing and approving 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 Abuse prevention and reporting;

4.6.9.4.5 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 may offer 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.

4.7.4 Value Added Services are not Medicaid-funded services; therefore, there is neither Appeal nor Fair Hearing rights. A denial of a Value Added Service will not be considered an Adverse Benefit Determination for purposes of Appeals or Fair Hearings. The CONTRACTOR shall send the Member a notification letter if the requested Value Added Service required prior approval and was not approved.

4.7.5 Reserved

4.8 Provider Network

4.8.1 General Requirements

4.8.1.1 The CONTRACTOR shall comply with the requirements specified in 42 CFR § 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 CFR § 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 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 CFR § 438.208(c)(4).

4.8.1.2 The CONTRACTOR shall submit a Provider Network Development and Management Plan as directed by HSD.

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 establishment or termination of a Preferred Vendor and/or Sole Source Provider in order to monitor potential consequences of narrowed networks or reduced member access.

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 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 CFR § 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 for any reason.

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:

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.

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 8 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.

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.

4.8.7.5.13 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.

4.8.7.5.13.1 The surveys shall be conducted with a sample of PCPs in frontier, rural and urban regions across the State to monitor the appointment standards for routine and urgent visits for children and adults.

4.8.7.5.13.2 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 and Rural Health Clinics

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 much of 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, including, but not limited to, for such services as transportation, care coordination and case management I/T/Us. The CONTRACTOR is encouraged to use the sample I/T/U Addendum as described in 42 C.F.R. § 438.14 to develop and Addendum specific to New Mexico that can 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 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 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.

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; and

4.8.13.3 Support brokers to assist with administering the SDCB.

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. §§ 455.104, 455.105, 455.106 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;

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 Screen all providers against the "List of Excluded Individuals/Entities (LEIE)" or Medicare Exclusion Databases monthly to ensure providers are not employing or contracting with excluded individuals 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;

4.8.14.1.11 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 load provider contracts and claims systems must be able to recognize the provider as a network provider no later than forty-five (45) calendar days after a provider is credentialed, if required.

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 to be enrolled with New Mexico Medicaid 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.

4.8.15.3.2 CMS Program:

The DOH CMS program provides statewide clinic based services to members, ages 0-21, with chronic medical conditions.

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. Part 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;

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 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 Assist Project ECHO with engaging PCPs in Project ECHO's CMMI grant project;

4.8.16.2.5 Reimburse Primary Care clinics for participating in the Project ECHO model;

4.8.16.2.6 Reimburse "intensivist" teams;

4.8.16.2.7 Provide Claims data to support evaluation of Project ECHO;

4.8.16.2.8 Appoint a centralized liaison to obtain prior authorizations approvals related to Project ECHO; and

4.8.16.2.9 Track quality of care and outcome measures related to Project ECHO.

4.8.16.2.10 CONTRACTORs 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 The CONTRACTOR shall participate in efforts to link Criminal Justice Involved Recipients with covered health services in accordance with State prescribed requirements and standards including but not limited to participation in "Connecting the Criminal Justice-Involved in Bernalillo County to Coverage" project. The CONTRACTOR shall produce reports on these efforts as directed by HSD.

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 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 network 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 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.

4.9.1.2 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.

4.9.1.3 The CONTRACTOR shall comply with 42 CFR § 438.808 regarding exclusion of entities, including all statutes and regulations referenced therein.

4.9.1.4 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.

4.9.1.5 Contract Provider agreements shall be executed in accordance with all

applicable federal and State statutes, regulations, policies, procedures and rules.

4.9.1.6 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.

4.9.1.7 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 provided in Sections 4.5.11, 4.5.12, and 4.18.14 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;

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 RESERVED;

4.9.2.19 Require laboratory service providers to meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

4.9.2.20 Describe, as applicable, any physician incentive plan and any other pay for performance programs the Contract Provider is subject to;

4.9.2.21 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;

4.9.2.22 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 Long-Term Care that is recognized as acceptable professional practices and/or the standards established by HSD;

4.9.2.23 Require that the Contract Provider comply with corrective action plans initiated by the CONTRACTOR;

4.9.2.24 Provide for the timely submission of all reports, clinical information, and Encounter Data required by the CONTRACTOR;

4.9.2.25 Provide for prompt submission of information needed to make payment;

4.9.2.26 Provide for payment to the Contract Provider upon approval of a Clean Claim properly submitted by the Contract Provider within the required timeframes (see Section 4.19.1.6 of this Agreement);

4.9.2.27 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;

4.9.2.28 Specify the Contract Provider's responsibilities regarding third party liability (TPL);

4.9.2.29 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;

4.9.2.30 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;

4.9.2.31 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;

4.9.2.32 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;

4.9.2.33 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;

4.9.2.34 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;

4.9.2.35 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;

4.9.2.36 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;

4.9.2.37 Include Marketing restrictions as described in Section 3.4 of this Agreement;

4.9.2.38 Require Contract Providers to comply with Section 7.16 of this Agreement, as applicable.

4.9.2.39 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;

4.9.2.40 Require Contract Providers to comply with applicable requirements of Section 3.5 of this Agreement;

4.9.2.41 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;

4.9.2.42 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;

4.9.2.43 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;

4.9.2.44 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;

4.9.2.45 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;

4.9.2.46 Require Community Benefit providers to immediately report any deviations from a Member's service schedule to the Member's care coordinator; and

4.9.2.47 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.

4.9.2.48 Require Community Benefit providers to comply with all applicable federal requirements for HCB 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.

4.10.2 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 Reserved.

4.10.2.4 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.

4.10.2.5 Pregnancy Termination

4.10.2.5.1 The CONTRACTOR shall pay Claims submitted by qualified and credentialed providers for State and federally approved pregnancy termination procedures rendered to eligible Members.

4.10.2.5.2 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.

4.10.2.5.3 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.

4.10.2.6 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.

4.10.2.7 Reimbursement for Members Who Disenroll While Hospitalized

4.10.2.7.1 If a Member is hospitalized at the time of enrollment or disenrollment from an MCO or upon an approved switch from one MCO to another,

the originating MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico Department of Health until the date of discharge. Upon discharge, the Member becomes the financial responsibility of the MCO receiving Capitation Payments.

4.10.2.7.2 Discharge, for the purposes of this Agreement, shall mean: (i) when a Member is moved from or to a Prospective Payment System ("PPS") exempt unit (such as a rehabilitation or psychiatric unit) within an acute care hospital; (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.

4.10.2.7.3 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.

4.10.2.7.4 If a Member is hospitalized and is disenrolled from an 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.

4.10.2.7.5 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.

4.10.2.8 State-Operated Long-Term Care Facilities

The CONTRACTOR shall negotiate rate(s) with DOH for State operated long-term care facilities.

4.10.2.9 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.

4.10.2.10 Pharmacy Services

4.10.2.10.1 The CONTRACTOR may determine its formula for estimating

acquisition cost and establishing pharmacy reimbursement.

4.10.2.10.2 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.

4.10.2.10.3 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;

4.10.2.10.4 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;

4.10.2.10.5 The CONTRACTOR shall have an open formulary for all Psychotropic 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.

4.10.2.10.6 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;

4.10.2.10.7 The CONTRACTOR shall reimburse family planning clinics, SBHCs and Department of Health public health clinics for oral contraceptive agents and Plan B when dispensed to Members and billed using HCPC codes and CMS 1500 forms; and

4.10.2.10.8 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.

4.10.2.10.9 The CONTRACTOR shall take part in a Drug Utilization Review (DUR) program that complies with the requirements set forth in 42 CFR

§ 438.3(s) and 42 CFR Part 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.

4.10.2.10.10 The CONTRACTOR representation on the DUR Board shall consist of one physician and one or two pharmacists.

4.10.2.10.11 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 30 calendar day notice before the effective date of the change.

4.10.2.11 Emergency Services

4.10.2.11.1 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.

4.10.2.11.2 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.

4.10.2.11.3 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).

4.10.2.11.4 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.

4.10.2.11.5 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.

4.10.2.11.6 The CONTRACTOR may not deny payment for treatment obtained when a representative of the CONTRACTOR instructs the Member to seek Emergency Services.

4.10.2.11.7 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.

4.10.2.11.8 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.

4.10.2.11.9 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.

4.10.2.12 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).

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.

4.10.3.1.2 Non-Contract Nursing Facilities one-hundred percent (100%) of the Medicaid fee schedule rate for the Covered Services provided; and

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 CFR §§ 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 Reserved

4.10.6 Physician Incentive Plans

The CONTRACTOR may operate a physician incentive plan in accordance with 42 C.F.R. §§ 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.

4.10.7 Value-Based Purchasing

4.10.7.1 The purpose of value-based purchasing (VBP) arrangements is to reward providers based on achieving quality and improved outcomes, rather than volume of services delivered.

4.10.7.1.1 Reserved.

4.10.7.1.2 Reserved.

4.10.7.2 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:

4.10.7.2.1 The CONTRACTOR's overall approach to VBP;

4.10.7.2.2 Initiatives, goals, targets and strategies;

4.10.7.2.3 Barriers and actions to overcome barriers.; and

4.10.7.2.4 Data sharing arrangements established with participating providers.

4.10.7.2.5 Reserved

4.10.7.2.6 Reserved

4.10.7.2.7 Reserved

4.10.7.3 Reserved.

4.10.7.4 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.

4.10.7.5 The CONTRACTOR shall submit quarterly DSIPT reports on templates provided by HSD.

4.10.7.5.1 Reserved

4.10.7.5.2 Reserved

4.10.7.6 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.

4.10.7.7 Reserved.

4.10.8 Safety-Net Care Pool Hospitals

4.10.8.1 The CONTRACTOR shall make best efforts to contract with the providers listed in Attachment 5.

4.10.8.2 The CONTRACTOR shall pay providers included in Attachment 5 at or above the Medicaid fee schedule for inpatient hospital services.

4.10.9 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.

4.10.10 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.

4.10.11 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.

4.11 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, copayments for Other Adult Group Members, 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, including the Utilization Management line/queue, meets the following performance standards 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 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, 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 provider trainings and educational materials and shall make such information available upon request of a 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 and 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; and

4.11.5.3.14 The provisions and limitations of the ABP

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 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 4.11.5.8 The CONTRACTOR shall conduct semi-annual in-person visits with the I/T/Us to resolve billing/claims 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 Long-Term Care), 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 CFR §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 external quality review (EQR) in accordance with 42 CFR § 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 CFR 438 Subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330.

4.12.3.2.2 EQR Protocol 2: Mandatory validation of performance measures required in accordance with 42 CFR § 438.330(b)(2) or performance measures calculated by the HSD during the preceding 12 months.

4.12.3.2.3 EQR Protocol 3: Mandatory validation of performance improvement projects required in accordance with 42 CFR § 438.330 (b)(1) that were underway during the preceding 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, timeframes and data indicators for tracking performance and other relevant QM/QI information, including adult 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) on service to children, 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 CFR § 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;

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 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 Consumer Assessment of Healthcare Providers and Systems (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 Obtain approval to use additional survey questions in addition to the

CAHPS that are relevant to the Centennial Care population, as specified by HSD;

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 Project (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 current reporting year with the exception of PM #8. 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. To the extent the CONTRACTOR has yet to achieve NCQA accreditation in the State of New Mexico, the CONTRACTOR shall report on the performance measures using NCQA HEDIS methods and technical specifications as specified by HSD or its designee. The CONTRACTOR may be required to collect, track, trend and report performance measures or other measures as directed by HSD or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HSD and/or its designee.

4.12.8.2 The performance measures (PMs) shall be evaluated using the following criteria.

4.12.8.2.1 PM #1 – Annual Dental Visit

The percentage of enrolled Members ages two (2) to twenty (20) years, who had at least one (1) dental visit during the measurement year.

4.12.8.2.2 PM #2 – Medication Management for People with Asthma

The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on at least 50% of their treatment period.

4.12.8.2.3 PM #3 – Controlling High Blood Pressure

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria:

Members 18–59 years of age whose BP was <140/90 mm Hg.

Members 60–85 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg.

Members 60–85 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.

The most recent BP reading during the measurement year (as long as it occurred after the diagnosis of hypertension). If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the member is "not controlled".

4.12.8.2.4 PM #4 – Comprehensive Diabetes Care (HbA1c Testing)

The percentage of Members ages eighteen (18) through seventy-five (75) years with diabetes (Type 1 or Type 2) who had each of the following during the measurement year: an HbA1c Test; HbA1c Poor Control (greater than 9%) a retinal eye exam; and a nephropathy screening test for kidney disease.

