



HUMAN SERVICES
D E P A R T M E N T

**State of New Mexico
Human Services Department**

**Amendment 7 to Medicaid Managed Care
Agreement**

Among

**New Mexico Human Services Department,
New Mexico Behavioral Health Purchasing Collaborative
and
UnitedHealthcare Insurance Company, Inc.**



PSC: 13-630-8000-0024 A7

**STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAID MANAGED CARE SERVICES AGREEMENT
FOR CENTENNIAL CARE**

AMENDMENT NO. 7

This Amendment No. 7 to PSC: 13-630-8000-0024 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 UnitedHealthcare Insurance Company, Inc. (“CONTRACTOR”), and is to be effective January 1, 2017.

WHEREAS, there are certain clarifications and revisions to the Contract that are necessary;

UNLESS OTHERWISE SET OUT BELOW, ALL OTHER PROVISIONS OF THE ABOVE REFERENCED AGREEMENT REMAIN IN FULL EFFECT AND IT IS MUTUALLY AGREED BETWEEN THE PARTIES THAT THE FOLLOWING PROVISIONS OF THAT AGREEMENT ARE AMENDED AS FOLLOWS:

1) **Section 2 of the Contract is amended to add the following definitions:**

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

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.

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].

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.

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.

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 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.

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.

2) **Section 3.5.1 of the Contract is amended and restated to read as follows:**

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 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) **Section 4.2.6 of the Contract is amended and restated to read as follows:**

4.2.6 The CONTRACTOR shall accept Recipients in accordance with 42 CFR § 434.25 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) **Section 4.4.2.1 of the Contract is amended and restated to read as follows:**

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 existing 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 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.

5) **Section 4.4.3.5.9 of the Contract is amended and restated to read as follows:**

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;

6) **Section 4.4.13.1 of the Contract is amended to add the following new Section 4.4.13.1.15:**

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.

7) **Section 4.5.1.1 of the Contract is amended to add the following new Section 4.5.1.1.1:**

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.

8) **Section 4.5.1 of the Contract is amended to add the following new Section 4.5.1.7:**

4.5.1.7 The CONTRACTOR shall comply with 42 CFR Parts 438, 440, 456, and 457 as it relates to the Mental Health Parity law and requirements established by HSD.

9) **Section 4.5.7 of the Contract is amended to add the following new Section 4.5.7.6:**

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.

10) **Sections 4.5.11 through 4.5.12 of the Contract are amended and restated to read as follows:**

4.5.11 Copayments

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]

11) **Section 4.5 of the Contract is amended to add the following new Sections 4.5.15 through 4.5.15.3:**

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 payment 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.

12) **Section 4.5 of the Contract is amended to add the following new Sections 4.5.16 through 4.5.16.3:**

4.5.16 **Institution for Mental Diseases (IMD)**

To address access issues for short term acute psychiatric and substance use disorder needs, a short-term stay (up to 15 Calendar Days per month) in an IMD may be necessary for members between 22-64 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 22 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.

13) **Section 4.7.5 of the Contract is deleted:**

4.7.5 Reserved

14) **Section 4.8.1.1 of the Contract is amended and restated to read as follows:**

4.8.1.1 The CONTRACTOR shall comply with the requirements specified in 42 CFR §438.12, § 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:

15) **Section 4.8.1.1.2 of the Contract is amended and restated to read as follows:**

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;

16) **Section 4.8.2.7 of the Contract is amended and restated to read as follows:**

4.8.2.7 Conduct screening of all 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;

17) **Section 4.8.3 of the Contract is amended to add the following new Section 4.8.3.1:**

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.

18) **Section 4.8.7.5 of the Contract is amended to add the following new Sections 4.8.7.5.13 through 4.8.7.5.13.2:**

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.

19) **Section 4.8.13 of the Contract is amended to add the following new Section 4.8.13.4:**

4.8.13.4 Community Benefit Providers

20) **Section 4.8.14.1.10 of the Contract is amended and restated to read as follows:**

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;

21) **Section 4.8.14 of the Contract is amended to add the following new Section 4.8.14.3:**

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.

