

**STATE OF NEW MEXICO**



**HUMAN  
SERVICES**  
DEPARTMENT  
MEDICAL ASSISTANCE DIVISION

**Amendment 3 to Medicaid Managed Care Agreement**

**among**

**New Mexico Human Services Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**UnitedHealthcare of New Mexico, Inc.**



**PSC: 13-630-8000-0024 A3**

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

**AMENDMENT NO. 3**

This Amendment No. 3 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 of New Mexico, Inc. (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

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

**IT IS MUTUALLY AGREED BY THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE REFERENCED CONTRACT ARE AMENDED AND RESTATED AS FOLLOWS:**

- 1) **Section 2 of the Contract is amended by adding the following definitions:**

**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.

**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.

- 2) **Section 2 of the Contract is further amended by amending and restating the following definitions to read as follows:**

**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.

3) **Section 3.3.3 of the Contract is amended to add the following new section 3.3.3.17:**

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.

4) **Section 4.1.1.2 of the Contract is amended and restated to read as follows:**

4.1.1.2 Recipients in the Medically Fragile 1915(c) Waiver will continue to receive HCBS through that waiver unless and until such services are transitioned into Centennial Care. Recipients in the Medically Fragile 1915(c) Waiver are required to enroll in the CONTRACTOR's MCO for all non-HCBS upon Go-Live. By January 1, 2015, CONTRACTOR shall identify, and submit to HSD, a dedicated staff person to manage the transition of the Medically Fragile waiver population's home and community-based services from fee-for-service to Centennial Care, including assisting the waiver providers in the credentialing and provider enrollment processes and conducting training for claims submission and payment.

5) **Section 4.4.2.7 of the Contract is amended and restated to read as follows:**

4.4.2.7 The CONTRACTOR shall make reasonable efforts to contact 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 (if a phone number is available) and one (1) attempt to contact 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 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.

6) **Section 4.4.10.6 of the Contract is amended by amending and restating subsections 4.4.10.6.1 and 4.4.10.6.2 as follows:**

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.

7) **Section 4.4.12.2 of the Contract is amended and restated to read as follows:**

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.

- 8) **Section 4.4.12.3 of the Contract is amended and restated to read as follows:**
  - 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.
  
- 9) **Section 4.4.12.5 of the Contract is amended and restated to read as follows:**
  - 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 the CONTRACTOR uses I/T/Us, PCMHs, Health Homes, CSAs, Community Health Workers and Centers for Independent Living to perform care coordination functions, such entities may be included in the ratios included in the following subsections:
  
- 10) **Section 4.4.13.2 of the Contract is amended and restated to read as follows:**
  - 4.4.13.2 The CONTRACTOR shall provide care coordination reports as directed by HSD.
  
- 11) **Subsection 4.4.14.1.7 of the Contract is amended and restated to read as follows:**
  - 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;
  
- 12) **Section 4.4.14.3 of the Contract is amended and restated to read as follows:**
  - 4.4.14.3 The CONTRACTOR shall submit reports on its electronic visit verification system as directed by HSD.
  
- 13) **Section 4.5.7.4 of the Contract is amended and restated to read as follows:**

- 4.5.7.4 The CONTRACTOR shall track each Member's Community Benefit and provide reports on such benefit as directed by HSD.
- 14) **Section 4.5.14 of the Contract is deleted in its entirety.**
- 15) **Section 4.7.5 of the Contract is amended and restated to read as follows:**
- 4.7.5 The CONTRACTOR shall provide a Value Added Service report to HSD in a format and frequency determined by HSD.
- 16) **Section 4.8.1.2 of the Contract is amended and restated to read as follows:**
- 4.8.1.2 The CONTRACTOR shall submit a Provider Network Development and Management Plan as directed by HSD.
- 17) **Section 4.8.1.3 of the Contract is amended and restated to read as follows:**
- 4.8.1.3 The CONTRACTOR must submit a provider suspension/termination report as directed by HSD.
- 18) **Section 4.8.4.3 of the Contract is amended and restated to read as follows:**
- 4.8.4.3 The CONTRACTOR shall submit a PCP Report as directed by HSD.
- 19) **Section 4.8.7.2 of the Contract is amended and restated to read as follows:**
- 4.8.7.2 The CONTRACTOR shall submit a Network Adequacy Report as directed by HSD.
- 20) **Section 4.8.10.2 of the Contract is amended and restated to read as follows:**
- 4.8.10.2 HSD shall designate CSAs and, as appropriate, shall provide the CONTRACTOR an updated list of designated entities.
- 21) **Subsection 4.8.16.1.6 of the Contract is amended and restated to read as follows:**
- 4.8.16.1.6 Report to HSD on the Telehealth outcomes of Telehealth projects and submit a Telehealth Report as directed by HSD;
- 22) **Section 4.8.16 of the Contract is amended to add the following new Section 4.8.16.3:**
- 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.

