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State of New Mexico Health Care Authority (HCA) (formerly the "New Mexico Human Services Department")

Medicaid Managed Care Services Agreement

Among

New Mexico Health Care Authority (formerly the "New Mexico Human Services Department")

New Mexico Children, Youth, and Families Department,

New Mexico Early Childhood Education and Care Department,

and

UnitedHealthcare Insurance Company

PSC 24-630-8000-0030 A5
CFDA 93.778

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STATE OF NEW MEXICO HEALTH CARE AUTHORITY

MEDICAID MANAGED CARE SERVICES AGREEMENT

PROFESSIONAL SERVICES CONTRACT

"TURQUOISE CARE"

This Agreement (the "Agreement" or the "Contract") is made and entered into by and between the New Mexico Health Care Authority ("HCA") (formerly the "Human Services Department" ("HSD"); the New Mexico Children, Youth, and Families Department ("CYFD"); the New Mexico Early Childhood Education and Care Department ("ECECD");; and UnitedHealthcare Insurance Company ("CONTRACTOR"); and is to be effective upon signatures by all parties.

RECITALS

WHEREAS, HCA's General Counsel and Chief Financial Officer have made a determination that this Agreement is exempt from the provisions of the New Mexico Procurement Code (New Mexico Statute Annotated [NMSA] 1978, 13-1-28 et seq.) pursuant to NMSA 1978, § 13-1-98.1, because it is for the purpose of creating a network of health care Providers to provide services to Medicaid-eligible Individuals that will or are likely to reduce health care costs, improve quality of care or improve access to care;

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

WHEREAS, the Special Terms and Conditions for New Mexico's Section 1115 Waiver between the Centers for Medicare & Medicaid Services (CMS) and HCA necessitate certain requirements in the Agreement;

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

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1 Introduction

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

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

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

1.3.1 The Request for Proposal (RFP), New Mexico's Section 1115 Waiver, all RFP amendments, HCA's answers to Offerors' questions and HCA's written clarifications;

1.3.2 The CONTRACTOR's proposal where consistent with this Agreement and subsequent amendments to this Agreement; and

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

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

1.4.1 The CONTRACTOR shall monitor State and federal statutes and regulations and proactively identify any changes or new statutes or regulations that impact the CONTRACTOR's responsibilities under this Agreement. If a change or new statute/regulations will impact the CONTRACTOR's responsibilities with respect to Providers or Members, the CONTRACTOR shall, within thirty (30) Calendar Days of public notice of the change or new statute/regulation, submit a plan to HCA that

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includes a summary of the change or new statute/regulation and how the CONTRACTOR will implement the change/new requirement, including a high-level work plan and timeline.

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

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

1.7 The Parties to this Agreement acknowledge the need to work cooperatively to address and resolve problems that may arise in the administration and performance of this Agreement. The Parties agree to document agreements in writing prior to implementation of any new Contract requirements.

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

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

1.10 The CONTRACTOR shall, by January 1, 2025, have a Dual Eligible Special Needs Plan (D-SNP) agreement in good standing with CMS, that meets the statewide phase in schedule defined below and agree to the terms and conditions set forth by HCA in the State Medicaid Agency Contract.

1.10.1 The CONTRACTOR shall have a D-SNP in good standing with CMS in at least 11 counties by January 1, 2025.

1.10.2 The CONTRACTOR shall have a D-SNP in good standing with CMS in at least 22 counties by January 1, 2026.

1.10.3 The CONTRACTOR shall have a statewide D-SNP in good standing with CMS by January 1, 2027.

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1.10.4 The CONTRACTOR shall provide and coordinate Medicare benefits to Dual Eligible Members enrolled in its D-SNP.

1.10.5 The CONTRACTOR shall ensure that all available Medicare claims data, including data from the CONTRACTOR's D-SNP, is captured in the CONTRACTOR's information system(s) and that the data is shared on quarterly basis with care coordinators and others as needed to improve coordination of care,

1.10.6 The CONTRACTOR shall provide written notification to HCA of the D-SNP's counties for the contract year within five (5) business days of CMS' approval

1.11 The CONTRACTOR shall share Medicare hospital and Nursing Facility admissions and discharge information with HCA, in the manner prescribed by HCA.

1.12 The CONTRACTOR's Capitation Rate will be established by HCA. HCA's actuaries will develop components of the Capitation Rates, to include the medical services components, premium tax, gross receipts tax for provider payments, and the administrative expense portion of the Capitation Rates.

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

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2 Definitions, Acronyms, and Abbreviations

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

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

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

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

Adult Protective Services (APS) is a division of New Mexico's Aging and Long-Term Services Department that provides a system of protective services to persons over the age of 18 who are unable to protect themselves from abuse, neglect, or exploitation.

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

Adverse Benefit Determination means, for purposes of an appeal: (i) the denial or limited authorization of a requested service, including determinations based on the type or level of

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service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service, a denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an Adverse Benefit Determination; (iv) the failure of the CONTRACTOR to provide services in a timely manner, as defined by HCA; (v) the failure of the CONTRACTOR to complete the standard resolution of grievances and appeals within specific time frames set forth in 42 C.F.R. § 438.408; and (vi) the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other Member financial liabilities.

Agency-Based Community Benefit means the consolidated benefit of home- and community-based services (HCBS) and Personal Care Services (PCS) that are available to Members meeting the Nursing Facility Level of Care. A list of the services available in the Agency-Based Community Benefit is included in Attachment 1: Turquoise Care Covered Services.

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

Agreement means this Medicaid Managed Care Services Agreement among HCA, CYFD, ECECD, the Collaborative, and the CONTRACTOR. Also referred to as "Contract."

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

Alternative Benefit Plan (ABP) means the services outlined in Attachment 4: Alternative Benefit Plan Covered Services

. The ABP lists the Covered Services available to Members in the Other Adult Group unless the Member is ABP Exempt.

Alternative Benefit Plan Exempt (ABP Exempt) means a Member subject to coverage under the ABP and who has been determined as meeting the definition and criteria of Medically Frail or is otherwise exempt from mandatory enrollment in the ABP as further explained in Section

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4.5.1.6 of this Agreement. An ABP Exempt Member is eligible to choose between ABP services outlined in Attachment 4: Alternative Benefit Plan Covered Services

and the Covered Services listed in Attachment 1: Turquoise Care Covered Services.

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

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

Assisted Living Facility (ALF) means any licensed facility that meets the requirements and provides services defined by this rule https://www.nmhealth.org/publication/view/rules/5778/.

Asymptomatic/Routine means showing no symptoms of illness/routine wellness care and follow-up.

Attributed Membership means the Members assigned to a Contract Provider who is accountable for the Members' cost and quality of care under terms established by the CONTRACTOR VBP arrangements.

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

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

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

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

Behavioral Health Drugs means the therapeutic classes of drugs listed in Attachment 7: List of Behavioral Health Drugs of this document, or the equivalent classes of drugs in other therapeutic classification systems.

Behavioral Health Services (BHS) means the Behavioral Health Services division of the CYFD and is the children's behavioral health authority of New Mexico.

Birthing Options Program means the State of New Mexico operated program that provides birthing options to pregnant women, such as homebirth and birth center midwifery services.

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

Business Days means Monday through Friday, except for State of New Mexico holidays. If the last date or the deadline for a given act falls on a day which is not a business day, the time for the given act shall be extended to the next business day.

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

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

Capitation Rate means a fixed monthly per Member per month (PMPM) by Rate Cohort for the Covered Services provided to Members and includes the operational functions required in the Agreement, including amounts for taxes determined by the taxing authority. Amounts associated with Indian Health Service, Tribal health Providers and Urban Indian Providers (I/T/U) services are excluded from the Capitation Rates.

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Care Coordination involves deliberately organizing Member care activities and sharing information among all of the participants concerned with a Member's care to achieve safer and more effective care. This means that the Member's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the Member.

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

Caregiver means, for purposes of Children in State Custody (CISC), the CISC's parent, guardian, or Resource Parent (New Mexico Administrative Code [NMAC] 8.26.2.7) and will be identified for the CONTRACTOR in the meeting outlined in Section 4.4.9.8.4 of this Agreement by the Permanency Planning Worker (PPW) within three (3) Business Days of the Member's involvement in CYFD.

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.

Centers for Medicare & Medicaid Services (CMS) means the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

Certified Community Behavioral Health Clinic (CCBHC) means an organization that has been provisionally or fully certified by the New Mexico Behavioral Health Services Division and Children's Youth and Families Department to provide, directly or through a formal contract with a designated collaborating organization (DCO), the state-defined CCBHC services. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age - including providing developmentally appropriate care for children and youth. CCBHCs must also provide care coordination with other health and social service providers to integrate physical health, behavioral health, and supportive services.

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Certified Family Support Worker (CFSW) means Family Peer Support Workers who are primary Caregivers and have "lived-experience" of being actively involved in raising a child with emotional, behavioral, mental health and/or substance use challenges. This includes young people with neurobiological differences as well as those diagnosed with a severe emotional disorder or substance abuse disorder. Endorsement for credentialing includes successful completion of a training program. CFSW also must pass the credentialing exam administered by the New Mexico Credentialing Board for Behavioral Health Professionals and remain current with continuing education requirements.

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

Certified Registered Nurse Anesthetist (CRNA) means a registered nurse who is licensed by the board for advanced practice as a certified registered nurse anesthetist and whose name and pertinent information are entered on the list of certified registered nurse anesthetists maintained by the board.

Change in Organizational Structure includes an acquisition, change in ownership, merger, or reorganization involving the CONTRACTOR.

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

Child and Adolescent Needs and Strengths (CANS) is a tool that summarizes the information gathered through a screening process. The CANS is an information integration tool that is used to identify the needs and strengths of children/youth and their families. The goals of CANS is the transformational change of children and their families.

Child(ren) in State Custody (CISC) means child(ren) and youth in the legal custody of CYFD's Protective Services division, including Native Children and children never removed from the Respondent's home or children returned to the Respondent's home following a

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removal. (Respondent(s) are defendant(s) in an abuse and neglect case under the New Mexico Children's Code.)

Children in State Custody (CISC) CONTRACTOR means the single, statewide CONTRACTOR selected to administer benefits to CISC Members enrolled in the CISC CONTRACTOR.

Children in State Custody (CISC) Program means the organizational, administrative, and clinical strategies that are the responsibility of the CISC CONTRACTOR to improve the individual and collective health outcomes of CISC Members.

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

Clean Claim means a Claim that can be processed without obtaining additional information from the Provider of the service or from a third party. It includes a Claim with errors originating in HCA's system. It does not include a Claim from a Provider who is under investigation for Fraud or Abuse, or a Claim under review for medical necessity.

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

Community Based Organization (CBO) means an organization aimed at making desired improvements to a community's social health, well-being, and overall functioning. Community organization occurs in geographically, psychosocially, culturally, spiritually, and digitally bounded communities.

Community Benefit means both the Agency-Based Community Benefit and the Self-Directed Community Benefit subject to the annual allotment as determined by HCA on an annual basis.

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

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

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

Compliance Officer shall have the meaning ascribed to such term in Section3.3.3.8 of this Agreement.

Comprehensive Addiction and Recovery Act (CARA) is national legislation that promotes programs and strategies to address the impact of substance use disorders on individuals, communities, and families. CARA help fund prevention, education, harm reduction, treatment and recovery services. In New Mexico, CARA is reflected in HB 230 and requires a plan of care to be created by hospitals and freestanding birth centers when applicable.

Comprehensive Addiction and Recovery Act (CARA) Member is an infant identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

Comprehensive Care Plan (CCP) means a comprehensive plan of services that meets the Member's Physical, Behavioral, and Long-Term Care needs.

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

Confidential Information means any communication or record – whether oral, written, electronically stored or transmitted, or in any other form – consisting of: (i) confidential Member information, including PHI as defined by the Health Insurance Portability and Accountability

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

Contract Administrator shall have the meaning ascribed to such term in Section 7.42 of this Agreement.

Contract Manager shall have the meaning ascribed to such term in Section 3.3.3.7 of this Agreement.

CONTRACTOR means the MCO that has signed this Agreement. Unless otherwise specified in this Agreement, requirements applicable to the CONTRACTOR also apply to the CONTRACTOR's Subcontractors, Major Subcontractors, employees, agents, and anyone acting for or on behalf of the CONTRACTOR.

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

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

Copayment means a fixed dollar amount that a Member must pay directly to a Provider for a service, visit, or item. A copayment is to be paid at the time of service or receipt of an item (if applicable).

Core Service Agencies (CSA) means multi-service agencies that help to bridge treatment gaps in the Child and Adult treatment systems, promote the appropriate level of service intensity for

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Members with complex Behavioral Health service needs, including SUD, ensure that community support services are integrated into treatment and develop the capacity for Members to have a single point of accountability for identifying and coordinating their Behavioral Health, Physical Health, and other social services.

Corrective Action Plan (CAP) means corrective action plan developed by the CONTRACTOR.

Covered Services means those Physical Health, Behavioral Health, and LTC services listed in Attachment 1: Turquoise Care Covered Services or the ABP services listed in Attachment 4: Alternative Benefit Plan Covered Services

of this Agreement that are to be delivered in accordance with this Agreement.

Critical Incident means a reportable incident that may include, but is not limited to: abuse; neglect; exploitation; misuse or unauthorized use of restrictive interventions or seclusion; medication error by provider; and death; occurring during an episode of Member care.

Cultural Competence means an awareness and appreciation of a Member's customs, values, socioeconomic considerations, and beliefs and the ability to incorporate them into the screening, assessment, treatment and all Member/family interactions to increase the quality of health care services and improve health outcomes. Cultural Humility is a necessary component of cultural competence, including recognition of power dynamics and imbalances, and a desire to fix those power imbalances and to develop partnerships with people and groups who advocate for others.

Cultural Humility means sensitivity and ongoing curiosity of the complex characteristics that make a Member and their and interaction with the health care system unique to better connect with individuals and communities. These complex characteristics include, but are not limited to: cultural norms, values, rituals, dietary preferences, beliefs, race, ethnicity, gender, language, dress, religion/spirituality, sexual orientation, education, socioeconomic status, and disability status.

Custodian means an adult with whom the child lives who is not a parent or guardian of the child in accordance with NMSA 1978 § 32A-1-4.

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

Demilitarized Zone (DMZ) is the software/web page for the transmission and storage of data.

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

Directed Corrective Action Plan (DCAP) means a directed corrective action plan developed for the CONTRACTOR by HCA.

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

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

Dual Eligible Special Needs Plans (D-SNP) means plans that enroll Members who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

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

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the federally required Early and Periodic Screening, Diagnostic and Treatment program, as defined in Section 1905(r) of the Social Security Act and 42 C.F.R. § 441, Subpart B for Members under the age of twenty-one (21). It includes comprehensive periodic and inter-periodic screening and diagnostic services to determine Physical and Behavioral Health needs as well as the provision of all

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Medically Necessary Services listed in Section 1902(a) of the Social Security Act even if the service is not available under the State's Medicaid State Plan.

Electronic Clinical Data Systems (ECDS) are a NCQA network of HEDIS data containing a Member's personal health information and records of their experiences within the health care system.

Electronic Health Record (EHR) means a record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

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

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

Emergency Room (ER) or Emergency Department (ED) means a portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

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

EPSDT Personal Care Services (EPSDT PCS) means medically necessary PCS provided to Members under twenty-one (21) years of age as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. See NMAC 8.320.2.18.

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Encounter means a record of any Member Claim adjudicated by the CONTRACTOR or any of its Major Subcontractors and Subcontractors, including a Medicare Claims for which there is no Medicaid reimbursement and/or record of any Member service or administrative activity provided by a CONTRACTOR or its Major Subcontractor and Subcontractors for a Member that represents a Member-specific service or administrative activity, regardless of whether that service was adjudicated as a Claim or whether payment for the service was made.

Encounter Data is information about claims adjudicated by the CONTRACTOR, or any of its Major Subcontractors or Subcontractors for goods and/or services rendered to Members. Such information includes whether Claims were paid or denied and any capitated or subcapitated payment arrangements made.

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

Excluded State-Funded Services means services designated by the State, by written State Notice, to be financed and administered outside the Medicaid program using state-only arrangements. As of the effective date/time stated in the State Notice, the CONTRACTOR has no obligations for such services under this Agreement.

External Quality Review (EQR) means the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a MCO (described in 42 C.F.R. § 438.310(c)(2)), or its contractors furnishes Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354 and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358 or both. Failure to report means failure to submit a complete, timely, and accurate report, in the specified format in accordance with Section 4.22 of this Agreement.

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

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

Financial Requirements means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. part 438, subpart K, deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include premiums, Aggregate Lifetime Dollar Limits, or Annual Dollar Limits.

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

Formulary means the list of drugs covered by the CONTRACTOR.

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

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

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

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Full Delegation Model is a Care Coordination Model in which the CONTRACTOR delegates the overall provision of Care Coordination to Providers, health systems, agencies and/or organizations as part of a value-based purchasing (VBP) arrangement or Health Home while the CONTRACTOR retains oversight and monitoring functions.

Go-Live means the date on which the CONTRACTOR assumes responsibility for the provision of Covered Services to Members. As of the date of this Agreement, the Go-Live date is July 1, 2024.

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

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

Guardian means, in accordance with NMSA 1978 § 32A-1-4, a person appointed as guardian by a court or Indian tribal authority or a person authorized to care for the child by a parental power of attorney as permitted by law.

Guardian Ad Litem means an attorney appointed by the children's court to represent and protect the best interests of the child in an Abuse and neglect case under the New Mexico Children's Code who has the powers and duties described in NMSA 1978 § 32A-1-7.

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

Health Disparity means a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of

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people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion, as defined in Health People 2030.

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

Health Equity means a health system where all Members can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, other socially determined circumstances, or intersections among these factors.

Health Home means an individual Provider, team of health care professionals or health team that meets all federal requirements and provides the following six (6) services to persons with one (1) or more specified chronic conditions: (i) comprehensive care management; (ii) Care Coordination and health promotion; (iii) comprehensive transitional care/follow-up; (iv) Member and family support; (v) referral to community and social support services; and (vi) use of Health Information Technology (HIT) to link services, if applicable.

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

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

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

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

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

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

Healthy Dual means a Member who is eligible for full Medicaid and Medicare and is not accessing LTC.

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

Health Insurance Portability and Accountability Act (HIPAA) means the Health Insurance Portability and Accountability Act of 1996, as amended and codified at 42 U.S.C. §§160, et seq. and its regulations to include provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), codified at 42 U.S.C §§17931 et seq.

Health Related Social Needs (HRSN) means individual-level, adverse social conditions that negatively impact a Member's health or health care, including those identified in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM).

High-Cost/High-Needs (HCHN) means Members with high health care service costs and/or needs. HCHN Members include:

- High-cost Members are Members in the top ten percent of spending the prior year.
- High-needs Members include:
    - Justice-Involved Individuals;
    - Traumatic Brain Injury Members;
    - Medically Fragile Members;

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- Individuals with Intellectual Disabilities;
- Children and Adults with Special Health Care Needs;
- Members with Housing Insecurity needs;
- Members with complex Behavioral Health needs, including SUD;
- CISC;
- CARA Members;
- Prenatal and postpartum Members;
- Members receiving long-term services and supports (LTSS)

Home & Community Base Services (HCBS) program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization.

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

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

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

Housing Insecurity is an umbrella term that encompasses a number of challenges, such as having trouble paying rent, overcrowding, moving frequently, co-habiting with relatives, or spending the bulk of household income on housing costs. Homelessness is an extreme form of housing insecurity.

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

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

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

Institution for Mental Diseases (IMD) shall have the same definition as found in 42 C.F.R. § 435.1010 for purposes of the Agreement – an inpatient or residential facility of more than sixteen (16) beds that specializes in psychiatric care. Medicaid funds are not available to these facilities for Members between the ages of twenty-one (21) and sixty-four (64), unless authorized via an 1115 demonstration waiver approved by CMS. Specifically, subparagraph (B) following Section 1902(a)(29) of the Social Security Act restricts Medicaid reimbursements to IMD.

Individuals with Intellectual Disabilities (IID) means an individual with significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, consistent with further definition in https://www.nmhealth.org/publication/view/help/3881/ and the Managed Care Policy Manual.

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

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

Justice-Involved Utilization of State Transitioned Healthcare (JUST Health) is a program established to ensure justice-involved individuals have timely access to health care services upon release from correctional facilities. To ensure this access can occur, individuals who have active Medicaid coverage at the time of incarceration do not lose their Medicaid eligibility, rather, have their Medicaid benefits suspended after 30 days. Benefits are reinstated upon the individual's release from incarceration which allows immediate access to care. Individuals who are not

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Medicaid participants but who appear to meet eligibility requirements are given the opportunity to apply while incarcerated.

Key Personnel refers to those positions listed in Section 3.3.3, and the additional positions listed in Section 3.7.2 for the CISC CONTRACTOR, of this Agreement.

Kinship Caregiver means any individual who is a relative, godparent, member of a child's tribe or clan, or an adult with a significant bond (fictive kin) who are raising a child or youth because the biological parents are not able or unwilling to do so.

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

Legacy CONTRACTOR means a Turquoise Care CONTRACTOR who provided Medicaid Covered Services January 1, 2019 through June 30, 2024.

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

Long-Term Care (LTC) is the overarching term that refers to the Community Benefit, the services of a Nursing Facility (NF) and the services of an institutional facility. LTC programs serve Members who are disabled and/or elderly.

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

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

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Managed Care Organization (MCO) means an entity that meets the requirements of 42 CFR § 438.2 and participates in Turquoise Care under contract with HCA to assist the State in meeting the requirements established under NMSA 1978, § 27-2-12.

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

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

Medicaid Home Visiting (MHV) Program means evidence-based early childhood home visiting delivery models that provide services to eligible pregnant and Postpartum women and their infants by Providers adhering to the approved MHV model that meets criteria established by US Department of Health and Human Services (DHHS).

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

Medically Frail means an Adult Member who would be covered under the ABP but who has been determined as meeting HCA's definitions and criteria for the following conditions: (i) disabling mental disorder, including individuals up to age twenty-one (21) with serious emotional disturbances (SEDs) and adults with serious mental illness (SMI); (ii) a chronic substance use disorder; (iii) a serious and complex medical condition as defined by HCA in Section 13 of the Managed Care Policy Manual; (iv) a physical, intellectual, or developmental disability that significantly impairs the Member's ability to perform one (1) or more activities of daily living (ADL); or (v) a disability determination based on Social Security criteria.

Medically Necessary means Physical Health, Behavioral Health, and LTSS, and supplies, that: (i) are essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain, or regain the Member's optimal functional capacity; (ii) are

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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 Health, Behavioral Health, and LTC needs of the Member; (iii) are provided within professionally accepted standards of practice and national guidelines; (iv) are required to meet the Physical Health, Behavioral Health, and LTC 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 HCA.

Member means a person who has been determined eligible for Turquoise Care and who has enrolled with the CONTRACTOR.

Member Advisory Board shall have the meaning ascribed to such term in Section 4.12.3.2 of this Agreement.

Member Materials shall have the meaning ascribed to such term in Section 4.15 of this Agreement.

Member Rewards means the Member Rewards program that provides incentives to Turquoise Care Members for participating in State-defined activities that promote healthy behaviors. A Member who participates in a State-defined activity that promotes healthy behaviors earns credits that are applied to a Member's account, which will be managed by the CONTRACTOR. Earned credits may be used for health-related expenditures as approved under the Member Rewards program as further explained in Section 4.23 of this Agreement.

Member Satisfaction Survey shall have the meaning ascribed to such term in Section 4.12.4 of this Agreement.

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

Minimum Data Set (MDS) means the standardized uniform Comprehensive Needs Assessment of all residents in Medicare- or Medicaid-certified facilities, mandated by federal law (P.L.100-

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203) to be completed and electronically transmitted to the State. The MDS identifies potential resident problems, strengths, and preferences.

National Committee for Quality Assurance (NCQA) is an independent organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation.

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

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

New Mexico Crisis Screening Tool (CAT) is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children, youth and their Caregivers. It is intended to be completed by those who are directly involved with the individual. The form serves as both a decision support tool and as documentation of the identified needs of the child/youth served along with the decisions made with regard to treatment and placement.

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

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

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

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

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

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

Nursing Facility Level of Care (NF LOC) means the Member's functional level is such that two (2) or more ADLs cannot be accomplished without consistent, ongoing, daily provision or assistance with prompting, of some or all of the following levels of service: skilled, intermediate or assisted. A Member must meet the NF LOC to be eligible for NF placement and community benefit services.

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

Other Provider Preventable Conditions (OPPCs) means other provider preventable conditions that include the following three (3) Medicare national coverage determinations: (i) wrong surgical or other invasive procedure performed on a Member; (ii) surgical or other invasive procedure performed on the wrong body part; and (iii) surgical or other invasive procedure performed on the wrong Member.

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 Social Security Act or any payment to the CONTRACTOR by the State to which the CONTRACTOR is not entitled under Title XIX of the Social Security 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 4.19.11 of this Agreement; (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 4.18.5.2.1 of this Agreement, less than fifty dollars ($50.00) or

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those funds recoverable through existing routine and customary adjustments using HIPAA compliant formats.

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

Pass-Through Pricing means the pharmacy benefit manager charges the CONTRACTOR for the amount paid to the pharmacy for a prescription drug, including a dispensing fee and an administrative fee.

Patient-Centered Medical Home (PCMH) means an approach to delivering high-quality, cost-effective primary care. Using a patient-centered, culturally appropriate, and team-based approach, the PCMH model coordinates Member care across the health system. Guidelines for PCMH can be found in *Guidelines for Patient-Centered Medical Home (PCMH) Recognition and Accreditation Programs* (https://www.acponline.org/system/files/documents/running_practice/delivery_and_payment_models/pcmh/understanding/guidelines_pcmh.pdf).

Patient Protection and Affordable Care Act (PPACA) means Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010).

Performance Measure (PM) means a regular measurement of outcomes and results, which generates reliable data on the effectiveness and efficiency of programs.

Permanency Planning Worker (PPW) means the Child Protective Service (CPS) staff who plans, organizes, and coordinates the activities of the CPS Permanency Planning Program, a CYFD program responsible for conducting assessments and developing permanency plans for CISC to promote child safety, permanency, and wellbeing. The PPW conducts ongoing assessments to determine child safety, permanency, and well-being. The PPW visits with family members on a monthly basis to assess safety and to determine if the case plan is being implemented and services are effective.

Personal Care Services (PCS) means those services established by HCA to assist individuals twenty-one (21) years of age or older who are eligible for full Medicaid coverage and meet the

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level of care criteria as defined by policy. PCS are provided to a Member unable to perform a range of ADLs and instrumental activities of daily living (IADLs).

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

Population Health means the health outcomes of groups of Members, including the distribution of such outcomes within the group. These groups may be defined by health care service utilization, common diagnoses, Physical Health or Behavioral Health needs, demographic characteristics, geography, social determinants, or Members attributed to a practice or Provider.