4.12.8.2.5 PM #5 – Timeliness of Prenatal and Postpartum Care

The percentage of Member deliveries of live births between November 6 of the year prior to the measurement years and November 5 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; the percentage of Member deliveries that had a postpartum visit on or between twenty-one (21) and fifty-six (56) Calendar Days after delivery.

4.12.8.2.6 PM #6 – Frequency of On-Going Prenatal Care

The percentage of Member deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year that received greater than eighty-one percent (81%) of expected prenatal visits.

4.12.8.2.7 PM #7 – Antidepressant Medication Management

The number 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 eight-four (84) Calendar Days (12 weeks) of continuous treatment with antidepressant medication or received at least one-hundred eighty (180) Calendar Days (6 months) of continuous treatment with an antidepressant medication.

4.12.8.2.8 PM #8 – 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. The CONTRACTOR will deliver an ad hoc report as directed by HSD.

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 calendar days of discharge. The follow-up service can be any service considered as outpatient, intensive outpatient, and recovery services delivered by a provider qualified to render such services.

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 through 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 through 17 years of age who had a follow-up visit within seven days after an IPF Discharge during the quarter.
- 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

4.12.8.3 Calendar Year 2016 Performance Measure Targets:

Performance Measures listed in this Agreement, Section 4.12.8.2 will require either: 1) a two (2) percentage point improvement above the MCO's CY2015 (HEDIS 2016) Audited HEDIS rates; or 2) achievement of the CY2015 (HEDIS 2016) Health and Human Services (HHS) Regional Average as determined by the HEDIS 2016 Quality Compass or HSD determined target. If the MCO's baseline CY2015 (HEDIS 2016) audited rate for a performance measure is within two (2) percentage points of the target, the performance

measure is only required improvement to the HHS Regional Average or HSD determined target.

Failure to meet the two (2) percentage point improvement or the HHS Regional Average or HSD-determined target to the Performance Measures in Calendar Year 2016 (HEDIS 2017) will result in a monetary penalty based on 2% of the total capitation paid to the MCO for Calendar Year 2016, divided by the 14 points listed below:

4.12.8.3.1 PM – Annual Dental Visits (1 point). HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.2 PM 2- Medication Management for People with Asthma (1 point). HSD target: 68%.

4.12.8.3.3 PM 3- Controlling High Blood Pressure (1 point). HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.4 PM 4 – Comprehensive Diabetes Care (4 points)

- Member 18-75 years of age who had a diagnosis of DM and had an HbA1c test. HEDIS 2016 Quality Compass HHS Regional Average.
- HbA1c poor control (> 9%). HEDIS 2016 Quality Compass HHS Regional Average.
- Member 18-75 years of age who had a diagnosis of DM and had a Retinal eye exam. HEDIS 2016 Quality Compass HHS Regional Average.
- Member 18-75 years of age who had a diagnosis of DM and had a nephropathy screening test or evidence of nephropathy. HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.5 PM 5 – Timeliness of Prenatal and Postpartum Care (2 points)

- Prenatal visit in the first trimester or within 42 days of enrollment. HEDIS 2016 Quarterly Compass HHS Regional Average.
- Postpartum visit on or between 21 and 56 days after delivery. HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.6 PM 6- Frequency of Ongoing Prenatal Care (1 point). HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.7 PM 7- Antidepressant Medication Management (2 points)

- Member 18 years and older who received at least 84 Calendar days of continuous treatment with antidepressant medication (Acute phase). HEDIS 2016 Quality Compass HHS Regional Average.

- Member 18 years and older who received at least 180 Calendar days of continuous treatment with an antidepressant medication Continuous phase). HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.3.8 PM 8 – Follow up after hospitalization for Mental Illness (2 points)

- Member six years and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within seven Calendar days after discharge. HEDIS 2016 Quality Compass HHS Regional Average.
- Member six years and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within Follow up within 30 Calendar days after discharge. HEDIS 2016 Quality Compass HHS Regional Average.

4.12.8.4 Calendar Year 2017 Performance Measure Targets

Performance Measures listed in this Agreement, Section 4.12.8.2 will require either 1) a two (2) percentage point improvement above the CONTRACTOR'S CY 2016 Audited HEDIS rates or a two (2) percentage point improvement above the CONTRACTOR's CY 2016 reported rate for PM#8; or 2) achievement of the CY 2016 Health and Human Services (HHS) Regional Average as determined by the NCQA Quality Compass for CY 2016 or the HSD determined target. If the MCO's baseline CY 2016 audited rate for a performance measure is within two (2) percent points of the target, the performance measure requirement is only improvement to the HHS Regional Average or HSD determined target.

Failure to meet the two (2) percentage point improvement, the HHS Regional Average or HSD-determined target to the Performance Measures in calendar year 2017 will result in a monetary penalty based on 2% of the total capitation paid to the MCO for Calendar Year 2017, divided by the 14 points listed below:

4.12.8.4.1 PM 1- Annual Dental Visits (1 point). CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.2 PM 2- Medication Management for People with Asthma (1 point). HSD target: 68%.

4.12.8.4.3 PM 3- Controlling High Blood Pressure (1 point). CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.4 PM 4- Comprehensive Diabetes Care (4 points)

- Member 18-75yrs of age who had a diagnosis of DM and had an HbA1c test. CY 2016 Quality Compass HHS Regional Average.
- HbA1c poor control (> 9%). CY 2016 Quality Compass HHS Regional Average. Member 18-75yrs of age who had a diagnosis of DM and had a Retinal eye exam. CY 2016 Quality Compass HHS Regional Average.
- Member 18-75yrs of age who had a diagnosis of DM and had a nephropathy screening test or evidence of nephropathy. CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.5 PM 5- Timeliness of Prenatal and Postpartum Care (2 points)

- Prenatal visit in the first trimester or within 42 days of enrollment. CY 2016 Quality Compass HHS Regional Average.
- Postpartum visit on or between 21 and 56 days after delivery. CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.6 PM 6- Frequency of Ongoing Prenatal Care (1 point). CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.7 PM 7- Antidepressant Medication Management (2 points)

- Member 18yrs and older who received at least 84 Calendar days of continuous treatment with antidepressant medication (Acute phase). CY 2016 Quality Compass HHS Regional Average.
- Member 18yrs and older who received at least 180 Calendar days of continuous treatment with an antidepressant medication (Continuous phase). CY 2016 Quality Compass HHS Regional Average.

4.12.8.4.8 PM 8- Follow-up after hospitalization for Mental Illness of 4 or more days (2 points)

- Members 6-17 years of age who had a follow-up visit within seven (7) days after an IPF discharge. HSD target: 75%
- Members 18 years of age and older who had a follow-up visit within seven (7) days after an IPF discharge. HSD target: 75%

4.12.8.5 Calendar Year 2018 Performance Measure Targets

Performance Measures listed in this Agreement, Section 4.12.8.2 will require either: 1) a two (2) percentage point improvement above the MCO's CY 2017 Audited HEDIS rates; 2) a two (2) percentage point improvement above the MCO's CY 2017 reported rate for PM #8; or 3) achievement of the CY 2017 Health and Human Services (HHS) Regional Average as determined by NCQA Quality Compass for CY 2017 or the HSD determined target. If the MCO's CY 2017 audited HEDIS rate for a performance measure or CY 2017 MCO reported

rate for PM#8 is within two (2) percentage points of the target, the performance measure requirement is only improvement to the HHS Regional Average or HSD determined target. Failure to meet the two (2) percentage point improvement, the HHS Regional Average or the HSD determined target for the Performance Measures in calendar year 2018 will result in a monetary penalty based on 2% of the total capitation paid to the MCO for Calendar year 2018, divided by the 14 points listed below:

4.12.8.5.1 PM 1-Annual Dental Visits (1 point). CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.2 PM 2-Medication Management for People with Asthma (1 point). HSD target: 68%.

4.12.8.5.3 PM 3-Controlling High Blood Pressure (1 point). CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.4 PM 4-Comprehensive Diabetes Care (4 points). Member 18-75 years of age who had a diagnosis of DM and had an HbA1c test. CY 2017 Quality Compass HHS Regional Average. Member 18-75 years of age with HbA1c poor control (> 9%). CY 2017 NCQA Quality Compass HHS Regional Average. Member 18-75 years of age who had a diagnosis of DM and had a Retinal eye exam. CY 2017 NCQA Quality Compass HHS Regional Average. Member 18-75 of age who had a diagnosis of DM and had a nephropathy screening test or evidence of nephropathy. CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.5 PM 5-Timeliness for Prenatal and Postpartum Care (2 points). Prenatal visit in the first trimester or within 42 days of enrollment. CY 2017 NCQA Quality Compass HHS Regional Average. Postpartum visit on or between 21 and 56 days after delivery. CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.6 PM 6-Frequency of Ongoing Prenatal Care (1 point). CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.7 PM 7-Antidepressant Medication Management (2 points). Member 18 years and older who received at least 84 Calendar days of continuous treatment with antidepressant medication (Acute phase). CY 2017 NCQA Quality Compass HHS Regional Average. Member 18 years and older who received at least 180 Calendar days of continuous treatment with an antidepressant medication (Continuous phase). CY 2017 NCQA Quality Compass HHS Regional Average.

4.12.8.5.8 PM 8-Follow-up after Hospitalization for Mental Illness (2 points) HSD target: 75%.

- Member 6-17 years of age who had a follow-up visit within seven (7) days after an inpatient psychiatric hospital stay of four (4) or more days.
- Member 18 years of age and older who had a follow-up visit within seven (7) days after an inpatient psychiatric hospitalization

of four (4) or more days.

4.12.9 Disease Management

4.12.9.5 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.

4.12.9.6 The CONTRACTOR shall improve its ability to manage chronic illnesses/diseases/conditions through DM protocols. The CONTRACTOR shall:

4.12.9.6.1 Participate in DM projects annually;

4.12.9.6.2 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);

4.12.9.6.3 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;

4.12.9.6.4 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

4.12.9.6.5 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.

4.12.10.5 The CONTRACTOR's UM system shall:

4.12.10.5.1 Ensure that Members receive services based on their current condition and effectiveness of previous treatment;

4.12.10.5.2 Ensure that services are based on the history of the problem/illness, its context, and desired outcomes;

4.12.10.5.3 Assist Members and/or their Representatives in choosing among providers and available treatments and services;

4.12.10.5.4 Emphasize relapse and crisis prevention, not just crisis intervention;

4.12.10.5.5 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;

4.12.10.5.6 Accept the uniform prior authorization form for prescription drug benefits as developed per NMSA 1978, § 27-2-12.18; and

4.12.10.5.7 Respond to the prescription drug benefit uniform prior authorization form requests within three (3) Business Days. If the CONTRACTOR does not respond within three (3) Business Days, the request for a prior authorization for a prescription drug benefit shall be deemed granted.

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. Part 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. Part 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.

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 timeframes stated in regulation. These required

timeframes shall not be affected by a "pend" decision. The decision-making timeframes must accommodate the clinical urgency of the situation and must not result in the delay of the provision of Covered Services to Members beyond HSD specified timeframes.

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 timeframes 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 on-going 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 General Requirements

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 Place appropriate limits on service: (i) on the basis of criteria approved by HSD, or the Collaborative to the extent it relates to a Behavioral Health service; or (ii) for the purpose of utilization control, 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;

4.12.12.5 For standard authorization decisions, provide notice as expeditiously as the Member's health condition requires, within fourteen (14) Calendar Days following receipt of a request for new services and within ten (10) Calendar Days following receipt of a request to continue ongoing services and within State prescribed parameters. An extension of up to fourteen (14) Calendar Days may be granted if:

4.12.12.5.1 The Member or the provider requests the 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 timeframe, the CONTRACTOR must give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Appeal 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 timeframe could seriously jeopardize the Member's life or health or the ability to attain, maintain or regain maximal function, the CONTRACTOR must make an expedited authorization decision and provide notice as expeditiously as

required and no later than seventy-two (72) hours after the receipt of request for services. 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 in CYFD Custody

4.12.13.1 The CONTRACTOR shall work with CYFD and other State agencies to promote early identification of children who are engaging in delinquent or high-risk factors including exhibiting signs of SED.

4.12.13.2 The CONTRACTOR shall coordinate services with the CYFD Protective Services ("PS"), Family Services ("FS"), and Juvenile Justice Services ("JJS") divisions, including discharge planning.

4.12.13.3 The CONTRACTOR shall participate in all FS, PS, and JJS clinical staffing reviews, including the CYFD Care Coordination Protocol process.

4.12.13.4 Upon request, the CONTRACTOR shall participate in the PS Team Decision-Making ("TDM") and JJS Multi-Disciplinary Team ("MDT") meetings.