23) **Section 4.10.3 of the Contract is amended and restated to read as follows:**

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

24) **Section 4.10.7 of the Contract is amended by amending and restating sections 4.10.7.1 through 4.10.7.3 to read as follows:**

4.10.7 Payment Reform Projects

4.10.7.1 General Expectations

4.10.7.1.1 The purpose of the payment reform projects is to begin the process of recognizing and rewarding providers based on outcomes, rather than the volume of services delivered.

4.10.7.1.2 The CONTRACTOR has the option to develop other pay for performance initiatives not specified in this Agreement with the approval of HSD.

4.10.7.2 The CONTRACTOR shall develop one (1) or more payment reform projects and submit a proposal(s) that will be subject to approval by HSD and that will include:

4.10.7.2.1 A brief summary of the proposed project(s);

4.10.7.2.2 The target population(s);

4.10.7.2.3 Justification and data to support the choice of project(s);

4.10.7.2.4 The nature and amount of any incentives or payments that are part of the project(s);

4.10.7.2.5 How the project(s) will be evaluated;

4.10.7.2.6 The measures that will be used to determine the success of the project(s); and

4.10.7.2.7 Detailed timelines that include implementation, data collection points and evaluations.

4.10.7.3 The CONTRACTOR shall comply with reporting requirements as prescribed by HSD.

25) **Section 4.10 of the Contract is amended to add the following new Sections 4.10.9, 4.10.10 and 4.10.11:**

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.

26) **Section 4.11.2.8 of the Contract is amended and restated to read as follows:**

4.11.2.8 The CONTRACTOR shall submit a Call Center Report as directed by HSD.

27) **Section 4.11.5.1 of the Contract is amended and restated to read as follows:**

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.

28) **Section 4.12.2.3 of the Contract is amended and restated to read as follows:**



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.

29) **Section 4.12.4.10 of the Contract is amended and restated to read as follows:**

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Long Term Care Services, one (1) on services to children, and PIPs as required by the Adult Medicaid Quality Grant. Quarterly and annual reports are required for the Adult Medicaid Quality Grant, as directed by HSD. PIP work plans and activities must be consistent with PIPs as required by the Adult Medicaid Quality Grant, federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the "EQR Managed Care Organization Protocol" available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>;

30) **Section 4.12.6 of the Contract is amended and restated to read as follows:**

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.

31) **Section 4.12.10.14 of the Contract is amended and restated to read as follows:**

4.12.10.14 The CONTRACTOR shall comply with utilization management reporting requirements as directed by HSD.

32) **Section 4.13.2 of the Contract is amended to add the following new Section 4.13.2.7:**

4.13.2.7 The CONTRACTOR shall issue monthly payments to its Health Home providers for its Members who are enrolled in the Health Home. The costs

associated with the Health Home are included in the CONTRACTOR's capitation payment.

4.13.2.7.1 The payment shall be an amount based on the CONTRACTOR's Centennial Care membership enrolled in the Health Home for that month using a PMPM set by HSD; and

4.13.2.7.2 The payment shall be made no later than five (5) Calendar Days, or at HSD's discretion, following the CONTRACTOR's receipt of the monthly capitation for membership from HSD.

33) **Section 4.14.3.1 of the Contract is amended to add the following new subsections 4.14.3.1.25 and 4.14.3.1.26:**

4.14.3.1.25 Include in a prominent place, the website for Members to access the full provider directory and instructions on 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.

34) **Section 4.14.6 of the Contract is amended and restated to read as follows:**

4.14.6 Member Handbook and Provider Directory Distribution

4.14.6.1 The CONTRACTOR shall comply with requirements regarding the mailing of Member enrollment materials including Member ID cards, Member handbook, and provider directory.