Population Health Management means the application of strategies and targeted interventions to defined populations of Members across the care continuum to improve their health and well-being.

Postpartum means the twelve (12) month period of time following the end of a pregnancy.

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

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

Precariously Housed means Members who are at imminent risk of homelessness. This includes Members living in unstable housing scenarios, including but not limited to Members who are: (i) within one (1) week of discharge from an institution or treatment facility without access to housing once released; (ii) "doubled-up" or temporarily living with family; (iii) "couch-surfers" or staying with friends and/or family for a few nights at a time; (iv) able to afford one (1) to two

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(2) weeks at a hotel or rental but cannot afford an entire month; (v) expecting eviction within seven (7) Calendar Days with no additional places to stay; (vi) living in substandard housing; or (vii) paying a high percentage of income (higher than thirty percent [30%]) for their rental/housing needs.

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

Preferred Drug means a covered drug on HCA's Preferred Drug List, which may include brand-name and/or generic drugs.

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

Primary Care means integrated, accessible health care service, provided by clinicians (general practitioner, family physician, internal medicine physician, nurse practitioner, physician assistant, obstetrician/gynecologist, pediatrician, or other practitioner as authorized by HCA) accountable to be the principle point of contact to manage a Member's personal health care needs in a flexible and customized manner, developing a sustained partnership with Members, their other Providers, and practicing in the context of family and community.

Primary Care Physician or Primary Care Provider (PCP) means an individual who is a Contract Provider and has the responsibility for supervising, coordinating, and providing Primary Care to Members, initiating referrals for specialist care and maintaining the continuity of the Member's care, as further described in Section 4.8.5 of this Agreement.

Project ECHO means the Extension for Community Healthcare Outcomes, conducted by the University Of New Mexico School of Medicine. The program works to educate providers in order to develop the expanded capacity to safely and effectively treat chronic, common and complex diseases in Rural and underserved areas and to monitor the outcomes of this treatment.

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

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

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

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

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

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

Rare Disease means a disease or medical condition that effects fewer than two hundred thousand people in the United States.

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

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

Rehabilitation Services and Devices means services or devices ordered by a Provider to help Members recover from an illness or injury.

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

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Request for Proposals (RFP) means the request for proposals issued by the State on September 30, 2022, RFP No. 23--630-8000-0006.

Respondent used in the context of CISC Members means the person(s) against whom a custody hearing has been filed.

Resource Parent or Resource Family means a person or persons, including a relative of the child, licensed or certified by CYFD or a child placement agency to provide care for children in the custody of CYFD or agency.

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

Rural for purposes of this Agreement refers to the counties in the State that are not Frontier or Urban.

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

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

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Self-Directed Community Benefit (SDCB) means certain HCBS that are available to Members meeting NF level of care. A list of the services available in the SDCB is included in Attachment 1: Turquoise Care Covered Services.

Sentinel Event means a Member safety event that results in death, permanent harm, or severe temporary harm. Sentinel events are debilitating to both Members and health care Providers involved in the event.

Serious Mental Illness (SMI) is a determination based on the age of the individual, functional impairment, duration of the disorder, and the diagnosis. Adults must meet all of the criteria on the SMI Criteria Checklist in the Appendix of the Behavioral Health Policy and Billing Manual.

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

Severe Emotional Disturbance (SED) is a determination based on the age of the individual, diagnoses, functional impairment, or symptoms, and duration of the disorder. The child/adolescent must meet all of the criteria on the HCA SED Criteria Checklist.

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

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

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

Social Security Administration Death Master File (DMF) - is an electronic database that contains records of Social Security Numbers (SSN) assigned to individuals since 1936, and

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includes, if available, the deceased individual's SSN, first name, middle name, surname, date of birth, and date of death.

Sole Source Provider means a Contract Provider who, alone, can furnish one (1) or more types of Covered Services to the Member(s).

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

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

Stabilized means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.

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

State Notice means a written designation, amendment, or rescission issued by the State under this Agreement identifying Excluded State Funded Services and related effective dates / times and technical specifications, delivered in accordance with Section [Notices].

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

Substantially All Drugs means that all drugs and unique dosage forms in these categories are expected to be included in the CONTRACTOR's formulary with the following exceptions: multi-source brands of the identical molecular structure; extended release products with the immediate-release product is included; products that have the same active ingredient or moiety; and dosage forms that do not provide a unique route of administration (e.g., tablets, capsules versus tablets and transdermals). Exceptions to products with the same active ingredient or moiety are those drugs used to treat HIV. All FDA approved products for HIV including PREP will be covered on the formulary including oral combination products and injectables.

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Substance Use Disorder (SUD) means a disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.

Support Broker (SB) means an individual who provides support to SDCB Members and assists the Member (or the Member's family or representative, as appropriate) in arranging for, directing and managing SDCB services and supports as well as developing, implementing and monitoring the SDCB care plan and budget. Individual SBs work for SB agencies contracted with the CONTRACTOR or may be directly employed by the CONTRACTOR.

Symptomatic means exhibiting or involving symptoms.

TDD/TTY are telecommunications devices for the deaf and/or telephone typewriter or teletypewriter devices for text communication via a telephone line, used when one (1) or more parties have hearing or speech difficulties. The CONTRACTOR provides a separate phone number for receiving TDD/TTY messages or uses the State/711 Relay Services.

Telemedicine (also referred to as "telehealth") means the use of electronic information, imaging, and communication technologies (including interactive audio, video, and data communications as well as store-and- forward technologies) to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education in accordance with NMAC 8.310.2.12.M.

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

Transition Home means a temporary housing accommodation and supportive services to homeless persons to facilitate movement to independent living, such as a temporary residential shelter.

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

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Trauma as defined by Substance Abuse and Mental Health Services Administration (SAMHSA) means an event or circumstance resulting in physical harm, emotional harm, and/or life-threatening harm. The event or circumstance has lasting adverse effects on the individual's mental health, Physical Health, emotional health, social well-being, and/or spiritual well-being.

Trauma-Informed means a strengths-based approach to service delivery that realizes the widespread impact of Trauma and understands potential paths to recovery; recognizes the signs and symptoms of Trauma in Members, families, staff, and others involved with the system; and responds by fully integrating knowledge about Trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

Traumatic Brain Injury (TBI) means an injury to the brain of traumatic or acquired origin, including an open or closed head injury caused by: an insult to the brain from an outside physical force; Anoxia; electrical shock; shaken baby syndrome; a toxic or chemical substance; near-drowning; infection; a tumor; a vascular lesion; an event that results in either temporary or permanent, partial or total impairments in one (1) or more areas of the brain that results in total or partial functional disability, including cognition, language, memory, attention, reasoning, abstract thinking, judgment, problem solving, sensory perception and motor abilities, psychosocial behavior, physical functions, information processing, and speech.

Treat First Model means a practice approach for Just Health and Comprehensive Addiction and Recovery Act (CARA) populations used to achieve immediate formation of a relationship while gathering needed historical assessment and treatment planning information over the course of four (4) therapeutic encounters.

Treatment Limitations means, for the purposes of compliance with Behavioral Health parity requirements in 42 C.F.R. part 438, subpart K, limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs and NQTLs. (See 42 C.F.R. § 438.910(d)(2) for an illustrative list of NQTLs.)

Tribal means of or denoting an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to

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the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. § 479 a located wholly or partially in the State of New Mexico.

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

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

Urban for purposes of this Agreement means the following counties in New Mexico: Bernalillo, Los Alamos, Santa Fe, and Doña Ana.

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

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

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

Value Added Service (VAS) means any service offered by the CONTRACTOR that is not a Medicaid covered benefit under this Agreement or provided In Lieu of Services or Settings.

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

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

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

Acronyms list:

ABA—Applied Behavior Analysis

ABP—Alternative Benefit Plan

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

ACT—Assertive Community Treatment

ADL—Activities of Daily Living

AHRQ—Agency for Healthcare Quality and Research

ALF – Assisted Living Facility

ALTSD—New Mexico Aging & Long-Term Services Department

API—Application Programming Interface

APS-Adult Protective Services

ARRA—American Recovery and Reinvestment Act

ARTC—Accredited Residential Treatment Center

BAA—Business Associate Agreement

BCBA— Board-Certified Behavior Analyst

BC-DR—Business Continuity and Disaster Recovery

BH – Behavioral Health

BHPC—Behavioral Health Planning Council

BHS—Behavioral Health Services Division of CYFD

BMS—Behavioral Management Service

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BP—Blood Pressure

CAHPS—Consumer Assessment of Healthcare Providers and Systems

CANS—Child and Adolescent Needs and Strengths

CAP—Corrective Action Plan

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

CARA—Comprehensive Addiction and Recovery Act

CAT—New Mexico Crisis Screening Tool

CBMA—Community Benefits Member Agreement

CBSQ—Community Benefits Services Questionnaire

CCBHC – Certified Community Behavioral Health Clinic

CBO – Community Based Organization

CCC—Children with Chronic Conditions

CCL—Care Coordination Level

CCP—Comprehensive Care Plan

CCSC—Consolidated Consumer Service Center

CCSS—Comprehensive Community Support Services

CDD—Center for Development & Disability

CEO—Chief Executive Officer

CFDA—Catalog of Federal Domestic Assistance

CFSW – Certified Family Support Worker

CFO—Chief Financial Officer

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C.F.R.—Code of Federal Regulations

CHW—Community Health Worker

CHP—Cultural Humility Plan

CHR—Community Health Representative

CISC—Children in State Custody

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

CNA—Comprehensive Needs Assessment

CNP—Certified Nurse Practitioner

CNS—Clinical Nurse Specialist

COBA—Coordination of Benefits Agreement

COE—Category of Eligibility

CPSW – Certified Peer Support Worker

CPT—Current Procedural Terminology

CRNA – Certified Registered Nurse Anesthetist

CSA—Core Service Agencies

CY—Calendar Year

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CYFD—New Mexico Children, Youth and Families Department

DCAP—Directed Corrective Action Plan

DD—Developmental Disability

DHHS— US Department of Health and Human Services

DM—Disease Management

DME—Durable Medical Equipment

DMF – Social Security Death Master File

DMZ—Demilitarized Zone

DOH—New Mexico Department of Health

DSM—Diagnostic and Statistical Manual of Mental Disorders

D-SNP—Dual Eligible Special Needs Plans

DSIPT—Delivery System Improvement Performance Target

DUR—Drug Utilization Review

DWI—Driving While Intoxicated

ECDS—Electronic Clinical Data Systems

ECECD—New Mexico Early Childhood Education and Care Department

ECHO—Extension for Community Healthcare Outcomes

ED – Emergency Department

EDI—Electronic Data Interchange

EEO—Equal Employment Opportunity

EHR—Electronic Health Record

ENT—Ear, Nose, Throat

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EOR—Employer of Record

EPSDT—Early and Periodic Screening, Diagnostic and Treatment

EPSDT PCS —Early and Periodic Screening, Diagnostic and Treatment Personal Care Services

EQR—External Quality Review

EQRO—External Quality Review Organization

ER—Emergency Room

FAQ—Frequently Asked Question

FDA—U.S. Food and Drug Administration

FDIC—Federal Deposit Insurance Corporation

FEIN—Federal Employer Identification Number

FEMA—Federal Emergency Management Agency

FFS—Fee-for-Service

FICA—Federal Insurance Contributions Act

FMA—Fiscal Management Agency

FQHC—Federally Qualified Health Center

FTE—Full-time Equivalent

FTP—File Transfer Protocol

FUTA—Federal Unemployment Tax Act

GH—Group Home

GRT— Gross Receipts Tax

HBRHC—Hospital Based Rural Health Clinic

HCAC—Health Care Acquired Condition

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HCBS—Home- and Community-Based Service

HCHN – High Cost/High Needs

HCPCS—Healthcare Common Procedure Coding System

HCRP— High Cost Member Risk Pool

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

HFW—High Fidelity Wraparound

HIV—Human Immunodeficiency Virus

HIX—Health Insurance Exchange

HRA—Health Risk Assessment

HRSN—Health Related Social Needs

HCA—New Mexico Health Care Authority

ICSS – Independent Consumer Supports System

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

IADL—Instrumental Activities of Daily Living

ICD-10—International Classification of Diseases, Tenth Edition

ICD-9—International Classification of Diseases, Ninth Edition

ICWA—Indian Child Welfare Act

ID—Identification

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IHS—Indian Health Service

IID – Individuals with Intellectual Disabilities

IMD – Institution for Mental Diseases

IOP—Intensive Outpatient Program

IPF—Inpatient Psychiatric Facility/Unit

IPRA—Inspection of Public Records Act

IRS—Internal Revenue Service

IT—Information Technology

IV—Intravenous

JJS—Juvenile Justice Services

JUST Health—Justice-Involved Utilization of State Transitioned Healthcare

LARC— Long-Acting Reversible Contraceptives

LEP—Limited English Proficiency

LGBTQ+—Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Others

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

MAT— Medication Assisted Treatment

MCO—Managed Care Organization

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MD—Doctor of Medicine

MDS—Minimum Data Set

MFEAD—New Mexico Medicaid Fraud & Elder Abuse Division

MHSIP—Mental Health Statistics Improvement Project

MHV—Medicaid Home Visiting

MIC—Medicaid Integrity Contractor

MIS—Management Information System

MITA—Medicaid Information Technology Architecture

MLR—Medical Loss Ratio

MMIS—Medicaid Management Information System

MMIS-R—Medicaid Management Information System Replacement

MST—Multi-Systematic Therapy

NAAB—Native American Advisory Board

NCPDP—National Council of Prescription Drug Programs

NCQA—National Committee for Quality Assurance

NF—Nursing Facility

NF LOC—Nursing Facility Level of Care

NMAC—New Mexico Administrative Code

NMHIC—New Mexico Health Information Collaborative

NMMIP—New Mexico Medical Insurance Pool

NMSA—New Mexico Statute Annotated

NOME—Not Otherwise Medicaid Eligible

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NPI—National Provider Identifier

NQMC—National Quality Measures Clearinghouse

NQTLs—Non-Quantitative Treatment Limitations

OB/GYN—Obstetrics and Gynecology

OIG—Office of Inspector General

OMB—Office of Management and Budget

OPPC—Other Provider Preventable Condition

PACDR—Post-Adjudicated Claims Data Reporting

PASRR—Pre-Admission Screening and Resident Review

PCMH—Patient-Centered Medical Home

PCP—Primary Care Physician/ Primary Care Provider

PCS—Personal Care Service

PDL—Preferred Drug List

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

PPW—Permanency Planning Worker

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Project ECHO – Project Extension for Community Healthcare Outcomes

PS—Protective Services

PSC—Professional Services Contract

PSR—Psychosocial Rehabilitation

Q1—First Quarter

Q2—Second Quarter

Q3—Third Quarter

Q4—Fourth Quarter

QM/QI—Quality Management/ Quality Improvement

QTLs—Quantitative Treatment Limitations

RAC—Medicaid Recovery Audit Contractor

RFP—Request for Proposal

RHC—Rural Health Clinic

RN—Registered Nurse

RTC—Residential Treatment Center

SAMHSA—Substance Abuse and Mental Health Services Administration

SB—Support Broker

SBHC—School-Based Health Center

SDCB—Self-Directed Community Benefit

SED—Serious Emotional Disturbance

SFY—State Fiscal Year

SMI—Serious Mental Illness

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SNP—Special Needs Plan

SOC – Setting of Care

SOE—Summary of Evidence

SSN—Social Security Number

STMII—Short Term Medicaid for Incarcerated Individuals

SUD—Substance Use Disorder

TBD—To Be Determined

TBI – Traumatic Brain Injury

TCN—Transaction Control Number

TDD/TTY— Telecommunication Device for the Deaf/Text Telephone/

TFC—Treatment for Foster Care

TM—Tracking Measure

TPL—Third Party Liability

UM—Utilization Management

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

UNM—University of New Mexico

USC—United States Code

USCDI—U.S. Core Data for Interoperability

VAS – Value Added Service

VBP—Value-Based Purchasing

VPN—Virtual Private Network

WIC—Supplemental Food Program for Women, Infants and Children

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YTD—Year-to-Date

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3 CONTRACTOR's Administrative Requirements

3.1 Requirements Prior to Operation

3.1.1 Licensure and Accreditation

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

3.1.1.1 The CONTRACTOR shall be either: (i) National Committee for Quality Assurance (NCQA) Health Plan accredited in the State of New Mexico or (ii) accredited in another state where the CONTRACTOR currently provides Medicaid services and initiates the NCQA accreditation process for the State of New Mexico upon notice of award and achieves New Mexico NCQA Health Plan accreditation within one and a half (1.5) years from Go-Live. **The Contractor is required to declare intent and timeline to achieve LTSS/HE accreditation no later than December 31, 2026.** The CONTRACTOR shall provide HCA the current and each reoccurring NCQA Health Plan accreditation award letter, the Accreditation Certificate, Accreditation Summary Report and the HEDIS Score Sheet within thirty (30) Calendar Days of receipt.

3.1.1.2 The CONTRACTOR shall, within eighteen (18) months of Go-Live, obtain NCQA Distinction in Multicultural Health Care/Health Equity Accreditation and Long-Term Services and Supports (LTSS) Distinction in the State of New Mexico. (The NCQA Distinction in Multicultural Health Care is scheduled to change to transition to NCQA "Health Equity Accreditation" and "Health Equity Accreditation Plus" for surveys after July 2022.) The CONTRACTOR shall provide HCA the current and each reoccurring NCQA accreditation and distinction award letter from NCQA to HCA within thirty (30) Calendar Days of receipt.

3.1.1.3 To the extent the CONTRACTOR is in active pursuit of NCQA accreditation(s) and distinction(s) in the State of New Mexico, HCA reserves the right to request

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additional information regarding the CONTRACTOR's progress in achieving NCQA accreditation(s) and distinction(s) in New Mexico.

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

3.1.2 Readiness Period

The CONTRACTOR shall participate in a readiness review period beginning upon signature of this Agreement by all parties and through June 2024. The CONTRACTOR must obtain HCA prior written approval of all readiness elements prior to July 1, 2024.

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

3.1.2.2 The CONTRACTOR shall submit policies and procedures and other deliverables specified by HCA. The CONTRACTOR shall make any changes requested by HCA to policies and procedures or other deliverables in the time frames specified by HCA.

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

3.1.2.4 If the CONTRACTOR is unable to demonstrate its ability to meet the requirements of this Agreement, as determined by HCA, within the timeframes

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specified by HCA, HCA may terminate this Agreement in accordance with Section 7.6 of this Agreement. If the Agreement is terminated in accordance with this Section 3.1.2.4 of this Agreement, HCA shall not make any payments to the CONTRACTOR and shall have no liability for any costs incurred by the CONTRACTOR.

3.2 General Requirements

3.2.1 Transition Management Agreement

3.2.1.1 Immediately upon award notification, the CONTRACTOR shall enter into a Transition Management Agreement with HCA.

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

3.2.2 Coordination with the New Mexico Health Insurance Exchange and the Office of the Superintendent of Insurance

3.2.2.1 In addition to providing Medicaid managed care services, the CONTRACTOR must also offer, at a minimum, one (1) statewide Silver and one (1) statewide Gold Qualified Health Plan (QHP) in the individual market of the New Mexico Health Insurance Exchange (NMHIX) (also known as "beWellnm") for consideration, approval, and authorization by the Office of the Superintendent of Insurance.

3.2.3 Targeted Readiness Reviews

3.2.3.1 During the term of this Agreement, the CONTRACTOR must notify and request HCA approval in writing of CONTRACTOR-initiated, significant program or operational changes (e.g., Claims system, Care Coordination system, IT system modifications, transportation Major Subcontractor) at least sixty (60) Calendar Days prior to the implementation of the change. HCA reserves the right to identify a CONTRACTOR program or operational change as significant for purposes of this section.

3.2.3.2 The CONTRACTOR's notification and request for approval must include a timeline, milestones, testing, and identify the impact of the change to Members

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and/or Providers, as applicable. The CONTRACTOR must ensure any change ensures the continuity of services to Members.

3.2.3.3 The CONTRACTOR must participate in HCA-conducted, targeted readiness reviews as required by HCA prior to the CONTRACTOR's implementation of the significant program or operational changes. The CONTRACTOR must demonstrate to HCA's satisfaction that the CONTRACTOR will be able to meet the requirements in this Agreement prior to implementing the change.

3.3 **Personnel Requirements**

3.3.1 Staffing Generally

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

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

3.3.1.3 The CONTRACTOR must employ the identified qualified key, required and organizational staff, sufficient in number, to meet performance and compliance expectations as set forth in this Agreement.

3.3.1.4 The CONTRACTOR must notify HCA in writing within ten (10) Business Days of any change in personnel that participates on HCA's initiated workgroups and/or committees.

3.3.2 Minimum Key Staff Positions

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The CONTRACTOR must designate key management and technical personnel who shall be assigned to perform under this Agreement. All key staff positions must reside and work in the state of New Mexico, unless prior written approval has been obtained from HCA.

3.3.3 The CONTRACTOR's Key Personnel

For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility (as opposed to multiple persons equaling a full-time equivalent [FTE]) for the functional areas described below. All Key Personnel must reside in the State of New Mexico. Exceptions to requirements related to Key Personnel must be prior approved in writing by HCA. The CONTRACTOR shall, at a minimum, employ the following Key Personnel:

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

3.3.3.2 A full-time Chief Medical Officer/Medical Director (CMO) dedicated to this Agreement who is licensed to practice medicine in the State of New Mexico. The CMO shall be responsible for leading the clinical and quality activities for the CONCTRACTOR's MCO program. The CMO, or their designee, must be available by telephone twenty-four (24) hours a day, seven days a week, for UM decisions;

3.3.3.3 A full-time senior executive dedicated to this Agreement who is a board-certified psychiatrist or an advanced practice provider specializing in Behavioral Health in the State of New Mexico and has at least five (5) years of combined experience in mental health and substance abuse services. This person shall have or acquire

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specialized education or experience related to standards of care for children. This person shall oversee and be responsible for all Behavioral Health activities and take an active role in the CONTRACTOR's medical management team and in clinical and policy decisions;

3.3.3.4 A full-time Behavioral Health Director dedicated to this Agreement who is licensed to provide Behavioral Health services in the State of New Mexico (MD, DO, RN with Advance Practice Registered Nurse [APRN] licensure, psychologist, licensed independent social worker [LISW], professional clinical counselor [LPCC], or independent marriage and family therapist [LIMFT]) with a minimum of five (5) years of experience in the provision and supervision of treatment service for individuals with mental health and SUDs. The Behavioral Health Director shall be responsible for oversight of all Behavioral Health initiatives and services delivered under this Agreement.

3.3.3.5 A full-time Senior Executive dedicated to this Agreement who has at least five (5) years of experience administering managed LTC programs. On a case-by-case basis, equivalent experience in administering LTC programs and services, including HCBS, or in managed care may be substituted, subject to HCA's prior written approval. This person shall oversee and be responsible for all LTC activities;

3.3.3.6 A full-time Chief Financial Officer (CFO) dedicated to this Agreement who has at least ten (10) years of financial experience (e.g., financial analysis, planning, accounting, reporting) in the health care, managed care, or insurance industry, preferably in Medicaid. The CFO is responsible for accounting and finance operations, including all audit activities;

3.3.3.7 A full-time Contract Manager dedicated to this Agreement; see Section 3.3.3 of this Agreement;

3.3.3.8 A full-time Compliance Officer dedicated to this Agreement, who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who shall lead a

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compliance committee that is accountable to senior management in accordance with Section 4.18 of this Agreement;

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

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

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

3.3.3.12 A full-time Care Coordination Director dedicated to this Agreement who shall oversee and be responsible for all Care Coordination activities;

3.3.3.13 A full-time Transition Coordinator who shall lead and oversee the CONTRACTOR's transition activities necessary to meet the transition of care requirements in Section 4.4.11 of this Agreement;

3.3.3.14 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Utilization Management activities;

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3.3.3.15 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Quality Management/ Quality Improvement (QM/QI) activities;

3.3.3.16 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all program integrity activities;

3.3.3.17 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Population Health activities;

3.3.3.18 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for all Cultural Competency activities;

3.3.3.19 A full-time staff person dedicated to this Agreement who shall oversee and be responsible for Health Equity activities;

3.3.3.20 A full-time staff person dedicated to this Agreement with the education and experience such that the staff person has the skills and/or knowledge necessary to work on Native American health disparity issues and Cultural Competence concerns related to Care Coordination, services, and care delivery;

3.3.3.21 A minimum of four (4) full-time staff persons to work directly with I/T/Us and a minimum of two (2) full-time staff persons to work directly with I/T/Us for billing and Claims issues. These staff persons must proactively outreach I/T/Us to inform I/T/Us about available Covered Services and other benefits (i.e., In Lieu of Services and Value Added Services) available to Native American Members, and offer training and technical assistance for billing and Claims. At least one (1) of these staff persons must be proficient in at least one (1) New Mexican Native American/pueblo language;

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

3.3.3.23 A full-time staff person dedicated to this Agreement who shall act as Claims administrator to, among other things: (i) develop and implement a Claims processing system capable of paying Claims in accordance with State and federal

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requirements; (ii) develop processes for cost avoidance; (iii) ensure minimization of Claim recoupments; and (iv) meet Encounter reporting requirements;

3.3.3.24 A full-time staff person dedicated to this Agreement who shall act as the Grievances and Appeals manager to manage Member and Provider disputes, including Grievances, Appeals, requests for Fair Hearings, and Provider Grievances and Appeal ;

3.3.3.25 A full-time staff person dedicated to this Agreement who shall serve as the School-Based Services Liaison to coordinate with the New Mexico Department of Health, Office of School and Adolescent Health; schools; school districts; and Providers to expand services delivered in School-Based Health Centers, including risk screenings, and referrals to other appropriate services and resources;

3.3.3.26 A full-time Member, Family, and Stakeholder Engagement Coordinator dedicated to this Agreement who is responsible for facilitating and coordinating a robust engagement strategy for Members, Families, Member-serving systems, and other stakeholders to inform and support the design, implementation, and ongoing improvement of the Turquoise Care program. The Member, Family, and Stakeholder Engagement Coordinator shall facilitate forums to actively solicit program improvement opportunities, including, for example, the development of Member materials and resources to assist Members and their families to navigate the program. The Engagement Coordinator shall be an individual with lived experience as a Medicaid recipient or family member, or an individual certified in alignment with New Mexico’s Certified Peer Support training and certification program;

3.3.3.27 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

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attention from care coordinators and other personnel and to understand their rights and responsibilities under Turquoise Care. The Ombudsman shall represent the Member on internal Turquoise Care issues and is separate and distinct from the CONTRACTOR's Grievance system and Appeals process, as prescribed in Section 4.17 of this Agreement. Upon hiring the Ombudsman, the CONTRACTOR shall include in its notification to HCA where in the CONTRACTOR's organizational structure the Ombudsman is located in order to assure significant independence from MCO management; and

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

3.3.4 Contract Management

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

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

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

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

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

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

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

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

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

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

3.3.4.1.10 Proactively notifying HCA when there are known compliance or performance concerns.

3.3.5 Additional Required Staff

For the purposes of this requirement, additional required staff are those staff principally responsibility for the functions described below. All additional required staff positions must reside and work in the state of New Mexico, unless prior written approval has been obtained from HCA. Required staff positions may not be filled by staff identified as Key Personnel and additional required staff must reside in the State of New Mexico. The CONTRACTOR shall ensure additional required staff have routine, established access to Key Personnel to improve the Turquoise Care Program and resolve Member issues effectively. Exceptions to the additional required staff

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requirements (including additional required staff serving in more than one role, depending upon the size of the population being served) must be prior approved in writing by HCA. The CONTRACTOR shall, at a minimum, employ the following additional required staff:

3.3.5.1 The CONTRACTOR shall employ a Justice System Liaison who serves as the CONTRACTOR's single point of contact for justice system stakeholders (e.g., jails/prisons/detention facilities, probation and parole offices, courts, and law enforcement entities,). The Justice System Liaison shall be responsible for ensuring Care Coordination of Justice-Involved Individuals and collaborates with system stakeholders to engage in collective initiatives (e.g., alternatives to arrest and/or incarceration) to reduce the number of individuals entering the justice system. This position is preferred to have lived experience with the justice system.