4.12.13.5 For requests for authorization of residential treatment center ("RTC") services for JJS youth in a detention facility, the CONTRACTOR shall make a decision and notify JJS and the provider of the decision within twenty-four (24) hours of receipt of the request.

4.12.13.6 The CONTRACTOR shall ensure that providers begin discharge planning with CYFD staff within twenty-four (24) hours of a child's admission to an acute Behavioral Health setting to identify antecedents to the placement and conditions for the child's return to the community, including but not limited to the permanency planning Behavioral Health needs of the child.

4.12.13.7 The CONTRACTOR shall ensure that children in the custody or supervision of CYFD receive a Behavioral Health screening within twenty-four (24) hours of a referral to a Behavioral Health Contract Provider and receive a Behavioral Health assessment, Medically Necessary Covered Services, and care coordination as appropriate.

4.12.13.8 The CONTRACTOR shall ensure the Member's assigned CYFD worker is actively involved in the Member's care coordination, provided that CYFD informs the CONTRACTOR of who is the assigned CYFD worker.

4.12.13.9 The CONTRACTOR shall promote coordination between juvenile detention facilities and the CONTRACTOR's Contract Providers to establish a process to communicate the physical health and Behavioral Health needs of juveniles

at intake and discharge and to establish continuity of care between the juvenile detention facility and the CONTRACTOR. The CONTRACTOR shall facilitate that coordination if requested.

4.12.13.9.1 Upon request, the CONTRACTOR shall provide training to juvenile detention 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, to the extent resources are available, and shall work with the Collaborative to implement criteria to prioritize CYFD-referred juveniles to prevent recidivism to the extent possible.

4.12.13.10 The CONTRACTOR shall work with CYFD to provide care coordination for committed juveniles identified as having high needs as they transition from juvenile correctional facilities (commitment facilities) back into the community.

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 timeframes 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.

4.12.16.2 The CONTRACTOR shall require its staff and Contract Providers to report, respond to, and document Critical Incidents 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.

4.12.16.4 The CONTRACTOR shall follow the required processes and instruct 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.

4.12.17 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 7.3.6.1. 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 discharges 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 enrollees 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 - Well-Child Visits in the First 15 Months of Life. Use current reporting year HEDIS technical specifications for reporting.

The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six or more well-child visits.

4.12.17.7 TM#5 – Children and Adolescents' Access to Primary Care Practitioners.
Use current reporting year HEDIS technical specifications for reporting.
The percentage of members 12 months – 19 years of age who had a visit with a PCP.

4.12.17.8 TM#6 Long Acting Reversible Contraceptive (LARC)

In CY17, the CONTRACTOR shall measure the use of Long Acting Reversible Contraceptives (LARC) among members age 15 through 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 Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Use current reporting year HEDIS technical specifications for reporting. The percentage of children and adolescents 1-17 years of age who were on two or more concurrent antipsychotic medications.

4.12.17.11 TM#9 Engagement of Alcohol and Other Drug Dependence (AOD) Treatment

Use current reporting year HEDIS technical specifications for reporting. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

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. To the extent HSD develops a new initiative; it will provide the CONTRACTOR with ninety (90) Calendar Days' notice.

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 Reserved

4.13.1.2.1 Reserved

4.13.1.2.2 Reserved

4.13.1.2.3 Reserved

4.13.1.2.4 Reserved

4.13.1.2.5 Reserved

4.13.1.2.6 Reserved

4.13.1.2.7 Reserved

4.13.1.3 The CONTRACTOR shall support engagement and transition of Primary Care practices to PCMHs by focusing on the following areas:

4.13.1.3.1 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 nursing facility level of care.

4.13.1.3.2 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;

4.13.1.3.3 Focusing care on prevention, chronic care management, reducing emergency room visits and unnecessary hospitalizations and improving care transitions;

4.13.1.3.4 Using access and quality measures (HEDIS and surveys), as defined by HSD;

4.13.1.3.5 Demonstrating improved health status and outcomes for Members as defined by HSD;

4.13.1.3.6 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;

4.13.1.3.7 Promoting adoption of the use of Health Information Technology ("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 Medicaid Claims/Encounter Data, MCO Claims/Encounter Data and CONTRACTOR authorization data as directed by HSD; and

4.13.1.3.8 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.

4.13.1.4 The CONTRACTOR shall report PCMH activities and expenditures to HSD in a format and methodology specified by HSD.

4.13.1.5 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 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; and; and

4.13.2.7.2 The claim payment shall be made, per Section 4.19 Claims Management.

4.13.3 New Mexico's Health Information Exchange (HIE)

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.

4.14 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 timeframes. 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 language that includes all 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.

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 CFR Part 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 and at a minimum comply with the following:

4.14.3.1.1 Reserved;

4.14.3.1.2 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;

4.14.3.1.3 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 Long-Term Care services;

4.14.3.1.4 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;

4.14.3.1.5 Include information about care coordination including the role of care coordinators;

4.14.3.1.6 Include information on how to access services when out of State;

4.14.3.1.7 Describe how to report suspected Fraud and Abuse;

4.14.3.1.8 Describe how to access language assistance services for individuals with LEP and auxiliary aids and services, including additional information in alternative formats or languages;

4.14.3.1.9 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;

4.14.3.1.10 A statement that failure to pay for non-Covered Services will not result in a loss of Medicaid benefits;

4.14.3.1.11 Describe cost sharing including an explanation that providers and/or the CONTRACTOR may utilize whatever legal actions are available to collect these amounts;

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

4.14.3.1.13 Explain any restrictions on Member's freedom of choice among Contract Providers;

4.14.3.1.14 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;

4.14.3.1.15 Provide information regarding Grievances, Appeals and Fair Hearing procedures and timeframes including all pertinent information provided

in 42 C.F.R. §§ 438.400 through 438.424;

4.14.3.1.16 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;

4.14.3.1.17 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;

4.14.3.1.18 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.;

4.14.3.1.19 Include language to clearly explain that a Native American Member may self-refer to an I/T/U for services;

4.14.3.1.20 Include information on how to contact a care coordinator and/or self-report a change in health status;

4.14.3.1.21 Include information on how to contact a Behavioral Health peer support specialist or wellness center;

4.14.3.1.22 Include Health Education and Health Literacy information as explained in Section 4.14.10 of this Agreement;

4.14.3.1.23 Include information regarding the Birthing Options Program;

4.14.3.1.24 Include information on how to request disenrollment from the CONTRACTOR's MCO;

4.14.3.1.25 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;

4.14.3.1.26 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;

4.14.3.1.27 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

4.14.3.1.28 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 CFR §§ 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 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, and whether the provider's office/facility has accommodations for Members with physical disabilities, including offices, exam room(s) and equipment; and whether the provider has completed cultural competence training; 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 Long-Term Care 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 Reserved;

4.14.9.3.7 The Member's date of birth;

4.14.9.3.8 The Member's enrollment effective date;

4.14.9.3.9 The Member's PCP;

4.14.9.3.10 Reserved;

4.14.9.3.11 Expiration date (the Member's eligibility review date for the next calendar year);

4.14.9.3.12 The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier, if applicable;

4.14.9.3.13 Whether the Member is enrolled in the ABP, indicated on the card as "Expansion ABP," or is ABP Exempt, indicated on the card as "Expansion State Plan"; and

4.14.9.3.14 The Member's State-issued Aspen identification number and applicable copayment amounts.

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 and submit it to HSD for prior review and approval. 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.

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, including the nurse triage/nurse advice line or queue, meets the following performance standards 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 Reserved.

4.16.2.2 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.

4.16.2.3 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.

4.16.2.4 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) Business Days of the decision to extend the timeframe.

4.16.2.5 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:

4.16.2.5.1 All information considered in investigating the Grievance;

4.16.2.5.2 Findings and conclusions based on the investigation;

4.16.2.5.3 The disposition of the Grievance; and

4.16.2.5.4 Reserved.

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 timeframes in 42 C.F.R. §§ 438.404 unless such timeframe 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. § 483.12(a)(5)(ii).

4.16.3.4 A Member may file an Appeal of a CONTRACTOR Adverse Benefit Determination either verbally or in writing within sixty (60) Calendar Days

of receiving the CONTRACTOR's notice of Adverse Benefit Determination. 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 the expected date of its resolution.

4.16.3.8 The CONTRACTOR may extend the thirty (30) Calendar Day timeframe 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 timeframe.

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 CFR § 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 timeframe 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 verbal notification and follow-up with a written notice within two (2) Calendar Days.

4.16.4.5 If the CONTRACTOR denies a request for expedited resolution of an Appeal, the CONTRACTOR shall transfer the Appeal to the timeframe 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, 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 CFR § 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/or Payment Error Rate Management and CMS Audit Medicaid Integrity Contractors (MIC). The CONTRACTOR, its Subcontractors, Major Subcontractors, and Contract Providers shall, upon request, make available to the RAC 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 RAC 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 31 U.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 articulate 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 changes 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 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. §§ 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 timeframes required by HSD:

4.17.2.3.1 Suspected Fraud, Waste and/or 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 The CONTRACTOR shall have a mechanism in place to suspend payments to any provider for which HSD, in accordance with 42 CFR 455.23, has determined that a credible allegation of fraud exists.

4.17.2.3.3 All confirmed, credible or suspected provider Fraud, Waste and/or Abuse shall be immediately reported to HSD and shall include the information provided in 42 CFR § 455.17, as applicable. It shall be HSD's responsibility to report verified cases to MFEAD; and

4.17.2.3.4 All confirmed or suspected Member Fraud, Waste and/or 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 timeframe. 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.

4.17.3 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 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/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 where 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 know ledge 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 timeframes specified in 4.17.4.1.1, the provider shall send an "Overpayment Report" to the CONTRACTOR and HSD which 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) if 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; or

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.

4.17.4.4 Failure To Self-Report And/or Refund Overpayments

4.17.4.4.1 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 timeframe 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 Net Worth Requirements

The CONTRACTOR shall at all times be in compliance with the net worth requirements under applicable insurance laws.

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 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 Start-Up Account

The CONTRACTOR, at the agreement execution, shall submit to HSD proof of 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. This provision shall not apply if the CONTRACTOR has been providing services to Medicaid Members for a period exceeding three (3) months.

4.18.4 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.

4.18.5 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.

4.18.6 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.

4.18.7 Fidelity Bond

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond in the amount of at least one million dollars ($1,000,000).

4.18.7.2 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.

4.18.7.3 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.

4.18.8 Insurance

4.18.8.1 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:

4.18.8.1.1 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;

4.18.8.1.2 Workers' compensation as required by State and/or federal regulations;

4.18.8.1.3 Unemployment insurance as required by State and/or federal regulations;

4.18.8.1.4 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 4.18.12 of this Agreement;

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

4.18.8.1.6 Health insurance for employees as further set forth in Section 7.30 of this Agreement.

4.18.8.2 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.

4.18.8.3 Reserved.

4.18.9 Working Capital Requirements

4.18.9.1 The CONTRACTOR shall demonstrate and maintain working capital as specified below. For purposes of this Agreement, working capital is defined as current assets minus current liabilities. Throughout the terms of this Agreement, the CONTRACTOR shall maintain a positive working capital, subject to the following conditions:

4.18.9.1.1 If the CONTRACTOR's working capital falls below zero (0), the CONTRACTOR shall submit a written plan to reestablish a positive working capital balance for approval by HSD; and

4.18.9.1.2 HSD may take any action it deems appropriate, including termination of this Agreement, if: (i) the CONTRACTOR does not propose a plan to reestablish a positive working-capital balance within a reasonable period of time; (ii) the CONTRACTOR violates a CAP or DCAP; or (iii) HSD determines that the negative working capital cannot be corrected within a reasonable time.

4.18.10 Financial Stability

4.18.10.1 Throughout the term of this Agreement, the CONTRACTOR shall:

4.18.10.1.1 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 to 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.

4.18.10.1.2 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.

4.18.10.2 The CONTRACTOR shall be responsible for sound financial management of its MCO.

4.18.10.3 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 following ratios and financial viability standards will be considered a material breach of this Agreement.

4.18.10.3.1 Current Ratio: Current assets divided by current liabilities must be greater than or equal to 1.00.

4.18.10.3.2 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

4.18.10.3.3 Reserved.

4.18.11 Performance Bond

4.18.11.1 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 4.18.11.3 of this Agreement.