4.14.6.2 The CONTRACTOR shall send a Member handbook within thirty (30) Calendar Days of receipt of notification of enrollment in the CONTRACTOR's MCO.

4.14.6.3 Upon request of a Member or Recipient, the CONTRACTOR shall send a provider directory and/or Member handbook within ten (10) Calendar Days. The CONTRACTOR shall give the person requesting a Member handbook and/or a provider directory the option to get the information from the CONTRACTOR's website or to receive a printed document.

4.14.6.4 The Member handbook and provider directory shall be up-to-date on the CONTRACTOR's website.

4.14.6.5 Printed copies of the provider directory shall be updated bi-annually.

4.14.6.6 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 how to request a printed copy.

35) **Section 4.14.10.1 of the Contract is amended and restated to read as follows:**

4.14.10.1 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.

36) **Section 4.14.10.5 of the Contract is amended and restated to read as follows:**

4.14.10.5 The CONTRACTOR shall notify Members of the schedule of educational events and shall post such information on its website.

37) **Section 4.14.10.8 of the Contract is amended and restated to read as follows:**

4.14.10.8 The CONTRACTOR shall submit a Health Education Plan Evaluation Report as directed by HSD.

38) **Section 4.15.2.3 of the Contract is deleted in its entirety.**

39) **Section 4.16.1.1 of the Contract is amended and restated to read as follows:**

4.16.1.1 The CONTRACTOR shall have a Grievance system in place for Members that includes a process related to the expressions of dissatisfaction and an Appeal process related to a CONTRACTOR Action. 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.

40) **Section 4.17.2.7 of the Contract is amended and restated to read as follows:**

4.17.2.7 The CONTRACTOR shall comply with the reporting requirements in Section 4.21 of this Agreement.

41) **Section 4.18.13.9 of the Contract is amended and restated to read as follows:**

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.

42) **Section 4.18.16 of the Contract is amended and restated to read as follows:**

4.18.16 Reporting

4.18.16.1 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.

43) **Section 4.19.2.2.14 of the Contract is amended and restated to read as follows:**

4.19.2.2.14 The CONTRACTOR shall submit a report of the number of denied Claims by invoice type (professional, institutional, pharmacy, dental) 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;

44) **Section 4.20.3.4 of the Contract is deleted and the following inserted therefor:**

4.20.3.4 Reserved.

45) **Section 4.21.1 of the Contract is amended and restated to read as follows:**

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 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 changes specified in writing by HSD, after HSD has discussed such changes with the CONTRACTOR. HSD shall notify the CONTRACTOR, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. The CONTRACTOR shall be held harmless on the first submission of the revised report if HSD fails to meet this requirement for any changes for existing reports. However, the CONTRACTOR is not otherwise relieved of any responsibility for the submission of late, inaccurate or otherwise incomplete reports. The first submission of a report revised by HSD to include a change in data requirements or definition will not be subject to penalty for accuracy; and
  - 4.21.1.5.2 HSD shall notify the CONTRACTOR, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.
- 4.21.1.6 The CONTRACTOR shall submit reports timely and in proper format. The submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report. "Timely submission" shall mean that the report was submitted on or before the date it was due. "Accuracy" shall mean the report was substantially prepared according to the specific written guidance, including report template, provided by HSD to the CONTRACTOR. "Complete" shall mean that all sections within the report contain the required information and/or data input for the reporting period, per the report instructions. All elements must be met for each required report submission. Therefore, the report must be

timely, accurate and complete. If any portion of the report element is not met, the report is deemed in "error" and the CONTRACTOR will be subject to liquidated damages 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. Failure to comply with the agreed upon timeframes for correction and resubmission shall be subject to liquidated damages.

- 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, as directed by HSD. Failure to report timely may result in liquidated damages. Reports or other required data shall be received on or before scheduled due dates.

<b>DELIVERABLE</b>	<b>DUE DATE</b>
Weekly Reports	Wednesday of the following week
Monthly Reports	Fifteenth (15th) Calendar Day of the following month
Quarterly Reports	Thirtieth (30 <sup>th</sup> ) Calendar Day of the following month*
Semi-Annual Reports	January 31 and July 31 of the Agreement year

DELIVERABLE	DUE DATE
Annual Report	As directed by HSD
Ad Hoc Reports	Within ten (10) Business Days from the date of the request unless otherwise specified by HSD

\*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 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. Extension for submission of reports should be under rare and unusual circumstances. If HSD grants an extension, and the report is submitted before the extended deadline, the report(s) will be considered timely and not subject to penalty for timeliness. Not requesting an extension within at least twenty-four (24) hours of the report due date is considered failure to report timely.
- 4.21.1.14 Anytime a report is rejected for any reason, the CONTRACTOR shall resubmit the report within ten (10) Business Days from notification of the rejection or as directed by HSD.
- 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 feedback to the CONTRACTOR regarding format and timeliness of reports 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.