3.3.5.2 The CONTRACTOR shall employ a Court Liaison who is the single point of contact for court system stakeholders (e.g., State, federal, county, municipal, and tribal courts) to ensure Member Care Coordination related to court orders and case dispositions. This position is also responsible for coordination of civil commitments and communication of court-related follow-up and requirements to appropriate staff. This allows for increased concentration on oversight and accountability for ensuring providers are adhering to the treatment requirements assigned through court ordered treatment.

3.3.5.3 The CONTRACTOR shall employ a Crisis Administrator who understands the CONTRACTOR's Behavioral Health crisis services and the Behavioral Health crisis resources and systems across the State. The Crisis Administrator is responsible for collaborating with the other MCOs, other crisis resources in the State, and first responders (e.g., fire departments, police, ambulance) to develop, implement, and oversee a comprehensive Behavioral Health crisis continuum for its Members.

3.3.5.4 The CONTRACTOR shall employ a Children's Services Liaison who serves as the primary point of contact to respond to inquiries from HCA, CYFD,

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Members/families, Caregivers, and Providers, and works collaboratively to address concerns related to the delivery of and access to services for CISC Members and child Members in out-of-home placements.

3.3.5.5 The CONTRACTOR shall employ an I/DD and Medically Fragile Services Liaison who serves as the primary point of contact to work collaboratively with Members/families, Caregivers, and Providers, to address and respond to concerns related to the delivery of and access to services for Members enrolled in the Developmental Disability 1915(c) Waiver or the Medically Fragile 1915(c) Waiver.

3.3.5.6 The CONTRACTOR shall have a full-time Supportive Housing Specialist dedicated to this Agreement to work with Members to assess housing needs and identify appropriate resources in order to help them attain and maintain housing. The Supportive Housing Specialist shall serve as the internal resource to provide training and technical assistance to the CONTRACTOR's care coordinators. The CONTRACTOR's identified Supportive Housing Specialist shall be located within the State, and shall be knowledgeable about federally, state, and locally funded housing resources in urban, rural, and frontier areas. Supportive Housing specifically targets the following populations:

3.3.5.6.1 Individuals who are chronically homeless, as defined by the U.S. Department of Housing and Urban Development (HUD) or Precariously Housed;

3.3.5.6.2 Individuals with frequent or lengthy institutional care;

3.3.5.6.3 Individuals with Serious Mental Illness (SMI) or chronic SUD, high emergency room or inpatient utilization, with crisis stabilization needs;

3.3.5.6.4 Individuals with frequent or lengthy adult residential care or treatment stays;

3.3.5.6.5 Individuals receiving LTSS and experiencing frequent turnover of in-home Caregivers or Providers; and

3.3.5.6.6 Individuals at highest levels of risk for expensive care and negative outcomes, defined by a Predictive Risk Intelligence System (PRISM) risk

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score of one point five (1.5) or higher, or defined in another manner as determined by HCA.

3.3.6 Staff Training

3.3.6.1 The CONTRACTOR shall provide regular and ongoing comprehensive training, including focus on supporting a Trauma responsive lens throughout the system of care for CONTRACTOR staff to ensure that they understand the goals of Turquoise Care, including the integration of Physical Health, LTC, and Behavioral Health, the provisions and limitations of the ABP, and the requirements of this Agreement. As issues are identified by the CONTRACTOR and/or HCA, the CONTRACTOR shall provide timely and targeted training to staff.

3.3.6.2 The CONTRACTOR shall submit an annual staff training plan to HCA for prior review and prior written approval. The staff training plan shall include the training topic, frequency of training, modality of the training (e.g., instructor-led, web-based), and the staff required to complete the training.

3.3.6.3 The CONTRACTOR shall provide an initial orientation and training as well as ongoing training, including training targeted to different types of staff, to ensure compliance with this Agreement. Targeted training must include:

3.3.6.3.1 Care Coordination;

3.3.6.3.2 NF LOC Determinations;

3.3.6.3.3 Medicaid eligibility coordination and renewals

3.3.6.3.4 Setting of Care (SOC) Submissions;

3.3.6.3.5 Community Benefit Services and Supplemental Questionnaire;

3.3.6.3.6 Behavioral Health Services;

3.3.6.3.7 Trauma-responsive training as approved by HCA;

3.3.6.3.8 Cultural Competency;

3.3.6.3.8.1 The CONTRACTOR shall provide training to all staff within the organization on Cultural Competency at least annually.

3.3.6.3.8.2 The CONTRACTOR shall regularly evaluate the training needs of its staff for Cultural Competency and update the training programs, when

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appropriate. The CONTRACTOR shall customize Cultural Competency training to staff based on the nature of the contacts they have with Providers and/or Members.

3.3.6.3.8.3 Training must be designed to develop a Culturally Competent and culturally sensitive workforce and must go beyond race/ethnicity to include cultural considerations for diverse populations, especially within the following priority populations:

3.3.6.3.8.3.1 Pregnant and Postpartum Members and young children, including Children In State Custody (CISC);

3.3.6.3.8.3.2 Seniors and Members with LTSS needs;

3.3.6.3.8.3.3 Members with Behavioral Health conditions;

3.3.6.3.8.3.4 LGBTQIA+ Members;

3.3.6.3.8.3.5 Native American Members; and

3.3.6.3.8.3.6 Justice-Involved Individuals.

3.4 **Marketing Requirements**

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

3.4.2 HCA shall review and approve the content, comprehension level, and language(s) of all Member Marketing Materials before use.

3.4.3 The CONTRACTOR shall distribute its Marketing Materials statewide.

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

3.4.5 The CONTRACTOR shall comply with the requirements in the Managed Care Policy Manual and all federal regulations regarding Medicare-Advantage and Medicaid Marketing (42 C.F.R. § 422 and § 438) and the CMS Medicare Marketing Guidelines, which can be found at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.

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3.4.6 Marketing Activities Not Permitted Under This Agreement

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

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

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

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

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

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

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

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

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

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

3.4.7 The CONTRACTOR shall take reasonable steps to prevent its Contract Providers, Subcontractors, Major Subcontractors, agents, consultants, or any other party affiliated with the CONTRACTOR from committing the acts prohibited in this Section 3.4. The CONTRACTOR shall be held liable only if it knew or should have

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known that the delegated Marketing activities were performed in violation as described here in and failed to take timely corrective action.

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

3.4.9 Marketing Time Frames

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

3.5 Cultural and Linguistic Competence

3.5.1 Cultural Competency Program and Cultural Humility Plan (CHP)

3.5.1.1 The CONTRACTOR shall develop and implement a comprehensive Cultural Competency program that aligns with National Culturally and Linguistically Appropriate Services (CLAS) Standards, is described in a written CHP, and is formally evaluated and updated at least annually.

3.5.1.2 The CONTRACTOR's CHP must identify and address health care disparities and ensure equitable access to and the delivery of services to all Members, including those with limited English proficiency, diverse cultural and ethnic backgrounds, or disabilities; and regardless of gender, sexual orientation, or gender identity.

3.5.1.3 The CHP must identify the goals and objectives of the CONTRACTOR's Cultural Competency program and align with the goals and objectives described in the CONTRACTOR's Population Health Management plan and HCA's Quality Strategy.

3.5.1.3.1 The CONTRACTOR shall evaluate its CHP annually to determine its effectiveness and identify opportunities for improvement.

3.5.1.3.2 The CONTRACTOR shall, as part of the evaluation of its CHP, evaluate the effectiveness and outcomes of cultural competency training provided and include evaluation results in its annual CHP.

3.5.1.4 The CONTRACTOR must submit the CHP and, starting in contract year two (2), the annual evaluation to HCA annually by April 30 of each Contract Year.

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3.5.1.5 The CHP shall demonstrate how the CONTRACTOR will recruit and retain a diverse staff to meet the cultural needs of its membership and include cultural competence as part of job descriptions.

3.5.1.6 Member and stakeholder feedback must be key components of the CHP development with clear indications of how Member and other stakeholder feedback was collected and incorporated into the CHP.

3.5.1.6.1 The CONTRACTOR shall attend the Native American Advisory Board meetings (NAAB).

3.5.1.6.2 The CHP shall provide evidence of how Members are selected for participation on the Member Advisory Board (see Section 4.12.3.2 in this Agreement) and how diversity of representation is achieved each year.

3.5.1.6.3 The CONTRACTOR shall share its CHP at one (1) of the annual statewide Member Advisory Board meetings for purposes of soliciting Member and stakeholder feedback, which shall be incorporated into the annual evaluation and update.

3.5.1.6.4 The CHP must describe how Members are supported to participate in the Member Advisory Board meetings, including but not limited to: access to materials ahead of time, child care, translation services, virtual attendance options, technology assistance, literacy support, and other accommodations that ensure member representatives are able to meaningfully participate.

3.5.1.7 The CHP shall describe how the CONTRACTOR will assess the cultural and linguistic needs of its Members and identify health disparities so that the CHP accurately represents and addresses the cultural and linguist needs of its Members and the CONTRACTOR's strategies to mitigate health disparities. The CONTRACTOR must also describe how the CONTRACTOR will continuously monitor for changes in the cultural and linguistic needs of its Members and/or health disparities and adjust its CHP to meet the evolving needs of its membership.

3.5.1.8 The CHP shall describe how the CONTRACTOR will use the CHP to shape and inform the CONTRACTOR's Network Development and Management plan and

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activities to ensure adequate access and availability of services that are delivered in a culturally competent, linguistically appropriate, and equitable manner. This must include how the CONTRACTOR will retain an accounting of annual required provider trainings on cultural competency.

3.5.1.9 The CHP shall describe how the CONTRACTOR will monitor and evaluate its Member-facing operational areas to ensure staff are providing culturally competent, linguistically appropriate, and equitable care for Members.

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

3.5.3 The report of the CONTRACTOR's evaluation of its CHP shall be used to inform the CONTRACTOR's Population Health Management and Quality Assurance program. Report findings shall be part of a continuing quality improvement cycle with goals developed to address any findings where the CONTRACTOR can improve in Cultural Competency, linguistic competency, and Health Equity.

3.5.4 The CHP must outline how the evaluation findings are leveraged by the CONTRACTOR to improve services and how the findings are used to update the CONTRACTOR's annual Population Health Management plan, QM/QI evaluation, and QM/QI program description.

3.6 Consolidated Consumer Service Center (CCSC)

The CONTRACTOR shall work with the State's CCSC as directed by HCA. The Contractor shall give priority to communications with the CCSC. The Contractor shall ensure that action is initiated within one business day on a CCSC communication regarding a Member or Provider concern.

3.7 Administrative Requirements for the CISC CONTRACTOR

3.7.1 General

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3.7.1.1 The CISC CONTRACTOR shall comply with the administrative requirements in Section 3.7 of this Agreement in addition to the other administrative requirements in Section 3 unless otherwise indicated. To the extent that requirements in Section 3.7 conflict with requirements elsewhere in Section 3, the requirements in Section 3.7 shall control.

3.7.2 CISC Key Personnel

The CISC CONTRACTOR shall, at a minimum, employ the following Key Personnel in addition to the Key Personnel identified in Section 3.3.3 of this Agreement:

3.7.2.1 A full-time CISC Program Director responsible for the implementation and general administration of the program requirements for the CISC population. The CISC Program Director must have prior experience administering managed care programs, and at least five (5) years of experience working with children and youth with Trauma, complex physical and Behavioral Health needs, and multi-systemic involvement. The CISC Program Director must have experience working with stakeholders and systems that serve children and youth in state custody. The CISC Program Director shall serve as the primary contact to HCA for the CISC program and other child-serving agencies and stakeholders to further develop, implement, and improve the program.

3.7.2.2 An Associate Medical Director, dedicated at least half-time (.5 FTE) to the CISC Program in this Agreement. The Associate Medical Director may be a Medical Doctor, Doctor of Osteopathy, or Certified Nurse Practitioner (CNP) licensed in the State of New Mexico. The Assistant Medical Director must have at least five (5) years of child and adolescent Behavioral Health experience. The Associate Medical Director shall be responsible for leading the clinical and quality activities for the CISC program and report to the CMO.

3.7.2.2.1 If the Associate Medical Director is a CNP, the CNP must:

3.7.2.2.1.1 Pass a national certifying exam;

3.7.2.2.1.2 Possess at least a Master's of Science in Nurse degree with a nurse practitioner specialty;

3.7.2.2.1.3 Possess New Mexico RN and CNP licensing;

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3.7.2.2.1.4 Consult within their certified nurse practitioner scope and collaborate as necessary with Medical Doctors or Doctors of Osteopathy when outside their certified scope and as needed;

3.7.2.2.1.5 Maintain their license through 50 contact hours every two years; and

3.7.2.2.1.6 Maintain prescriptive authority within New Mexico.

3.7.2.3 A Member, Caregiver, and Stakeholder Engagement Coordinator, dedicated full-time to this Agreement, responsible for facilitating and coordinating a robust engagement strategy for CISC, their Caregivers, member-serving systems, and other stakeholders to inform and support the design, implementation, and ongoing improvement of the CISC program. The CISC CONTRACTOR should consider an individual with lived experience as a Medicaid recipient or Caregiver, or an individual certified in alignment with New Mexico's Certified Family Peer Support training and certification program.

3.7.2.4 A full-time CISC Transition Coordinator with at least two (2) years of experience coordinating care and benefits necessary to meet the transition needs of populations with complex care needs, such as the CISC population. The Transition Coordinator must have the education and experience to understand, identify, and address the transition challenges and disparities within New Mexico's culturally diverse population. The Transition Coordinator must be fully dedicated to this Agreement and responsible for overseeing CISC Member transitions of care requirements.

3.7.2.5 The responsibilities of the Director of Pharmacy identified in Section 3.3.3 of this Agreement shall, for the CISC CONTRACTOR, include monitoring pharmacy utilization; identifying and addressing outlier prescribing practices; providing pharmacy-related consultation, guidance, and training specific to the CISC population to CISC CONTRACTOR staff and providers; and collaborating with HCA to fulfill expectations for CISC Members.

3.7.3 <u>CISC Expertise for Key Personnel</u>

In addition to ensuring the experience and expertise of the Key Personnel listed in Section 3.7.2 of this Agreement, the CISC CONTRACTOR shall ensure the

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following Key Personnel identified in Section 3.3.3 of this Agreement have knowledge and experience with the needs of CISC or similar populations, including as role-appropriate, the provision of Trauma-responsive care, Care Coordination for children with multi-system involvement, and treatment of children who have experienced Trauma and have complex behavioral, neuro-developmental, or Physical Health needs:

3.7.3.1 Behavioral Health Director;

3.7.3.2 Staff person responsible for network development and management;

3.7.3.3 Staff person with responsibility for Native American health disparity issues and Cultural Competence concerns related to Care Coordination, services and care delivery;

3.7.3.4 Population Health Director;

3.7.3.5 Care Coordination Director;

3.7.3.6 UM Director; and

3.7.3.7 QM/QI Director.

3.7.4 Training for CISC-Dedicated Staff

3.7.4.1 The CISC CONTRACTOR shall provide an annual staff training plan to HCA for review and prior written approval describing the training for CISC-dedicated staff administering the CISC program. The annual staff training plan shall include the following trainings and training topics:

3.7.4.1.1 Child and Adolescent Needs and Strengths (CANS) assessment tool trainings. The CONTRACTOR shall have two (2) certified CANS trainers that are responsible for training Care Coordination staff and other relevant members of the organization, including but not limited to utilization management staff. Both the certification and train-the-trainer curriculum will be provided by the State.

3.7.4.1.2 Trauma-responsive training as approved by HCA;

3.7.4.1.3 Care Coordination of CISC Members;

3.7.4.1.4 Motivational Interviewing techniques;

3.7.4.1.5 Unique physical, behavioral, and developmental needs of CISC;

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3.7.4.1.6 CISC program and program requirements;

3.7.4.1.7 CYFD and Juvenile Justice Services systems;

3.7.4.1.8 New Mexico's Indian Family Protection Act;

3.7.4.1.9 Evidence-based practices;

3.7.4.1.10 New Mexico's Behavioral Health delivery system;

3.7.4.1.11 CISC settlement agreement and metrics;

3.7.4.1.12 Role and decision-making authorities of the Member, biological parents, Caregivers, resource parent/family, CYFD staff (PPW for Protective Services [PS] involved children) in Care Coordination and planning, and instruction related to the ability to share information with each party;

3.7.4.1.13 Process to augment bundled services (e.g., Therapeutic Foster Care) with additional services and resources;

3.7.4.1.14 Availability of community-based services and resources not covered by Medicaid;

3.7.4.1.15 CISC Member transition expectations, including age-related transitions;

3.7.4.1.16 Child and Family Team meetings: individualized planning meetings (IPMs) and individualized planning process (IPPs) overview, purpose, and roles;

3.7.4.1.17 High Fidelity Wraparound: overview and CONTRACTOR roles with Care Coordination and utilization management;

3.7.4.1.18 Crisis Now and 988 network standards, including but not limited to the standards for the crisis triage centers (CTC), Mobile Crisis Teams (MCT), Children's Mobile Response and Stabilization Services (MRSS), crisis receiving models, and separate pathways to or in an ED. ;

3.7.4.1.19 The CANS screen: training and certification and use in the Care Plan;

3.7.4.1.20 Use of psychotropic medications with CISC populations: New Mexico Standards; and

3.7.4.1.21 NMAC and New Mexico's Children's Code.

4 CONTRACTOR's Scope of Work

4.1 Eligibility

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4.1.1 General

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

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

4.1.1.2.1 The CONTRACTOR shall use best efforts to contract with the UNM Health Sciences Center – Center for Development & Disability (UNM/CDD) to coordinate care for medically fragile individuals receiving EPSDT and/or Community Benefit services, and shall use all best efforts to have this contract executed prior to the 30th day of September for each year prior to the forthcoming calendar year. In the event that a CONTRACTOR and UNM are unable to reach a reasonable contract, HCA will intervene to resolve the situation. The CONTRACTOR shall ensure that contract negotiations do not jeopardize Member access of care.

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

4.1.1.3 HCA shall send eligibility recertification information to the Member in advance of the Member's Medicaid redetermination deadline. The CONTRACTOR shall assist the Member and facilitate in gathering the necessary documentation required for HCA or its designee. Assistance to the Member includes, but is not limited to, outreach, reminders, and corresponding follow up with the Member to review the eligibility renewal process.

4.1.2 Level of Care Determinations for Not Otherwise Medicaid Eligible Individuals

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

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

4.1.2.2 The CONTRACTOR shall use the tools and processes that have been approved by HCA in conducting the NF LOC evaluation. The CONTRACTOR shall interface with HCA eligibility system for level of care in a file format prescribed and approved by HCA.

4.1.2.3 If a Not Otherwise Medicaid Eligible individual has met the NF LOC determination, either because he or she is in a NF or because HCA issued a waiver allocation for Community Benefit services, the CONTRACTOR shall inform HCA of the individual's level of care determination.

4.1.2.4 If the individual is determined to meet a NF LOC, the CONTRACTOR shall notify HCA to continue the eligibility determination process.

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

4.1.3 <u>Level of Care Determinations for Members who are expected to always meet NF LOC</u>

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

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

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

4.1.4 Effective December 1, 2025, the CONTRACTOR is required to provide the HCA with regular updated address (physical and /or mailing) information that was received directly from or verified with the Member. The regularity of address information from the MCO will occur at a periodicity and in a format agreed upon by the HCA and the CONTRACTOR.

4.2 **Enrollment**

4.2.1 General

HCA shall enroll individuals determined eligible for Turquoise Care. Enrollment in a MCO may be the result of a Recipient's selection of a particular MCO or assignment by HCA. The CONTRACTOR is not entitled to an equal share or particular number of Members, auto-assigned Members, nor to a grouping of Members with equivalent medical expenses. HCA's auto-assignment algorithm may auto-assign Members in different numbers and with different expenses. HCA makes no warranty relative to the Members' risk profiles.

4.2.2 Mandatory Enrollment of CISC Recipients

HCA shall assign all CISC Recipients to the CISC CONTRACTOR, with the exception of the following:

4.2.2.1 Enrollment of Native American CISC Recipients in the CISC CONTRACTOR shall be voluntary. Native American CISC Recipients may enroll with the CISC CONTRACTOR, another MCO, or receive services through HCA's FFS program.

4.2.3 Current Medicaid Recipients

Recipients who are eligible and currently enrolled will have an opportunity to select a Turquoise Care MCO beginning in April 2024 (unless excluded from mandatory

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enrollment in Turquoise Care). If the recipient does not select a Turquoise Care MCO, the recipient will be auto-assigned in accordance with Section 4.2.5 of this Agreement.

4.2.4 New Medicaid Recipients.

Individuals determined eligible for Centennial Care 2.0 after April 2024 and before July 1, 2024, will select a current Centennial Care 2.0 MCO at the time of application for Medicaid eligibility. These individuals will also have an opportunity to select a Turquoise Care MCO prior to July 1, 2024. Recipients eligible on or after July 1, 2024, will have the opportunity to select a Turquoise Care MCO at the time of application. Recipients who do not select a Turquoise Care MCO upon the opportunity to do so will be auto-assigned in accordance with Section 4.2.5 of this Agreement.

4.2.5 Auto-Assignment

4.2.5.1 HCA will auto-assign a Recipient to a Turquoise Care MCO in specified circumstances, including but not limited to: (i) the Recipient does not select an MCO at the time of eligibility or (ii) the Recipient cannot be enrolled in the requested MCO pursuant to the terms of this Agreement (e.g., the CONTRACTOR is subject to and has reached its enrollment limit).

4.2.5.2 Auto-assignment during the initial open enrollment period for Turquoise Care will be determined by HCA. However, during initial enrollment:

4.2.5.2.1 Turquoise Care MCO enrollment will be driven by Recipient and Member choice.

4.2.5.2.2 Centennial Care 2.0 Members who do not select a Turquoise Care MCO and whose current Centennial Care 2.0 is awarded a contract to become a Turquoise Care MCO will remain enrolled in their current MCO. Centennial Care 2.0 Members who do not select a Turquoise Care MCO and whose current Centennial Care 2.0 MCO is not awarded a contract to become a Turquoise Care MCO will be auto-assigned during initial enrollment as determined by HCA.

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4.2.5.2.3 Members currently enrolled in a Centennial Care 2.0 MCO awarded a contract for Turquoise Care will remain in their current plan, unless they elect a different Turquoise Care MCO through open enrollment.

4.2.5.2.4 The upper enrollment limit established by HCA pursuant to 4.2.8 of this Section will not prevent or limit enrollment in any Turquoise Care MCO based upon Recipient/Member choice.

4.2.5.3 Following the initial open enrollment period for Turquoise Care, the auto-assignment process will consider the following:

4.2.5.3.1 If a Recipient was previously enrolled with a Turquoise Care MCO and loses eligibility for a period of three (3) months or less, the Recipient will be re-enrolled with that Turquoise Care MCO;

4.2.5.3.2 If the Recipient has family Members in a Turquoise Care MCO, the Recipient will be enrolled in that Turquoise Care MCO;

4.2.5.3.3 If the Recipient is a newborn, the Recipient will be assigned to their mother's Turquoise Care MCO; and

4.2.5.3.4 If none of the above applies, the Recipient will be assigned using an auto-assignment algorithm default logic that considers nationally-recognized quality standards or other auto-assignment algorithm methodologies that reward MCOs that demonstrate superior performance on one (1) or more key dimensions of performance as determined by HCA. HCA will notify the CONTRACTOR at least twelve (12) months in advance of changes to the quality metrics impacting the auto-assignment algorithm.

4.2.5.3.5 If a Turquoise Care MCO exceeds the upper enrollment limit established by HCA pursuant to 4.2.8 of this Section, auto-assignment into that Turquoise Care MCO will be limited to Recipients meeting the auto-assignment criteria as described in 4.2.5.3.1 through 4.2.5.3.5 of this Section.

4.2.5.4 HCA reserves the right to modify the auto-assignment methodology any time at its discretion.

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4.2.5.5 Recipient and Member choice shall be the primary driver for MCO enrollment and supersedes auto-assignment in all cases during the initial enrollment and open enrollment periods.

4.2.6 Newborns

4.2.6.1 When a child is born to a mother enrolled in Turquoise Care, the hospital or other Provider shall notify the HCA of the child's birth. Hospitals or other Providers shall notify HCA by either using the electronic process available through the Baby Bot program (or its successor) or by completing a Notification of Birth, MAD Form 313 (or its successor) prior to or at the time of discharge. Upon receipt of the notification of the child's birth, HCA shall ensure that the eligibility process is immediately commenced and that upon completion of the eligibility process the newborn is enrolled into their mother's MCO.

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

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

4.2.6.4 When a Medicaid-eligible child is born to a mother on the New Mexico Health Insurance Exchange and the mother's Qualified Health Plan is not a Turquoise Care MCO, the newborn shall be auto-assigned and enrolled in a Turquoise Care MCO (in accordance with Section 4.2.5 of this Agreement) retroactively to the month of birth. The mother shall have one (1) opportunity anytime during the three (3) months from the effective date of enrollment to change the newborn's MCO assignment.

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

4.2.7 Non-Discrimination

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

4.2.8 Enrollment Limits

4.2.8.1 HCA will establish an upper enrollment limit for Turquoise Care MCOs following the RFP awards to CONTRACTORs.

4.2.8.2 HCA reserves the right to modify enrollment limits any time at its discretion.

4.2.9 Effective Date of Enrollment

4.2.9.1 Current Medicaid Recipients. The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.3 of this Agreement shall be Go-Live.

4.2.9.2 New Medicaid Recipients. The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.4 of this Agreement is the first day of the month in which the Recipient's eligibility becomes effective.