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.5 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

4.18.11.1.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit Insurance Corporation (FDIC) or equivalent federally insured deposit;

4.18.11.1.1.3 Surety Bond issued by a surety or insurance company licensed to do business in New Mexico;

4.18.11.1.1.4 Certificate of Deposit; and

4.18.11.1.1.5 Investment account with financial institute licensed to do business in the State of New Mexico.

4.18.11.2 The performance bond must be restricted to the CONTRACTOR's Centennial Care program.

4.18.11.3 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.

4.18.11.4 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.

4.18.11.5 The CONTRACTOR is prohibited from using a parental guarantee to fulfill the requirements of the Performance Bond.

4.18.11.6 The CONTRACTOR shall purchase the performance bond within forty five (45) Calendar Days of receipt of the first month of capitation from HSD.

4.18.11.7 The CONTRACTOR may not change the amount, duration or scope of the performance bond without prior written approval from HSD.

4.18.11.8 The CONTRACTOR is prohibited from leveraging the bond for another loan or creating other creditors from using this bond as security.

4.18.11.9 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.

4.18.11.10 The CONTRACTOR shall hold the performance bond with any organization or trustee acceptable through which a custodial or controlled account is utilized.

4.18.12 Reinsurance

4.18.12.1 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.

4.18.12.2 HSD reserves the right to revisit reinsurance annually and 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.

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 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.

4.18.13 Third-Party Liability

4.18.13.1 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:

4.18.13.1.1 Is responsible for identification of third-party coverage of Members and coordination of benefits with applicable third-parties;

4.18.13.1.2 Shall inform HSD monthly regarding any member who has other health coverage;

4.18.13.1.3 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

4.18.13.1.4 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:

4.18.13.1.4.1 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;

4.18.13.1.4.2 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;

4.18.13.1.4.3 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;

4.18.13.1.4.4 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;

4.18.13.1.4.5 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.

4.18.13.2 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 avoid 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., long-term care insurance) pays a cash benefit to the Member, regardless of services used, or does not allow the Member to assign his or her benefits.

4.18.13.3 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.

4.18.13.4 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.

4.18.13.5 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.

4.18.13.6 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.

4.18.13.7 Claims for EPSDT, pregnancy care and prenatal care shall be paid at the time presented for payment by the provider and the CONTRACTOR shall bill the responsible third party.

4.18.13.8 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.

4.18.13.9 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.

4.18.13.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.18.13, 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.

4.18.13.11 Cost sharing and patient liability responsibilities shall not be considered TPL.

4.18.13.12 The CONTRACTOR shall provide TPL data to any provider having a Claim denied by the CONTRACTOR based upon TPL.

4.18.13.13 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.

4.18.13.14 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.

4.18.13.15 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.

4.18.13.16 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.

4.18.13.17 HSD shall be solely responsible for estate recovery activities and shall retain any and all funds recovered through these activities.

4.18.14 Patient Liability

4.18.14.1 The CONTRACTOR shall have policies and procedures to ensure that, where applicable, Members residing in residential facilities pay their patient liability.

4.18.14.2 HSD will notify the CONTRACTOR of any applicable patient liability amounts for Members via the eligibility/enrollment file.

4.18.14.3 The CONTRACTOR shall delegate collection of patient liability to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount.

4.18.14.4 The CONTRACTOR shall submit patient liability information associated with Claim payments to providers in its Encounter Data submission.

4.18.14.5 HSD shall reconcile patient liability amounts in accordance with section 6.8.4 of this Agreement.

4.18.15 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.

4.18.16 Reporting

4.18.16.1 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.

4.18.16.2 The CONTRACTOR shall submit third party liability recoveries including Medicare payment information on a date of services basis as directed by HSD.

4.18.16.3 The CONTRACTOR shall submit reports on patient liability information on a date of service basis as directed by HSD.

4.18.16.4 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;

4.19.1.1.1 The CONTRACTOR shall ensure its Claims Processing capabilities are compliant with the national conversion from ICD-9 to ICD-10.

4.19.1.2 Assigning unique identifiers for all Claims received from providers;

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 Meeting both State and federal standards for processing Claims, except as provided for in this Agreement;

4.19.1.10 Generating remittance advice and/or electronic response files to providers for all Claims submissions;

4.19.1.11 Participating on a committee or committees with HSD to discuss and resolve systems and data related issues, as required by HSD;

4.19.1.12 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;

4.19.1.13 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;

4.19.1.14 Meeting all TPL requirements described in Section 4.18.13 of this Agreement;

4.19.1.15 Using the third party liability (TPL) file provided by HSD to coordinate benefits with other payers;

4.19.1.16 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;

4.19.1.17 Developing and maintaining an NPI HIPAA-compliant electronic billing system for all Providers or Major Subcontractors submitting bills directly to the CONTRACTOR or Subcontractor.

4.19.1.18 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:

4.19.1.18.1 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; and

4.19.1.18.2 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.

4.19.1.18.3 The CONTRACTOR shall adjudicate all claims, which did not pay according to the lesser of logic/COB claims processing guidelines to ensure Medicaid is the payer of last resort as it relates to third-party coverage liability through an insurer.

4.19.1.18.4 The CONTRACTOR shall enter into a coordination of benefits agreement with Medicare and participate in the automated claims crossover process.

4.19.1.19 Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service Medicare claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in the next section, including but not

limited to:

4.19.1.19.1 Services provided under subcapitation payment arrangements;

4.19.1.19.2 Services provided as part of a bundled rate; and

4.19.1.19.3 Services performed by CONTRACTOR staff, even where no payment is made or identified for those services, such as care coordination activities;

4.19.1.20 Adhering to federal and State timely filing requirements;

4.19.1.21 Configuring the CONTRACTOR's own system to meet HSD's editing criteria; and

4.19.1.22 Submitting information to the State's all payers claim database at a time and in a format prescribed 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 Encounter Data submitted 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. 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 Reserved;

4.19.2.2.6 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;

4.19.2.2.7 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;

4.19.2.2.8 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; (ii) any Medicare claims paid by the SNP or Medicare Advantage Plan for a Member for which there is no Medicaid obligation (no coinsurance or deductible) must be submitted as Encounters complete with all Claim adjustment reason codes explaining the difference between the provider's billed charges and the CONTRACTOR's allowed and paid amounts. These non-Medicaid Encounters will not go through the full range of Encounter edits but

must match a valid Member and must fully balance and pass all HIPAA transaction edits, and (iii) 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;

4.19.2.2.9 Have a formal monitoring and reporting system to reconcile submission and resubmission of Encounter Data between the CONTRACTOR and HSD to assure timeliness of submissions, resubmissions and corrections and the overall completeness and accuracy of data;

4.19.2.2.10 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;

4.19.2.2.11 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;

4.19.2.2.12 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;

4.19.2.2.13 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;

4.19.2.2.14 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;

4.19.2.2.15 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; and

4.19.2.2.16 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 fee-for-service 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.

4.19.2.2.17 The CONTRACTOR shall transmit behavioral health encounter data on a monthly basis to HSD, as directed and in a format prescribed by HSD and the Collaborative, to house in the Behavioral Health Services Division Data Warehouse.

4.19.2.2.18 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; and

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.

4.20 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 Number (NPI) 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 and 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,

4.20.1.1.7 Monitor the completeness of the data being received to detect Providers or Major Subcontractors who are transmitting partial or no records;

4.20.1.1.8 Transmit data securely and electronically;

4.20.1.1.9 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;

4.20.1.1.10 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 an MCO;

4.20.1.1.11 Transmit to HSD or another contractor, data elements associated with Members who have been receiving ongoing services within the

CONTRACTOR's MCO; and

4.20.1.1.12 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 timeframe 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 notification file to New Mexico Medicaid's

fiscal agent that identifies by NPI any new provider who has requested participation with the CONTRACTOR and any existing provider for which there has been a change in the provider's affiliation with the CONTRACTOR to include any change in provider servicing location, change in licensure/certification, status as a PCP, and the date on which the provider is no longer participating with the CONTRACTOR. The CONTRACTOR shall send this file when the change occurs, not on any specified time schedule;

4.20.1.7.3 Transmitting, upon request by HSD, the CONTRACTOR's full provider network file to New Mexico Medicaid's fiscal agent that identifies by NPI all Contract Providers;

4.20.1.7.4 Accepting a provider confirmation update file from New Mexico Medicaid that contains any newly active 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, recommended taxonomy for Claims submission, PCP indicator and dates of enrollment/termination;

4.20.1.7.5 Accepting periodically a full provider confirmation file from HSD and returning this file to HSD with any updates as to CONTRACTOR participation and PCP status;

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), recommended taxonomy for Claims submission, 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 and/or using the Medicaid ID as a secondary identifier on the Encounter Claim as an alternate to the taxonomy match to the correct provider type/specialty; and

4.20.1.7.7 Maintain an online provider directory for Members as specified in Section 4.14.5 of this Agreement.

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 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 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, nursing facility level 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 copayment amounts paid to date, nursing facility level of care, Community Benefit status, Behavioral Health 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, 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 Reserved.

4.20.3.5 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:

4.20.3.5.1 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;

4.20.3.5.2 Have the date and identification "stamp" displayed on any online inquiry;

4.20.3.5.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

4.20.3.5.4 Be supported by listings, transaction reports, update reports, transaction logs or error logs;

4.20.3.5.5 Facilitate auditing of individual records as well as batch audits; and

4.20.3.5.6 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.

4.20.3.6 The CONTRACTOR's systems shall have inherent functionality that prevents the alteration of finalized records.

4.20.3.7 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.

4.20.3.8 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.

4.20.3.9 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.

4.20.3.10 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.

4.20.3.11 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).

4.20.3.12 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.

4.20.5.3 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.

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.

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 timeframe determined by HSD after consulting with the CONTRACTOR. In such a situation, failure to comply with the agreed upon timeframes 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	Timeframe as determined by HSD at time of the request.

*Quarterly financial reports are due Forty-Five (45) calendar days from the end of the 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 Section 7.3 #7, and #11 of this Agreement. If CONTRACTOR cures the deficiency identified by the 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 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. The one time cure period applies only to the initial rejection of a report and not subsequent rejections of the same report notwithstanding the above; the CONTRACTOR is subject to $5,000 rejection penalty.

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 forty-five (45) Calendar Days from the due date 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 work with the other Centennial Care MCOs to establish a program to provide incentives to Members for healthy behaviors.

4.22.1.1.2 The program must allow for the opportunity for all Members to participate, adhere to this Section 4.22.1 of this Agreement and be prior approved 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. Behaviors to be rewarded will be agreed to by the CONTRACTOR, the other Centennial Care MCOs and HSD.

4.22.1.2.2 Members shall earn credits for each healthy behavior based on a schedule agreed to by the CONTRACTOR, the other Centennial Care MCOs and HSD. Credits may be redeemed for HSD-approved items available through a catalog jointly developed by the CONTRACTOR and the other Centennial Care MCOs or a loadable card issued by the MCOs' reward fulfillment subcontractor and accepted by approved retailers.

4.22.1.2.3 The credits in the Member's account shall be available to the Member if the Member enrolls in a different MCO.

4.22.1.3 Data Sharing and Reporting

4.22.1.3.1 Subject to HSD approval, the CONTRACTOR shall establish an automated process for capturing and accumulating the credits awarded for participation in qualified activities and programs.

4.22.1.3.2 The credits for qualified activities and programs may be tracked based on Claim submissions.

4.22.1.3.3 The credits 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 credits 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.

4.22.1.3.4 The CONTRACTOR shall design and operate an automated system to communicate information on the credits 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 solved 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 require 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 and social security number, the Member's address and telephone number, the Member's date of birth and gender, the availability of third-party coverage, the Member's rate category and the Member's 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 The CONTRACTOR shall accept the Capitation Payment received each month as payment in full by the HSD for all services provided to enrollees covered under this agreement and the administrative costs incurred by the CONTRACTOR in providing or arranging for such services. Unless otherwise specified in this agreement, any and all costs incurred by the CONTRACTOR in excess of the Capitation Payment shall be borne in total by the CONTRACTOR.

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.

6.1.4 The CONTRACTOR shall comply with all requirements stated in NMAC 8.305.11 and NMAC 8.306.11. HSD shall make payments under capitated Risk Contracts that are actuarially sound. Capitation Rates shall be developed in accordance with generally accepted actuarial principles and practices. Capitation Rates must be appropriate for the populations to be covered, the services to be furnished under the Agreement and be certified as meeting the foregoing requirements by actuaries. The actuaries must meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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 Insurer Provider 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 to the CONTRACTOR for the provision of the managed care benefit package. Capitation Rates determined through discussion between the Parties are considered confidential. The monthly rate for each Member is based on actuarially sound Rate Cohorts. Members shall be held harmless against any liability for debts of a CONTRACTOR that were incurred within the Agreement in providing Covered Services to the Medicaid Member. Section 6.13 of this Agreement addresses the payment associated with the Health Insurer Provider Fee under Section 9010 of the ACA.