46) **Sections 4.21.2 through 4.21.12 of the Contract are deleted in their entirety:**

47) **Section 6.1.5 of the Contract is amended and restated to read as follows:**

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 amounts 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 amount to the CONTRACTOR for the provision of the managed care benefit package. Rates determined through discussion between the Parties are considered confidential. The monthly rate for each Member is based on actuarially sound capitation rate cells. 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.

48) **Section 6.10.1 of the Contract is amended and restated to read as follows:**

6.10.1 The CONTRACTOR shall withhold one and a half percent (1.5%), net of premium taxes and New Mexico Medical Insurance Pool assessments, of HSD's capitation payments. This withhold shall include 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. The withheld funds shall be named the Delivery System Improvement Fund. The CONTRACTOR shall place this Delivery System Improvement Fund in a separate liability account and shall provide to HSD a quarterly statement of the account in order to verify that the funds are being maintained during the period of time specified in this Agreement as directed by HSD.

49) **Section 6 of the Contract is amended to add the following new section 6.13:**

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.

50) Attachment 3 to the Contract is amended and restated to read as follows:

### Attachment 3: Delivery System Improvement Targets

Delivery System Improvement Targets for Year Two (2) of Centennial Care

<b>Delivery System Improvement Objective</b>	<b>Delivery System Improvement Target for Release of Withhold</b>	<b>Number of Points out of 100</b>
Community Health Workers	Each CONTRACTOR shall submit for HSD approval a delivery system improvement project that is designed to increase the use of 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. The project shall emphasize creating a sustainable funding stream for CHW work on behalf of Medicaid Members, and reducing barriers and impediments faced by Medicaid Members in achieving good health outcomes. The CONTRACTOR's submission should include: a brief description of the project; a clearly stated goal(s) that can be validated with data; a discussion of the base line from which the plan seeks to make progress and the data used to determine the base line; and a discussion about measuring progress toward the goal and the data used to measure progress. The CONTRACTOR's plan shall be submitted to HSD by February 1, 2015 and HSD will provide feedback/approval within two (2) weeks of receipt of the CONTRACTOR's plan. The goal agreed to by the CONTRACTOR and HSD will become the target for release of the withhold associated with this objective.	25

Telehealth	A minimum of a fifteen percent (15%) increase in telehealth “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. Telehealth visits conducted at I/T/Us outside of the Albuquerque area are included. Project ECHO is not considered “telehealth” for this delivery system improvement target nor is routine telemedicine such as interpretations of radiologic exams by a radiologist at a remote site. The Member must be present at the originating site to count as a telehealth visit. Each CONTRACTOR must submit its baseline using 2014 experience, and an explanation of the data used to arrive at the baseline, to HSD by February 1,2015.	25
Patient-Centered Medical Homes Section 4.13.1 of this Agreement	-A minimum of five percent (5%) 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 2014 experience as a basis to measure an increase in 2015, and shall submit 2014 experience to HSD by February 1, 2015.	25
Emergency Room Diversion	-A minimum of a ten percent (10%) reduction in the per capita use of emergency room as compared to utilization in 2014. The baseline to determine the reduction will be provided to the CONTRACTOR by HSD based on historical data.	25

The CONTRACTOR shall submit a report no later than by February 1, 2016, describing the results of the delivery system improvement on (i) Community Health Workers, (ii) telehealth, (iii) Patient-Centered Medical Homes, and emergency room diversion based on the targets established for 2015 set forth in this Attachment 3.

- 51) **Attachment 4 to the Contract is deleted in its entirety and marked as “Reserved”:**

52) Attachment 6 to the Contract is replaced with the following:

### Attachment 6: Alternative Benefit Plan Covered Services

Alternative Benefit Plan Services Included Under Centennial Care
Allergy testing and injections
Annual physical exam and consultation <sup>1</sup>
Autism spectrum disorder (through age 22) <sup>2</sup>
Bariatric surgery <sup>3</sup>
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiovascular rehabilitation <sup>4</sup>
Chemotherapy
Dental services <sup>5</sup>
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 <sup>6</sup>
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 <sup>7</sup>
Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
Genetic evaluation and testing <sup>8</sup>

<sup>1</sup> Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.