4.2.9.3 At HCA's discretion, the effective date of enrollment pursuant to Section 4.2.9.2 of this Agreement may be modified during the term of this Agreement. HCA will notify the CONTRACTOR of any changes to the effective date of enrollment and related processes with at least ninety (90) Calendar Days prior notice.

4.2.10 Enrollment Period

4.2.10.1 After enrolling in the CONTRACTOR's MCO (whether as the result of selection or assignment, Members shall have one (1) opportunity anytime during the three (3) month period immediately following the effective date of enrollment with the CONTRACTOR's MCO to request to change MCOs. After exercising this right to change MCOs, a Member shall remain enrolled with the MCO until the annual choice period described in Section 4.2.10.2 of this Agreement, unless the Member's change of enrollment is permitted in accordance with NMAC

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8.308.7.9.H or the Member is disenrolled in accordance with Section 4.3 of this Agreement and NMAC 8.308.7.10.

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

4.2.10.3 CISC Members mandatorily enrolled in the CISC CONTRACTOR shall not be offered an opportunity to change MCOs following enrollment in the CISC CONTRACTOR nor have an annual choice period. CISC Members shall be offered an opportunity to change MCOs when the CISC member transitions in and out of state custody and when a CISC Member ages out of the foster care system.

4.2.10.4 Native American Members may change enrollment between New Mexico's Medicaid fee-for-service program and the Turquoise Care program at any time. However, Native American Members enrolled in the Turquoise Care program with a Turquoise Care MCO may only change directly to another MCO during the annual choice period or for cause as described in 4.3.2.3 of this Section and in alignment with NMAC 8.308.6.9 requirements. If a Native American is dually eligible or in need of long-term care services, the individual is required to enroll in a MCO. Native Americans may change enrollment between New Mexico's Medicaid fee-for-service program and the Turquoise Care program at any time.

4.2.11 Transfers from Other MCOs

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

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

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

4.3 **Enrollment Data**

4.3.1 The CONTRACTOR shall receive, process, and update enrollment files from HCA. Enrollment data shall be updated or uploaded to the CONTRACTOR's eligibility/enrollment database(s) within twenty-four (24) hours of receipt from HCA ensure that the CONTRACTOR complies with Section 4.20.2.6 of this Agreement.

4.3.2 Member Disenrollment Initiated by Member

4.3.2.1 In accordance with Section 4.2.10 of this Agreement, a Member, other than a CISC Member, has the opportunity to change MCOs during the first ninety (90) Calendar Days following the effective date of enrollment with the CONTRACTOR. After exercising change rights, the Member shall remain enrolled with the CONTRACTOR until the annual choice period described in Section 4.2.10.2 of this Agreement.

4.3.2.2 In accordance with Section 4.2.10.2 of this Agreement, a Member, other than a CISC Member, may select another MCO during the Member's annual choice period.

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

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with the determination denying the request to disenroll. The following are causes for Member initiated disenrollment:

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

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

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

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

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

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

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

4.3.3 Member Disenrollment Initiated by HCA

4.3.3.1 HCA may disenroll a Member if:

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4.3.3.1.1 The Members loses Medicaid eligibility; or

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

4.3.4 Effective Date of Disenrollment

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

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

4.3.6 In accordance with NMAC 8.308.7.10.a, the CONTRACTOR shall not, under any circumstances, disenroll a Member. HCA retains the sole authority to disenroll a Member from the CONTRACTOR and from the Turquoise Care program. The CONTRACTOR shall not request disenrollment because of a change in the Member's health status, because of their utilization of medical or Behavioral Health services, their diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs (except when their continued enrollment seriously impairs the CONTRACTOR's ability to furnish services to either that particular Member or other Members).

4.4 **Care Coordination**

4.4.1 General

4.4.1.1 The CONTRACTOR shall provide Care Coordination that complies with 42 C.F.R. § 438.208 and all requirements set forth in this Agreement. The CONTRACTOR's Care Coordination program must be designed to cover a wide spectrum of episodic and chronic health care conditions for Members including those in the top ten percent of cost of Members, including those with special health care needs, with an emphasis on addressing health disparities, facilitating care transitions, helping Members with care navigation, removing barriers to care, proactive health promotion, health education, and disease management. The

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CONTRACTOR shall provide Care Coordination in consultation with a Member's treatment team and direct engagement with Members resulting in improved Physical and Behavioral Health outcomes. The CONTRACTOR shall ensure those activities are performed by Care Coordinators who have expertise in Member self-management approaches, Member advocacy, navigating complex systems and communicating with a wide spectrum of professional and laypersons, including family members, physicians, specialists, and other health care professionals.

4.4.1.2 The CONTRACTOR shall ensure that performing Care Coordination requirements does not impede a Member's ability to timely access necessary services.

4.4.1.3 The CONTRACTOR's Care Coordination program must reflect the following principles:

4.4.1.3.1 Person-Centered – Care Coordination supports the Member's choices and goals through an approach that is individualized, Trauma-informed, and Culturally Competent;

4.4.1.3.2 Holistic – Care Coordination assesses and addresses the Member's Physical Health needs, Behavioral Health needs, and social needs that impact health outcomes;

4.4.1.3.3 Strengths-based – Care Coordination leverages the strengths of the CONTRACTOR (e.g., expertise, data, information systems) and community-based resources (e.g., providers with whom Members have established relationships, individuals who work in the communities in which Members reside, local organizations that support Members' social needs) in coordination with an individual Member's strengths, needs, and preferences; and

4.4.1.3.4 Well-coordinated – Care Coordination provides clear and timely communication between and among Providers, Members, Member-serving systems, and individuals involved in the care and treatment of the Member in order to identify the Member's needs, identify and secure access to

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necessary resources and services, and monitor and adjust resources and services as necessary to meet the Member's needs.

4.4.1.4 Care Coordination may be provided to a Member by or through the CONTRACTOR using one (1) of the Care Coordination models offered by the CONTRACTOR. The CONTRACTOR may offer one (1) or more of the following three (3) models: CONTRACTOR-Driven, Full Delegation, or Shared Functions Models of Care Coordination. In addition, the CONTRACTOR must offer the Full Delegation Model of Care Coordination for all prenatal and Postpartum Members. The Full Delegation Model of Care Coordination for Prenatal and Postpartum Members does not require a specific VBP level, the CONTRACTOR may offer the Full Delegation Model with Level 1, Level 2, or Level 3 VBP arrangements as defined in Attachment 2.A. The assignment to other than a model of Full Delegation for Prenatal and Postpartum Members may occur only with HCA prior written approval as detailed in the MCO Policy Manual. The CONTRACTOR shall promote, support, and expand the availability and use of the Full Delegation Model and the Shared Functions Model (when offered) of Care Coordination. The CONTRACTOR shall ensure its Members' Care Coordination needs are met regardless of the model of Care Coordination used to provide Care Coordination to a Member. For those that decline Care Coordination, if their circumstances change, the Contractor is required to offer Care Coordination again upon change in circumstance (e.g. entering into auto-assigned category such as pregnant member).

4.4.1.5 The CONTRACTOR shall expand the availability and use of CHWs to perform Care Coordination activities through its Full Delegation Model and Shared Functions Model (when offered) of Care Coordination.

4.4.1.6 In order to assist Care Coordination to meet the holistic needs of Members, including the social needs that impact Member health outcomes, the CONTRACTOR shall enter into written agreements with community based organizations that offer resources necessary to address HRSNs.

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

4.4.2 Care Coordination Program

4.4.2.1 The CONTRACTOR shall design and implement a Care Coordination program that meets the requirements in Section 4.4 of this Agreement.

4.4.2.2 The CONTRACTOR's Care Coordination program shall be consistent and comply with the requirements in the Managed Care Policy Manual and MCO Systems Manual.

4.4.2.3 The CONTRACTOR shall submit a written Care Coordination program description for HCA's prior written approval. After the initial submission, the CONTRACTOR shall annually submit a data driven, written evaluation of its Care Coordination program, addressing Member outcomes, identifying areas for improvement, actions taken in response, and any proposed changes to the Care Coordination program for HCA review and prior written approval.

4.4.2.4 The CONTRACTOR's Care Coordination program description must address each of the following program components, and meet the Care Coordination requirements set forth in this Section 4.4 of this Agreement:

4.4.2.4.1 Care Coordination staffing and training;

4.4.2.4.2 Assessments;

4.4.2.4.3 Care Coordination Level Assignment;

4.4.2.4.4 Comprehensive Care Plan;

4.4.2.4.5 Care Coordination activities;

4.4.2.4.6 Disease Management approach;

4.4.2.4.7 Care Coordination for special and high needs populations;

4.4.2.4.8 Delegated Care Coordination Models (Full Delegation Model or Shared Functions Model, when offered), including the CONTRACTOR's strategies to promote, support, and expand the availability and use of the Full

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Delegation Model and the Shared Functions Model (when offered) of Care Coordination;

4.4.2.4.9 Transitions of care;

4.4.2.4.10 Care Coordination systems and analytics; and

4.4.2.4.11 Care Coordination monitoring and reporting.

4.4.3 Care Coordination Staffing and Training

4.4.3.1 Care Coordination Staffing

4.4.3.1.1 The CONTRACTOR may use a Care Coordination team approach to performing Care Coordination activities described in Section 4.4 of this Agreement. For Members in Care Coordination Levels (CCLs) one (1) and two (2), the CONTRACTOR's Care Coordination team shall consist of the Member's care coordinator and other Care Coordination staff with relevant expertise and experience necessary to address the needs of the Members.

4.4.3.1.2 The CONTRACTOR shall use local resources, such as I/T/Us, primary care and specialty clinics, Patient Centered Medical Homes (PCMHs), Health Homes, Core Service Agencies (CSAs), School-Based Health Center (SBHCs), CHWs, Community Health Representatives (CHRs), High Fidelity Wrap-Around (HFW) Teams, Paramedicine programs, community-based agencies, PCS agencies, Centers for Independent Living, and Tribal services, reimbursing them in mutually agreeable arrangements, to assist in performing the Care Coordination functions specified throughout Section 4.4 of this Agreement. The CONTRACTOR shall perform monitoring and oversight of all Care Coordination functions delegated to local resources, per Section 7.14.2.1.3 of this Agreement.

4.4.3.1.3 The CONTRACTOR's Care Coordination program description shall specify:

4.4.3.1.3.1 The qualifications, experience, and training of each member of the Care Coordination team and how the CONTRACTOR ensures that Care Coordination key functions are performed by a qualified care coordinator and supervised by a qualified supervisor. At a minimum, unless otherwise approved by HCA, the CONTRACTOR shall ensure

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that the care coordinator completing the CNA has a bachelor's degree or two (2) years of relevant health care experience; and a care coordinator's direct supervisor has a bachelor's degree and a minimum of two (2) years of relevant health care experience, unless approved in writing by HCA;

4.4.3.1.3.2 The number of care coordinators, Care Coordination supervisors, and other Care Coordination team members dedicated to the CONTRACTOR's Care Coordination program;

4.4.3.1.3.3 The proposed ratio of care coordinators, subject to HCA-established maximum caseload ratios, to Members and the analysis that supports the proposed ratios are sufficient to meet the needs of the CONTRACTOR's Members. The CONTRACTOR's proposed ratios shall consider travel requirements for care coordinators serving Members in Rural, Frontier, and Tribal areas of the State and Members who require more extensive Care Coordination support;

4.4.3.1.3.4 The method by which the CONTRACTOR will maintain the ratios approved by HCA;

4.4.3.1.3.5 The method by which the CONTRACTOR will ensure that such ratios continue to be sufficient to fulfill the requirements specified in this Agreement;

4.4.3.1.3.6 The roles and responsibilities for each member of the Care Coordination team;

4.4.3.1.3.7 How the CONTRACTOR will use and expand the use of delegated and local resources to meet the Care Coordination needs of its Members; and

4.4.3.1.3.8 How the CONTRACTOR will provide oversight of all Care Coordination functions delegated to local resources.

4.4.3.2 Care Coordinator Training

4.4.3.2.1 The CONTRACTOR's Care Coordination program description shall specify the onboarding and ongoing training provided to Care Coordination staff by

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topic, frequency, and modality. Training must include, but is not limited to, the staff training described in Section 3.3.6 of this Agreement.

4.4.3.2.2 The CONTRACTOR shall employ or use contract training instructors from New Mexico Tribes. Training shall address all topic areas necessary for Care Coordination staff to perform their job responsibilities in Section 4.4 of this Agreement.

4.4.4 Assessments

4.4.4.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's process for conducting Health Risk Assessments (HRAs) and CNAs to inform the CONTRACTOR's assignment of a CCL. The process shall be consistent with the assessment requirements in this Section 4.4.4. The program description shall include the type and source of data and information that will be used to perform quarterly data mining reviews and the analytics used to identify the need to perform a reassessment or reevaluate the Member's need for a change in the level of Care Coordination.

4.4.4.2 The CONTRACTOR shall use HCA's standardized HRA, CNA (when indicated), CONTRACTOR'S utilization data, and/or Claims data to determine Member need for Care Coordination and assign a CCL to each Member. The CONTRACTOR shall assign CCLs as follows:

4.4.4.2.1 Care Coordination Level 0 (CCL0) for Members the CONTRACTOR was unable to reach after making reasonable outreach efforts as described in Section 4.4.4.4.3, for Members assessed to not have a current need for an assigned care coordinator; or for Members who have been contacted and refuse Care Coordination;

4.4.4.2.2 Care Coordination Level 1 (CCL1) for Members assessed to have moderate health risk factors and a current need for an assigned care coordinator; and

4.4.4.2.3 Care Coordination Level 2 (CCL2) for Members assessed to have high health risk factors and a current need for an assigned care coordinator.

4.4.4.3 Health Risk Assessment (HRA)

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4.4.4.4 The HRA is conducted for the purpose of: (i) introducing the CONTRACTOR to the Member; (ii) obtaining basic health and demographic information about the Member; and (iii) confirming the need for a CNA.

4.4.4.4.1 The CONTRACTOR shall perform a HRA for:

4.4.4.4.1.1 All Members who are newly enrolled in Turquoise Care, including those with retroactive eligibility;

4.4.4.4.1.2 Members who are in CCL0 and who have a change in circumstance or health condition that requires an assessment for a higher level of care; and

4.4.4.4.1.3 Members transitioning from another MCO without a CCL span, or with an expired CCL span, per HCA guidelines and processes.

4.4.4.4.2 The CONTRACTOR shall complete the HRA within thirty (30) Calendar Days of the notification to the CONTRACTOR of the Member's enrollment in the CONTRACTOR using HCA's standardized HRA. The CONTRACTOR shall not add questions to the HRA without the prior written approval from HCA.

4.4.4.4.3 The CONTRACTOR shall make and document at least three (3) reasonable outreach efforts (e.g., attempting to contact the Member on different days at different times of the day, using alternative contact numbers, using community agencies to engage Member) to contact a Member to perform the HRA. In addition, for difficult to engage Members and unable to reach transitioning from an inpatient level of care setting including general hospital, psychiatric hospital, skilled nursing, or residential treatment centers or who have had two (2) or more Behavioral Health readmissions within thirty (30) Calendar Days, the CONTRACTOR shall make and document a face-to-face outreach attempt by a care coordinator with behavioral health experience. If those efforts are unsuccessful, the CONTRACTOR shall send a letter to the Member's most recently reported address that provides information about Care Coordination, the importance of completing an HRA, and how to complete the HRA.

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4.4.4.4.4 Members have the right to refuse to participate in Care Coordination. In the event a Member refuses Care Coordination, the CONTRACTOR shall have the Member sign an HCA approved Care Coordination declination form. If a Member refuses to sign the Care Coordination declination form, the CONTRACTOR shall document such refusal in the Member's record.

4.4.4.4.5 For all Members, the CONTRACTOR shall perform quarterly data mining reviews (DMRs) to determine if there is a change in the Member's health status that warrants the need to reinitiate Member outreach efforts or to perform an updated HRA or CNA.

4.4.4.5 Comprehensive Needs Assessment

4.4.4.5.1 The CONTRACTOR shall perform a CNA for each Member who has been determined as needing a CNA. As part of the CNA for Members who need Community Benefits, the care coordinator must conduct a NF LOC determination, administer the Community Benefits Services Questionnaire (CBSQ) and complete the Community Benefits Member Agreement (CBMA), and inform the Member of available Community Benefits. If the Member is enrolled in a Health Home, the CONTRACTOR shall follow the requirements in Section 4.13.2 of this Agreement. The CONTRACTOR may perform the HRA and the CNA concurrently.

4.4.4.5.2 For all Members who are identified through the HRA as requiring a CNA, the CONTRACTOR shall complete the CNA within thirty (30) Calendar Days of the HRA unless the Member is in the Full Delegation Model, the JUST Health Transition of Care (TOC) population, the CARA population, and/or in the Treat First model of care.

4.4.4.5.3 The CONTRACTOR shall perform the CNA in-person at the Member's primary residence unless the Member is homeless or in a Transition Home; the Member is part of the justice-involved population preparing for release; or the Member is a newborn in an inpatient setting. The in-person visit may occur at another location only with HCA prior written approval. For Members who reside in a NF, rather than conduct a CNA, the

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CONTRACTOR shall ensure the Minimum Data Set (MDS) is completed and shall collect supplemental information related to Behavioral Health needs and the Member's interest in receiving HCBS.

4.4.4.5.4 The CONTRACTOR shall use HCA's standardized CNA to assess the Member's Physical Health, Behavioral Health, LTC, and social needs.

4.4.4.5.5 For Members meeting one (1) of the indicators below, the CONTRACTOR shall conduct a CNA, utilizing motivational interviewing techniques and HCA's standardized CNA, to determine whether the Member should be assigned to CCL1 or CCL2:

4.4.4.5.5.1 High cost Members in the top 10% of spending in the prior year;

4.4.4.5.5.2 Is in an out-of-State medical placement;

4.4.4.5.5.3 Is a dependent child in an out-of-home placement;

4.4.4.5.5.4 Is a Child In State Custody Member;

4.4.4.5.5.5 Is a transplant recipient;

4.4.4.5.5.6 Is Perinatal/Postpartum Members or Members engaged in Maternal Home Visiting (MHV);

4.4.4.5.5.7 Has a Behavioral Health diagnosis, (including non-SUD, SMI, SED) ;

4.4.4.5.5.8 Is a Medically Fragile Member;

4.4.4.5.5.9 Is residing in an ICF/IID;

4.4.4.5.5.10 Has frequent emergency room use with four or more annual individual patient visits;

4.4.4.5.5.11 Has an acute or terminal disease;

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

4.4.4.5.5.13 Is Medically Frail;

4.4.4.5.5.14 Has Dementia or mild or more significant cognitive deficits requiring prompting or cueing;

4.4.4.5.5.15 Has housing insecurity, not limited to homeless Members;

4.4.4.5.5.16 Has multi-comorbidity;

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4.4.4.5.5.17 Has a current NF LOC and/or requires assistance with two (2) or more ADLs or IADLs living in the community;

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

4.4.4.5.5.19 Waiver Members;

4.4.4.5.5.20 Comprehensive Addiction and Recovery Act (CARA) Members;

4.4.4.5.5.21 Justice Involved Members;

4.4.4.5.5.22 Members with a Traumatic Brain Injury (TBI);

4.4.4.5.5.23 Members with three (3) or more complaints, grievances, or appeals related to the Members experience with the service delivery system.

4.4.4.6 The CONTRACTOR shall conduct the CNA at least annually for CCL1 Members and at least semi-annually for CCL2 Members, or as the care coordinator deems necessary due to a request from the Member, Member's Representative, or Member's Provider, or as a result of change in health status that indicates the need for a CNA as identified in this Section 4.4.4.4.5.

4.4.4.7 Nursing Facility Level of Care

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

4.4.4.7.2 For Members in the ABP who meet NF LOC, the CONTRACTOR shall notify the Member that they may be ABP Exempt, explain the benefit differences for ABP Exempt individuals and facilitate their movement into the ABP exempt benefit package (the Covered Services included in Attachment 1: Turquoise Care Covered Services) at the Member's choice.

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4.4.4.7.3 For Members transitioning from a Medicare NF stay to a Medicaid short-term acute NF stay, the CONTRACTOR shall complete the short-term stay authorization determination no later than five (5) Business Days before the transition occurs, and follow the process prescribed by HCA so as to ensure no lapse in payment to the NF if the Member is determined to meet the criteria for Medicaid payment.

4.4.5 Care Coordination Assignment

4.4.5.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's process for the assignment of a Care Coordination Level, a change in Care Coordination Level, assignment of care coordinators, and care coordinator caseload ratios. The process shall be consistent with the Care Coordination assignment requirements in this Section 4.4.5 and dependent on the outcome of the CNA. HCA's expectation is for the MCO to conduct a Comprehensive Needs Assessment (CAN) specific to the individual Member, applying assessment tools and clinical expertise to determine the need for Care Coordination and the level most appropriate for the Member.

4.4.5.2 Care Coordination Level Zero (CCL0)

4.4.5.2.1 The CONTRACTOR shall assign Members to CCL 0, as follows:

4.4.5.2.1.1 Members the CONTRACTOR was unable to reach after making reasonable outreach efforts as described in Section 4.4.4.4.3,

4.4.5.2.1.2 Members assessed to not have a current need for an assigned care coordinator;

4.4.5.2.1.3 Members who have been contacted and refuse Care Coordination;

4.4.5.2.2 In addition to outreach and engagement efforts, CCL0 care coordinators are responsible for reviewing and monitoring data including, but not limited to, encounters, utilization patterns including hospital and ED visits for individuals that are high-risk (would benefit and fit within the parameters of CCL1 or CCL2), pharmacy trends, or difficult to engage or refused to engage. CCL0 care coordinators are to monitor for membership in CCL0 on the high-cost high-needs report. CCL0 care coordinators are to re-engage in

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outreach upon indication of connection with an inpatient, crisis utilization, or ED facility. This can include face-to-face approach while inpatient, prior to discharge. Upon a member change in clinical presentation, CCL0 care coordination would attempt to engage again if the member previously was difficult to engage or refused.

4.4.5.2.3 For Members with one (1) of the indicators listed below in 4.4.5.3.1.1 through 4.4.5.3.1.12 and 4.4.5.4.1.1 through 4.4.5.4.1.16 HCA expects the MCO to thoughtfully consider the specific needs of the Member when determining the Member's Care Coordination Level.

4.4.5.3 Care Coordination Level One (CCL1)

4.4.5.3.1 The CONTRACTOR shall assign Members to CCL1, at a minimum, as follows:

4.4.5.3.1.1 Members who meet NF LOC or are receiving Long Term Service and Supports (LTSS);

4.4.5.3.1.2 Perinatal and maternal health Members, including Members in the MHV program

4.4.5.3.1.3 Members with a Behavioral Health Diagnosis (non-SUD/SMI/SED);

4.4.5.3.1.4 Waiver Populations not listed under 4.4.5.4;

4.4.5.3.1.5 Members with multiple (three or more) complaints, grievances, or appeals related to the Member's experience with the service delivery system;

4.4.5.3.1.6 Members with Housing Insecurity;

4.4.5.3.1.7 Has Dementia or mild or more significant cognitive deficits requiring prompting or cueing;

4.4.5.3.1.8 Has been readmitted to the hospital within thirty (30) Calendar Days of discharge;

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

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4.4.5.3.1.10 Has frequent emergency room use with four or more annual individual patient visits;

4.4.5.3.1.11 Member with an acute disease as defined by the MCO, and

4.4.5.3.1.12 Justice involved Members.

4.4.5.4 Care Coordination Level Two (CCL2)

4.4.5.4.1 The CONTRACTOR shall assign Members to CCL2 as follows:

4.4.5.4.1.1 HCHN Members;

4.4.5.4.1.2 Members with SUD;

4.4.5.4.1.3 Members with SED;

4.4.5.4.1.4 Members with SMI;

4.4.5.4.1.5 Justice-Involved Individuals who have been incarcerated in the last year;

4.4.5.4.1.6 Members with TBI;

4.4.5.4.1.7 Members who are homeless;

4.4.5.4.1.8 CISC Members;

4.4.5.4.1.9 CARA Members;

4.4.5.4.1.10 Members in a out-of-state medical placement.

4.4.5.4.1.11 Medically Fragile Member;

4.4.5.4.1.12 Transplant Recipient;

4.4.5.4.1.13 Member with multi-comorbidities;

4.4.5.4.1.14 Member with a terminal disease;

4.4.5.4.1.15 Medically Frail, and

4.4.5.4.1.16 Members residing in an ICF/IDD

4.4.5.4.1.17 Dependent child in out-of-state placement

4.4.5.5 Changes in CCL

4.4.5.5.1 The CONTRACTOR shall perform ongoing monitoring to identify reassessment triggers for Members who may need a change in CCL. The CONTRACTOR shall assess a Member's need for a change in CCL upon

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self-identification, internal and external referrals, and through data mining review (DMRs). For most Member populations, a Member may be leveled down from Care Coordination levels identified in 4.4.5.3.1 through 4.4.5.1.1.16 depending on the need for Care Coordination as determined by the CNA. However, there will be certain categories that shall not be leveled down and must remain in the auto-assignment Care Coordination level, regardless of the complexity of the Member per the CNA. See chart included in the MAD 867 Comprehensive Needs Assessment (CNA).

4.4.5.6 Assignment of Care Coordinator

4.4.5.6.1 The CONTRACTOR shall assign a specific care coordinator to each Member assigned to CCL1 or CCL2.

4.4.5.6.2 The CONTRACTOR shall notify the Member of the assigned care coordinator and how to contact the care coordinator as set forth in the Managed Care Policy Manual.

4.4.5.6.3 When assigning care coordinators to Members, the CONTRACTOR shall consider the alignment of the care coordinator's qualifications, expertise, geographic proximity, language, and cultural background with the needs or preferences of the Member. The CONTRACTOR's considerations shall include, but are not limited to, the following:

4.4.5.6.3.1 The assigned care coordinator for Members who choose the SDBC shall have specific experience with self-direction and additional training regarding self-direction.

4.4.5.6.3.2 The CONTRACTOR must make reasonable accommodations for non-English speaking Members who request assignment to a care coordinator who speaks the Member's preferred language.

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

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reasonable efforts to offer a Native American care coordinator from the same Tribe, Nation, or Pueblo as the Member.

4.4.5.6.4 The CONTRACTOR shall allow the Member to change their assigned Care Coordinator. However, in order to ensure continuity of care, the CONTRACTOR shall minimize the number of changes in a Member's care coordinator initiated by the CONTRACTOR.

4.4.5.7 Caseload Ratios

The CONTRACTOR shall establish and maintain maximum caseloads ratios per care coordinator for Members in CCL1, and CCL2.

4.4.5.7.1 The CONTRACTOR's maximum caseload ratios shall not exceed the following:

4.4.5.7.1.1 CCL1 - 1:75

4.4.5.7.1.2 CCL2 - 1:50

4.4.5.7.2 As the CONTRACTOR delegates more Care Coordination functions to local resources, the CONTRACTOR may request, in writing, an adjustment to Care Coordination caseload requirements from HCA. All caseload ratio adjustments must be prior approved by HCA in writing.