6.1.6 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 prior to Go-Live. 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 and be based on services as specified in 42 CFR §§438.3(c)(1)(ii) and 438.3(e). Accordingly, HSD's offer of all Capitation Rates 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 renegotiate these Capitation Rates. HSD's decision to renegotiate the Capitation Rates under the circumstances described above is binding on the CONTRACTOR.

6.1.7 By signature on this Agreement, the CONTRACTOR explicitly agrees that this section shall not independently convey any inherent rights, responsibilities or obligations,

relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by the CONTRACTOR. In the event that the Capitation Payment certified by the state's actuary and approved by CMS are different from the Capitation Payments included with this Agreement, the CONTRACTOR agrees to participate in a reconciliation process with HSD to bring Capitation Payments to the CONTRACTOR in line with the approved Capitation Rates.

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's enrollment is terminated. The CONTRACTOR shall be responsible for Covered Services 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 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. HSD must notify the CONTRACTOR of this retro Capitation Payment by the last day of the month. If this notification is not made by the last day of the month, the CONTRACTOR may choose to refuse the retro Capitation Payment.

6.2.3 Retro Capitation Payments may not be issued for Members for the same coverage month in which fee-for-service claims have already been paid by Medicaid except in special situations determined by HSD. When retro a Capitation Payment is not issued for a particular month, the Member will remain enrolled with fee-for-service for that month.

6.2.4 HSD shall have the discretion to recoup Capitation Payments made by HSD pursuant to the time periods governed by this Agreement for the following:

6.2.4.1 Members incorrectly enrolled with more than one CONTRACTOR;

6.2.4.2 Members who die prior to the enrollment month for which a Capitation Payment was made; and/or

6.2.4.3 Members whom HSD later determines were not eligible for Medicaid during the enrollment month for which 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, may not recoup payments for any Value Added Services provided.

6.2.4.4 Members with a length of stay in an IMD that exceeds 15 Calendar Days within the Calendar Month as specified in section 4.5.16.2.1.

6.2.5 For individuals who were enrolled with more than one CONTRACTOR, the

CONTRACTOR from whom the Capitation Payment is recouped shall have the right to recoup incurred expenses from the CONTRACTOR who retains the Capitation Payment.

6.2.6 In the event of an error that causes payment(s) to the CONTRACTOR to be issued by HSD, 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 (30^{th}) Calendar Day following the notice. Any process that automates the recoupment procedures will be discussed in advance by HSD and the CONTRACTOR and documented in writing prior to implementation of a new automated recoupment process. The CONTRACTOR has the right to dispute any recoupment requests in accordance with Section 7.11 of this Agreement.

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 of Native Americans provided at I/T/Us. This payment shall be separate from the Capitation Rate process and be based upon the HSD's validation of data provided by the CONTRACTOR to the HSD.

6.3.2 HSD shall pay the CONTRACTOR for services rendered to Medicaid Members in I/T/Us. HSD will reimburse the CONTRACTORS based on Encounters that have cleared all systems edits in the Medicaid Management Information System (MMIS) per quarter. HSD will cross reference the "Payments to I/T/Us", each quarter; however the Encounters paid and accepted by HSD will supersede or take preference if there is a difference between paid Encounters versus the report required by HSD to report I/T/U expenditures.

6.3.3 The CONTRACTOR shall have up to two (2) years from a Claim's first date of service to submit a Claim. Claims not submitted within two (2) years of the first date of service are not eligible for reimbursement.

6.3.4 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. Contract Providers have no obligation to continue to see Members for treatment if the Member fails to meet copayment obligations except in emergency situations.

6.3.5 The CONTRACTOR shall submit all Encounters for I/T/U payments.

6.3.6 The CONTRACTOR shall report expenditures on a date of service basis for I/T/U payment amounts.

6.4 Behavioral Health Capitated Agreements

The CONTRACTOR shall ensure that the funding, through the Capitation Payments, is made available for Behavioral Health services.

6.5 Payment on Risk Basis for non-Other Adult Group Members

The CONTRACTOR is at risk of incurring losses if its expenses for providing the Centennial Care benefit package exceed its Capitation Payment. HSD shall not provide a retroactive Capitation 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 for the non-Other Adult Group Members.

6.6 Changes in the Capitation Payment Rates

6.6.1 The Capitation Rates awarded with this Agreement shall be effective for the term of this Agreement. The Capitation Rates may be adjusted based on factors such as changes in the scope of work, CMS requiring a modification of the 1115(a) Waiver if now or amended federal or State statutes or regulations are implemented, inflation, significant changes in the demographic characteristics of the Member population, or the disproportionate enrollment selection of the CONTRACTOR by Members in certain Rate Cohorts, or in the event that the Capitation Rates certified by the state's actuary and approved by CMS are different from the Capitation Rates included with this Agreement. Any changes to the Capitation Rates shall be actuarially sound and implemented pursuant to Section 6.1.6 or 6.1.7 of this Agreement.

6.6.2 HSD shall compensate the CONTRACTOR for work performed under this Agreement at the Capitation Rates shown on the rate sheets for the Contract period.

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

6.7 Compensation and Programmatic Changes

6.7.1 The Parties further understand that program changes affecting the rate of compensation for managed care are likely to occur during the term of this Agreement and further agree to the following if such program changes are implemented by HSD during the term of this Agreement:

6.7.1.1 In the event that HSD initiates a programmatic change affecting compensation and payment reimbursement 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.

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

6.7.1.3 If the CONTRACTOR does not request discussion for a modification of the Agreement concerning the change in compensation and payment reimbursement for managed care and program changes, within fifteen (15) Calendar Days of the notice from HSD, then the change shall be implemented and become effective, subject to the continued actuarial soundness of the rates.

6.7.1.4 On an annual basis, the Parties shall evaluate the projected versus actual cost of the Member Rewards program through the first eight months of the contract year. In the event that actual costs are significantly lower or higher than projected, HSD shall recoup or adjust payment as mutually agreed by the Parties.

6.7.1.5 HSD will annually evaluate the LTSS blended Rate Cohorts and self-directed Rate Cohorts. At HSD's discretion HSD may periodically reevaluate the blended Rate Cohorts and self-directed Rate Cohorts to determine if a revision to the mix is necessary on a prospective basis only.

6.8 Patient Liability

6.8.1 HSD monthly Capitation Payments will be "net" of patient liability. The Capitation Payments are based on "gross" cost and reduced by the amount of patient responsibility.

6.8.2 The CONTRACTOR shall delegate the collection of patient liability to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount.

6.8.3 The CONTRACTOR shall submit patient liability information associated with Claim payments to providers in their Encounter Data submission.

6.8.4 Interim Evaluation

HSD will perform an initial evaluation of the patient liability reconciliation between July and September in the year following the end of the contract period being measured when the evaluation includes the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the year following the contract period being measured. 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 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 in the year following the end of the contract period being measured.

6.8.5 Final Evaluation

HSD will perform final evaluation of the patient liability reconciliation between July and September in the second year following the end of the contract period being measured when the evaluation includes the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the second year following the contract period being measured. 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 final evaluation by no later than the last business day of May in the second year following the end the end of the contract period being measured.

6.8.6 Retroactive changes to the data following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation is adjusted 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 (2.0%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

6.9 Implementation of Risk-Adjusted Rates

6.9.1 HSD reserves the right to modify the Capitation Payment methodology from the process outlined in Section 6.2 of this Agreement for future Contract periods.

6.9.2 HSD will notify the CONTRACTOR of any change in payment methodology at least six (6) months prior to the effective date of change.

6.10 Delivery System Improvement Performance Targets

6.10.1 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 Delivery System Improvement Performance Tagets 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.

6.10.2 The Delivery System Improvement Performance Targets are outlined in Attachment 3.

6.10.3 The CONTRACTOR's Delivery System Improvement Performance Targets will be evaluated in the second quarter of the calendar year following the performance target 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. No partial points will be awarded.

6.10.4 If the CONTRACTOR does not meet the Delivery System Improvement performance targets, 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.

6.11 Community Benefit Reconciliation

6.11.1 HSD shall review services for Members determined by the CONTRACTOR to need the Community Benefit. If a Member does not utilize Community Benefit services within ninety (90) Calendar Days of the effective date of the Setting of Care (SOC), HSD will recoup the Capitation Payment from the CONTRACTOR for the months in which Community Benefit services were not received. The ninety (90) Calendar Day period begins on the effective date of the SOC.

6.11.2 The CONTRACTOR shall adhere to the NFLOC and Setting of Care timelines outlined in the policy manual.

6.11.3 HSD will not retroactively adjust payments from Physical Health or healthy dual Rate Cohort to a Long-Term Care Rate Cohort. It is the CONTRACTOR'S responsibility to ensure timely submission of correct Setting of Care for the member. Notwithstanding the foregoing, if CONTRACTOR has made good faith efforts to complete the CNA and CONTRACTOR demonstrates through encounter data that it has continued to provide the LTC benefits after expiration of the NFLOC determination, then retroactive payment adjustments to the appropriate LTC Cohort may be made.

6.11.4 Interim Evaluation

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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the year following the contract period being measured. 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 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 in the year following the

end of the contract period being measured.

6.11.5 Final Evaluation

HSD will perform 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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the second year following the contract period being measured. 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 final evaluation by no later than the last business day of May in the second year following the end the end of the contract period being measured.

6.11.6 Retroactive changes to the data following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation is adjusted 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 (2.0%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

6.12 Retroactive Period Reconciliation

6.12.1 The CONTRACTOR is required to reimburse providers for the medical expenses incurred by the Member in the Retroactive Period (The retroactive period is defined in Section 2 - Definition, Acronyms and Abbreviations, of this Agreement). The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the prospective Capitation Rate development.

6.12.2 HSD shall reconcile the difference between the medical expenses incurred by the CONTRACTOR during the Retroactive Period 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 and are not considered in the prospective payment rate development.

6.12.3 Reserved

6.12.4 The reconciliation process for the Retroactive Period is outlined in Attachment 9.

6.13 ACA Section 9010 Health Insurer Provider Fee

6.13.1 HSD agrees to reimburse the CONTRACTOR for the Health Insurer Provider Fee under

Section 9010 of the ACA including the impact of applicable income tax, assessments and premium tax applicable to the CONTRACTORS liability for the New Mexico Medicaid program.

6.13.2 The CONTRACTOR agrees to provide HSD with all necessary documentation, as determined by HSD, related to the CONTRACTOR's Health Insurance Provider Fee liability.

6.13.3 HSD agrees to make payment to the CONTRACTOR after the receipt of the final documentation outlined in section 6.13.2 and within the calendar year that the fee is imposed on the CONTRACTOR.

6.14 Hepatitis C Drug Reconciliation

6.14.1 The CONTRACTOR receives payment in the capitated rate for assumed utilization and cost associated with specialty drug treatment for Hepatitis C. The utilization, cost and the number of Members by Rate Cohort assumed to seek treatment is communicated to the CONTRACTOR annually.

6.14.2 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.

6.14.3 The reconciliation process for the Hepatitis C reconciliation is outlined in Attachment 11 and the specialty drug list as part of the reconciliation will be provided to each CONTRACTOR by HSD.

6.14.4 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.

6.14.4.1 In the event that the CONTRACTOR produces information the CONTRACTOR wants HSD to treat as confidential, in response to 6.14.4, 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.

6.14.5 If the CONTRACTOR cannot provide or refuses to provide the information outlined in 6.14.4 then HSD shall utilize an assumed supplemental rebate or discount amount to reduce the reported payment in the encounter data for purposes of the reconciliation.

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 **Limitation on Underwriting Gain**

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 7.2.9 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 4.5.15. 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 arrangement 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 7.2.8 of this Agreement) incurred during the

annual period including expenses for care coordination services deemed to be administrative per Section 7.2.9 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 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 Medical Expense Ratio

The CONTRACTOR shall spend no less than eighty-six percent (86%) of net Medicaid line of business Net Capitation Revenue, defined in Section 7.2.2 of this Agreement, on direct medical expenses defined in Section 7.2.2 of this Agreement 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) 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 7.2.1-7.2.2.4.

7.2.7.1 For the purposes of this requirement, the medical loss ratio calculation standards shall be consistent with 42 CFR 438.8. HSD will develop a separate medical loss ratio report as part of the Financial Reporting Package. Key components of the medical loss ratio calculation are outlined below.