<sup>2</sup> 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.

<sup>3</sup> Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight, BMI and health status.

<sup>4</sup> Limited to short-term therapy (two consecutive months) per cardiac event.

<sup>5</sup> 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.

<sup>6</sup> 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.

<sup>7</sup> Sterilization reversal is not covered. Infertility treatment is not covered.

<b>Alternative Benefit Plan Services Included Under Centennial Care</b>
Habilitative and rehabilitative services, including physical, speech and occupational therapy <sup>9</sup>
Hearing screening as part of a routine health exam <sup>10</sup>
Holter monitors and cardiac event monitors
Home health care, skilled nursing and intravenous services <sup>11</sup>
Hospice care services
Hospital inpatient and outpatient services
Immunizations <sup>12</sup>
Inhalation therapy
Inpatient physical and behavioral health hospital/medical services and surgical care <sup>13</sup>
Inpatient rehabilitative services/facilities <sup>14</sup>
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 <sup>15</sup>
Osteoporosis diagnosis, treatment and management
Outpatient surgery
Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions <sup>16</sup>
Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol, and other preventive/diagnostic care and screenings <sup>17</sup>

<sup>8</sup> Limited to Triple Serum Test and genetic testing for the diagnosis or treatment of a current illness. Does not include random genetic screening.

<sup>9</sup> Limited to short-term therapy (two consecutive months) per condition.

<sup>10</sup> Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for recipients age 19-20.

<sup>11</sup> Home health care is limited to 100 visits per year. A visit cannot exceed four hours.

<sup>12</sup> Includes ACIP-recommended vaccines.

<sup>13</sup> 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.

<sup>14</sup> 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.

<sup>15</sup> Transplants are limited to two per lifetime.

<sup>16</sup> 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.

Alternative Benefit Plan Services Included Under Centennial Care
Physician visits
Podiatry and routine foot care <sup>18</sup>
Prescription medicines
Primary care to treat illness/injury
Pulmonary therapy <sup>19</sup>
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing <sup>20</sup>
Sleep studies <sup>21</sup>
Smoking cessation treatment
Specialist visits
Specialized behavioral health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR) <sup>22</sup>
Telemedicine services
Urgent care services/facilities
Vision care for eye injury or disease <sup>23</sup>
Vision hardware (eyeglasses or contact lenses) <sup>24</sup>

<sup>17</sup> 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.

<sup>18</sup> Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

<sup>19</sup> Limited to short-term therapy (two consecutive months) per condition.

<sup>20</sup> Subject to the 100-visit home health limit when provided through a home health agency.

<sup>21</sup> Limited to diagnostic sleep studies performed by certified providers/facilities.

<sup>22</sup> The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.

<sup>23</sup> Refraction for visual acuity and routine vision care are not covered, except for recipients age 19-20.

<sup>24</sup> 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.

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: Y. A. G. I. / H

Date: 8 DEC 2014

Title: CHIEF EXECUTIVE OFFICER

**STATE OF NEW MEXICO**

By: [Signature]  
Cabinet Secretary  
Human Services Department

Date: 12/22/14

By: [Signature]  
Chief Financial Officer  
Human Services Department

Date: 12/22/14

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

By: Annette Romero

Date: 12/31/14

Title: CYFO AS Deputy Director

By: Petra Ward

Date: 1/12/15


Title: Cabinet Secretary  
Department of Health

By: [Signature]

Title: Cabinet Secretary, HSD

CERTIFIED FOR LEGAL SUFFICIENCY:  
[Signature] 01/09/2015  
Department of Health  
Assistant General Counsel  
Date: 1/09/15

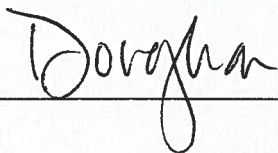
**Approved as to Form and Legal Sufficiency:**

By:  \_\_\_\_\_ Date: 12/17/14  
General Counsel  
Human Services Department

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: 03-145330-00-9**

By:  \_\_\_\_\_ Date: 1/18/15