HUMAN SERVICES
DEPARTMENT

State of New Mexico
Human Services Department

Amendment 6 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 A-6

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CFDA 93.778

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

AMENDMENT NO. 6

This Amendment No. 6 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 July 1, 2016.

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 to add the following definitions:**

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

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

Comprehensive Needs Assessment (CNA): The CNA will assess the Member's physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member's assessed needs. The CNA may also include a functional assessment, if applicable.

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

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

2) **Section 2 of the Contract is amended to add the following list of acronyms at the end of the Section:**

ABA—Applied Behavioral Analysis
ABP—Alternative Benefit Plan
ACA—Affordable Care Act (Patient Protection and Affordable Care Act)
ACIP—Advisory Committee on Immunization Practices
ACT—Assertive Community Treatment
ADL—Activities of Daily Living
AHRQ—Agency for Healthcare Quality and Research
ARRA—American Recovery and Reinvestment Act
ARTC—Accredited Residential Treatment Center
BAA—Business Associate Agreement
BC-DR—Business Continuity and Disaster Recovery
BHH—Behavioral Health Home
BHPC—Behavioral Health Planning Council
BMS—Behavioral Management Service
BP—Blood Pressure
CAHPS—Consumer Assessment of Healthcare Providers and Systems
CNA—Comprehensive Needs Assessment
CAP—Corrective Action Plan
CAS—Claims Adjustment Code identifying the detailed reason the adjustment was made
CCC—Children with Chronic Conditions
CCL—Care Coordination Level
CCP—Comprehensive Care Plan
CCSS—Comprehensive Community Support Services
CD—Compact Disc
CDD—Center for Development & Disability
CEO—Chief Executive Officer
CFDA—Catalog of Federal Domestic Assistance
CFO—Chief Financial Officer
CFR—Code of Federal Regulations
CHW—Community Health Worker
CIO—Chief Information Officer
CLIA—Clinical Laboratory Improvement Amendments
CLNM - CareLink NM (New Mexico's Health Home)
CMHC—Community Mental Health Center
CMMI—Center for Medicare and Medicaid Innovation
CMO—Chief Medical Officer
CMS—Centers for Medicare & Medicaid Services
CNP—Certified Nurse Practitioner
CNS—Clinical Nurse Specialist
COBA—Coordination of Benefits Agreement
CPT—Current Procedural Terminology
CSA—Core Service Agencies

CY—Calendar Year
CYFD—New Mexico Children, Youth and Families Department
DCAP—Directed Corrective Action Plan
DD—Developmental Disability
DM—Disease Management
DME—Durable Medical Equipment
DMZ—DMZ is short for DeMilitarized Zone and is software/web page for the transmission and storage of data.
DOH—New Mexico Department of Health
DSM—Diagnostic and Statistical Manual of Mental Disorders
DWI—Driving While Intoxicated
ECHO—Extension for Community Healthcare Outcomes
EDI—Electronic Data Interchange
EEO—Equal Employment Opportunity
EHR—Electronic Health Record
ENT—Ear, Nose, Throat
EOR—Employer of Record
EPSDT—Early and Periodic Screening, Diagnosis, and Treatment
EQRO—External Quality Review Organization
ER—Emergency Room
FAQ—Frequently Asked Question
FDA—U.S. Food and Drug Administration
FDIC—Federal Deposit Insurance Corporation
FEIN—Federal Employer Identification Number
FEMA—Federal Emergency Management Agency
FICA—Federal Insurance Contributions Act
FMA—Fiscal Management Agency
FQHC—Federally Qualified Health Center
FS—Family Services
FTE—Full-time Equivalent
FTP—File Transfer Protocol
FUTA—Federal Unemployment Tax Act
GH—Group Home
HCAC—Health Care Acquired Condition
HCBS—Home and Community-Based Service
HCPCS—Healthcare Common Procedure Coding System
HCSC—Health Care Service Corporation
HEDIS—Healthcare Effectiveness Data and Information Set
HIE—Health Information Exchange
HIPAA—Health Insurance Portability and Accountability Act
HITECH Act—Health Information Technology for Economic and Clinical Health Act
HIT—Health Information Technology
HIV—Human Immunodeficiency Virus
HIX — Health Insurance Exchange
HRA—Health Risk Assessment