7.2.7.1.1 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

CFR Part 158.

7.2.7.1.2 Denominator: The adjusted premium revenue, which is premium revenue less the CONTRACTOR's federal, state, local taxes and licensing and regulatory fees.

7.2.7.1.3 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.

7.2.7.1.4 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 issues by CMS for the private market.

7.2.7.2 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.

7.2.8 Administrative Expense Reporting

7.2.8.3 Determinations shall be made using the following list as administrative expenses and/or costs; all other expenses shall be considered paid for by CONTRACTOR for direct services to Medicaid members. Administrative expenses and/or costs do not include premium tax and the NMMIP assessments, which are neither administrative nor direct medical expenses. The following are considered valid administrative expenses and/or costs:

7.2.8.3.1 Network development and contracting;

7.2.8.3.2 Direct provider contracting;

7.2.8.3.3 Credentialing and re-credentialing;

7.2.8.3.4 Information systems;

7.2.8.3.5 Health Information Technology;

7.2.8.3.6 Health Information Exchange;

7.2.8.3.7 Encounter Data collection and submission;

7.2.8.3.8 Claims processing for select contractors;

7.2.8.3.9 Member Advisory Board and Native American Advisory Board meetings;

7.2.8.3.10 Member services;

7.2.8.3.11 Training and education for providers and Members;

7.2.8.3.12 Financial reporting;

7.2.8.3.13 Licenses;

7.2.8.3.14 Taxes, excluding premium tax, NMMIP and HIX assessments, and PPACA-related insurer fees;

7.2.8.3.15 Plant expenses;

7.2.8.3.16 Staff travel;

7.2.8.3.17 Legal and risk management;

7.2.8.3.18 Recruiting and staff training;

7.2.8.3.19 Salaries and benefits to MCO staff;

7.2.8.3.20 Non-medical supplies;

7.2.8.3.21 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;

7.2.8.3.22 Depreciation and amortization;

7.2.8.3.23 Audits;

7.2.8.3.24 Grievances and Appeal System;

7.2.8.3.25 Capital outlay;

7.2.8.3.26 Reporting and data requirements;

7.2.8.3.27 Compliance;

7.2.8.3.28 Surveys;

7.2.8.3.29 Quality assurance;

7.2.8.3.30 Quality improvement/quality management;

7.2.8.3.31 Marketing;

7.2.8.3.32 Damages/penalties;

7.2.8.3.33 Project ECHO multi-disciplinary team.

7.2.8.3.34 Electronic Visit Verification (EVV)

7.2.8.4 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.

7.2.9 Care Coordination Expenses

7.2.9.3 The CONTRACTOR shall provide care coordination services in accordance with Section 4.4 of this Agreement.

7.2.9.4 For purposes of this Agreement, the following care coordination functions will be deemed medical services:

7.2.9.4.1 Comprehensive needs assessment;

7.2.9.4.2 Face-to-face meetings between the care coordinator and the Member;

7.2.9.4.3 Telephonic meetings between the care coordinator and the Member;

7.2.9.4.4 Case management;

7.2.9.4.5 Discharge consultation;

7.2.9.4.6 CCP development and updates;

7.2.9.4.7 Health education provided to the Member;

7.2.9.4.8 Disease management provided to the Member; and

7.2.9.4.9 Costs associated with Community Health Workers.

7.2.9.5 The CONTRACTOR shall submit Member care coordination activities through Encounter Data.

7.2.9.6 For purposes of this Agreement, the following care coordination functions will be deemed administrative services:

7.2.9.6.1 Health risk assessments (HRAs);

7.2.9.6.2 Data runs;

7.2.9.6.3 Referrals; and

7.2.9.6.4 Case assignation and scheduling.

7.2.10 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 CONTRACTOR fails to meet the requirements set forth herein, HSD shall, at the time it issues its final calculation, advise CONTRACTOR of this deficiency and require CONTRACTOR to remit the overpayment to HSD, or its designee, or otherwise advise CONTRACTOR as to how the overpayment shall be treated for purposes of compliance with this Section. If CONTRACTOR disputes HSD'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 CONTRACTOR's dispute. If the Parties cannot informally resolve the matter, CONTRACTOR may exercise its rights under Section 7.11 of this Agreement.

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 timeframe specified in the CAP/DCAP, HSD may impose additional sanctions.

7.3.2.6 If HSD staff is required to spend more than 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 CFR § 422.208 and 42 CFR § 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 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 CFR § 438.710.

7.3.3.5 Civil Monetary Penalties, as provided in 42 CFR § 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.

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 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 Reserved;

7.3.3.6.4 Monetary penalties 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.

7.3.3.7 HSD reserves the right to assess a general monetary penalty of five hundred dollars ($500) in addition to any deficiency amount specified under this Agreement.

7.3.4 Other Monetary Penalties

	PROGRAM ISSUES		PENALTY
1.	Failure to comply with Claims processing as described in Section 4.19 of this Agreement		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
3.	Failure to comply with the timeframes for a Comprehensive Needs Assessment for care coordination level 2 and level 3		$1,000 per Member where the CONTRACTOR fails to comply with the timeframes for that Member.
4.	Failure to complete or comply with CAPs/DCAPs		.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 timeframe for responding to Grievances and Appeals required in Section 4.16 of this Agreement		$1,000 per occurrence where the CONTRACTOR fails to comply with the timeframes.
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 2% of the total Capitation Payment paid to the CONTRACTOR for the Agreement year, divided by the number of performance measures specified in the Agreement year.

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, involves a significant 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 timeframes 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.

7.3.5 Payment of Monetary Penalties

7.3.5.1 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.

7.3.5.2 Monetary penalties as described in Section 7.3.4 of this Agreement shall not be passed on to a Major Subcontractor, Subcontractor or Contract Provider.

7.3.6 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.

7.3.7 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, Amending and Restating the Agreement effective February 1, 2013, Amending and Restating the Agreement effective January 1, 2016, Amending and Restating the Agreement effective January 1, 2018, including any amendments and any changes made by notice to adjust the Capitation Rates, shall be effective commencing on January 1, 2018, and ending on December 31, 2018.

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 effected through an amendment to the Agreement.

7.4.3 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 Part 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. Part 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 CFR Part 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 CFR Parts 35, 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 Reserved.

7.6.6.2 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.

7.6.6.3 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.

7.6.6.4 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.

7.6.6.5 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 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 Long-Term Care 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 Submit a termination plan to HSD for review, which is subject to HSD 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 twelve (12) 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 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 Sections 6.7, 6.9. 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 change, 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, then 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's 1115(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 if 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 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

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, in its discretion, which shall be effected by HSD sending written notice to the CONTRACTOR. Any changes to the scope of work and compensation to 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;

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 fifteen (15) Calendar Days of the date the reporting Party receives notice of the sanction. The decision of the MAD Director regarding the dispute shall be delivered to the Parties in writing within thirty (30) Calendar Days of the date the MAD Director receives the written dispute. The decision shall be final and conclusive unless, within fifteen (15) Calendar Days from the date of the decision, either Party files with the Secretary of HSD a written appeal of the decision of the MAD Director.

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 thirty (30) Calendar Days and shall be final and conclusive unless, within fifteen (15) Calendar Days from the date of the decision, either Party files with the Secretary of 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 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. The Secretary of HSD shall notify the Parties of the decision within thirty (30) Calendar Days of the notice of the appeal, unless otherwise agreed to by the Parties in writing or extended by the Secretary 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, or employees nor 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.

7.12.4 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 or 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)-(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; 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 policies and procedures, an audit of applicable files or records and implementation of a corrective action plan if warranted. If a delegated entity is under a corrective action plan, the CONTRACTOR must conduct the annual review onsite.

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.

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 and 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 Subcontracotr 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. Part 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 MajorSubcontractor 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. Part 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 to Members 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.

7.15.3 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, including but not limited to records relating to services provided to Members, including a separate medical record for each Member. Each medical record shall be maintained on paper and/or in electronic format in a manner that is timely, legible, current and organized, and that permits effective and confidential patient care and quality review.

7.16.2 Financial Records

7.16.2.1 The CONTRACTOR agrees to maintain, and requires 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 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 assuring that files contain sufficient information to identify the Grievance and/or Appeal, the date it was received, the nature of the Grievance and/or Appeal, notice to the Member of receipt of the Grievance and/or Appeal, all correspondence between the CONTRACTOR and the Member, the 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.

7.16.4 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 CFR § 455.104 and prohibited affiliations as specified in 42 CFR § 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 CONTACTOR 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 CFR § 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's 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 who may be injured or damaged by the CONTRACTOR in the performance or failure in performance of this Agreement resulting from such acts of omissions. The provisions of this Section 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, 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 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 or ground 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 that 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. Part 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. Part 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 ways 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 or employee of the State of New Mexico, or employee of the State 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's 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 of 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; and

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 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 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 and in no event later than five (5) calendar days after discovery of the breach or potential breach. 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.

7.25.3 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 CFR § 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 that 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 will 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 Subcontractors, 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, or 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, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Parties in investigating or preventing the reoccurrence of any unauthorized possession, use, or 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 Providers shall, upon request, 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.

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;

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; or

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 CFR Part 3017 or 45 CFR Part 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 incligible 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 CFR §§ 438.610 and 438.808(b).

7.29.1.1 Reserved

7.29.1.2 Reserved

7.29.1.2.1 Reserved

7.29.1.2.2 Reserved

7.29.1.2.3 Reserved

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.

7.30.4 Reserved.

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

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:

Nancy Smith-Leslie, Director
Medical Assistance Division
New Mexico Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

or

Christopher Collins, 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:

Sharon Huerta
VP Medicaid Operations, Centennial Care CEO
HCSC Insurance Services Company
AKA Blue Cross and Blue Shield of New Mexico
5701 Balloon Fiesta Parkway NE
Albuquerque, NM 87113

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

IN WITNESS WHEREOF, the parties have executed this amended and restated contract as of the date of signature by the Human Services Department.

CONTRACTOR

By: _____ Date: 9.25.17

Title: Vice President, New Mexico Medicaid

STATE OF NEW MEXICO

By: _____ Date: 10/2/17

Brent Earnest, Cabinet Secretary
Human Services Department

By: _____ Date: 9/28/17

Danny Sandoval, CFO
Human Services Department

THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

By: _____ Date: 10/2/17

Title: Secretary HSD

By: _____ Date: 10/5/17

Title: Secretary - DOH

By: _____ Date: 10/11/17

Title: Deputy Secretary - CYFD

Approved as to Form and Legal Sufficiency:

By: _____ Date: 9/29/17

Christopher Collins, Chief Legal Counsel
Human Services Department

CERTIFIED FOR LEGAL SUFFICIENCY
BY: _____ 10/4/2017
DEPARTMENT OF HEALTH
ASSISTANT GENERAL COUNSEL

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

TAXATION AND REVENUE DEPARTMENT

ID Number: 02-445429-00-0

Taxation and Revenue is only verifying the registration and will not confirm or deny taxability statements contained in this contract.