22) **Section 4.9.1.3 of the Contract is amended and restated to read as follows:**

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

23) **Section 4.9.2.47 of the Contract is amended and restated to read as follows:**

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.

24) **Section 4.9.2 of the Contract is amended to add the following new Section 4.9.2.48:**

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

25) **Section 4.10.4 of the Contract is amended and restated to read as follows:**

4.10.4 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.

26) **Sections 4.10.7 through 4.10.7.6 of the Contract are amended and restated to read as follows:**

- 4.10.7 Value-Based Purchasing
 - 4.10.7.1 General Expectations
 - 4.10.7.1.1 The purpose of value-based purchasing (VBP) arrangements is to reward providers based on achieving quality and outcomes, rather than volume of services delivered.
 - 4.10.7.1.2 The CONTRACTOR has the option to develop VBP initiatives not specified in this Agreement with the approval of HSD.
 - 4.10.7.2 The CONTRACTOR shall develop VBP strategies as outlined in Attachment 3, Delivery System Improvement Performance Targets, and track and report on agreed-upon process and efficiency metrics.
 - 4.10.7.2.1 [RESERVED]
 - 4.10.7.2.2 [RESERVED]
 - 4.10.7.2.3 [RESERVED]
 - 4.10.7.2.4 [RESERVED]
 - 4.10.7.2.5 [RESERVED]
 - 4.10.7.2.6 [RESERVED]
 - 4.10.7.2.7 [RESERVED]
 - 4.10.7.3 The CONTRACTOR shall comply with reporting requirements as prescribed by HSD, including quarterly submission of the agreed-upon payment reform template, and submit an annual VBP evaluation plan with quarterly updates on progress.

- 4.10.7.4 [RESERVED]
- 4.10.7.5 [RESERVED]
- 4.10.7.5.1 [RESERVED]
- 4.10.7.5.2 [RESERVED]
- 4.10.7.6 [RESERVED]
- 27) **Section 4.12.2.1 of the Contract is amended to add the following new Section 4.12.2.1.1:**
- 4.12.2.1.1 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.
- 28) **Section 4.12.8.1 of the Contract is amended and restated to read as follows:**
- 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. HSD considers calendar year 2014 and calendar year 2015 to be noncompetitive baseline years for performance measure thresholds and for setting future targets. The first full audited HEDIS results will be expected in SFY 2016. 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. PM#8 targets for CY17 will be set using DSIPF CY16 data.
- 29) **Section 4.12.8.2.8 of the Contract is amended and restated to read as follows:**
- 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.

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, or recovery treatment.

Members who are enrolled with the MCO at the time of the member's discharge and are eligible for Medicaid services under New Mexico's State Plan. For purposes of this calculation, use age at time of discharge. Measure should be sorted by two categories and in two member groups:

- Number of IPF Discharges of Members six years of age to 17 years of age during the quarter.
- Number of IPF Discharges of Members 18 years of age and older during the quarter.
- Number of Members six years of age to 17 years of age who had a follow-up visit within seven days after an IPF Discharge during the quarter.
- 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.

30) **Section 4.12.8.3 of the Contract is amended and restated to read as follows:**

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 1 – 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 for Prenatal and Postpartum Care (2 points).
- Prenatal visit in the first trimester or within 42 days of enrollment. HEDIS 2016 Quality 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.

31) **Section 4.12.17 of the Contract is amended to add the following new Section 4.12.17.8:**

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.

32) **Section 4.12.17 of the Contract is amended to add the following new Section 4.12.17.9:**

4.12.17.9 TM#7 Smoking Cessation

The CONTRACTOR shall monitor the use of smoking cessation products and counseling utilization.

33) **Section 4.14.4.2.6 the Contract is amended and restated to read as follows:**

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;

34) **Section 4.14.4.2.7 of the Contract is amended and restated to read as follows:**

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;

35) **Section 4.14.10.3.7 of the Contract is amended and restated to read as follows:**

4.14.10.3.7 The risks associated with the use of alcohol, tobacco and other substances and available products and counseling, i.e. smoking cessation products.