HSD—New Mexico Human Services Department
HTN—Hypertension
I/T/U—Indian Health Service, Tribal health provider, and Urban Indian provider
IADL—Instrumental Activities of Daily Living
ICD-10—International Classification of Diseases 10
ICD-9— International Classification of Diseases 9
ICF/MR/DD— Intermediate Care Facility for Individuals with Mental Retardation or Developmental Disabilities
ICSS—Independent Consumer Supports System
ICWA—Indian Child Welfare Act
ID—Identification
IEP—Individualized Education Plan
IHS—Indian Health Service
IOP—Intensive Outpatient Program
IPF—Inpatient Psychiatric Facility/Unit
IPoC—Individualized Plan of Care
IPRA—Inspection of Public Records Act
IRS—Internal Revenue Service
ISP—Individual Service Plan
IT—Information Technology
IV—Intravenous
JJS—Juvenile Justice Services
LEIE—List of Excluded Individuals/Entities
LEP—Limited English Proficiency
LISW—Licensed Independent Social Worker
LMFT—Licensed Marriage and Family Therapist
LPCC—Licensed Professional Clinical Counselor
LTC—Long-Term Care
LTSS—Long-Term Services and Supports
MAD—Medical Assistance Division
MCO—Managed Care Organization
MD—Doctor of Medicine
MDS—Minimum Data Set
MDT—Multi-Disciplinary Team
MFEAD—New Mexico Medicaid Fraud & Elder Abuse Division
MHSIP—Mental Health Statistics Improvement Project
MIC—Medicaid Integrity Contractor
MIS—Management Information System
MMIS—Medicaid Management Information System
MST—Multi-Systematic Therapy
NCPDP—National Council of Prescription Drug Programs
NCQA—National Committee for Quality Assurance
NFLOC—Nursing Facility Level of Care
NMAC—New Mexico Administrative Code
NMHIC—New Mexico Health Information Collaborative
NMMIP—New Mexico Medical Insurance Pool

NMSA—New Mexico Statute Annotated
NPI—National Provider Identifier
NQMC—National Quality Measures Clearinghouse
OB-GYN—Obstetrics and Gynecology
OIG—Office of Inspector General
OMB—Office of Management and Budget
OPPC—Other Provider Preventable Condition
PASRR—Pre-Admission Screening and Resident Review
PCMH—Patient-Centered Medical Home
PCP—Primary Care Physician/ Primary Care Provider
PCS—Personal Care Service
PHH—Physical Health Home
PHI—Protected Health Information
PIP—Performance Improvement Project
PL—Public Law
PM—Performance Measure
PMPM—Per-Member Per-Month
PPACA—Patient Protection and Affordable Care Act
PPC—Provider Preventable Condition
PPS—Prospective Payment System
PS—Protective Services
PSC—Professional Services Contract
PSR—Psychosocial Rehabilitation
Q1—First Quarter
Q2—Second Quarter
Q3—Third Quarter
Q4—Fourth Quarter
QM/QI—Quality Management/ Quality Improvement
RAC—Recovery Audit Contractor
RFP—Request for Proposal
RHC—Rural Health Clinic
RN—Registered Nurse
RTC—Residential Treatment Center
SAMHSA—Substance Abuse and Mental Health Services Administration
SBHC—School-Based Health Center
SDCB—Self-Directed Community Benefit
SED—Serious Emotional Disturbance
SFY—State Fiscal Year
SMI—Serious Mental Illness
SNP—Special Needs Plan
SOE—Summary of Evidence
SSN—Social Security Number
SSRI—Selective Serotonin Reuptake Inhibitor
TBD—To Be Determined
TCN—Transaction Control Number
TDD—Text Telephone

TDM—Team Decision Making
TFC—Treatment for Foster Care
TM—Tracking Measure
TPL—Third Party Liability
TTY—Telecommunication Device for the Deaf
UM—Utilization Management
UNM/CDD—University of New Mexico Center for Development and Disability
UNM—University of New Mexico
USC—United States Code
VPN—Virtual Private Network
WIC—Supplemental Food Program for Women, Infants, and Children
YTD—Year-to-Date

3) **Section 4.1.1 of the Contract is amended to add the following new Section 4.1.1.4:**

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

4) **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.