By: Amber Rieder Date: 10/4/17

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 timeframes (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
3.3.3	Listing of Key Personnel (including resumes)	Implementation manager, contract manager, provider network development manager and information technology director/CIO by February 15, 2013; All others by May 1, 2013
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 29, 2013
3.4.1	Policies and procedures regarding distribution and development of Marketing Materials	March 29, 2013
3.5.1.1/ 4.21.3.1	Cultural Competency/Sensitivity Plan	March 29, 2013
3.5.1.2	Policies and procedures to ensure Covered Services are provided in a Culturally Competent manner	March 29, 2013
3.5.1.4	Plan for interpretive services/written materials for Members	March 29, 2013

3.5.2	Initial organizational self-assessment of culturally and linguistically competent-related activities	March 29, 2013

4.1.2.2/ 4.4.5.7.1	Tools and processes for conducting nursing facility level of care determinations	May 17, 2013
4.2.10.2	Policies and procedures for mass transfer	May 17 , 2013
4.4.2.5	HRA tool	May 17, 2013
4.4.5.4/ 4.4.5.5	Comprehensive needs assessment tool	May 17, 2013
4.4.8.1	Policies and procedures for ongoing identification of Members who may be eligible for higher levels of care coordination	May 17, 2013
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	May 17, 2013
4.4.10.5	Policies and procedures regarding care coordinator involvement in discharge planning from hospitals or institutional settings	May 17, 2013
4.4.12.3	Policies and procedures regarding qualifications, experience and training of members of the care coordination team	March 29, 2013
4.4.12.8	Care coordination staffing plan	March 29, 2013
4.4.12.14	Policies and procedures for distributing notices to Members regarding care coordination changes	May 17, 2013
4.4.12.16	Training plan for newly hired care coordinators	March 29, 2013
4.4.13.3	Policies and procedures regarding electronic case management system for care coordination	May 17, 2013
4.4.16.1.1	Policies and procedures to ensure that Members are contacted in a timely manner in accordance with the timeframes prescribed in this Agreement	May 17, 2013
4.4.17	Policies and procedures regarding individuals transitioning from Qualified Health Plans on the Health Insurance Exchange.	May 17, 2013
4.5.4.3	Policies and procedures regarding emergency and non-emergency use of services in outpatient settings	May 17, 2013
4.5.6	Policies and procedures regarding Advance Directives	May 17, 2013

4.5.8.1	Policies and procedures for educating Members on their rights to family planning services	May 17, 2013
4.6.3.2	Policies and procedures regarding the roles and responsibilities of care coordinators and support brokers	March 29, 2013
4.6.5.1	Form for Member statement to participate in the Self-Directed Community Benefit	May 17, 2013

4.7.2	Value Added Services offered by the CONTRACTOR	March 29, 2013

4.8.1.1	Policies and procedures regarding compliance with State requirements for provider networks	March 29, 2013
4.8.1.2/ 4.21.5.1.5	Annual provider network and development management plan	March 29, 2013
4.8.2.1	Policies and procedures regarding provider recruitment, retention and termination	March 29, 2013
4.8.3	Mechanisms to monitor provider activities to ensure compliance with the CONTRACTOR's and State's policies	March 29, 2013
4.8.6	Policies and procedures regarding the process for Member selection of PCPs and requests for change	May 17, 2013
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	May 17, 2013
4.8.14.1.1	Policies and procedures regarding credentialing and recredentialing of providers	March 29, 2013
4.8.14.1.1	Policies and procedures to ensure that providers have appropriate licenses and certifications	March 29, 2013
4.8.16.1.4	Policies and procedures to comply with federal and State security and procedure guidelines for Telemedicine	May 17, 2013
4.9.1.1	Templates/sample contracts for each type of Contract Provider	February 28, 2013
4.10.6	Physician Incentive Plan, if applicable	May 17, 2013
4.11.1	Provider handbook	March 29, 2013
4.11.2.2	Policies and procedures for the provider service call center line	March 29, 2013
4.11.3	Screenshots of provider website portal	May 17, 2013

4.11.3.3	Policies and procedures to ensure provider website is updated and accurate	May 17, 2013
4.11.5.1	Provider Training and Outreach Plan	March 29, 2013
4.11.5.2/ 4.21.5.2.1	Policies and procedures to implement Provider Training and Outreach Plan	March 29, 2013

4.12.4.1/ 4.21.9.3	QM/QI annual program description (including annual workplan)	June 21, 2013
4.12.5.3.1	Policies and procedures for conducting Member surveys	June 21, 2013
4.12.7	Practice guidelines	June 21, 2013
4.12.9.2.4/ 4.21.9.2	Disease management protocols and description	June 21, 2013
4.12.10.4	Annual UM edits	June 21, 2013
4.12.10.5/ 4.21.8.1	Annual UM program description	June 21, 2013
4.12.10.7	UM clinical criteria	June 21, 2013
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	June 21, 2013
4.12.16.1	Policies and procedures to address, respond to and report Critical Incidents	June 21, 2013
4.14.2.1	Policies and procedures regarding the development and distribution of Member Materials	March 29, 2013
4.14.3.1	Member handbook	March 29, 2013
4.14.4.2	Policies and procedures regarding Members' and Representatives' rights	March 29, 2013
4.14.5.3	Provider directory	Ongoing
4.14.8	Sample Member ID card	March 29, 2013
4.14.9	Screenshots of Member website portal	March 29, 2013
4.14.10/ 4.21.2.1.1	Health Education Plan	June 21, 2013

4.15.1.2	Policies and procedures regarding the Member service call center line	March 29, 2013
4.16.1.2.1	Policies and procedures regarding Member Grievances and Appeal System	May 17, 2013
4.16.8	Policies and procedures regarding provider Grievances and Appeals	May 17, 2013
4.17.1.8	Policies and procedures regarding Program Integrity	June 21, 2013
4.17.3	Annual Fraud and Abuse compliance plan	June 21, 2013
4.18.13.2	Policies and procedures regarding TPL responsibilities	June 21, 2013
4.18.14.1	Policies and procedures, where applicable, regarding patient liability payments for Members residing in residential facilities	TBD
4.20.5/ 4.21.10.1	Business Continuity and Disaster Recovery Plan (BC-DR)	May 17, 2013
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	June 21, 2013
7.26.1.4	Policies and procedures for protection of records and all other documents deemed confidential	June 21, 2013

Attachment 2: Centennial Care Covered Services

Non-Community Benefit Services Included Under Centennial Care
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
Community Interveners for the Deaf and Blind
Comprehensive Community Support Services
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, Diagnosis and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services
Family Planning
Family Support (Behavioral Health)
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations
Home Health Services
Hospice Services
Hospital Inpatient (including Detoxification services)
Hospital Outpatient
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
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

[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
Outpatient Hospital based Psychiatric Services and Partial Hospitalization
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
Outpatient Health Care Professional 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)
Rural Health Clinics Services
School-Based Services
Smoking Cessation Services
Speech and Language Therapy
Swing Bed Hospital Services
Telemedicine Services
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Treatment Foster Care
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
Home Health Aide
Personal Care Services
Private Duty Nursing for Adults
Respite
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
Home Health Aide
Homemaker/Personal Care
Nutritional Counseling
Private Duty Nursing for Adults
Related Goods
Respite
Skilled Maintenance Therapy Services
Specialized Therapies
Transportation (non-medical)

Attachment 3: Delivery System Improvement Performance Targets

Delivery System Improvement Performance Targets for Year Five (5) of Centennial Care

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Community Health Workers	A minimum 10% increase in the number of members served by Community Health Workers (CHWs)/or Community Health Representatives (CHRs)/ or Certified Peer Support Workers (CPSWs) for activities such as care coordination activities, health education, health literacy, translation and/or community supports linkages in Rural, Frontier, tribal and underserved communities in Urban regions of the state above the CONTRACTOR's CY17 baseline number. Each CONTRACTOR shall submit for HSD approval a delivery system improvement performance project that is designed to increase the number of members served by CHWs and/or CHRs and/or CPSWs include a reimbursement project for CHRs working with Tribal 638 facilities who are serving Centennial Care members. The project must address the lack of CHWs in the northeast quadrant of the State. The project for 2018 shall elaborate on the Contractor's efforts to create a sustainable funding stream for CHW/CHR//CPSW work and include a plan to extend such efforts to provider practices and clinics serving Medicaid Members by the end of 2018. The CONTRACTOR's submission should include: (1) a brief description of the project's fourth year; (2) clearly stated goals for 2018 that can be validated with data; (3) a discussion of the CY17 baseline from which the CONTRACTOR is expected to progress and the data used to determine the CY17 baseline; and (4) a discussion about measuring progress toward the goals and the data used to measure progress. The CONTRACTOR's plan shall be submitted to HSD by April 1, 2018. The CONTRACTOR shall provide quarterly reports to HSD of the number of CHWs hired/contracted and the number of CHRs supported at Tribal 638 facilities and the number of CPSWs hired/contracted by provider practices and clinics in 2018, as well as an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the end of the quarter.	20

Delivery System Improvement Performance Objective	**Delivery System Improvement Performance Target**	**Number of Points out of 100**
Telemedicine	A minimum of a fifteen percent (15%) increase in telemedicine "office" visits with specialists, including Behavioral Health providers, for Members in Rural and Frontier areas. At least five percent (5%) of the increase must be visits with Behavioral Health providers. Telemedicine visits conducted at I/T/Us outside of the Albuquerque area are included. Project ECHO is not considered "telemedicine" for this delivery system improvement performance target nor is routine telemedicine, such as interpretations of radiologic exams by a radiologist at a remote site; however, may include virtual visits or e-visits. Each CONTRACTOR must submit its baseline using 2017 experience, and an explanation of the data used to arrive at the baseline, to HSD by April 1, 2018. The CONTRACTOR shall provide quarterly reports to HSD of the number of telemedicine "office" visits and an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the quarter ends.	20
Patient-Centered Medical Homes Section 4.13.1 of this Agreement	A minimum of a five percent (5%) increase of the CONTRACTOR's Members being served by Patient-Centered Medical Homes (including both PCMHs that have achieved NCQA accreditation and those that have not). The CONTRACTOR shall use 2017 experience as a basis to measure an increase in 2018, and shall submit 2017 experience to HSD by March 1, 2018. If the CONTRACTOR achieves a minimum of forty-five percent (45%) of membership being served by PCMHs, verified with data submission on March 1, 2018, then the CONTRACTOR must maintain that same minimum percentage at end of calendar year in order to meet this target.	20
Hepatitis C	The CONTRACTOR shall treat at least eighty percent (80%) of the MCO's target number of patients receiving Hepatitis C drug treatments (which were included in the capitated rate) during the contract period. Treatments are defined as the number of unique members who have an initial pharmacy encounter for one or more of the Hepatitis C drugs as identified in the CONTRACTOR payment rate signature sheets including periodic updates made by HSD to the Hepatitis C drug list. The CONTRACTOR must meet eighty percent (80%) of its target for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations for CY18. Cases that begin in CY17 for which treatment continues into CY18 will not be	20

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
	considered when HSD performs this measurement. If, however, a member receives treatment in CY17 and requires treatment again in CY18 because (a) the member is re-infected or (b) the initial treatment is ineffective, the treatment occurring in CY18 may be included in the DSIPT measurement. If a member receives treatment in CY18 and requires treatment again in the same contract year because (a) the member is re-infected or (b) the initial treatment is ineffective, both treatments occurring in CY18 may be counted multiple times in the DSIPT measurement. For these two circumstances, the CONTRACTOR must submit medical necessity documentation that supports these circumstances these members for HSD's approval. The target will be adjusted at the end of the calendar year based on the CONTRACTOR's final proportion of membership in each of the three populations. The formula used to determine the number of required treatments is as follows: **Formula:** $$\frac{\text{[Member Months for Hepatitis C Impacted Rate Cohorts (excluding retroactive eligibility members] x Hepatitis C PMPM x 80\%}}{\text{Average Hepatitis C treatment cost}}$$ HSD shall provide the CONTRACTOR with the information necessary to monitor the Hepatitis C performance. The Capitation Rate signature sheets shall include (a) Hepatitis C impacted Rate Cohorts, (b) the Hepatitis C PMPM by Rate Cohort and (c) the average Hepatitis C treatment cost for the contract period the average treatment cost will remain the same for the calendar year. The CONTRACTOR shall evaluate the Hepatitis C DSIPT target on a monthly basis using the CONTRACTOR's actual enrollment for impacted Rate Cohorts and the information from the Capitation Rate signature sheets. The CONTRATOR shall submit the results of its monthly evaluation to HSD no later than 10 calendar days following the end of each calendar quarter (March 31, June	

<table>
<tr><th>Delivery System Improvement Performance Objective</th><th>Delivery System Improvement Performance Target</th><th>Number of Points out of 100</th></tr>
<tr><td></td><td>30, September 30, and December 31) for each month in the reporting period. HSD shall provide instructions and a template for the CONTRACTOR to use to submit Hepatitis C information. For each reporting period, the CONTRACTOR shall refresh information for the prior quarter submission.</td><td></td></tr>
<tr><td>Value Based Purchasing</td><td>The CONTRACTOR must implement value based purchasing as outlined in the table below. In order to meet the target, the CONTRACTOR must have met the percentages established below in all three levels; however, CONTRACTORs with more advanced VBP strategies may substitute higher percentages in Level 2 and/or Level 3 for lower percentages in Level 1; or CONTRACTOR may substitute higher percentages in Level 3 for lower percentages or requirements in Level 1 and Level 2 as long as the overall target of 20% of payments in VBP arrangements is met for the calendar year.
<table>
<tr><th>VBP LEVEL 1</th><th>VBP LEVEL 2</th><th>VBP LEVEL 3</th></tr>
<tr><td>A minimum of 7% of all CONTRACTOR provider payments* for dates of service between January 1, 2018 and December 31, 2018 will meet the following criteria:</td><td>A minimum of 10% of all CONTRACTOR provider payments* for dates of service between January 1, 2018 and December 31, 2018 will meet the following criteria:</td><td>A minimum of 3% of all CONTRACTOR provider payments* for dates of service between January 1, 2018 and December 31, 2018 will meet the following criteria:</td></tr>
</table></td><td>20</td></tr>
</table>

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target			Number of Points out of 100
	• Fee schedule based with bonus or incentives and/or withhold (at least 5% of provider payment)—available when outcome/quality scores meet agreed-upon targets.	• Fee schedule based, upside-only shared savings--available when outcome/ quality scores meet agreed-upon targets (may include downside risk), and • Two or more bundled payments for episodes of care.	• 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.	
	Additional requirements for VBP in CY 2018 • At least 3% of the overall 20% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital's CY2016 baseline. • CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements. • The CONTRACTOR shall not count the cost of care more than once for the targets established in the contract year. HSD and the CONTRACTOR will collaborate to establish an appropriate methodology to ensure that cost of care is counted once and that reporting is consistent. • The CONTRACTOR shall establish a process for providers in VBP arrangements to have access to data that provides information about			

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100
	members' utilization of services including total cost of care on a quarterly basis. ***MCOs may exclude provider payments for dually-eligible members from the calculation.***	

For calendar year 2018, the CONTRACTOR will report the results of the DSIPT on Community Health Workers, Telemedicine, Patient-Centered Medical Homes, Hepatitis C, and Value-Based Purchasing.