4.4.6 Comprehensive Care Plan

4.4.6.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's process for developing, sharing, and updating the Comprehensive Care Plan (CCP). The process shall be consistent with the CCP requirements in this Section 4.4.6.

4.4.6.2 The CONTRACTOR shall develop and implement CCPs, using HCA's standardized CCP, for Members in CCL1 and CCL2 within fourteen (14) Business Days of completion of the initial CNA, unless the Member is in the Treat First model of care. For Members in the Treat First model of care, the CCP shall be completed within fourteen (14) Business Days of the completion of four (4) therapeutic encounters, but no later than thirty (30) Business Days of the CNA completion. The CCP shall be individualized based upon the Member's

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assessed needs, preferences, and circumstances and updated at each touch point, as necessary, to reflect changes in the Member's needs, preferences, and circumstances. The CCP developed through Full Delegation or Shared Functions Models of Care Coordination is not required to adhere to timelines described in this Section 4.4.6.2; however, the CONTRACTOR must ensure the CCP is completed in within the timelines and in compliance with its agreement with the delegated individual or entity.

4.4.6.3 The CONTRACTOR shall ensure at a minimum that the Member and the Member's Representative participate in developing the CCP, and that care coordinators consult with interdisciplinary team experts, the Member's PCP, specialists, Behavioral Health Providers, other Providers, CSAs, CCBHCs, CYFD, ECECD, DOH, Corrections, School Systems, FQHCs, Housing Entities, BHSD, and other Member-serving entities as needed.

4.4.6.4 For CISC Members, the CONTRACTOR shall consult with the CISC's PPW as well as the CISC Member and the CISC Member's Representative when developing the CCP. The CONTRACTOR shall receive a copy of the CANS and CAT from CYFD and utilize those screening tools in developing the CCP to inform service needs to avoid Members having to repeat sharing sensitive information. The CONTRACTOR shall ensure the CCP is developed to align with the CAT and CANS.

4.4.6.5 The care coordinator shall ensure that the Member's needs (including needs related to HRSN) and services are documented in the Member's CCP. As applicable, the care coordinator shall also include the Member's choice to receive institutional care or HCBS, and the Member's choice of HCBS and Providers.

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

4.4.6.7 The care coordinator shall provide a copy of the Member's completed CCP, including any updates, to the Member and the Member's Representative, as applicable. The Care Coordination team shall provide copies to other Providers authorized to deliver care to the Member, as allowable, or inform Providers in

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writing of services to be performed by the Provider, including all relevant information needed to ensure the provision of quality care for the Member.

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

4.4.7 Care Coordination Activities

4.4.7.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR’s performance of Care Coordination activities. The process shall be consistent with the requirements for Care Coordination activities in this Section 4.4.7.

4.4.7.2 Care coordinators for Members in CCL1 or CCL2 shall provide and/or arrange for the following Care Coordination services:

4.4.7.2.1 Outreaching to Members to engage in Care Coordination;

4.4.7.2.2 Offering and linking Members who would benefit from a Health Home;

4.4.7.2.3 Leading the development, implementation, and ongoing updates to the CCP;

4.4.7.2.4 Offering and linking Members to targeted health education, disease management (DM), and wellness/prevention coaching, as appropriate, offered through the CONTRACTOR or in the community;

4.4.7.2.5 Coordinating Member access to Covered Services as needed (e.g., scheduling appointments, arranging transportation, making referrals);

4.4.7.2.6 Educating the Member about available community resources and services and assisting the Member in accessing those resources and services;

4.4.7.2.7 Facilitating access to supports that assess housing needs and identify appropriate resources to help Members attain and maintain community housing;

4.4.7.2.8 Informing each Member of the Member’s Medicaid eligibility end date, the importance of maintaining eligibility, and that Members will be contacted near the date on which a redetermination is needed to assist them with the process (e.g., collecting appropriate documentation and completing the necessary forms);

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4.4.7.2.9 Performing in-person, in-home CNAs as needed, but at least annually for CCL1 Members and semi-annually for CCL2 Members, to determine if the CCP is appropriate and if a higher or lower level of Care Coordination is needed;

4.4.7.2.10 Performing in-person, in-home, face-to-face Care Coordination visits as part of the review process for any home modifications and/or services delivered in the home including personal care services;

4.4.7.2.11 Performing in-person and in-home visits with the Member as required in the Managed Care Policy Manual;

4.4.7.2.12 Communicating and exchanging information with Providers (e.g., PCP, specialists, labs, imaging facilities, HCBS Providers) to coordinate the care of the Member;

4.4.7.2.13 Participating in discharge planning activities with the discharging inpatient facility (including SUD and psychiatric facilities) to support a safe discharge placement and to prevent unplanned or unnecessary readmissions, ED visits, and adverse outcomes;

4.4.7.2.14 Ensuring Member access to post discharge services as specified in the discharge plan;

4.4.7.2.15 Facilitating clinical hand offs between the discharging facility and other Contract Providers involved in the care and treatment of the Member;

4.4.7.2.16 Monitoring the CCP to determine if the services are delivered as recommended and if the CCP is meeting the Member's identified needs; and

4.4.7.2.17 Monitoring data and information to identify, address, and evaluate service gaps to determine their cause and to minimize gaps going forward to ensure that back-up plans are implemented and effectively working.

4.4.7.3 For Members meeting a NF LOC, Care Coordination activities shall also include:

4.4.7.3.1 Conducting a level of care reassessment at least annually and within five (5) Business Days of becoming aware of a change in the Member's functional or medical status that may affect a level of care determination. No level of care

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reassessment is necessary for Members who meet ongoing NF LOC criteria as stated in Section 4.1.3 of this Agreement; and

4.4.7.3.2 As appropriate, ensure that all Pre-Admission Screening and Resident Review (PASRR) requirements are met prior to the Member's admission to a NF as required in 42 C.F.R. § 483.100-138.

4.4.8 Disease Management

4.4.8.1 The CONTRACTOR shall provide DM strategies to Members with identified chronic conditions as part of its Care Coordination processes and activities. The CONTRACTOR's DM strategies must include at a minimum population identification/stratification, collaborative practice models, self-management education, evidence-based practice guidelines, process and outcomes measurements and internal quality improvement processes.

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

4.4.8.2.1 Participate in DM projects annually; and

4.4.8.2.2 Provide comprehensive DM for a minimum of two (2) chronic disease states, one (1) applicable/relevant to the Adult population and one (1) to the pediatric population, using strategies consistent with nationally recognized DM guidelines, such as those available through the Agency for Healthcare Research and Quality (AHRQ), the National Quality Measures Clearinghouse (NQMC), or the Care Continuum Alliance).

4.4.8.3 The CONTRACTOR's Care Coordination program description must describe the CONTRACTOR's DM strategies, including, at a minimum, the CONTRACTOR's approach to population identification/stratification, collaborative practice models, Member self-management education, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

4.4.8.4 The CONTRACTOR shall include the following in its annual written evaluation of its Care Coordination program described in Section 4.4.2.3:

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4.4.8.4.1 A quantitative and qualitative evaluation of the efficacy of the prior year's DM strategies that documents how well goals were achieved, such as identification, enrollment, targeted interventions, and outcomes; and

4.4.8.4.2 Cumulative data-driven measurements with written analysis describing the effectiveness of its DM interventions, as well as any modifications implemented by the CONTRACTOR to improve its DM performance. All DM data submitted to HCA shall be New Mexico Medicaid-specific.

4.4.9 Care Coordination for Special and High Needs Populations

4.4.9.1 The CONTRACTOR's Care Coordination program description shall reflect Care Coordination requirements specific to special and high needs populations described in this Section 4.4.9.

4.4.9.2 For JUST Health TOC Members, the CONTRACTOR shall complete the Justice Involved TOC Assessment/Plan/HRA template that is in Section 5.12 of the Managed Care Policy Manual.

4.4.9.3 For Members receiving services from CSAs, CCBHCs, CYFD, ECECD, DOH, Corrections, School Systems, FQHCs, Housing Entities, BHSD, and/or other Member-serving entities, the CONTRACTOR shall ensure that the Member-serving agency or entity is included in Care Coordination processes described in Section 4.4 of this Agreement.

4.4.9.4 For Members receiving HCBS in a provider owned or controlled setting, the care coordinator shall assess Member experience and provider compliance with federal home- and community-based (HCB) settings requirements during face-to-face visits with Members, using the process and tools approved by HCA. The care coordinator's assessment is intended to determine ongoing provider compliance with federal HCB settings requirements.

4.4.9.5 The CONTRACTOR shall employ or contract with dedicated care coordinators and supervisors with relevant expertise to meet the needs for each population listed below. The dedicated number of care coordinators for each population must be commensurate with the proportion of the CONTRACTOR's enrollment size for each of these populations.

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4.4.9.5.1 Justice-Involved Individuals;

4.4.9.5.2 Traumatic Brain Injury Members;

4.4.9.5.3 Medically Fragile Members;

4.4.9.5.4 Individuals with Intellectual Disabilities;

4.4.9.5.5 Children and Adults with Special Health Care Needs;

4.4.9.5.6 Members with Housing Insecurity needs;

4.4.9.5.7 Members with complex Behavioral Health needs, including SUD;

4.4.9.5.8 CISC; and

4.4.9.5.9 CARA Members.

4.4.9.6 Comprehensive Addiction Recovery Act (CARA) program

4.4.9.6.1 The Comprehensive Addiction Recovery Act (CARA) is a 2016 federal law- that amended the Child Abuse and Treatment Act (CAPTA), was adopted in New Mexico in 2019 under legislation (HB230), and is administered by CYFD, HCA, and ECECD. CARA is a program that offers supports and services to the families of babies who are born with exposure to substances that can affect their health and development. These substances include, but are not limited to alcohol, nicotine, marijuana, and drugs or medications, including controlled or prescribed substances such as opioids.

4.4.9.6.2 CARA requires that all infants born exposed to substances have a comprehensive plan of care created by the hospital discharge team and that utilization of supportive services by the mothers and infant are tracked by the CONTRACTOR. The success of the CARA program relies heavily on intensive care coordination. CARA Members are part of the maternal and child health targeted population, and as such, the CONTRACTOR shall ensure that all care coordination activities for CARA Members are provided through its CONTRACTOR Driven Model.

4.4.9.6.3 The CONTRACTOR shall develop a written plan for monitoring and overseeing delegated care coordination and the services provided to CARA Members subject to HCA approval to ensure compliance with the following program requirements:

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4.4.9.6.3.1 Use of the "treat first" model of care. The CONTRACTOR shall ensure that no medically necessary services are withheld or delayed awaiting completion of the CNA.

4.4.9.6.3.2 Contact is made with the CARA mother and the guardian of the infant (if they are different people) and the HRA is completed within twenty-four (24) hours of discharge from the hospital. The CONTRACTOR shall ensure that, whenever possible, completion of the HRA and the first contact with the family shall be made in the hospital.

4.4.9.6.3.3 CNAs are performed in person and completed within seven days of first contact.

4.4.9.6.3.4 Three attempts to contact mother are made within the first 48 hours of discharge. The CONTRACTOR shall ensure that if the care coordinator is unable to reach the mother and the baby is in the mother's custody, the care coordinator contacts the CARA navigation team to relay contact limitations and seek other options for member contact.

4.4.9.6.3.5 Care coordinators serving CARA Members regularly meet with CARA Member-assigned pediatricians, hospitals, and home visiting agencies in their community to discuss communication challenges and processes.

4.4.9.6.3.6 Care coordinators serving CARA Members complete a transition plan to the CARA navigation team within 60 days prior to the Member's graduation from the CARA program (at the one year mark) to ensure continuity of care for the Member.

4.4.9.6.3.7 The CARA Member and mother shall be assigned the same care coordinator.

4.4.9.6.4 The CONTRACTOR shall submit the plan of care created by the hospital, the HRA, and the CNA to the infant's PCP (pediatrician, midwife, family medicine MD, etc.) within 14 days of discharge from the hospital.

4.4.9.6.5 At a minimum the CONTRACTOR shall report the following to HCA:

4.4.9.6.5.1 The CONTRACTOR's Member count of CARA Members.

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4.4.9.6.5.2 The number of plans of care sent by the CONTRACTOR to infant's PCPs relative to total count of CARA Members.

4.4.9.6.5.3 The number of mothers of CARA Members who have utilized behavioral health and substance use treatment services.

4.4.9.6.5.4 The number of other Community Based Organization (CBO) services accessed by the mother or guardian of the infant.

4.4.9.6.5.5 The number of women who have maintained custody of their CARA Member children for the duration of the first year.

4.4.9.6.6 The CONTRACTOR shall comply with HCA changes to CARA reporting requirements.

4.4.9.6.7 Effective July 1, 2026, CARA navigation and plan-of-safe care coordination will be performed by HCA or its contractor. The CONTRACTOR shall:

4.4.9.6.7.1 Identify and refer CARA Members to HCA's CARA navigation program

4.4.9.6.7.2 Exchange required data elements

4.4.9.6.7.3 Coordinate non-CARA services consistent with this Agreements; and

4.4.9.6.7.4 Cooperate in transitions and member communications as directed by HCA.

4.4.9.7 Coordination and Collaboration with CYFD

4.4.9.7.1 The CONTRACTOR shall work with CYFD and other State agencies to promote the early identification of children and transition-age youth (ages sixteen [16] to twenty-one [21]) who are engaged in unlawful behaviors, are high-risk, have experienced traumatic events, and/or may be exhibiting signs of SED or SMI.

4.4.9.7.2 The CONTRACTOR shall coordinate services and supports that reflect the least restrictive level of care with the CYFD PS, Behavioral Health Services (BHS), and Juvenile Justice Services (JJS) divisions, including discharge planning.

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4.4.9.7.3 Upon request, the CONTRACTOR shall provide and/or participate in trainings regarding service availability to Contract Providers, family members, Kinship Supports, and youth, including but not limited to:

4.4.9.7.3.1 Medicaid and Non-Medicaid services and supports available, as appropriate, such as Substance Use Programs, HFW, Youth Support Services, Infant Mental Health Child-Parent Psychotherapy, and Prevention Services targeted to parents and children involved with CYFD;

4.4.9.7.3.2 The referral process; and

4.4.9.7.3.3 Eligibility criteria to promote coordination and access to services. Training and information shall incorporate and be reflective of a Trauma-informed, youth- and family-driven, and culturally and linguistically responsive approach to care.

4.4.9.7.4 The CONTRACTOR shall ensure the Member's care coordinator is actively involved with the CYFD PPW for PS involved children and youth, juvenile probation officer or juvenile facility staff for JJS involved youth, and BHS community behavioral health clinician for CYFD involved children/youth, provided that CYFD informs the CONTRACTOR of the assigned CYFD lead worker.

4.4.9.7.5 The CONTRACTOR shall ensure that children in the custody or supervision of CYFD receive a Behavioral Health screening within forty-eight (48) hours of a referral to a Behavioral Health Contract Provider and receive a Behavioral Health assessment, access to Medically Necessary Covered Services, and Care Coordination as appropriate.

4.4.9.7.6 The CONTRACTOR shall participate in all PS, BHS, and JJS clinical staffing reviews related to the CYFD care planning process.

4.4.9.7.7 Upon request, the CONTRACTOR shall participate in the PS Family Centered Meetings, JJS Multi-Disciplinary Team meetings, and/ or Behavioral Health team meetings, which shall include family members or Kinship Supports, as appropriate. For Members receiving services through

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Comprehensive Community Support Services (CCSS) and HFW service models, the CONTRACTOR shall ensure the participation of the Member's MCO care coordinator and include other stakeholders in the development of the service plan as described in NMAC.

4.4.9.7.7.1 The CONTRACTOR shall engage in the BHSD-facilitated billing and credentialing meetings and find ways to reduce or remove provider administrative barriers for accessing Behavioral Health services and implementing HFW.

4.4.9.7.8 The CONTRACTOR shall collaborate with CYFD for CYFD involved children and youth experiencing a transition. Transitions include:

4.4.9.7.8.1 Moving from a higher level of care to a lower level of care;

4.4.9.7.8.2 Moving from a residential placement or institutional facility (including psychiatric hospitals) to a community placement;

4.4.9.7.8.3 Moving from an out-of-state placement to an in-state placement;

4.4.9.7.8.4 Being released from incarceration or detention facilities;

4.4.9.7.8.5 Entering or returning home from a foster care placement; and

4.4.9.7.8.6 Turning twenty-one (21) years of age.

4.4.9.7.9 The CONTACTOR shall ensure an appropriate level of Care Coordination to meet the needs and ensure that the child or youth is placed in the least restrictive placement.

4.4.9.7.10 The CONTRACTOR shall ensure that Providers initiate discharge planning with CYFD staff in accordance with NMAC 7.20.11.23.

4.4.9.7.11 The CONTRACTOR shall participate with the State on a workgroup to develop and implement the Family First Prevention and Services Act.

4.4.9.7.12 The CONTRACTOR shall notify the assigned CYFD lead worker of the decision within twenty-four (24) hours of an authorization or denial of the continuance of stay for CYFD involved children/youth. Precipitous discharge from these placements is prohibited. The assigned care coordinator shall work collaboratively with CYFD and other applicable stakeholders to ensure that the discharge plan is in place prior to discharge.

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4.4.9.7.13 The CONTRACTOR shall ensure Care Coordination of high-risk transition-age youth ages sixteen (16) to twenty-one (21) with all relevant Providers and State departments currently involved in the Member's care and with the family, relevant individuals identified by the youth, and the Member's legal guardian or designated representative.

4.4.9.7.14 The CONTRACTOR shall promote coordination between juvenile justice facilities and the CONTRACTOR's Contract Providers to establish continuity of care.

4.4.9.7.15 Upon request, the CONTRACTOR shall provide training to juvenile justice facility staff and Contract Providers regarding service availability, the referral process, and eligibility criteria to promote coordination and access to services upon release.

4.4.9.7.16 The CONTRACTOR shall ensure assessment and provide appropriate Covered Services for all CYFD-referred juveniles.

4.4.9.7.17 The CONTRACTOR shall work with CYFD to provide Care Coordination for committed juveniles identified as having high needs as they transition from juvenile justice facilities back into the community.

4.4.9.7.18 For requests for authorization of residential treatment services for children and youth in custody or supervision of CYFD, the CONTRACTOR shall make a decision upon receipt of all necessary and relevant documentation supporting the request, and in accordance with the Prior Authorization Act of 2019 and notify the CYFD lead worker and the provider within twenty-four (24) hours of the decision.

4.4.9.8 Care Coordination for CISC

4.4.9.8.1 The CONTRACTOR shall establish dedicated full-time specific Care Coordinators with knowledge and experience providing Care Coordination for individuals with complex needs including CISC Members and those children at risk of entering state custody (e.g., individuals with Behavioral Health conditions, multi-system involvement, Trauma).

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4.4.9.8.2 The CONTRACTOR shall review the enrollment data file uploaded by HCA daily to identify Members having CYFD COEs.

4.4.9.8.2.1 The CONTRACTOR shall assign all CISC to CCL2.

4.4.9.8.2.2 The CONTRACTOR shall perform in-person visits with the Member monthly; this includes out-of-state placements in facilities.

4.4.9.8.3 The CONTRACTOR shall contact the Member's assigned CYFD PPW within three (3) Business Days of notification of the Member's involvement in CYFD and assign a care coordinator to engage with the Member and/or Member's team. The CONTRACTOR shall request contact information for the child's Caregiver, legal Representative, and legal Custodian during this contact. Children fourteen (14) years or older can both participate in their CCP and identify their authorized representative. The PPW will share the list of appropriate contacts identifying the authorized representatives with the CONTRACTOR, such as the youth's guardian, Guardian Ad Litem (GAL), legal representative, Caregiver, and/or Resource Family/Parent. Notification can occur either through the enrollment data file or through referrals from the Member, the Member's family, Member's Provider, Juvenile Justice Services (JJS), HCA, or other referral source.

4.4.9.8.4 The CONTRACTOR shall request copies of all relevant screenings completed by CYFD and/or assessments by the Member's Provider, if available, to begin the HRA and CNA assessment process as outlined in Section 4.4.4 of this Agreement.

4.4.9.8.5 The CONTRACTOR shall engage with the Member and shall complete an HRA, and a CNA concurrently using previous CYFD screenings and/or Provider assessments, if available.

4.4.9.8.6 The CONTRACTOR shall provide completed HRAs and CNAs to the Member's CYFD PPW.

4.4.9.8.7 In the event a CISC Member's guardian/representative refuses Care Coordination, the CONTRACTOR shall have the CISC Member's guardian/representative sign an HCA-approved Care Coordination

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declination form. If the CISC Member's guardian/representative refuses to sign the Care Coordination declination form, the CONTRACTOR shall document such refusal in the Member's file. CISC Members who are fourteen (14) years or older can sign the Care Coordination declination form. The CONTRACTOR shall contact the CISC Member's CYFD PPW within three (3) Business Days of the Member's refusal of Care Coordination to inform them of the refusal. The CONTRACTOR will include documentation in the Member file of the CYFD contact.

4.4.9.8.8 The CONTRACTOR shall participate in psychotropic medication review staffings every sixty (60) Calendar Days as requested and scheduled by the Member's CYFD PPW.

4.4.9.9 Care Coordination for Children in Tribal Custody or Under Tribal Supervision

4.4.9.9.1 The CONTRACTOR shall ensure that children in Tribal custody or under Tribal supervision pursuant to a Tribal court order (as such term is defined in NMSA 1978 § 32A-1-4) receive a Behavioral Health screening within twenty-four (24) hours of a referral to a Behavioral Health Contract Provider and receive a Behavioral Health assessment, Medically Necessary Covered Services and Care Coordination as appropriate.

4.4.9.9.2 If requested by an Indian Tribe, Nation, or Pueblo located partially or wholly in New Mexico, the CONTRACTOR shall negotiate in good faith to enter into agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to children in Tribal custody or under Tribal supervision who are in need of such services. Should a Tribe, Nation, or Pueblo choose not to enter into such agreements, the CONTRACTOR shall not be liable for providing Covered Services to those children.

4.4.10 Delegated Care Coordination

4.4.10.1 Two (2) key goals of Turquoise Care are to transition more Care Coordination functions to local resources and to advance VBP arrangements. To align these

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goals, HCA has established expectations for two (2) delegated Care Coordination models, the Full Delegation Model and the Shared Functions Model.

4.4.10.2 The CONTRACTOR shall oversee and monitor the delegated Care Coordination models it offers and is prohibited from delegating the oversight and monitoring of Care Coordination in Turquoise Care to another health plan or administrative entity.

4.4.10.3 The CONTRACTOR'S Care Coordination Program description shall describe the CONTRACTOR's strategies to promote, support, and expand the availability and use of the Full Delegation Model and Shared Functions Model (if offered) of Care Coordination.

4.4.10.4 As part of readiness review period in Section 3.1.2 of this Agreement, the CONTRACTOR must provide representative templates of written delegation agreements for the Full Delegation Model and the Shared Functions Model (if offered) for HCA review and approval. HCA reserves the right to request, review, and approve delegation agreements throughout the term of this Agreement.

4.4.10.5 The CONTRACTOR may delegate Care Coordination functions to entities or individuals such as those listed below. When the Primary Care Council's primary care payment reform model goes live, the CONTRACTOR must delegated care coordination to any primary care clinic that is in a fully capitated arrangement. The CONTRACTOR shall provide technical assistance and support to these and other entities and individuals interested in performing delegated Care Coordination functions:

4.4.10.5.1 PCPs, clinics and PCMHs;

4.4.10.5.2 FQHCs;

4.4.10.5.3 CHWs;

4.4.10.5.4 CHRs;

4.4.10.5.5 SBHCs;

4.4.10.5.6 Correctional facilities;

4.4.10.5.7 CSAs and CCBHCs;

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4.4.10.5.8 Paramedicine programs;

4.4.10.5.9 County entities;

4.4.10.5.10 Centers for Independent Living; and

4.4.10.5.11 Tribal entities.

4.4.10.6 Full Delegation Model

In the Full Delegation Model, the CONTRACTOR is permitted to delegate the full set of Care Coordination functions to a Contract Provider (the delegate) for an attributable membership, and retains oversight and monitoring functions.

4.4.10.6.1 The CONTRACTOR is only permitted to fully delegate Care Coordination when Care Coordination is included as part of a VBP arrangement(s) that outlines a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes. The CONTRACTOR shall clearly define the terms of the VBP payment and Care Coordination delegation in order to fully delegate Care Coordination to the delegate for the Attributed Membership.

4.4.10.6.2 The CONTRACTOR shall ensure the additional Care Coordination delegation requirements in VBP arrangements are met as described in the VBP delivery system improvement target in Attachment 2.A.

4.4.10.6.3 The CONTRACTOR's Care Coordination program description shall describe the CONTRACTOR's roles and responsibilities in Attributed Membership and providing oversight and monitoring for its Full Delegation model. In establishing its Full Delegation model, the CONTRACTOR shall comply with the requirements in the Managed Care Policy Manual.

4.4.10.7 Shared Functions Model

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

4.4.10.7.1 Potential shared Care Coordination functions may include the following:

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4.4.10.7.1.1 Conducting HRAs;

4.4.10.7.1.2 Conducting CNAs;

4.4.10.7.1.3 Conducting periodic touch points with Members as needed either in-person or telephonically;

4.4.10.7.1.4 Coordinating referrals and linking Members to community services;

4.4.10.7.1.5 Locating and engaging with Members categorized as CCL0; and

4.4.10.7.1.6 Other functions as prior approved by HCA.

4.4.10.7.2 The CONTRACTOR shall develop written agreements with individuals and entities that specify shared Care Coordination functions, reporting responsibilities, and a mutually-agreed upon reimbursement rate for shared functions of Care Coordination.

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

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

4.4.10.7.5 The CONTRACTOR's Care Coordination program description shall describe the CONTRACTOR's roles and responsibilities providing oversight and monitoring for its Shared Functions Model. When offered, the CONTRACTOR shall ensure individuals and entities providing shared Care Coordination have a clear understanding of the delineated roles and responsibilities in its Shared Functions Model of Care Coordination to avoid duplication and gaps in Care Coordination. The CONTRACTOR shall share

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its Care Coordination policies and procedures with individuals and entities providing shared Care Coordination.

4.4.10.7.6 The CONTRACTOR shall be responsible for including Member outcomes from the Shared Functions Model in applicable HCA required reports, including but not limited to reporting performance and tracking measures as outlined in Section 4.12 of this Agreement. The CONTRACTOR shall validate the reports from individuals and entities performing delegated Care Coordination functions and include the information in report submissions to HCA.

4.4.10.7.7 The CONTRACTOR shall provide HCA with the details of the reimbursement agreement for each Shared Functions Model, including provider identification number, effective dates, and payment methodology and amount for the shared functions of Care Coordination.

4.4.10.7.8 The CONTRACTOR shall submit all payments to individuals and entities performing shared functions of Care Coordination as Encounters (per Section 4.10 of this Agreement) for each Member served by the individual or entity.