5) **Section 4.2.4.2.1 of the Contract is amended and restated to read as follows:**

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

6) **Section 4.4.1.2 of the Contract is amended and restated to read as follows:**

4.4.1.2 The CONTRACTOR shall design and implement care coordination that includes the following steps addressed in this Section 4.4 of this Agreement, unless otherwise stated in 4.13.2 of this Agreement, due to the Member's enrollment in a Health Home:

7) **Section 4.4.1.2.1 of the Contract is amended and restated to read as follows:**

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

8) **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 newly enrolled in Centennial Care, 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.

9) **Section 4.4.2.2 of the Contract is amended and restated to read as follows:**

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

10) **Section 4.4.2.3 of the Contract is amended and restated to read as follows:**

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

11) **Sections 4.4.2.4 and 4.4.2.4.1 of the Contract are deleted:**

4.4.2.4 Reserved

4.4.2.4.1 Reserved

12) **Section 4.4.2.5 of the Contract is amended and restated to read as follows:**

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

13) **Sections 4.4.2.5.1 through 4.4.2.5.8 of the Contract are deleted:**

4.4.2.5.1 Reserved

4.4.2.5.2 Reserved

4.4.2.5.3 Reserved

4.4.2.5.4 Reserved

4.4.2.5.5 Reserved

4.4.2.5.6 Reserved

4.4.2.5.7 Reserved

4.4.2.5.8 Reserved

14) **Sections 4.4.2.6 through 4.4.2.6.5 of the Contract are deleted:**

4.4.2.6 Reserved

4.4.2.6.1 Reserved

4.4.2.6.2 Reserved

4.4.2.6.2 Reserved

4.4.2.6.3 Reserved

4.4.2.6.4 Reserved

4.4.2.6.5 Reserved

15) **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 new Members to conduct an HRA and provide information about care coordination. Such efforts shall include, but shall not be limited to, engaging community supports such as Community Health Workers, CSAs and Centers for Independent Living. The CONTRACTOR shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member using the Member's last reported residential

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

16) **Section 4.4.2.7 of the Contract is amended to add the following new Sections 4.4.2.7.1 and 4.4.2.7.2:**

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

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

17) **Sections 4.4.3.1 through 4.4.3.3 of the Contract are amended and restated to read as follows:**

4.4.3.1 The HRA shall determine if a Member requires a comprehensive needs assessment to determine if the Member should be assigned to care coordination level two (2) or level three (3).

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

4.4.3.3 Within ten (10) Calendar Days of completion of the HRA, Members requiring a comprehensive needs assessment shall receive:

18) **Section 4.4.3.4 of the Contract is amended and restated to read as follows:**

4.4.3.4 Members who are identified as NOT needing a comprehensive needs assessment shall be monitored by the care coordination unit according to the provisions in Section 4.4.4 of this Agreement.

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

4.4.3.5.9 Has high emergency room use, defined as three (3) or more emergency room visits in a thirty (30) days;

20) **Sections 4.4.4 through 4.4.4.1.2 of the Contract are amended and restated to read as follows:**

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

4.4.4.1.1 Review of predictive modeling software, claims and utilization data at least quarterly to determine if the Member has a change in health status and is in need of a comprehensive needs assessment and potentially higher level of care coordination:

4.4.4.1.2 Reserved.

21) **Section 4.4.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.1 The CONTRACTOR shall perform an in-person, in-home comprehensive needs assessment on all Members identified for care coordination level 2 or level 3-at the Member's primary residence. The visit may occur in another location only with HSD approval. For members who reside in a nursing facility, rather than conduct a CNA, the CONTRACTOR shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

22) **Sections 4.4.5.2 through 4.4.5.2.2 of the Contract are amended and restated to read as follows:**

4.4.5.2 For all Members the CONTRACTOR shall:

4.4.5.2.1 Schedule a comprehensive needs assessment within fourteen (14) Calendar Days

4.4.5.2.2 Complete the comprehensive needs assessment within thirty (30) Calendar Days of the HRA if required, unless the member is in a health home and/or using the Treat First model of care.