Attachment 4: Reserved

Attachment 5: 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 6: Alternative Benefit Plan Covered Services

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation[1]
Autism spectrum disorder (through age 22)[2]
Bariatric surgery[3]
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiovascular rehabilitation[4]
Chemotherapy
Dental services[5]
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[6]
Electroconvulsive therapy
Early and Periodic Screening, Diagnosis 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 and contraceptives[7]
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing[8]
Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]
Hearing screening as part of a routine health exam[10]
Holter Monitors and cardiac event monitors

[1] Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
[2] Covers speech, occupational and physical therapy, and applied behavioral analysis for recipients age 19-20, or age 21-22 who are enrolled in high school.
[3] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.
[4] Limited to short-term therapy (two consecutive months) per cardiac event.
[5] The ABP covers dental services for adults in accordance with 8.310.7 NMAC. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
[6] 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.
[7] Sterilization reversal is not covered. Infertility treatment is not covered.
[8] Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.
[9] Limited to short-term therapy (two consecutive months) per condition.
[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.

Alternative Benefit Plan Services Included Under Centennial Care
Home health care, skilled nursing and intravenous services[11]
Immunizations[12]
Inhalation therapy
Inpatient physical and behavioral health hospital/medical services and surgical care[13]
Inpatient rehabilitative services/facilities[14]
IV infusions
Lab tests, x-ray services and pathology
Maternity care, including delivery and inpatient maternity services, and pre- and post-natal care
Medication assisted therapy for opioid addiction
Non-emergency transportation when necessary to secure covered medical services and/or treatment
Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity
Organ and tissue transplants[15]
Osteoporosis diagnosis, treatment and management
Outpatient surgery
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions[16]
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings[17]
Physician visits
Podiatry and routine foot care[18]
Prescription medicines
Primary Care to treat illness/injury
Pulmonary therapy[19]
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing[20]
Sleep studies[21]

[11] Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.
[12] Includes ACIP-recommended vaccines.
[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. The ABP does not include inpatient drug rehabilitation services. Free-standing psychiatric hospitals (or Institutions for Mental Disease) are not covered under the ABP or ABP-exempt benefit package, except for recipients age 19-20. Surgeries for cosmetic purposes are not covered.
[14] 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.
[15] Transplants are limited to two per lifetime.
[16] Other over-the-counter items may be considered for coverage only when the item is considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.
[17] 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.
[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.
[19] Limited to short-term therapy (two consecutive months) per condition.
[20] Subject to the 100-visit home health limit when provided through a home health agency.
[21] Limited to diagnostic sleep studies performed by certified providers/facilities.

Alternative Benefit Plan Services Included Under Centennial Care
Smoking cessation treatment
Specialist visits
Specialized behavioral health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[22]
Telemedicine services
Urgent care services/facilities
Vision care for eye injury or disease[23]
Vision hardware (eyeglasses or contact lenses)[24]

[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.
[23] Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.
[24] 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 is covered for recipients age 19-20 following a periodicity schedule.

Attachment 7: Reserved

Attachment 8: 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 Agencies (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. Hem/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 9: 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 HSDs notification date to the CONTRACTOR outlined in Sections 4.2.5.5, 4.2.8 and 6.12.1.

2. The reconciliation for the Retroactive Period is limited to medical expenses only.

3. For purposes of this Attachment, "medical expense" is defined as the expenditures for Covered Services in Attachment 2. Value added services, care coordination, Centennial Rewards and administrative expenditures will not be countable expenses in the calculation of the reconciliation. Indian Health Services / Tribal 638 providers reimbursed through the supplemental process described in section 6.3 are also excluded from retroactive reconciliation.

4. HSD will permit the CONTRACTOR to retain 5.50 percent of the total medical expense for administrative costs.

5. HSD shall adjust the final reconciliation for applicable premium tax depending on the outcome of the reconciliation.

6. HSD will utilize encounter data received and accepted by HSD as the source for the measurement of the reconciliation on a Rate Cohort basis limited to Members who are in the Retroactive Period and eligible according to HSD's eligibility system in the month they incurred medical expenses.

7. Actual medical cost plus the administrative allowance and premium tax will be compared to the payment made by HSD to the CONTRACTOR for the Retroactive Period to determine the value of recoupment from or payment to the CONTRACTOR.

8. HSD makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

9. **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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the year following the contract period being measured. 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 is responsible for communicating any issues that impact the information that HSD uses to perform the final evaluation by no later than the last business day of May in the year following the end of the contract period being measured.

10. **Final Evaluation**

HSD will perform 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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the second year following the contract period being measured. 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 final evaluation by no later than the last business day of May in the second year following the contract period being measured.

11. **Retroactive changes to the data following the Final Evaluation**

In the circumstance that the capitation or enrollment information used in the final evaluation is adjusted 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 (2.0%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.

Attachment 10: List of Psychotropic Drugs and Medications

GENERAL DESCRIPTION	THERAPEUTIC CLASS (MCO must use [illegible] comparable therapeutic classes)	PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names begin with a capital letter)				
Anti-Anxiety Medications (non-benzodiazepines)	H2F, H2E	buspirone (BuSpar)	eszopiclone (Lunesta)	zaleplon (Sonata)	zolpidem (Ambien)	zopiclone (Imovane)
Antidepressants	H2F, H2J, H2S, H2U, H7B, H7C, H7D, H7E, H7F, H20, **Antipsychotics** H2G, H7P, H7R, H7S, H7U, H70, 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 (Aventyl, Pamelor)	paroxetine (Paxil, Pexeva)	protriptyline (Vivactil)
		sertraline (Zoloft)	trazodone (Desyrel)	trimipramine (Surmontil)	venlafaxine (Effexor)	
Monoamine Oxidase Inhibitors	H2H, H7J	isocarboxazid (Marplan)	phenelzine (Nardil)	tranylcypromine (Parnate)		selegiline (Emsam)
Anti-Mania Medications	H2M	lithium carbonate		lithium citrate		
	H2G, H7T, H7X, H8W,					

Phenothiazines, Other Major Tranquilizers and Antipsychotics, including Second Generation	H7P, H7R, H7S, H7U, H70, H7Z	aripiprazole (Abilify)	asenapine (Saphris)	brexiprazole (Rexulti)	cariprazine (Vraylar)
		chlorpromazine	clozapine (Clozaril)	Droperidol (Inapsine)	fluphenazine
		haloperidol (Haldol)	iloperidone (Fanapt)	loxapine (Loxitane)	lurasidone (Latuda)
		molindone (Moban)	olanzapione (Zyprexa)	paliperidone (Invega)	perphenazine
		perphenazine (Trilafon)	pimozide (Orap)	prochlorperazine	quetiapine (Seroquel)
		risperidone (Risperdal)	thioridazine	thiothixene (Navane)	thorazine
		Trifluorperazine (Stelazine)	ziprasidone (Geodon)	Brexpiprazole (Rexulti)	fluoxetine & olanzapine (Symbyax)
Anticonvulsant Mood Stabilizers	H4B	carbamazepine (Tegretol)	divalproex sodium (Depakote)	lamotrigine (Lamictal)	valproic acid
		Oxcarbazepine (Trileptal)	Topiramate (adjunct) (Topamax)	Gabapentin (adjunct) (Neurontin)	
Alzheimer Treatments	J1B, H1A	Donepezil (Aricept)	Galantamine (Razadyne)	Memantine (Namenda)	Rivastigmine (Exelon)
ADHD treatments	H7Y, A4B, J5B, H2V, H8M	Atomoxetine (Strattera)	Clonidine (Catapres)	d-amphetamine (Dexedrine)	d,l-amphetamine (Adderall)
		d,l-methylphenidate (Concerta, Ritalin)	Guanfacine (Intuniv)	d-methylphenidate (Focalin)	

Long Acting Injectable Antipsychotics	H7T, H7X, H7O, H2G	Risperidone i/m (Risperidal Consta)	Paliperidone Palmitate (Invega Sustenna)	Paliperidone Palmitate ER (Invega Trinza)	Aripiprazole i/m (Abilify Maintena)
		Aripiprazole lauroxil (Aristada)	Olanzapine i/m (Zypreza Relprevv)	Haloperidol Decanoate (Haldol)	Fluphenazine Decanoate (Prolixin)
Medication Assisted Treatment for substance use disorders	H3W, H3T, C0D,	Buprenorphine (Buprenex/ Butrans)	Naltrexone (Revia/ Vivtrol)	Acamprosate (Campral)	Disulfiram (Antabuse)
Other	P3A, J7B, H7E, H6A	Liothyronine (Cytomel) (for augmentation in severe depression)	Prazosin (for PTSD) (Minipress)	Trazodone (non benzodiazepine sedative) (Oleptro)	Pramipexole (for augmentation in severe depression) (Mirapex)

Attachment 11: Hepatitis C Risk Corridor

1. For CY2018, the Hepatitis C Risk Corridor applies to the following populations: Physical Health, Long Term Services and Supports and Other Adult Group.

2. HSD shall implement a risk corridor for Hepatitis C for the physical health population, defined by Rate Cohorts 001 through 012 and Medicaid Only Rate Cohorts (302, 303, 312, 322), and Other Adult Rate Cohorts (110-122) for the incurred period between January 1, 2018 and December 31, 2018. The CONTRACTOR and HSD shall share in excess gains or losses generated under this Agreement as outlined in the Capitation Rate sheet for the contract periods identified in items 1 and 2 Section 7.2 and Attachment 7 outlines the risk corridor parameters for the Other Adult Group.

3. The risk corridor is limited to the pharmacy cost, less applicable rebates (including financial incentives, rebates or discounts negotiated with manufacturers), associated with Hepatitis C treatment. HSD shall communicate the pharmacy cost component of the capitated payment rate to the CONTRACTOR subject to the risk corridor. The CONTRACTOR is requested to provide all supplemental rebate, discount or incentive information to HSD. As outlined in 6.14.4. If the CONTRACTOR cannot or refuses to provide this information to HSD an assumed supplemental rebate or discount will be utilized to reduce the cost reported in the encounter data.

4. For purposes of this Attachment, "covered pharmacy cost associated with Hepatitis C treatment" is limited to the FDA-approved drug list maintained and communicated to the CONTRACTOR by HSD for the period identified in item 1. Expenditures not identified and included in the drug list will not be countable expenses in the calculation of the risk corridor. The premium tax component of the rate will be adjusted depending on the outcome of the risk corridor measurement.

5. HSD will utilize encounter data received and accepted by HSD and specific rebate information provided by the CONTRACTOR or assumed if information is not provided as sources for the measurement of the risk corridor limited to Members who are eligible according to HSD's eligibility system and classified as being eligible for the applicable population discussed in items 1 and 2 in Rate Cohorts 001 through 012 and Medicaid Only Rate Cohorts (302, 312, 322, 303), and Other Adult Group Rate Cohorts (110-122), in the month they incurred countable expenses.

6. HSD has established the risk corridor but makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

7. **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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the year following the contract period being measured. 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 and provide HSD with any 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 in the year following the end the end of the contract period being measured.

8. **Final Evaluation**

HSD will perform 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 the use of Capitation Payment and accepted encounter data, which will include processing dates through the last business day of June of the second year following the contract period being measured. 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 final evaluation by no later than the last business day of May in the second year following the contract period being measured.

9. **Retroactive changes to the data following the Final Evaluation**

In the circumstance that the capitation or enrollment information used in the final evaluation is adjusted 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 (2.0%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract period.