4.4.11 Transitions of Care

4.4.11.1 The CONTRACTOR shall identify and facilitate coordination of care for all Members during various transitions consistent with the requirements in the Managed Care Policy Manual. Examples of Member transitions of care include but are not limited to the following transitions:

4.4.11.1.1 Justice-Involved Individuals from prisons, jails, and detention facilities into the community, including tribal communities and reservations for Native American Members;

4.4.11.1.2 Between health care settings and levels of care;

4.4.11.1.3 Between MCOs;

4.4.11.1.4 Between FFS and the CONTRACTOR;

4.4.11.1.5 Between the CONTRACTOR and the Health Insurance Exchange;

4.4.11.1.6 Child Members transitioning in and out of state custody;

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4.4.11.1.7 Age-related transitions; and

4.4.11.1.8 Members transitioning to the CONTRACTOR who are pregnant.

4.4.11.2 The CONTRACTOR's Care Coordination program description shall describe each type of transition and the CONTRACTOR's protocols that ensure continuity of care and timely access to Covered services for its Members during the transition. The CONTRACTOR's program description shall include the circumstances and time period in which the CONTRACTOR will allow Members to continue receiving services from Non-Contract Providers and honor existing service authorizations, unless otherwise set forth in this Section 4.4.11.

4.4.11.3 For planned transitions, the CONTRACTOR shall conduct a transition of care assessment using the HCA-approved, standardized transition of care assessment tool and develop a transition plan, facilitated by the care coordinator with the Member and/or Member's Representative, which shall remain in place until the transition has occurred and a new CCP is in place.

4.4.11.4 For all transitions of care of CYFD-involved children and youth, the CONTRACTOR shall involve the assigned CYFD PPW for CPS involved children and youth in the development of the transition of care plan, and notify the assigned CYFD PPW for CPS within three (3) Business Days prior to transition in care. The CONTRACTOR shall ensure the continuity of care for CISC Members by allowing CISC Members to continue receiving services from Non-Contract Providers, honor existing service authorizations, and reimbursing Non-Contract Providers at the greater of CONTRACTOR's Contract provider rate or Medicaid FFS rate.

4.4.12 Care Coordination Systems and Analytics

4.4.12.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's Care Coordination systems and analytics that will be used to support its Care Coordination program. The program description shall be consistent with the requirements for Care Coordination systems and analytics in this Section 4.4.12.

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4.4.12.2 The CONTRACTOR shall develop and maintain an electronic case management system that includes the analytics and functionality necessary to ensure compliance with all Care Coordination requirements specified in the 1115(a) Waiver, State and federal statutes and regulations, this Agreement, and the CONTRACTOR's Care Coordination program description and associated policies and protocols.

4.4.12.3 The CONTRACTOR's Care Coordination system shall maintain individual case files for each Member that contains the information necessary to meet the requirements in Section 4.4 of this Agreement.

4.4.12.4 The CONTRACTOR shall configure its Care Coordination system to allow HCA-identified staff to have remote access to case files.

4.4.12.5 The CONTRACTOR shall have systems in place to facilitate timely communication and information exchange between internal departments (e.g., member services, Population Health, utilization management, and claims processing) and care coordinators, including care coordinators affiliated with delegated Care Coordination models, to ensure all relevant information regarding the Member is available to care coordinators.

4.4.13 Care Coordination Monitoring and Reporting

4.4.13.1 The CONTRACTOR's Care Coordination program description shall specify the CONTRACTOR's monitoring activities and reporting processes, including outcome indicators and measurements. The program description shall be consistent with the requirements for Care Coordination monitoring and reporting in this Section 4.4.13.

4.4.13.2 The CONTRACTOR shall perform ongoing monitoring to ensure that the Care Coordination needs of its Members are met, regardless of the model of Care Coordination. The CONTRACTOR's monitoring shall identify Member-specific and systemic opportunities for improvement.

4.4.13.3 The CONTRACTOR shall monitor process requirements as well as outcome indicators, including but not limited to the following:

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4.4.13.3.1 Review and analyze data indicators (e.g., emergency room utilization, crisis services utilization, prescription drug utilization, inpatient admissions and readmissions, Critical Incidents, and gaps in care);

4.4.13.3.2 Review and analyze Member and Provider grievances and Provider complaints; and

4.4.13.3.3 Perform case reviews to assess whether Care Coordination standards have been met. Case reviews shall include random sample audits of NF LOC determinations for both facility and community benefit Members based on HCA NF LOC instructions and tool guidelines each quarter.

4.4.13.4 Following the identification of Care Coordination concerns, the CONTRACTOR shall take immediate action to address Member-specific unmet needs, and remediate poor performance and noncompliance with Care Coordination program requirements. The CONTRACTOR shall track and trend all such findings to identify and remediate systemic poor performance and/or noncompliance. The CONTRACTOR shall evaluate and ensure that the remediation activities successfully resolve Member-specific concerns, poor performance, and noncompliance.

4.4.13.5 The CONTRACTOR shall provide Care Coordination reports as directed by HCA, including but not limited to the following:

4.4.13.5.1 The CONTRACTOR shall report on and ensure that Care Coordination activities are occurring timely and are meeting the following performance standards on a quarterly basis:

4.4.13.5.1.1 Eighty-five percent (85%) of HRAs are completed with Members (excluding Members in CCL0) as required in Section 4.4.4 of this Agreement within thirty (30) Calendar Days of enrollment notification to the CONTRACTOR.

4.4.13.5.1.2 Eighty-five percent (85%) of HRAs are completed with Members in CCL0 and CCL1 that have a change in health condition that requires a higher level of Care Coordination within thirty (30) Calendar Days of the CONTRACTOR’s knowledge of the change in condition.

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4.4.13.5.1.3 Eighty-five percent (85%) of CNAs are completed with Members (excluding Members in CCL0) within contract time frames as stated in Section 4.4.4 of this Agreement.

4.4.13.5.1.4 Eighty-five percent (85%) of CCPs are developed and authorized within the time frames as stated in Section 4.4.6 of this Agreement.

4.4.13.5.1.5 Unique count of high-cost Members (top ten percent of spending the prior year).

4.4.13.5.1.5.1 In the report of high-cost Members, the CONTRACTOR shall include all prior authorizations and service denials, including concurrent and retrospective reviews for the Members identified within the prior year.

4.4.13.5.2 The CONTRACTOR shall report the results and findings of audits of NF LOC determinations for both facility and Community Benefit Members as identified in Section 4.4.13.2 of this Agreement to HCA along with any quality improvement or performance improvement plan, if necessary.

4.4.13.5.3 The CONTRACTOR shall provide Care Coordination outcome reports as directed by HCA, including but not limited to the following outcome measures, to HCA on a quarterly basis, in the format specified by HCA. For each outcome measure, the CONTRACTOR shall indicate the performance by each of the Care Coordination Models (CONTRACTOR-driven, Full Delegation, or Shared Functions) it offers:

4.4.13.5.3.1 Member engagement in each Care Coordination Model;

4.4.13.5.3.2 Inpatient admission rates;

4.4.13.5.3.3 Inpatient readmission rates;

4.4.13.5.3.4 ED utilization; and

4.4.13.5.3.5 CAHPS for Care Coordination questions (annually).

4.5 **Benefits/Service Requirements and Limitations**

4.5.1 General

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4.5.1.1. The CONTRACTOR shall provide and coordinate comprehensive and integrated health care benefits to each enrolled Member and shall cover the Physical Health, Behavioral Health, and LTC services outlined in Attachment 1: Turquoise Care Covered Services or the ABP services listed in Attachment 4: Alternative Benefit Plan Covered Services

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

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

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

4.5.1.5. The CONTRACTOR shall provide all Members who are enrolled in the ABP with information related to: (i) the ABP and (ii) exemptions to mandatory enrollment in the ABP as described in Section 4.5.1.7 of this Agreement.

4.5.1.6. Members who are enrolled in the ABP are eligible to receive defined services that are Medically Necessary in the ABP if they are not ABP Exempt. Adult Members who are ABP Exempt may choose to receive the ABP outlined in Attachment 4: Alternative Benefit Plan Covered Services or the Covered Services outlined in Attachment 1: Turquoise Care Covered Services. Adult Members who are ABP Exempt and who select the Covered Services outlined

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in Attachment 1: Turquoise Care Covered Services may be eligible to receive the Community Benefit and/or NF care if they meet NF LOC as described in Section 4.5.7 of this Agreement.

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

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

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

4.5.1.7.3. Pregnant women; or

4.5.1.7.4. Individuals who are Medically Frail.

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

4.5.1.8.1 Self-identifying to the CONTRACTOR that they are exempt from mandatory enrollment into the ABP because they are an individual listed in Section 4.5.1.7 above. Adult Members may self-declare ABP Exempt status to the CONTRACTOR at any time. Upon the Member's self-identification, the CONTRACTOR, based on criteria established by HCA, shall evaluate and confirm whether the Member qualifies as ABP Exempt. The CONTRACTOR shall confirm ABP Exempt status within no more than ten (10) Business Days of the Member's self-identification to the CONTRACTOR. The Member remains enrolled in the ABP until the CONTRACTOR has confirmed ABP Exempt status and the Member has chosen to receive the ABP Exempt benefit package (the Covered Services included in Attachment 1: Turquoise Care Covered Services); or

4.5.1.8.2 If an Adult Member does not self-identify as being ABP Exempt but the CONTRACTOR determines that the Member meets the ABP Exempt criteria listed in Section 4.5.1.7 above through the Care Coordination processes explained in Section 4.4 of this Agreement or otherwise, the

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CONTRACTOR shall notify the Member that he/she may be ABP Exempt, explain the benefit differences for ABP Exempt individuals and facilitate his/her/their movement into the ABP Exempt benefit package (the Covered Services included in Attachment 1: Turquoise Care Covered Services) at the Member's choice.

4.5.1.8.3 If the Member disagrees with the CONTRACTOR's ABP Exempt status determination, the Member may use the CONTRACTOR's grievance and Appeals process as described in Section 4.17 of this Agreement.

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

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

4.5.1.9.2 The CONTRACTOR shall cooperate with HCA to demonstrate ongoing compliance with 42 C.F.R. part 438, subpart K regarding Behavioral Health parity. This will include but not be limited to participating in meetings, providing information (documentation, data, etc.) as requested by HCA to assess ongoing parity compliance, working with HCA to solve any noncompliance, and notifying HCA of any changes to benefits or limitations that might impact parity compliance.

4.5.1.9.3 As requested by HCA, the CONTRACTOR shall conduct an analysis to determine compliance with 42 C.F.R. part 438, subpart K regarding Behavioral Health parity and provide the results of the analysis to HCA.

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

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

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

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

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

4.5.1.9.9 In accordance with 42 C.F.R. § 438.910(d), the CONTRACTOR shall not impose a NQTL on Mental Health or SUD services in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the policies and procedures of the CONTRACTOR as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Mental Health or SUD services in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for Physical Health services in the classification.

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

4.5.1.9.11 The CONTRACTOR shall conduct ongoing monitoring to determine compliance with Behavioral Health parity and provide HCA an annual report of the CONTRACTOR's Behavioral Health parity analysis, monitoring activities, and an attestation of compliance. The CONTRACTOR's report must describe:

4.5.1.9.11.1 Changes to financial requirements and quantitative treatment limits;

4.5.1.9.11.2 Changes to benefit packages, covered services, or service delivery structures (e.g., change in Subcontractors performing delegated functions);

4.5.1.9.11.3 Changes to policies or procedures of the CONTRACTOR or its Subcontractors performing delegated functions on the CONTRACTOR's behalf that impact benefit coverage, access to care, or provider contracting;

4.5.1.9.11.4 The CONTRACTOR's self-monitoring activities and analysis conducted to ensure quantitative and non-quantitative treatment limitations are, in writing and operation, applied no more stringently to Mental Health/SUD benefits than to medical/surgical benefits; and

4.5.1.9.11.5 A summary of:

4.5.1.9.11.5.1 Behavioral Health parity compliance concerns identified;

4.5.1.9.11.5.2 The financial requirement, quantitative treatment limit, or non-quantitative treatment limit associated with the Behavioral Health parity compliance concern;

4.5.1.9.11.5.3 The applicable benefit package and classifications impacted;

4.5.1.9.11.5.4 The nature of the Behavioral Health parity compliance concern; and

4.5.1.9.11.5.5 The actions taken by the CONTRACTOR to remedy the Behavioral Health parity compliance concern.

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4.5.2 Medically Necessary Services

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

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

4.5.2.1.2 The CONTRACTOR, in making the determination of medical necessity of Covered Services shall do so by: (i) evaluating individual physical and Behavioral Health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history, including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; (ii) considering the views and choices of the individual or the individual's Representative regarding the proposed Covered Service as provided by the clinician or through independent verification of those views; and (iii) considering the services being provided concurrently by other service delivery systems; (iv) considering the services provided at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment and meet the individual needs;

4.5.2.1.3 Physical health, Behavioral Health, and LTC services shall not be denied solely because the Member has poor prognosis. Medically Necessary Services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness, or condition;

4.5.2.1.4 The benefit package includes the delivery of federally mandated EPSDT services as set forth in Section 1902(a)(10) and 1905(r) of the Social Security Act. The CONTRACTOR agrees to meet all federal requirements of the EPSDT program pursuant to 42 C.F.R. § 441.61 through § 441.62 and all State requirements, including NMAC 8.308.9 and 8.320.2. The

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CONTRACTOR shall adhere to the State's periodicity schedules (as recommended by the American Academy of Pediatrics and Bright Futures) for eligible Members under twenty-one (21) years of age;

4.5.2.1.4.1 The CONTRACTOR shall implement protocols to increase EPSDT screening rates and referrals for treatment, such as:

4.5.2.1.4.1.1 Notifying Members under twenty-one (21) years of age when periodic assessments or needed services are due and coordinating appointments for services;

4.5.2.1.4.1.2 Tracking Member participation in EPSDT screenings and providing outreach when missed screenings and appointments are identified;

4.5.2.1.4.1.3 Providing delegated Care Coordination entities, PCMH Providers, and other Providers lists of Members who have missed EPSDT screenings under the EPSDT periodicity requirements; and

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

4.5.3 Anti-Gag Requirement

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

4.5.3.1.1 The Member's health status, medical care, or treatment for the individual's condition of disease, including any alternative treatment that may be self-administered, regardless of whether such care or treatment are Covered Services;

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

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

4.5.3.1.4 The Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about future treatment decisions.

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

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

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

4.5.3.2.3 Notifies HCA within ten (10) Business Days after the effective date of this Agreement of its current policies and procedures regarding CONTRACTOR's objection to providing such counseling or referral services based on moral or religious grounds, or within fifteen (15) Calendar Days after CONTRACTOR adopts a change in policy regarding such counseling or referral services;

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

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

4.5.4 Emergency and Post-Stabilization Services

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

4.5.4.2 The CONTRACTOR shall review and approve or disapprove Claims for Emergency Services based on the definition of Emergency Medical Condition specified in Section 2 of this Agreement. The CONTRACTOR shall base coverage decisions for Emergency Services on the severity of symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical

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Condition in the judgment of a prudent layperson. The CONTRACTOR shall not impose restrictions on the coverage of Emergency Services that are more restrictive than those permitted by the prudent layperson standard.

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

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

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

4.5.4.6 Post-Stabilization Services are Covered Services related to an Emergency Medical Condition that are provided after a Member is Stabilized in order to maintain the Stabilized condition or to improve or resolve the Member's Emergency Medical Condition.

4.5.5 Birthing Options Program

4.5.5.1 The CONTRACTOR shall participate in HCA's Birthing Options Program, as operated at the time of execution of this Agreement or as directed by HCA during the term of this Agreement. The Birthing Options Program is an out-of-hospital birthing option for pregnant women enrolled in the Medicaid program who are at low-risk for adverse birth outcomes.

4.5.5.2 Birthing Options Program services are provided by an eligible midwife that enrolls as a Birthing Options Program provider with the Health Care Authority/Medical Assistance Division (HCA/MAD) for basic obstetric care for uncomplicated pregnancies and childbirth, including immediate newborn care

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that is limited to stabilization of the baby during this transition. The program does not cover the full scope of midwifery services nor replace pediatric care that should occur at a primary care clinic.

4.5.5.3 The Birthing Options Program out-of-hospital birth locations include a pregnant Member's home or a Licensed Birth Center.

4.5.6 Advance Directives

4.5.6.1 The CONTRACTOR shall provide Members and/or their Representatives with written information on Advance Directives that includes a description of applicable State and federal law and regulation, the CONTRACTOR's policies respecting the implementation of the right to have an Advance Directive and that complaints concerning noncompliance with Advance Directive requirements may be filed with HCA. The information must reflect changes in State law and regulation as soon as possible, but no later than ninety (90) Calendar Days after the effective date of such change.

4.5.6.2 The CONTRACTOR shall honor Advance Directives within UM protocols.

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

4.5.6.4 The CONTRACTOR shall ensure that:

4.5.6.4.1 Written information is provided to Members and/or their Representatives concerning their rights to accept or refuse medical or surgical treatment and to formulate Advance Directives, and informing Members of the CONTRACTOR's policies and procedures with respect to the implementation of such rights, including the provision of a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;

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

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

4.5.6.4.4 The CONTRACTOR complies with requirements of State and federal statutes and regulations respecting Advance Directives; and

4.5.6.4.5 Education is provided for staff, Contract Providers, and the community on issues concerning Advance Directives.

4.5.7 Community Benefit

4.5.7.1 For Members meeting NF LOC, the CONTRACTOR shall provide the Community Benefit, as determined appropriate based on the CNA.

4.5.7.2 The CONTRACTOR shall offer Members eligible for the Community Benefit the option to select either the Agency-Based Community Benefit or the SDCB.

4.5.7.2.1 The CONTRACTOR shall offer Members selecting the Agency-Based Community Benefit the choice of the consumer delegated model or consumer directed model for Personal Care Services (PCS).

4.5.7.2.2 The SDCB is further described in Section 4.6 of this Agreement.

4.5.7.3 Members may not choose to move between the Agency-Based Community Benefit and the SDCB without prior approval from HCA.

4.5.7.4 The CONTRACTOR shall track each Member's Community Benefit and provide reports on such benefit as directed by HCA.

4.5.7.5 The maximum allowable cost of care (cost limitation) for the Community Benefit will be tied to the State's cost of care for persons served in a private NF, except as described in Section 4.6.1.7 of this Agreement (for "grandfathered" SDCB Members). However, the maximum allowable cost of care is not an entitlement. The actual amount that can be spent by a Member for the Community Benefit will be determined by the Member's CNA.

4.5.7.5.1 The annual cost limitation will be determined by HCA prior to the beginning of each annual period for this Agreement based on the projected cost of placement in a Medicaid custodial Nursing Facility, excluding State Owned NFs for low level of care.

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4.5.7.5.2 The actual amount that can be spent by a Member in their CCP per year is determined by the Member's CNA.

4.5.7.5.3 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HCA for expenditures exceeding the cost limitation developed by HCA Section 4.5.7.5.1 and 4.6.1.7.1 of this Agreement.

4.5.7.6 The CONTRACTOR shall ensure that any services covered in this Agreement 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 are delivered in settings consistent with federal HCB settings requirements. The CONTRACTOR shall monitor the provision of all Community Benefits to ensure provider compliance with all applicable federal HCB settings requirements.

4.5.7.7 The CONTRACTOR must conduct monitoring activities to ensure that all Community Benefit providers, including SDCB employees meet provider requirements per the Managed Care Policy Manual, including individual attendant/Caregiver requirements. The monitoring activities may not be delegated to the provider.

4.5.7.7.1 The CONTRACTOR must perform annual audits of all contracted Agency-Based Community Benefit (ABCB) providers using an audit tool that is approved by HCA. The CONTRACTOR shall collaborate with other MCO CONTRACTORS to develop an audit schedule that ensures that all ABCB providers are audited only once per calendar year.

4.5.7.7.2 The CONTRACTOR must perform an annual audit of the contracted SDCB Fiscal Management Agency using an audit tool that is approved by HCA.

4.5.8 Family Planning Services

4.5.8.1 Federal law prohibits restricting access to family planning services for Medicaid recipients. The CONTRACTOR shall not require prior authorization for family planning services. The CONTRACTOR shall implement written policies and procedures, prior approved by HCA in writing, that define how Members are educated about their right to family planning services, freedom of choice (including access to Non-Contract Providers) and methods for accessing family

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planning services. The CONTRACTOR's family planning policy shall ensure that Members of the appropriate age, regardless of sex or gender, who seek family planning services shall be provided with counseling pertaining to the following:

4.5.8.1.1 Human Immunodeficiency Virus (HIV) and other sexually transmitted diseases and risk reduction practices;

4.5.8.1.2 All methods of contraception, including birth control pills and devices (including Plan B) and that such family planning services do not require prior authorization; and

4.5.8.1.3 The ability of Members to self-refer to Non-Contracted family planning Providers.

4.5.9 Prenatal and Postpartum Care Program

4.5.9.1 The CONTRACTOR shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American College of Obstetrics and Gynecology. Gynecological or obstetrical ultrasounds shall be provided without requiring a prior authorization of any kind.

4.5.9.2 The CONTRACTOR's prenatal and Postpartum care program shall include comprehensive lactation support services (including counseling, human donor milk, and breastfeeding equipment and supplies) to ensure the successful initiation and maintenance of breastfeeding. Breastfeeding equipment and supplies include, but are not limited to, double electric breast pumps (including pump parts and maintenance). The CONTRACTOR shall not require prior authorization for the purchase of personal use (non-hospital grade) manual or double electric breast pumps when a pump is prescribed by a licensed practitioner.

4.5.9.3 The CONTRACTOR's prenatal and postpartum care program shall include Doula services as a preventative service for individuals navigating pregnancy-related care before, during, and after pregnancy or childbirth. Doula services are provided as preventive services and must be recommended by a physician or

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other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complication and/or promote the physical and mental health of the beneficiary.

4.5.9.4 The CONTRACTOR's Prenatal and Postpartum Care Program shall include Doula services including: no more than nine-two hour visits per calendar year for prenatal & post-partum physical, emotional, and evidence-based education support and linkages to community-based resources. One non-medical Labor & Delivery (L&D) support per pregnancy and no more than nine-two hour visits per calendar year for other Doula services such as counseling related to pre-conception, pregnancy loss, infant loss, termination of pregnancy. The CONTRACTOR shall not require prior authorization for initial Doula services but may require a prior authorization for additional visits per year.

4.5.9.5 The CONTRACTOR shall include medically necessary gender affirmation services for members ages twelve to seventeen with a diagnosis (F64.2) gender identity disorder of childhood. Members twelve years to seventeen years of age are eligible for hormone therapy only. Members aged eighteen and older with a diagnosis (F64.9) gender identity disorder, unspecified, are eligible for hormone therapy, procedural and surgical interventions. The CONTRACTOR may require a prior authorization for gender affirmation services.

4.5.9.6 The CONTRACTOR's shall include medically necessary biomarker services for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a New Mexico Medicaid managed care member's disease or condition when the test is supported by medical and scientific evidence. The CONTRACTOR may require a prior authorization for biomarker services.

4.5.10 Care Coordination

4.5.10.1 The CONTRACTOR shall provide Care Coordination services in accordance with Section 4.4 of this Agreement.

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4.5.10.2 Section 7.2.10 of this Agreement details which Care Coordination services will be deemed medical expenses and which will be deemed administrative expenses in determining the CONTRACTOR's medical loss ratio.

4.5.11 Second Opinions

Members or their Representatives shall have the right to seek a second opinion from a qualified health care professional within the CONTRACTOR's network, or the CONTRACTOR shall arrange for the Member to obtain a second opinion outside the network, at no cost to the Member. A second opinion may be requested when the Member or the Member's Representative needs additional information regarding recommended treatment or believes the provider is not recommending necessary care.

4.5.12 The CONTRACTOR shall not impose any enrollment fee, premium or similar charge and shall not impose any deductible, copayment, cost sharing or similar charge to Members who are Native American, who were furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or by a health provider through referral under contract health services for which Medicaid payment may be made. In addition, payment to these Providers may not be reduced by any such charges. This requirement is in accordance with Section 5006(a)(1)(A) of the American Recovery and Reinvestment Act of 2009 (ARRA).

4.5.13 In Lieu of Services or Settings

In Lieu of Services or Settings (ILOSs) are alternative services or services in settings that are not Medicaid covered benefits, as set forth in Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services, but are medically appropriate and cost-effective substitutes. The CONTRACTOR may not require a Member to use ILOS Settings as a substitute for Covered Services, but may offer and cover such services or settings, if approved by HCA, as a means of ensuring that appropriate care is provided in a cost-effective manner.

4.5.13.1 The CONTRACTOR must obtain approval in writing from HCA prior to offering or paying Claims for In Lieu of Services or Settings services. The CONTRACTOR shall ensure that the ILOS is a medically appropriate and cost-effective substitute for the Covered Services and shall provide support for all

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required criteria to HCA. Approved ILOS are specified in the Contract according to the name and definition, the Covered Service or setting for which the ILOS is a medically appropriate and cost-effective substitute, the clinically defined target population for the ILOS, and the specific billing codes to identify the In ILOS in Encounter Data.

4.5.13.2 ILOS may not be used by the CONTRACTOR to reduce, discourage, or jeopardize Members' access to Covered Services. If a Member chooses not to receive an ILOS, they always retain their right to receive the Covered Service or setting on the same terms as would apply if an ILOS were not an option. The CONTRACTOR is not permitted to deny a Member a medically appropriate Covered Service on the basis that a Member has been offered an ILOS, is currently receiving an ILOS, or has received an ILOS in the past. ILOS must not violate any applicable federal requirements, including general prohibitions on payment for room and board costs under Title XIX of the Social Security Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Emergency Medical Treatment and Labor Act.

4.5.13.3 The CONTRACTOR shall specify member protections pertaining to ILOS in the Member Handbook, including a description of the process to determine eligibility for a particular ILOS, the voluntary nature of ILOS, and the grievance and appeal rights for ILOS.

4.5.13.4 The CONTRACTOR must use a consistent process to ensure a provider (either a Network Provider or the CONTRACTOR's licensed clinical staff) using professional judgment determines that an ILOS is medically appropriate for each Member and such determination is documented in the Member's medical record, plan of care, or other record that documents the Member's care needs.

4.5.13.5 The CONTRACTOR must develop and maintain a network of Providers that have the capacity and capability to deliver approved ILOS.

4.5.13.6 HCA may not consider the costs of the ILOS service in the CONTRACTOR’s Capitation Rate if the ILOS is not approved by HCA, not cost-effective, or the CONTRACTOR fails to provide supporting documentation to HCA. The

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CONTRACTOR shall supply any information needed by HCA to assist in calculating cost projections for approved or potential ILOS, including but not limited to, specific claims, cost information, Encounter Data, and other Member data that will assist HCA in meeting CMS documentation requirements.