36) **Section 4.15.1.6 of the Contract is amended and restated to read as follows:**

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.

37) **Section 4.15.1.14 of the Contract is amended and restated to read as follows:**

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 close of business on the next Business Day.

38) **Section 4.17.2.5 of the Contract is amended and restated to read as follows:**

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.

39) **Section 4.17.2.6 of the Contract is amended and restated to read as follows:**

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 CONTRACTOR; or (ii) due to concerns other than fraud, such as integrity or quality.

40) **Sections 4.17.3.1 through 4.17.3.2.7 of the Contract are amended and restated to read as follows:**

4.17.3.1 The CONTRACTOR shall have a written Fraud, Waste and Abuse Compliance Plan. A paper and electronic copy of the Compliance Plan shall be provided to HSD annually by July 1. HSD shall provide notice of approval, denial, or modification to the CONTRACTOR within thirty (30) Calendar Days of receipt. The CONTRACTOR shall make any changes required by HSD within thirty (30) Calendar Days of a request.

4.17.3.2 The CONTRACTOR's Fraud, Waste and Abuse Compliance Plan shall:

4.17.3.2.1 Require reporting of suspected and/or confirmed Fraud, Waste and Abuse be done as required by this Agreement;

4.17.3.2.2 Outline activities proposed for the next reporting year regarding employee education of federal and State law and regulations related to Medicaid program integrity and Fraud/Waste/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

41) **Section 4.18.2.1 of the Contract is amended and restated to read as follows:**

- 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.

42) **Section 4.19.1.8 of the Contract is amended and restated to read as follows:**

- 4.19.1.8 The CONTRACTOR may be at risk for any payments made to a non-Medicaid enrolled provider. The CONTRACTOR is required to ensure that all providers reflected on the claim are enrolled as an HSD Medicaid provider for the dates of service on the claim. If the provider is enrolled but the CONTRACTOR is not affiliated, that claim will trigger a Provider Notification record sent within 24 hours of the claims payment.

43) **Section 4.19.1.13 of the Contract is amended and restated to read as follows:**

- 4.19.1.13 Editing all claims, regardless of whether paid directly by the MCO or by a 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;

44) **Section 4.19.1.18.3 of the Contract is amended and restated to read as follows:**

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.

45) **Section 4.19.2.2.11 of the Contract is amended and restated to read as follows:**

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, subcapitated arrangement, or performed by the CONTRACTOR.

46) **Section 4.19.2.2.15 of the Contract is amended and restated to read as follows:**

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

- 47) **Section 4.21.1.12 of the Contract is amended and restated to read as follows:**
- 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.
- 48) **Sections 6.10 through 6.10.4 of the Contract are amended and restated to read as follows:**
- 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 and New Mexico Medical Insurance Pool assessments, of HSD's capitation payments including one-time lump sum payments. 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 first quarter of CY2018 by HSD. 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.
- 49) **Sections 6.12.1 through 6.12.3 of the Contract are amended and restated to read as follows:**
- 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 payment 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]

50) **Sections 7.2.1 through 7.2.2.4 of the Contract are amended and restated to read as follows:**

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.

51) **Section 7.2.7 of the Contract is amended and restated to read as follows:**

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.

52) **Section 7.3.4 of the Contract is amended and restated to read as follows:**

7.3.4 Program Issues
Item #5
PENALTY

\$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.

Item #10

Failure to meet targets for the performance measures described in Section 4.12.8 of this Agreement.

53) **Section 7.5.2 of the Contract is amended and restated to read as follows:**

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;

54) **Section 7.5.4 of the Contract is amended and restated to read as follows:**

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;

55) **Section 7.5.5 of the Contract is amended and restated to read as follows:**

7.5.5 Titles II and III of the Americans with Disabilities Act, 42 U.S.C. 12101 et seq., and regulations issued pursuant thereto, 28 CFR Parts 35, 36;

56) **Section 7.24.1 of the Contract is amended and restated to read as follows:**

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:

57) **Section 7.26.1.6 of the Contract is amended and restated to read as follows:**

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.