23) **Sections 4.4.5.3 through 4.4.5.3.6 of the Contract are amended and restated to read as follows:**

4.4.5.3 The CONTRACTOR shall:

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

4.4.5.3.2 Reserved.

4.4.5.3.3 Reserved.

4.4.5.3.4 Reserved.

4.4.5.3.5 Reserved; and

4.4.5.3.6 Reserved.

24) **Section 4.4.5.5.2 of the Contract is amended and restated to read as follows:**

4.4.5.5.2 Assess Long-Term Care needs including but not limited to: environmental safety including items such as smoke detectors, pests/infestation, and trip and fall dangers and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the Community Benefit, the CONTRACTOR shall assess for all Community Benefit services.

25) **Section 4.4.6.1.2 of the Contract is amended and restated to read as follows:**

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

26) **Section 4.4.6.1.6 of the Contract is amended and restated to read as follows:**

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

27) **Section 4.4.6.2 of the Contract is amended and restated to read as follows:**

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

28) **Section 4.4.6.3.6 of the Contract is amended and restated to read as follows:**

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

29) **Section 4.4.7.1.2 of the contract is amended and restated to read as follows:**

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

30) **Section 4.4.7.3.3 of the Contract is amended and restated to read as follows:**

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

31) **Section 4.4.8.2.6 of the Contract is amended and restated to read as follows:**

4.4.8.2.6 Information from a periodic review, at least quarterly, of the following: (i) Claims or Encounter Data; (ii) hospital admission or discharge data; (iii) pharmacy data; (iv) predictive modeling software and (v) data collected through UM processes.

32) **Section 4.4.9.2 of the Contract is amended and restated to read as follows:**

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

33) **Section 4.4.10.1 of the Contract is amended and restated to read as follows:**

4.4.10.1 The CONTRACTOR shall conduct ongoing care coordination to ensure that Members receive all necessary and appropriate care. Ongoing care coordination functions shall include at a minimum, unless the member is enrolled in a health home, the following activities:

34) **Section 4.4.11.2.5 of the Contract is amended and restated to read as follows:**

4.4.11.2.5 The most recent health risk assessment, comprehensive needs assessment, level of care assessment, and documentation of care coordination level;

35) **Section 4.4.12.5.1 through 4.4.12.5.3.3 of the Contract is amended and restated to read as follows:**

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

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

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

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

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

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

36) **Section 4.4.14.1 of the Contract is amended and restated to read as follows:**

4.4.14.1 The CONTRACTOR, together with the other Centennial Care MCOs, shall contract with a vendor to implement a statewide electronic visit verification system to monitor Member receipt and utilization of the Community Benefit. The CONTRACTOR shall ensure that all contracted personal care service providers are participating in the EVV system unless granted an exception as approved in writing by HSD. The CONTRACTOR shall ensure, in the development of such system, the following minimal functionality, including the ability to:

37) **Section 4.6.1.2 of the Contract is amended and restated to read as follows:**

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HSD to provide assistance to members who choose the SDCB. The CONTRACTOR shall conduct contract oversight and ensure that FMA issues with SDCB provider payments are addressed within ten (10) business days.

38) **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 United States Department of Health and Human Services Office of Inspector General Exclusion List ("List of Excluded Individuals/Entities") and the Medicare exclusion databases;

39) **Section 4.8.14.1 of the Contract is amended to add the following new Section 4.8.14.1.13:**

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

40) **Section 4.11.5 of the Contract is amended to add the following new Sections 4.11.5.7 and 4.11.5.8:**

4.11.5.7 The CONTRACTOR shall schedule claims/billing calls at least quarterly with the Albuquerque Area I and the Navajo Area I.