4.5.13.7 Encounter Data submitted by the CONTRACTOR for ILOS must, when available, include data necessary for HCA to stratify ILOS utilization by sex (including sexual orientation and gender identity), race, ethnicity, disability status, and language spoken to inform health equity initiatives and efforts to mitigate health disparities. To the extent the existing billing codes do not accurately identify ILOS, HCA will provide specific codes and modifiers to ensure consistent use.

4.5.13.8 The CONTRACTOR may discontinue offering an approved ILOS with notice to HCA at least 60 Calendar Days prior to the discontinuation date. The CONTRACTOR must ensure ILOSs that were authorized for a Member prior to the discontinuation of that specific ILOS are not disrupted by a change in ILOS offerings, either by completing the authorized service or by seamlessly transitioning the Member into other medically necessary services or programs that meet the Member's needs. This transition plan must be provided to HCA as part of the ILOS discontinuation process. The transition plan must identify the total number of Members utilizing the ILOS through the discontinuation date and the alternative services that will be offered (either State Plan Services or other approved ILOS). At least forty-five (45) Calendar Days before discontinuing an ILOS, the CONTRACTOR must notify affected Members of the change and timing of the discontinuation and the procedures that will be used to ensure completion of the ILOS and transition into comparable medically appropriate service. The CONTRACTOR shall not offer the ILOS after the date of discontinuation.

4.5.13.9 In the event HCA, CMS, or both determine an ILOS not to be medically appropriate and/or cost-effective, the CONTRACTOR will assist HCA in preparing a transition plan to phase out the applicable ILOS while ensuring

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access for affected Members to contractually required services with minimal disruption of care. The transition plan will include a process to notify Members of the termination of the ILOS that they are currently receiving as expeditiously as required by the Member's health condition. Discontinuation of an ILOS by HCA will result in an amendment to this Contract.

4.5.14. Institution for Mental Diseases (IMD)

To address access issues for short term, acute psychiatric needs, a short-term stay (up to fifteen [15] Calendar Days per month) in an IMD may be necessary for Members between twenty-one (21) and sixty-four (64) years old during the term of this Agreement. The use of an IMD is an In Lieu of Services and Settings service, and the CONTRACTOR must meet the requirements outlined in Section 4.5.13 of this Agreement. This section applies to the extent CMS has not authorized section 1115 demonstration authority for longer stays in an IMD.

4.5.14.1. The utilization of an IMD for Members between twenty-one (21) and sixty-four (64) years old for psychiatric needs is limited to fifteen (15) Calendar Days in a Calendar Month. The fifteen (15) Calendar Days may be consecutive or cumulative in a Calendar Month.

4.5.14.2. It is the responsibility of the CONTRACTOR to ensure that the fifteen (15) Calendar Day limit is not exceeded.

4.5.14.2.1 If HCA finds that that the CONTRACTOR has allowed a stay of more than fifteen (15) Calendar Days in a Calendar Month, then HCA shall recoup the Capitation Payment made to the CONTRACTOR for the Member and month for which a stay in excess of fifteen (15) total Calendar Days occurs. This section applies to the extent CMS has not authorized section 1115 demonstration authority for longer stays in an IMD.

4.5.14.3 If the CONTRACTOR fails to limit the psychiatric stay to fifteen (15) Calendar Days, HCA will only consider the first fifteen (15) Calendar Days in the development of prospective Capitation Rate as outlined in Section 6 of this Agreement and disregard costs associated with psychiatric days in excess of fifteen (15) Calendar Days.

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

4.5.15.1 JUST Health individuals are inmates who have been incarcerated/detained for more than thirty (30) consecutive Calendar Days. The CONTRACTOR is responsible for Covered Services provided outside of the facility of incarceration to Members during the time frame preceding the Member's effective date as an inmate. A Member may be detained or incarcerated for up to thirty (30) consecutive Calendar Days before meeting the definition of an inmate, and this period of detention/incarceration has no bearing on the Member's Medicaid eligibility/MCO enrollment or benefit package, or on the CONTRACTOR's responsibility to provide payment for Covered Services. Prior authorizations may be required for some services. MAT services may be provided in the facility of incarceration/detention by a Medicaid enrolled Provider who is certified to perform MAT services, if the services are provided prior to the suspension of the Member's Medicaid benefits.

4.5.15.2 The CONTRACTOR retains the financial responsibility to pay for Covered Services received by incarcerated/detained Members prior to the suspension of benefits for the duration of any month in which a Member is enrolled and a Capitation Payment has been paid and not recouped by HCA.

4.5.15.3 When an individual is considered an inmate as described in Section 4.5.15.1 above, the CONTRACTOR's Capitation Payments will cease on the last day of the month in which the inmate's Medicaid benefits were suspended. The Capitation Payment for the month in which a suspension occurred will not be recouped by HCA. The only exception to this process will be when an inmate's suspension date occurs on the first day of the month. In these cases, enrollment with the CONTRACTOR will be terminated effective on the final day of the preceding month.

4.5.15.4 When an inmate is released from incarceration, MAD will reinstate the individual's Medicaid benefits. Capitation Payments will generally be effective on the first day of the month in which the inmate was released and their benefits were reactivated.

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4.5.15.5 The only exception to this process will be when an inmate is released on the last day of the month. In these cases, Capitation Payments will begin on the first day of the next month.

4.5.15.6 For an inpatient hospital stay of an incarcerated individual, the CONTRACTOR retains the financial responsibility to pay for any professional services related to the inpatient stay for the duration of any month in which a Member is enrolled and a Capitation Payment has been made and not recouped by HCA, as well as for the hospital stay if the discharge takes place during the month for which a Capitation Payment was made. For incarcerated individuals who are discharged during a month in which the CONTRACTOR is not paid a Capitation Payment and the Member is not enrolled with the CONTRACTOR, the CONTRACTOR's standard processes shall apply for disenrolled individuals as described in Section 4.10.3.7.4 of this Agreement.

4.5.15.7 The CONTRACTOR is required to designate a liaison for Justice-Involved Care Coordination and transitions of care. The designated liaison is to be the single point-of-contact to communicate with the prisons, jails, and detention facilities, and facilitate the Care Coordination process for Justice-Involved Members, to include Native American Members transitioning from incarceration and minor Members transitioning from juvenile detention facilities.

4.5.16 Tobacco Cessation Program

4.5.16.1 The CONTRACTOR shall operate a tobacco cessation program to assist Members with tobacco cessation.

4.5.16.1.1 The tobacco cessation program shall include, at a minimum, the following:

4.5.16.1.1.1 Cessation Quitline;

4.5.16.1.1.2 Group counseling;

4.5.16.1.1.3 Individual counseling; and

4.5.16.1.1.4 U.S. Food and Drug Administration (FDA) approved pharmacotherapies and/or nicotine replacement therapies such as Bupropion, Varenicline, nicotine patch, chewing gum, nasal spray, inhaler, and lozenges.

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4.5.16.1.2 The CONTRACTOR shall not require prior authorization for tobacco cessation services, including counseling, or nicotine replacement products or therapies. The CONTRACTOR shall have no limits on length of treatment or quit attempts per year and no step therapy requirements, and shall encourage but not require enrollment in counseling as part of the tobacco cessation program.

4.5.17 UM Program Standards

The CONTRACTOR shall establish and implement a UM program that follows NCQA UM standards and promotes quality of care, adherence to standards of care, the efficient use of resources, Member choice, and the identification of service gaps within the service system.

4.5.17.1 The CONTRACTOR's UM program shall:

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

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

4.5.17.1.3 Assist Members and/or their Representatives in choosing among Providers and available treatments and services;

4.5.17.1.4 Ensure the use of the least restrictive setting for crisis response and stabilization, emphasizing relapse and crisis prevention, not just crisis intervention;

4.5.17.1.5 Detect over- and under-utilization of services to assess the quality and appropriateness of services furnished to Members with special health care needs, and to identify health care disparities for remediation;

4.5.17.1.6 Inform Population Health Management strategies and activities;

4.5.17.1.7 Accept the New Mexico Uniform Prior Authorization Form for non-emergency medical and pharmaceutical benefits, as required per the 2019 New Mexico Health Insurance Prior Authorization Act;

4.5.17.1.8 Respond to prescription drug prior authorization requests in accordance with NMAC 8.308.9.26.E(7)(a)(b);

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4.5.17.1.9 Ensure that prior authorization requirements comply with the requirements for parity in mental health and SUD benefits as specified in 42 C.F.R. § 438.910(d); and

4.5.17.1.10 Ensure that prior authorization is not required for service codes specified by HCA.

4.5.17.2 The CONTRACTOR shall comply with State and federal requirements for Utilization Management, including but not limited to, 42 C.F.R. § 438.910(d) and 42 C.F.R. part 456.

4.5.17.3 The CONTRACTOR shall maximize the effectiveness of care by evaluating clinical appropriateness and authorizing the type and volume of services through fair, consistent, and Culturally Competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes.

4.5.17.4 The CONTRACTOR shall submit to HCA on an annual basis the UM edits in the CONTRACTOR's Claims processing system that control utilization and prevent payment for Claims that are duplicates, unbundled when they should be bundled, or already covered under another charge.

4.5.17.5 The CONTRACTOR shall define and submit annually to HCA a written copy of the CONTRACTOR's UM program description, UM work plan, and UM evaluation, which shall include, but not be limited to:

4.5.17.5.1 A description of the CONTRACTOR's UM program structure and accountability mechanisms;

4.5.17.5.2 A description of how the UM work plan supports the goals described in the UM program description and specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention. The UM work plan must be data driven with key indicators that are used to ensure that under-and-over utilization are detected by the CONTRACTOR and addressed appropriately; and

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4.5.17.5.3 A comprehensive UM program evaluation that includes an evaluation of the overall effectiveness of the UM program, an overview of UM activities and an assessment of the impact of the UM program on management and administrative activities. The review and analysis of any impact from the previous year shall be incorporated in the development of the following year's UM work plan.

4.5.18 General Requirements

4.5.18.1 The CONTRACTOR shall:

4.5.18.1.1 Ensure that Covered Services are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid pursuant to 42 C.F.R. § 440.230, including coverage of all codes included in the Medicaid fee schedule;

4.5.18.1.2 Ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished;

4.5.18.1.3 Ensure appropriate service by providing treatment at the most appropriate, least-restrictive level of care necessary to provide safe and effective treatment that meets an individual's needs. Level of care and utilization control for Behavioral Health services shall follow the guidelines issued by HCA provided the services furnished can reasonably be expected to achieve their purpose;

4.5.18.1.4 Not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of diagnosis, type of illness, or Member's condition;

4.5.18.1.5 Ensure the involvement of appropriate, knowledgeable, currently practicing practitioners in the development of UM procedures;

4.5.18.1.6 Submit to HCA proposed UM clinical criteria to be used for services requiring prior authorization for review and approval;

4.5.18.1.7 Develop and implement policies and procedures by which UM decisions may be Appealed by Members or their Representatives in a timely manner,

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including all necessary requirements and time frames based on all applicable State and federal statutes and regulations;

4.5.18.1.8 Comply with Utilization Management reporting requirements as directed by HCA; and

4.5.18.1.9 Ensure that the Pharmacy and Therapeutics Committee membership includes Behavioral Health expertise to aid in the development of pharmacy and practice guidelines for PCPs regarding psychotropic and antidepressant medications.

4.5.19 Authorization of Services

For the processing of requests for initial and continuing authorization of services, the CONTRACTOR shall:

4.5.19.1 Ensure that prior authorization is not required for codes specified by HCA;

4.5.19.2 Define service authorization requests in a manner that includes a Member's request for the provision of services;

4.5.19.3 Have, and follow, written policies and procedures for processing requests for initial and continuing authorizations for services, and require that its Major Subcontractors or Subcontractors do the same;

4.5.19.4 Have, and follow, written policies and procedures to issue extended prior authorization for Covered Services provided to address chronic conditions that require care on an ongoing basis. These services shall be authorized for an extended period of time, and the CONTRACTOR shall provide for a review and periodic update of the course of treatment, according to best practices;

4.5.19.5 Have in effect mechanisms to ensure consistent application of UM criteria for authorization decisions;

4.5.19.6 Consult with the Provider when appropriate;

4.5.19.7 Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease, such as the CONTRACTOR's medical director. The CONTRACTOR shall contract with a Board Certified Behavioral Analyst

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(BCBA) for utilization review of Applied Behavior Analysis prior authorization requests. The CONTRACTOR must ensure the BCBA contracted has no conflict of interests with individuals and/or entities requesting prior authorization for a Member;

4.5.19.8 Comply with the most rigorous standards or applicable provisions of either the New Mexico Health Insurance Prior Authorization Act, NCQA, HCA regulation, or 42 C.F.R. part 438.210(d) related to timeliness of decisions, including routine/non-urgent and emergent situations;

4.5.19.8.1 The CONTRACTOR shall ensure that required time frames for decisions are not affected by a "pend" decision. The decision-making time frames must accommodate the clinical urgency of the situation and must not result in the delay of the provision of Covered Services to Members.

4.5.19.8.2 The CONTRACTOR shall adjudicate standard prior authorization requests within seven (7) Business Days after receipt of all necessary and relevant documentation supporting a prior authorization request. Prior authorizations shall be deemed granted for determinations not made within the seven (7) Business Day turn-around time, except where:

4.5.19.8.2.1 An extension of up to fourteen (14) Calendar Days is granted based upon the Member's or provider's request for an extension; or

4.5.19.8.2.2 The CONTRACTOR justifies (to HCA upon written request) the need for additional information and how the extension is in the Member's best interest;

4.5.19.8.3 If the CONTRACTOR extends the time frame, the CONTRACTOR must give the Member written notice of the reason for the decision to extend the time frame and inform the Member of the right to file a Grievance in accordance with Section 4.17 of this Agreement if the Member disagrees with the decision; and

4.5.19.8.4 In cases in which the Provider indicates, or the CONTRACTOR determines, that following the standard time frame could seriously jeopardize the Member's life or health or the ability to attain, maintain, or regain maximal

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function, the CONTRACTOR must make an expedited authorization decision no later than twenty-four (24) hours after the receipt of all necessary and relevant documentation supporting the prior authorization request. Prior authorizations shall be deemed granted for determinations not made within the twenty-four (24) hour turn-around time. In the event that the expedited authorization decision is to deny or limit services, the CONTRACTOR shall automatically file an Appeal on behalf of the Member in accordance with Section 4.17.4 of this Agreement.

4.5.19.9 Establish policies and procedures that describe how UM decisions will be communicated to the Member and the Member's PCP or to the provider requesting the authorization;

4.5.19.10 Provide UM decision criteria to Providers, Members and their families, and the public upon request; and

4.5.19.11 Develop and offer Providers an opportunity to request peer-to-peer reviews of the CONTRACTOR's UM decisions.

4.5.19.11.1 The CONTRACTOR must offer a peer-to-peer review within 24 hours of a Provider's request, or at the Provider's first availability, for a peer-to-peer review at a mutually-agreed upon time.

4.5.19.11.2 The CONTRACTOR must ensure that staff conducting peer-to-peer reviews are the CONTRACTOR's Medical Directors or health care professionals who have clinical expertise in treating the Member's condition.

4.5.19.11.3 The CONTRACTOR staff conducting the peer-to-peer review must clearly identify the documentation the Provider must proffer to obtain approval of the specific item, procedure, or service; or identify a more appropriate clinical course of action based upon accepted clinical guidelines.

4.5.20 Notice of Adverse Benefit Determination

The CONTRACTOR must notify the requesting Provider, and give the Member written notice of any decision by the CONTRACTOR to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements set forth in 42 C.F.R. part 438,

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subpart F and the Managed Care Policy Manual. The CONTRACTOR must ensure that the Notice of Adverse Benefit Determination clearly explains the reason for the CONTRACTOR's decision in plain language and provides sufficient detail to allow the Member to make an informed decision regarding appealing the determination. If the reason for the Adverse Benefit Determination is the lack of necessary information, the written notice must clearly explain what information is needed and how and when to provide the necessary information.

4.5.20.1 The CONTRACTOR shall notify the requesting Provider and provide the Member or authorized representative and the Caregiver a notice of Adverse Benefit Determination when a team involved in the individualized planning process recommends a service for a CISC be reduced, modified, delayed, denied, or not approved within ten (10) Calendar Days of recommendation. The notice of Adverse Benefit Determination shall be provided to the Member and the Member's Caregiver, authorized representative, and legal custodian. CYFD will be the authorized representative for these children. For children fourteen (14) years and older, notices will go the Member, Member's Caregiver, authorized representative, and legal custodian. The Member's authorized representative, Caregiver, and legal custodian will be identified by the child with their PPW.

4.5.21 Excluded State-Funded Services

4.5.21.1 Exclusion. Excluded State-Funded Services are not Medicaid-covered services under this Agreement. The CONTRACTOR shall not authorize, arrange, pay for, include in capitation or MLR, submit as encounters, or otherwise report Excluded State-Funded Services.

4.5.21.2 Designation by State Notice. The State may designate or modify Excluded State-Funded Services by State Notice delivered pursuant to Section 7.47. Each State Notice shall identify the service(s), the effective date and time, and any technical specifications. The CONTRACTOR shall operationalize the designation by the effective date/time stated in the State Notice.

4.5.21.3 No effect on other benefits. Except as expressly designated by State Notice, Covered Services remain unchanged. (d) CHIP parallel. References in this

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Section apply equally to the State's Title XXI (CHIP managed care arrangements under this Agreement. E. Precendence. To the extent any other provision or exhibit could be read to impose any obligations under this Agreement to Excluded State Funded Services, this Section governs and such obligations do not apply.

4.5.22 The CONTRACTOR shall cover routine patient care costs incurred as a result of the Medicaid eligible recipient's participation in an approved Qualified Clinical Trial (QCT). The contractor does not need to cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices included in the QTC or routine items or services provided to the beneficiary solely to satisfy data collection and analysis for the QTC.

4.6 **Self-Directed Community Benefit (SDCB)**

4.6.1 General

4.6.1.1 The CONTRACTOR shall offer the SDCB to: (i) non-ABP Members who meet NF LOC and are determined through a CNA/reassessment to need the Community Benefit; and (ii) ABP Exempt Members who select the Covered Services in Attachment 1: Turquoise Care Covered Services who meet NF LOC and are determined through a CNA/reassessment to need the Community Benefit. Self-direction in Turquoise Care affords Members the opportunity to have choice and control over how SDCB services are provided, who provides the services, and how much Providers are paid for providing care in accordance with a range of rates per service established by HCA. A list of SDCB services is included in Attachment 1: Turquoise Care Covered Services.

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HCA to provide assistance to Members who choose the SDCB. The contract shall include performance metrics that are monitored by the CONTRACTOR. The

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CONTRACTOR shall conduct contract oversight and ensure that FMA issues with SDCB provider payments are addressed within ten (10) Business Days.

4.6.1.3 Members who participate in the SDCB choose either to serve as the Employer of Record (EOR) of their Providers or to designate an individual to serve as the EOR on their behalf. A Member who is an un-emancipated minor or under guardianship cannot serve as the EOR and must designate an individual to assume the functions on their behalf.

4.6.1.4 The EOR and Authorized Agent, if any, must be documented in the Member's file. The care coordinator shall also include a copy of any EOR and Authorized Agent forms in the Member's file and provide copies to the Member, the Member's Representative and the FMA.

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

4.6.1.6 HCA will include the PMPM expenses for the required activities of the FMA in the Capitation Payments made by HCA to the CONTRACTOR. Costs incurred for activities not included in the PMPM payment will not be reimbursed by HCA.

4.6.1.7 "Grandfathered" SDCB Members

4.6.1.7.1 Turquoise Care Members who were enrolled in Centennial Care effective January 1, 2014 and had approved self-directed budgets prior to December 31, 2013 that exceeded the cost limitation in Section 4.5.7.5 of this Agreement have been "grandfathered" with their prior approved self-directed budget, which became their annual cost limitation subject to Section 4.6.1.7.2 of this Agreement.

4.6.1.7.2 "Grandfathered" clients, while not subject to the annual Community Benefit cost limitations imposed by Section 4.5.7.5 of this Agreement, will be subject to the CNA and CCP development process.

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4.6.1.7.3 The CONTRACTOR is prohibited from imposing reimbursement modifications to existing Providers for "grandfathered" clients.

4.6.1.7.4 HCA will provide the CONTRACTOR with information to identify "grandfathered" Members.

4.6.1.8 SDCB Members

4.6.1.8.1 Members who did not have an approved self-directed budget that exceeded the cost limitation described in Section 4.5.7.5 of this Agreement prior to January 1, 2014 are subject to annual cost limitations defined by HCA in Section 4.5.7.5.1 of this Agreement.

4.6.1.8.2 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HCA for expenditures exceeding the cost limitation developed by HCA in Section 4.5.7.5 of this Agreement.

4.6.1.9 Members who enter the SDCB program on or after January 1, 2019 are subject to annual limits on the following services:

4.6.1.9.1 Related Goods: $2,000 limit;

4.6.1.9.2 Specialized Therapies: $2,000 limit; and

4.6.1.9.3 Non-Medical Transportation: $1,000 limit.

4.6.2 CONTRACTOR Responsibilities

4.6.2.1 The CONTRACTOR shall ensure that the Member and/or the Member's Representative fully participate in developing and administering the SDCB, and that sufficient supports are made available to assist Members who require assistance. This includes, but is not limited to, the development of the annual budget amount based on the Member's needs as identified in the annual CNA. In this capacity, the CONTRACTOR shall fulfill, at a minimum, the following tasks:

4.6.2.1.1 Understand the Member's and EOR's roles and responsibilities;

4.6.2.1.2 Identify resources outside the Turquoise Care program, including natural and informal supports that may assist in meeting the Member's needs;

4.6.2.1.3 Understand the array of the SDCB;

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4.6.2.1.4 Determine the annual budget for the SDCB, based on the CNA, to address the needs of the Member in accordance with the requirements stated in this Section 4.6 and the Member's Community Benefit;

4.6.2.1.5 Monitor utilization of SDCB services and goods on a regular basis;

4.6.2.1.6 Conduct employer-related activities, such as assisting a Member in identifying a designated EOR (as appropriate);

4.6.2.1.7 Identify and resolve issues related to the implementation of the CCP;

4.6.2.1.8 Assist the Member with quality assurance activities to ensure implementation of the Member's SDCB care plan and utilization of the authorized budget;

4.6.2.1.9 Recognize and report Critical Incidents, including Abuse, neglect, exploitation, Emergency Services, law enforcement involvement and environmental hazards; and

4.6.2.1.10 Monitor quality, including but not limited to: (i) the adequacy of Member-to-Support Broker (SB) ratios; (ii) the relationship between SBs and care coordinators; and (iii) the services provided by SBs.

4.6.2.2 The care coordinator shall work with the Member to determine the appropriate level of assistance necessary to recruit, interview, and hire Providers and provide the necessary assistance for successful program implementation.

4.6.3 Support Broker Functions

4.6.3.1 The CONTRACTOR shall perform, or contract with a qualified vendor to perform, the SB functions for Members electing the SDCB.

4.6.3.1.1 If the CONTRACTOR performs the support broker functions, in addition to its employed SBs, it must also offer the Member a choice of at least two additional SB agencies.

4.6.3.1.2 If the CONTRACTOR does not perform the SB functions, it must offer the Member a choice of multiple contracted SB agencies.

4.6.3.2 The CONTRACTOR shall be responsible for ensuring that all applicable requirements are met. At minimum, the CONTRACTOR (either directly or through a Subcontractor) shall perform the following SB functions:

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4.6.3.2.1 Educate Members on how to use self-directed supports and services and provide information on program changes or updates;

4.6.3.2.2 Review, monitor and document progress of the Member's SDCB services and budget;

4.6.3.2.3 Assist in managing budget expenditures and complete and submit budget revision requests;

4.6.3.2.4 Assist with employer functions, such as recruiting, hiring and supervising Providers;

4.6.3.2.5 Assist with approving/processing job descriptions for direct supports;

4.6.3.2.6 Assist with completing forms related to employees;

4.6.3.2.7 Assist with approving timesheets and purchase orders or invoices for goods, obtaining quotes for services and goods, as well as identifying and negotiating with vendors;

4.6.3.2.8 Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;

4.6.3.2.9 Facilitate resolution of any disputes regarding payment to Providers for services rendered;

4.6.3.2.10 Develop the care plan for SDCB services, based on the budget amount and ensure that it is included in the CCP; and

4.6.3.2.11 Assist in completing all documentation required by the FMA.

4.6.3.3 The CONTRACTOR shall have policies and procedures in place to ensure that SBs and care coordinators work in a collaborative manner, and do not duplicate activities or functions.

4.6.3.4 The CONTRACTOR shall conduct an annual audit of the SB network to ensure that all above requirements and those outlined in the Managed Care Policy Manual are met.

4.6.4 <u>FMA Training</u>

4.6.4.1 The CONTRACTOR shall work in collaboration with other MCOs to provide education and training to the FMA and its staff regarding key requirements of this Agreement.

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4.6.4.2 The CONTRACTOR shall conduct initial education and training to the FMA and its staff at least forty-five (45) Calendar Days prior to Go-Live. This education and training shall include, but not be limited to, the following:

4.6.4.2.1 The role and responsibilities of the care coordinator, including, but not limited to, CNA and CCP development, CCP implementation and monitoring processes, including the development and activation of a back-up plan for Members participating in the SDCB;

4.6.4.2.2 The FMA's responsibilities for communicating with the CONTRACTOR, Members, EORs, Authorized Agents, Providers, HCA and the process by which to do this;

4.6.4.2.3 Requirements and processes regarding referral to the FMA;

4.6.4.2.4 Requirements and processes, including time frames for authorization of the SDCB;

4.6.4.2.5 Requirements and processes, including time frames, for Claims submission and payment and coding requirements;

4.6.4.2.6 Systems requirements and Health Information Exchange (HIE) requirements;

4.6.4.2.7 HIPAA compliance;

4.6.4.2.8 Turquoise Care program quality requirements; and

4.6.4.2.9 EVV requirements and processes

4.6.4.3 The CONTRACTOR shall provide ongoing FMA education, training and technical assistance as deemed necessary by the CONTRACTOR or HCA in order to ensure compliance with this Agreement.

4.6.4.4 The CONTRACTOR shall provide to the FMA, in electronic format (including, but not limited to access via a web link) a Member handbook and updates thereafter annually or any time material changes are made.

4.6.5 Self-Assessment

4.6.5.1 The care coordinator shall provide the Member with a self-assessment instrument developed by HCA. The self-assessment instrument shall be completed by the

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Member with assistance from the Member's care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the Member's file.

4.6.5.2 If, based on the results of the self-assessment, the care coordinator determines that a Member requires assistance to direct their services, the care coordinator shall inform the Member that he or she will need to designate an EOR to assume the self-direction functions on their behalf.

4.6.6 Back-up Plan

4.6.6.1 The SB shall assist the Member/EOR in developing a back-up plan for the SDCB that adequately identifies how the Member/EOR will address situations when a scheduled provider is not available or fails to show up as scheduled.