58) **Section 7.27.1 of the Contract is amended and restated to read as follows:**

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.

59) **Section 7.27.11.1.5 of the Contract is amended and restated to read as follows:**

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.

60) **Section 7.29 of the Contract is amended and restated to read as follows:**

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 ineligible for the award of contracts by any federal department or agency; (ii) have not, within a three (3) year period preceding the effective date of this Agreement, been convicted of or had a civil judgment rendered against them for: commission of Fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) contract or subcontract; violation of federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false

statements, tax evasion, or receiving stolen property; (iii) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with, commission of any of the offenses enumerated above in this Section 7.29; (iv) have not, within a three (3) year period preceding the effective date of this Agreement, had one or more public agreements or transactions (federal, State or local) terminated for cause or default; and (v) have not been excluded from participation from Medicare, Medicaid, federal health care programs or federal Behavioral Health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes. The CONTRACTOR shall not employ or have any relationship or affiliation with an individual or entity that has been excluded from participation in health care programs pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1320a-7 and other applicable federal statutes and regulations. The CONTRACTOR shall not be an entity that must be excluded pursuant to 42 CFR § 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]

61) **Section 7.43 of the Contract is amended and restated to read as follows:**

7.43 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.

62) **Attachment 3, Delivery System Improvement Performance Targets of the Contract is amended, attached hereto and referenced herein.**

63) **Attachment 7: Other Adult Group Risk Corridor of the Contract is removed and Attachment 7 is reserved for future use, attached hereto.**

- 64) **Attachment 11: Hepatitis C Risk Corridor – Physical Health and Medical Only LTSS Population of the Contract is amended, attached hereto and referenced herein.**

Attachment 3: Delivery System Improvement Performance Targets

Delivery System Improvement Performance Targets for Year Four (4) 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) for care coordination activities, health education, health literacy, translation and community supports linkages in Rural, Frontier and underserved communities in Urban regions of the state above the CONTRACTOR's CY16 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 Community Health Workers (CHWs). The project for 2017 shall elaborate on the Contractor's efforts to create a sustainable funding stream for CHW work and include a plan to extend such efforts to provider practices and clinics on behalf of Medicaid Members by the end of 2017. The CONTRACTOR's submission should include: (1) a brief description of the project's third year; (2) clearly stated goals for 2017 that can be validated with data; (3) a discussion of the CY16 baseline from which the CONTRACTOR is expected to progress and the data used to determine the CY16 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 February 1, 2017 and HSD will provide feedback/approval within two (2) weeks of receipt of the CONTRACTOR's plan. The CONTRACTOR shall provide quarterly reports to HSD of the number of CHWs hired by the CONTRACTOR and the number of community-based CHWs that will be supported by the CONTRACTOR for provider practices and clinics by the end of 2017, as well as an analysis of trends observed. The quarterly reports are due to HSD 30 calendar days after the quarter's end.	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 2016 experience, and an explanation of the data used to arrive at the baseline, to HSD by February 1, 2017. 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 end.	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 2016 experience as a basis to measure an increase in 2017, and shall submit 2016 experience to HSD by February 1, 2017. If the CONTRACTOR achieves a minimum of 45% of membership being served by PCMHs, verified with data submission on February 1, 2017, 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 75% 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.	20