4.11.5.8 The CONTRACTOR shall conduct semi-annual in-person visits with the I/T/Us to resolve billing/claims issues.

41) **Section 4.12.8 of the Contract is amended to add the following new Section 4.12.8.3:**

4.12.8.3 Calendar Year 2016 Performance Measure Targets:
Performance Measures listed in the MCOs' Contract, Section 4.12.8.2, will require a two percent (2%) improvement above the MCO's 2015 Audited HEDIS rates for Calendar Year 2014. If the MCO has achieved the 2015 National Average as determined by the Quality Compass or HSD's determined target as listed below for each Performance Measure, then the MCO must maintain that same percentage at the end of Calendar Year 2016 in order to have met the target.

Failure to meet the required 2% improvement to the Performance Measure 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). 2015 Quality Compass National Average: 49%.

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). 2015 Quality Compass National Average: 57%.

4.12.8.3.4 PM 4- Comprehensive Diabetes Care (4 points)

- Member 18-75yrs of age who had a diagnosis of DM and had an HbA1c test. 2015 Quality Compass National Average: 86%.
- HbA1c poor control (> 9%). 2015 Quality Compass National Average: 44% (lower is better)
- Member 18-75yrs of age who had a diagnosis of DM and had a Retinal eye exam. 2015 Quality Compass National Average: 54%.
- Member 18-75yrs of age who had a diagnosis of DM and had a nephropathy screening test or evidence of nephropathy. 2015 Quality Compass National Average: 81%

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

- Prenatal visit in the first trimester or within 42 days of enrollment. 2015 Quality Compass National Average: 82%
- Postpartum visit on or between 21 and 56 days after delivery. 2015 Quality Compass National Average: 62%.

4.12.8.3.6 PM 6- Frequency of Ongoing Prenatal Care (1 point). 2015 Quality Compass National Average: 55%.

4.12.8.3.7 PM 7- Antidepressant Medication Management (2 points)

- Member 18yrs and older who received at least 84 Calendar days of continuous treatment with antidepressant medication (Acute phase). 2015 Quality Compass National Average: 52%.

- Member 18yrs and older who received at least 180 Calendar days of continuous treatment with an antidepressant medication (Continuous phase). 2015 Quality Compass National Average: 37%.

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

- Member 6yrs and older who were hospitalized for treatment of selected mental health disorders with follow-up with a mental health practitioner within 7 Calendar days after discharge. 2015 Quality Compass National Average: 44%.

- Member 6yrs 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. 2015 Quality Compass National Average: 63%.

42) **Section 4.12.17 of the Contract is amended to add the following new Sections 4.12.17.6 and 4.12.17.7:**

4.12.17.6 TM#4 – Well-Child Visits in the First 15 Months of Life. Use current reporting year HEDIS technical specifications for reporting.
The percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six or more well-child visits.

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

43) **Section 4.13.2.2 of the Contract is amended and restated to read as follows:**

4.13.2.2 The Contractor shall implement Health Homes in accordance with New Mexico's Medicaid State Plan and the Managed Care Policy Manual.

44) **Section 4.14.1.3 of the Contract is amended and restated as follows:**

4.14.1.3 Member and Marketing materials shall be approved by HSD in accordance with the procedures specified in the Managed Care Policy Manual.

45) **Section 4.19.1.7 of the Contract is amended and restated to read as follows:**

4.19.1.7 Paying interest as required in Paragraph (1) of Subsection 8.308.20.9 (E) of NMAC.

46) **Section 4.19.1.18 of the Contract is amended to add the following new Section 4.19.1.18.3:**

4.19.1.18.3 MCOs 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.

47) **Section 4.19.2.2.13 of the Contract is amended and restated to read as follows:**

4.19.2.2.13 Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per adjudication invoice type (Inpatient and Inpatient crossovers and pharmacy encounters are adjudicated at the header level, all others are adjudicated at the line level), calculated for a quarter's worth of submissions. HSD will monitor the CONTRACTOR corrections to denied Encounters for services covered under this Agreement by random sampling performed quarterly and over the term of the Agreement. The methodology for the error rates will be determined by HSD. Seventy-five percent (75%) of the denied Encounters for services covered under this Agreement included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial;

48) **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 quarterly report of the number of paid Claims by adjudication type (Inpatient and Inpatient crossovers and pharmacy encounters are adjudicated at the header level, all others are adjudicated at the line level) by date of payment and date of service as directed by HSD. This report will be compared to Encounter Data to evaluate the completeness of data submitted. A variance between the CONTRACTOR's report and the record of Encounters received cannot exceed five percent (5%) for months of payment greater than ninety (90) Calendar Days. The methodology for the variances will be determined by HSD;

49) **Section 4.22.2 of the Contract is amended and restated to read as follows:**

4.22.2 The CONTRACTOR shall monitor the potential for abuse or overuse of services and require that a Member visit a certain PCP when the CONTRACTOR has identified continuing utilization of unnecessary services. Prior to placing the Member on PCP lock-in, the CONTRACTOR shall inform the Member of the intent to lock-in, including the reasons for imposing the PCP lock-in. The CONTRACTOR's Grievance procedure shall be made available to any Member being designated for PCP lock-in. The PCP lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD every quarter. The Member shall be removed from PCP lock-in when the CONTRACTOR has determined that the utilization problems have been solved and that recurrence of the problems is judged to be improbable. HSD shall be notified of all lock-in removals.

50) **Section 4.22.3 of the Contract is amended and restated to read as follows:**

4.22.3 The CONTRACTOR monitors the potential for abuse or overuse of services and require that a Member visit a certain pharmacy provider when Member compliance or drug-seeking behavior is suspected. Prior to placing the Member on pharmacy lock-in, the CONTRACTOR shall inform the Member and/or his or her Representative of the intent to lock-in. The CONTRACTOR's Grievance procedure shall be made available to the Member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the CONTRACTOR and reported to HSD every quarter. The Member shall be removed from pharmacy lock-in when the CONTRACTOR has determined that the compliance or drug-seeking behavior has been resolved and the recurrence of the problems is judged to be improbable. HSD shall be notified of all lock-in removals.

51) **Section 6.1.2 of the Contract is amended and restated to read as follows:**

6.1.2 The CONTRACTOR shall accept the capitation payment received each month as payment in full by the HSD for all services provided to enrollees covered under this agreement and the administrative costs incurred by the CONTRACTOR in providing or arranging for such services. Unless otherwise specified in this agreement, any and all costs incurred by the CONTRACTOR in excess of the capitation payment shall be borne in total by the CONTRACTOR.

52) **Section 6.1 of the Contract is amended to add the following new Section 6.1.7:**

6.1.7 By signature on this Agreement, the Contractor explicitly agrees that this section shall not independently convey any inherent rights, responsibilities or obligations, relative to these rates, and shall not itself be the basis for any cause of administrative, legal or equitable action brought by the Contractor. In the event that the rates certified by the state's actuary and approved by CMS are different from the rates included with this Agreement, the Contractor agrees to participate in a reconciliation process with HSD to bring capitation payments to the Contractor in line with the approved rates.

53) **Section 6.3.2 of the Contract is amended and restated to read as follows:**

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

54) **Section 6.6 and 6.6.1 of the Contract is amended and restated to read as follows:**

6.6 Changes in the Capitation Payment Rates

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

55) **Section 7.2.8.1 of the Contract is amended to add the following new Section 7.2.8.1.34:**

7.2.8.1.34 Electronic Visit Verification (EVV)

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

Item #2:

Program Issues

Failure to comply with Encounter submission as described in Section 4.19 of this Agreement

Penalty

Monetary penalties up to two percent (2%) of the CONTRACTOR's Medicaid capitation payment for each quarter in which the penalty is assessed. HSD will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction

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

CONTRACTOR

By: _____ Date: 4/14/16

Title: CEO

STATE OF NEW MEXICO

By: _____ Date: 5/11/16
Brent Ernest, HSD Cabinet Secretary

By: _____ Date: 5/9/16
Danny Sandoval, HSD CFO

THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

By: _____ Date: 5/11/16

Title: Secretary HSD

By: _____ Date: 5-16-16

Title: Secretary CYFD

By: K Lynn Gallagher Date: 5/17/16

Title: Secretary, DOH

Approved as to Form and Legal Sufficiency:

By: _____ Date: 5/6/16
Christopher Collins, HSD Chief Legal Counsel

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

TAXATION AND REVENUE DEPARTMENT

ID Number: 03-145330-000-9

By: _____ Date: 5-13-16