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target	Number of Points out of 100						
	<p>The CONTRACTOR must meet 75% of its target for the combined Physical Health, Medicaid Only LTSS, and Other Adult Group populations for CY 2017. An individual who has started treatment and has a Hepatitis C pharmacy encounter before the end of the contract period will be counted in this measurement. Individuals who started treatment during CY2016 and continue treatment into CY2017 will not be considered when HSD performs this measurement. 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.</p>							
Value Based Purchasing	<p>The CONTRACTOR must implement value based purchasing as outlined in the table below. Due to enrollment threshold challenges, the CONTRACTOR may substitute a higher percentage in Level 2 for a lower percentage in Level 3; 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 16% of payments in VBP arrangements is met for the calendar year. The CONTRACTOR shall submit the percentage of provider payments from 2016 in each of the three levels by February 1, 2017.</p> <table border="1" data-bbox="545 1234 1268 1604"> <thead> <tr> <th data-bbox="545 1234 786 1262">VBP LEVEL 1</th> <th data-bbox="786 1234 1026 1262">VBP LEVEL 2</th> <th data-bbox="1026 1234 1268 1262">VBP LEVEL 3</th> </tr> </thead> <tbody> <tr> <td data-bbox="545 1262 786 1604"> A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria: </td> <td data-bbox="786 1262 1026 1604"> A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria: </td> <td data-bbox="1026 1262 1268 1604"> A minimum of 3% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria: </td> </tr> </tbody> </table>	VBP LEVEL 1	VBP LEVEL 2	VBP LEVEL 3	A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 3% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	20
VBP LEVEL 1	VBP LEVEL 2	VBP LEVEL 3						
A minimum of 5% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 8% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:	A minimum of 3% of all CONTRACTOR provider payments* for dates of service between January 1, 2017 and December 31, 2017 will meet the following criteria:						

Delivery System Improvement Performance Objective	Delivery System Improvement Performance Target			Number of Points out of 100
	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	
	<p>Additional requirements for VBP in CY 2017</p> <ul style="list-style-type: none"> • At least 3% of the overall 16% in VBP contracting must be with high volume hospitals and require readmission reduction targets of at least 5% of the hospital’s baseline. • CONTRACTOR must include payments to behavioral health community providers in calculating the percentage of overall spend in its VBP arrangements. <p><i>*MCOs may exclude provider payments for dually-eligible members from the calculation.</i></p>			

For calendar year 2017, 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 7: [RESERVED]

Attachment 11: Hepatitis C Risk Corridor

1. For the periods CY2015, the Hepatitis C Risk Corridor applied to Physical Health population only. For CY2016, the Hepatitis C Risk Corridor applied to Physical Health and Long Term Services and Supports populations.
2. For CY2017, the Hepatitis C Risk Corridor applies to all populations (Physical Health, Long Term Services and Supports and Other Adult Group).
3. HSD shall implement a risk corridor for Hepatitis C for the physical health population, defined by Cohorts 001 through 012 and Medicaid Only Cohorts (302, 312, 322, 303), and Other Adult Cohorts (110-122) for the incurred period between January 1, 2017 and December 31, 2017. 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.
4. 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.
5. 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 periods identified in items 1 and 2 between January 1, 2016 and December 31, 2016. 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.
6. 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 Cohorts 001 through 012 and Medicaid Only Cohorts (302, 312, 322, 303), and Other Adult Group cohorts (110-122), in the month they incurred countable expenses.
7. HSD intends to measure the risk corridor on an interim basis during the term of this Agreement. For interim reconciliations HSD shall recoup from or make payment to the CONTRACTOR on a pro-rated percentage basis for each measurement. The interim evaluation will be done at HSD's discretion and is dependent on encounter data submission quality.
8. HSD has established the risk corridor but makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

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: [Signature]

Date: 10/7/16

Title: Charles Milligan, CEO

STATE OF NEW MEXICO

By: [Signature]
Brent Ernest, HSD Cabinet Secretary

Date: 10/12/16

By: [Signature]
Danny Sandoval, HSD CFO

Date: 10/26/16

THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

By: [Signature]
Title: Secretary, HSP

Date: 10/19/16

By: [Signature]
Title: Secretary, D&IT

Date: 10/21/16

By: [Signature]
Title: CABINET SECRETARY, CYED

Date: 10/28/16

Approved as to Form and Legal Sufficiency:

By: [Signature]
Christopher Collins, HSD Chief Legal Counsel

Date: 10/18/16

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: 03-145330-000-9

By: [Signature]

Date: 10/20/16