4.6.6.2 The CONTRACTOR shall file a copy of the back-up plan in the Member's file.

4.6.6.3 The Member's SB shall assess the adequacy of the Member's back- up plan on at least an annual basis and any time there are changes in the type, amount, duration, scope of the SDCB or the schedule at which such services are needed, changes in Providers (when such Providers also serve as a back-up to other Providers) or changes in the availability of paid or unpaid back-up Providers to deliver needed care.

4.6.7 Budget

4.6.7.1 The care coordinator shall develop a budget for the SDCB services the Member is identified to need as a result of the CNA.

4.6.7.2 The SB and the Member shall work together to develop a plan for the SDCB services that are part of the overall CCP within the SDCB budget. The SB and Member shall refer to the range of rates specified by HCA in selecting payment rates for Providers.

4.6.7.3 The budget for the SDCB services shall be based upon the Member's assessed needs. The Member shall have the flexibility to negotiate provider rates within the rate range and allocated budget. A Member shall have the flexibility to choose from the range of HCA specified rates for all SDCB services.

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

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4.6.7.5 The SB shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the SDCB care plan will necessitate adjustments to the budget and that the Member does not exceed their budget.

4.6.8 Provider Qualifications

4.6.8.1 The FMA shall verify that all potential Providers meet all applicable qualifications prior to delivering services.

4.6.8.2 If a Provider is unable to pass a nationwide criminal history screening pursuant to NMSA 1978, 29-12-2 et seq. and/or is listed in the Abuse registry as defined in NMSA 1978, 27-7a-1 et seq., that person may not provide any services under Turquoise Care.

4.6.8.3 Members shall have the flexibility to hire persons with whom they have a close personal relationship to serve as a Provider, such as a neighbor or a friend.

4.6.8.4 Following formal approval from the CONTRACTOR, legally responsible individuals (including parents) of minors, who must provide care to the minor, may serve as Providers under extraordinary circumstances in order to assure the health and welfare of the minor and to avoid institutionalization. The CONTRACTOR shall make decisions regarding legally responsible individuals serving as Providers for minors on a case-by-case basis.

4.6.8.5 Following formal approval from the CONTRACTOR, spouses of Members may serve as Providers under extraordinary circumstances in order to assure the health and welfare of the Member and to avoid institutionalization. The CONTRACTOR shall provide such approval on a case-by-case basis.

4.6.8.6 Members shall have an employment agreement or vendor agreement, as appropriate, with each of their Providers. The employment agreement/vendor agreement template shall be prescribed by HCA. Prior to a payment being made to a Provider for SDCB Services, the FMA shall ensure that: (i) the Provider meets all qualifications; and (ii) an employment agreement/vendor agreement is signed between the EOR and the Provider.

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4.6.8.7 Employment agreements/vendor agreements shall be updated anytime there is a change in any of the terms or conditions specified in the agreement. Employment agreements/vendor agreements shall be signed by the new EOR when there is a change in EORs.

4.6.8.8 A copy of each employment agreement/vendor agreement shall be provided to the Member and/or EOR. The CONTRACTOR shall give a copy of the employment agreement/vendor agreement to the Provider and shall maintain a copy for its files.

4.6.8.9 The FMA shall ensure that an employment agreement/vendor agreement is in place for each Provider prior to the provision of services.

4.6.9 Training

4.6.9.1 The CONTRACTOR shall require all Members electing to enroll in the SDCB program and their EORs to receive relevant training. The SB shall be responsible for arranging for initial and ongoing training of Members and/or EORs.

4.6.9.2 At a minimum, self-direction training for Members and/or EORs shall address the following issues:

4.6.9.2.1 Understanding the role of Members and EORs with the SDCB;

4.6.9.2.2 Understanding the role of the SB and the FMA;

4.6.9.2.3 Selecting Providers;

4.6.9.2.4 Critical Incident reporting;

4.6.9.2.5 Abuse and Neglect prevention and reporting;

4.6.9.2.6 Being an employer, evaluating provider performance and managing Providers;

4.6.9.2.7 Fraud and Financial Abuse prevention and reporting;

4.6.9.2.8 Performing administrative tasks, such as reviewing and approving Electronic Visit Verification System (EVV) electronically-captured visit information; and

4.6.9.2.9 Scheduling Providers and back-up planning.

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4.6.9.3 The CONTRACTOR shall arrange for ongoing training for Members and/or EORs upon request and/or if a SB, through monitoring, determines that additional training is warranted.

4.6.9.4 The CONTRACTOR shall arrange for initial and ongoing training of direct care Providers (not vendors). At a minimum, training shall consist of the following required elements:

4.6.9.4.1 Overview of the Turquoise Care program and the SDCB;

4.6.9.4.2 Caring for elderly and disabled populations;

4.6.9.4.3 Abuse and Neglect identification and reporting;

4.6.9.4.4 Fraud and Financial Abuse prevention and reporting;

4.6.9.4.5 Cardiopulmonary resuscitation (CPR) and first aid certification;

4.6.9.4.6 Critical Incident reporting;

4.6.9.4.7 Submission of required documentation and withholdings; and

4.6.9.4.8 As appropriate, administration of self-directed health care task(s).

4.6.9.5 The SB shall assist the Member/EOR in determining to what extent the Member/EOR shall be involved in the above-specified training. The Member/EOR shall provide additional training to the Provider regarding individualized service needs and preference.

4.6.9.6 The CONTRACTOR shall verify that Providers have successfully completed all required training prior to service initiation and payment for services.

4.6.9.7 Additional training and refresher components may be provided to a Provider to address issues identified by the SB, Member, and/or the EOR or at the request of the Provider.

4.6.10 Monitoring

4.6.10.1 The care coordinator shall monitor the quality of service delivery and the health, safety, and welfare of Members participating in the SDCB.

4.6.10.2 The care coordinator shall monitor implementation of the back-up plan by the Member or their EOR/Authorized Agent.

4.6.10.3 The care coordinator shall monitor a Member's participation in the SDCB to determine, at a minimum, the success and the viability of the service delivery

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model for the Member. The care coordinator shall note any patterns, such as frequent turnover of EORs and Providers that may warrant intervention by the care coordinator. If problems are identified, a care coordinator shall also ask a Member to complete a self-assessment to determine what additional supports, if any (such as designating an EOR or Authorized Agent) could be made available to assist the Member.

4.6.10.4 The CONTRACTOR shall adhere to all State requirements for Critical Incident identification, reporting, and investigation.

4.6.10.5 The CONTRACTOR must conduct monitoring activities to ensure that all Community Benefit providers, including SDCB employees, meet provider requirements per the Managed Care Policy Manual, including individual attendant/caregiver requirements. The CONTRACTOR shall not delegate monitoring activities to the Provider.

4.6.10.5.1 The CONTRACTOR must perform an annual audit of the SDCB Fiscal Management Agency using an audit tool that is approved by HCA. The CONTRACTOR shall collaborate with other Turquoise Care MCOs to conduct one shared audit of the FMA per calendar year.

4.6.10.5.2 The CONTRACTOR must report on provider compliance to HCA annually, in a manner prescribed by HCA.

4.6.11 Termination from SDCB

4.6.11.1 The CONTRACTOR may involuntarily terminate a Member from the SDCB under any of the following circumstances:

4.6.11.1.1 The Member refuses to follow HCA requirements after receiving focused technical assistance on multiple occasions, support from the care coordinator or FMA, which is supported by documentation of the efforts to assist the Member;

4.6.11.1.2 There is an immediate risk to the Member's health or safety by continued self-direction of services, i.e., the Member is in imminent risk of death or serious bodily injury. Examples include, but are not limited to, the following: the Member: (i) refuses to include and maintain services in their

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CCP that would address health and safety issues identified in their CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, Care Coordination or FMA; (ii) is experiencing significant health or safety needs and refuses to incorporate the care coordinator's recommendations into their CCP; or (iii) exhibits behaviors that endanger him/her or others;

4.6.11.1.3 The Member misuses their SDCB budget following repeated and focused technical assistance and support from the care coordinator and/or FMA, which is supported by documentation;

4.6.11.1.4 The Member expends their entire SDCB budget prior to the end of the CCP year; or

4.6.11.1.5 The Member commits Medicaid Fraud.

4.6.11.2 The CONTRACTOR shall submit to HCA any requests to terminate a Member from the SDCB with sufficient documentation regarding the rationale for termination.

4.6.11.3 Upon HCA written approval, the CONTRACTOR shall notify the Member regarding termination in accordance with HCA rules and regulations. The Member shall have the right to Appeal the determination by requesting a Fair Hearing.

4.6.11.4 The CONTRACTOR shall facilitate a seamless transition from the SDCB to ensure there are no interruptions or gaps in services.

4.6.11.5 Involuntary termination of a Member from the SDCB shall not affect a Member's eligibility for Covered Services or enrollment in Turquoise Care.

4.6.11.6 The CONTRACTOR shall notify the FMA within one (1) Business Day of processing the outbound enrollment file when a Member is involuntarily terminated from the SDCB and when a Member is disenrolled from Turquoise Care. The notification shall include the effective date of termination and/or disenrollment, as applicable.

4.6.11.7 Members who have been involuntarily terminated may request to be reinstated in the SDCB. Such request may not be made more than once in a twelve (12) month

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period. The care coordinator shall work with the FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement. All Members shall be required to participate in SDCB training programs prior to re-instatement in the SDCB.

4.6.12 Claims Submission and Payment

4.6.12.1 Members shall review and approve timesheets of their Providers to determine accuracy and appropriateness.

4.6.12.2 No SDCB Provider shall exceed forty (40) hours paid work in a consecutive seven (7) Calendar Day period.

4.6.12.3 Payments to SDCB Providers shall comply with State and federal minimum wage statutes and regulations.

4.6.12.4 Timesheets must be submitted and processed on a two (2) week pay schedule according to HCA's prescribed payroll payment schedule.

4.6.12.5 The FMA shall be responsible for processing payments for approved services and goods.

4.6.12.6 The CONTRACTOR shall reimburse the FMA for authorized SDCB services provided by Providers at the appropriate rate for the self-directed HCBS, which includes applicable payroll taxes.

4.7 Value Added Services

4.7.1 The CONTRACTOR may offer Value Added Services to its Members that are not Covered Services (see Attachments 1 and 4).

4.7.2 The CONTRACTOR is encouraged to consider the unique and unmet needs of Members and, where appropriate, their families or Caregivers when proposing Value Added Services.

4.7.3 Value Added Services must be prior approved in writing by HCA.

4.7.4 The cost of Value Added Services will not be included in the Capitation Rate. All Value Added Services shall be identifiable and measurable through the use of unique payment and/or processing codes, approved by HCA. At the CONTRACTOR's request, HCA may assist in identifying a compliant code.

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4.7.5 The CONTRACTOR shall send Members notices of Adverse Benefit Determination regarding Value Added Services that comply with the requirements in the Managed Care Policy Manual. Denial of a Value Added Service will not be considered an Adverse Benefit Determination for purposes of Appeals or Fair Hearings.

4.8 **Provider Network**

4.8.1 General Requirements

4.8.1.1 The CONTRACTOR shall develop, maintain, and monitor a comprehensive Provider network that supports the needs of all Members enrolled in the CONTRACTOR's MCO.

4.8.1.2 The CONTRACTOR shall comply with the requirements specified in 42 C.F.R. § 438.12, § 438.14, § 438.207(c), § 438.214 and all applicable State requirements regarding provider networks. The CONTRACTOR shall have policies and procedures that reflect these requirements.

4.8.1.3 The CONTRACTOR shall enter into new contracts with providers for Turquoise Care, unless the provider and the CONTRACTOR mutually agree to forgo entering into a new agreement.

4.8.1.4 Pursuant to Section 1932(b)(7) of the Social Security Act, and consistent with 42 C.F.R. § 438.12, the CONTRACTOR shall not discriminate against Providers that serve high- risk populations or specialize in conditions that require costly treatment.

4.8.1.5 The CONTRACTOR shall ensure its Provider network provides physical access, accessible equipment, reasonable accommodations, and culturally competent communications for all Members, including those with physical, behavioral, or cognitive conditions/disabilities.

4.8.1.6 The CONTRACTOR shall not discriminate with respect to participation, reimbursement, or indemnification of any Provider acting within the scope of that Provider's license or certification under applicable State law solely on the basis of the Provider's license or certification.

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4.8.1.7 Upon declining to include individual or groups of Providers in its network, the CONTRACTOR shall give the affected Providers and HCA written notice of the reason for its decision.

4.8.1.8 The CONTRACTOR may negotiate different reimbursement amounts for different specialties or for different practitioners in the same specialty, but shall not be negotiated to be less than HCA's FFS rate.

4.8.1.9 The CONTRACTOR may establish measures that are designed to maintain quality of services and control of costs that are consistent with its responsibility to Members.

4.8.1.10 The CONTRACTOR shall not make payment to any Provider who has been barred from participation based on existing Medicare, Medicaid, or Children's Health Insurance Program (CHIP) sanctions, except for Emergency Services.

4.8.1.11 The CONTRACTOR shall provide Members with special health care needs direct access to a specialist, as appropriate for the Member's health care condition, as specified in 42 C.F.R. § 438.208(c)(4).

4.8.1.12 The CONTRACTOR must ensure that Members have access to a twenty-four (24) hours a day, seven (7) days a week pharmacy in each geographic location where such pharmacy is available and comply with the Distance Requirements in Section 4.8.8.5 of this Agreement.

4.8.1.13 The CONTRACTOR shall support the Certified Community Behavioral Health Clinics (CCBHC) model as directed by HCA and make its best efforts to expand its Provider network by contracting with CCBHCs as they become certified and enrolled providers.

4.8.1.14 The CONTRACTOR shall contract with all State-certified Certified Community Behavioral Health Clinics (CCBHCs) and cover the provision of CCBHC services to eligible members.

4.8.1.15 The CONTRACTOR shall comply with all Crisis Now and 988 network standards as developed and identified in collaboration with HSD, including but not limited to standards for crisis triage centers (CTC), Mobile Crisis Teams (MCT), Children's Mobile Response and Stabilization Services (MRSS), crisis

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receiving models, and separate pathways to or in an ED. CONTRACTOR shall make best efforts to contract with Crisis Now and 988 network providers including but limited to 988 call centers, CTC, MCT, MRSS, ED.

4.8.1.16 .

4.8.1.16.1 The CONTRACTOR shall collaborate to ensure Behavioral Health Providers meet requirements related to reporting and monitoring of open beds for crisis services.

4.8.1.16.2 The CONTRACTOR shall require its Behavioral Health Providers that provide crisis services to screen for HRSNs, using HCA-standardized screening tools.

4.8.1.17 The CONTRACTOR must submit a provider suspension/termination report as directed by HCA.

4.8.1.18 The CONTRACTOR shall obtain HCA prior written approval of any plan to utilize a Preferred Vendor(s) and/or Sole Source Provider(s) to substantially provide a service in Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services

4.8.1.19 in order to monitor potential consequences of narrowed networks or reduced Member access.

4.8.2 Provider Network Development and Management Plan and Evaluation

4.8.2.1 The CONTRACTOR shall develop and submit an annual Provider Network Development and Management Plan and Evaluation to HCA for review that demonstrates the CONTRACTOR maintains a network of Providers that is sufficient in number, type, capacity, and geographic distribution to meet the requirements of this Agreement and the needs of its enrolled Members. The CONTRACTOR's Provider Network Development and Management Plan and Evaluation shall be submitted consistent with HCA reporting instructions.

4.8.2.2 The CONTRACTOR's Provider Network Development and Management Plan and Evaluation must demonstrate the CONTRACTOR maintains a network of Providers, including but not limited to placements, that meets the complex and/or co-occurring needs of its Members, including but not limited to:

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- LTSS and SMI
- SMI and Intellectual or Developmental Disabilities (IDD)
- SMI and Traumatic Brain Injury (TBI)
- LTSS and TBI
- BH and SUD
- CISC and Autism Spectrum Disorder (ASD)
- CISC and SUD
- SED and ASD
- Pregnancy/Postpartum and Behavioral Health

4.8.2.3 The CONTRACTOR shall continually assess network sufficiency and capacity using multiple data sources, including but not limited to: the CONTRACTOR'S CHP, Network Adequacy Report, appointment standards, Population Health/quality improvement data, utilization data, Grievance and Appeal data, Member and Provider satisfaction surveys, and demographic data.

4.8.2.4 The CONTRACTOR shall implement strategies to increase Provider and workforce recruitment and retention in order to meet the needs of its Members, particularly in Rural, Frontier, and other regions considered health care deserts within the State. The CONTRACTOR must demonstrate best efforts to achieve network gains in underserved areas.

4.8.3 Required Policies and Procedures

The CONTRACTOR shall:

4.8.3.1 Maintain written policies and procedures on provider recruitment, retention, and termination of Contract Provider participation with the CONTRACTOR. HCA must prior approve these policies and procedures in writing and may review them upon demand. The recruitment policies and procedures shall describe how a CONTRACTOR responds to a change in the network that affects access and its ability to deliver services in a timely manner;

4.8.3.2 Require that each Provider either billing for or rendering services to Members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

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4.8.3.3 Require that any Provider, including Providers ordering or referring a Covered Service, have a National Provider Identifier (NPI) to the extent such Provider is not an atypical provider as defined by CMS;

4.8.3.4 Consider, in establishing and maintaining the network of appropriate Providers, its:

4.8.3.4.1 Anticipated enrollment;

4.8.3.4.2 Expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented in the CONTRACTOR's population;

4.8.3.4.3 Numbers and types (in terms of training, experience, and specialization) of Providers required to furnish Covered Services;

4.8.3.4.4 Numbers of Contract Providers who are not accepting new patients; and

4.8.3.4.5 Geographic location of Contract Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities;

4.8.3.5 Ensure that Contract Providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees;

4.8.3.6 Establish mechanisms such as notices or training materials to ensure that Contract Providers comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply;

4.8.3.7 Conduct screening of all Major Subcontractors and Contract Providers, in accordance with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 29-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility and Program Criminal Records Screening Act, NMSA 1978, § 32A-15-1 to 32A-15-4, PPACA (see Section 4.9.2.47 of this Agreement) and ensure that all Major Subcontractor and Contract Providers are screened against the New Mexico "List of Excluded Individuals/Entities" and the Medicare exclusion databases and not employ or contract with entities or Providers excluded from participation in

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federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority;

4.8.3.8 Provide Members and Contract Providers with clear instructions on how to access Covered Services, including those that require prior approval and referral;

4.8.3.9 Meet all availability, time, and distance standards set by HCA and have a system to track and report compliance with these standards; and

4.8.3.10 Provide Member access to Non-Contract Providers if the CONTRACTOR is unable to provide Medically Necessary services covered under this Agreement in a manner that meets the availability, time, and distance standards under this Agreement. The CONTRACTOR shall continue to authorize the use of Non-Contract Providers for as long as the CONTRACTOR is unable to provide these services through Contract Providers. The CONTRACTOR must ensure that the cost to the Member is no greater than it would be if the services were provided within the CONTRACTOR's network.

4.8.4 CONTRACTOR Responsibility for Providers

4.8.4.1 The CONTRACTOR shall monitor all provider activities to ensure compliance with the CONTRACTOR's and the State's policies. The CONTRACTOR shall establish mechanisms to ensure that Contract Providers comply with the timely access requirements, monitor Contract Providers regularly to determine compliance, and take corrective action if there is a failure to comply. The CONTRACTOR shall educate PCPs about special populations and their service needs. The CONTRACTOR shall ensure that PCPs successfully identify and refer Members to specialty Providers as Medically Necessary.

4.8.4.2 The CONTRACTOR shall ensure HCBS provider compliance with HCB settings requirements (see 42 C.F.R. § 441.301[c][4]), as applicable, and conduct provider monitoring as directed by HCA.

4.8.5 Primary Care Providers (PCPs)

4.8.5.1 With the exception of Dual Eligibles, the CONTRACTOR shall ensure that each Member is assigned a PCP. For Dual Eligibles, the CONTRACTOR will be responsible for coordinating the primary, acute, Behavioral Health, and LTC

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services with the Member's Medicare PCP. For all other Members, the PCP shall be a medical or Behavioral Health Contract Provider who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care and maintaining the continuity of the Member's care. The CONTRACTOR is prohibited from excluding Contract Providers as PCPs based on the proportion of high-risk patients in their caseloads.

4.8.5.2 The CONTRACTOR may designate the following types of Contract Providers as PCPs, as appropriate:

4.8.5.2.1 Medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, gynecology, and pediatrics;

4.8.5.2.2 Naturopathic doctors;

4.8.5.2.3 Certified nurse practitioners, certified nurse midwives, and physician assistants;

4.8.5.2.4 Specialists, on an individualized basis, for Members whose care is more appropriately managed by a specialist, such as Members with infectious diseases, chronic illness, complex Behavioral Health conditions, or disabilities;

4.8.5.2.5 Primary Care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include certified advanced practice providers who, at the Member's request, may serve as the point of first contact; in both instances, the CONTRACTOR shall organize its team to ensure continuity of care to Members and shall identify a "lead physician" within the team for each Member; the "lead physician" shall be an attending physician (medical students, interns, and residents may not serve as "lead physician");

4.8.5.2.6 FQHCs, Rural Health Clinics (RHCs), or I/T/Us; or

4.8.5.2.7 Other Contract Providers that meet the credentialing requirements for PCPs.

4.8.5.3 The CONTRACTOR shall submit a PCP Report as directed by HCA.

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4.8.6 Primary Care Responsibilities

4.8.6.1 The CONTRACTOR shall ensure that the following Primary Care responsibilities are met by the PCP, or in another manner:

4.8.6.1.1 The PCP shall ensure coordination and continuity of care with Providers, including all Behavioral Health and LTC Providers, according to the CONTRACTOR's policy; and

4.8.6.1.2 The PCP shall ensure that the Member receives appropriate prevention services based on the Member's age group, self-identified gender, and risk factors.

4.8.6.2 The CONTRACTOR shall ensure PCPs refer Members for Behavioral Services based on the following indicators:

4.8.6.2.1 Suicidal/homicidal ideation or behavior;

4.8.6.2.2 At-risk of hospitalization due to a Behavioral Health condition;

4.8.6.2.3 Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;

4.8.6.2.4 Trauma victims;

4.8.6.2.5 Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment. or other intellectual and developmental disabilities;

4.8.6.2.6 Request by Member or Representative for Behavioral Health services;

4.8.6.2.7 Clinical status that suggests the need for Behavioral Health services;

4.8.6.2.8 Identified psychosocial stressors and precipitants;

4.8.6.2.9 Treatment compliance complicated by behavioral characteristics;

4.8.6.2.10 Behavioral and psychiatric factors influencing medical condition;

4.8.6.2.11 Victims or perpetrators of Abuse and/or neglect and Members suspected of being subject to Abuse and/or neglect;

4.8.6.2.12 Non-medical management of substance abuse;

4.8.6.2.13 Follow-up to medical detoxification;

4.8.6.2.14 An initial PCP contact or routine physical examination indicates a substance abuse problem;

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4.8.6.2.15 A prenatal visit indicates substance abuse problems;

4.8.6.2.16 Positive response to questions indicates substance abuse, observation of clinical indicators, or laboratory values that indicate substance abuse;

4.8.6.2.17 A pattern of inappropriate use of medical, surgical, Trauma, or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or

4.8.6.2.18 The persistence of serious functional impairment associated with a primary BH disorder.

4.8.7 Selection of or Assignment to a PCP

The CONTRACTOR shall maintain and implement written policies and procedures governing the process of Member selection of a PCP and requests for change.

4.8.7.1 *Initial Enrollment.* At the time of enrollment, the CONTRACTOR shall ensure that each Member has the freedom to choose a PCP that is within the distance requirements specified in Section 4.8.8 of this Agreement from the Member's place of residence. The process whereby a CONTRACTOR assigns Members to PCPs shall include at least the following features:

4.8.7.1.1 The CONTRACTOR shall provide the means for selecting a PCP within five (5) Business Days of processing the enrollment file;

4.8.7.1.2 The CONTRACTOR shall contact pregnant Members within five (5) Business Days of processing an enrollment file that designates the Member as pregnant to assist the Member in selecting a PCP;

4.8.7.1.3 The CONTRACTOR shall offer freedom of choice to Members in making a PCP selection;

4.8.7.1.4 The Member must have fifteen (15) Calendar Days from enrollment to select a PCP. If a Member does not select a PCP within fifteen (15) Calendar Days of enrollment, the CONTRACTOR shall make the assignment and notify the Member in writing of their PCP's name, location, and office telephone number, while providing the Member with an opportunity to select a different PCP if the Member is dissatisfied with the assignment; and

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4.8.7.1.5 The CONTRACTOR shall assign a PCP based on factors such as Member age, residence, and if known, current Provider relationships.

4.8.7.2 *Subsequent Change in PCP Initiated by Member*. The CONTRACTOR shall allow Members to change PCPs at any time, for any reason. The request can be made in writing or by telephone. If a request is made on or before the twentieth (20th) Calendar Day of a month, the change shall be effective as of the first (1st) of the following month. If a request is made after the twentieth (20th) Calendar Day of the month, the change shall be effective the first (1st) Calendar Day of the second month following the request.

4.8.7.3 *Subsequent Change in PCP Initiated by the CONTRACTOR*. The CONTRACTOR may initiate a PCP change for a Member under the following circumstances:

4.8.7.3.1 The Member and the CONTRACTOR agree that assignment to a different PCP in the CONTRACTOR's provider network is in the Member's best interest, based on the Member's medical condition;

4.8.7.3.2 A Member's PCP ceases to be a Contract Provider;

4.8.7.3.3 A Member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made reasonable efforts to accommodate the Member;

4.8.7.3.4 A Member has initiated legal actions against the PCP; or

4.8.7.3.5 The PCP is suspended or terminated.

4.8.7.3.6 A claims-based utilization analysis indicates the member's preference for a different PCP (e.g, if a member visits a particular PCP consistently, this indicates the member's choice of PCP). If indicated, the MCO may reassign the member to the best PCP option and send the member a letter indicating they've been reassigned, explaining why, and giving them 30 days to pick a new PCP or stay with the PCO they've been reassigned to.

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4.8.7.4 The CONTRACTOR shall make a good faith effort to give written notice of termination of a Contract Provider, by the later of thirty (30) Calendar Days prior to the effective date of the termination or fifteen (15) Calendar Days after receipt or issuance of the termination notice, to each Member who received their Primary Care from, or was seen on a regular basis by, the terminated Provider. In such instances, the CONTRACTOR shall allow affected Members to select a PCP or shall make an assignment within fifteen (15) Calendar Days of the termination effective date.

4.8.8 Access to Services

The CONTRACTOR shall have an adequate provider network to ensure access to quality care, and the CONTRACTOR shall demonstrate that its network is sufficient to meet the health care needs of all Members. Changes affecting access to care shall be communicated to HCA and remedied by the CONTRACTOR in an expeditious manner.

4.8.8.1 HCA may grant exceptions to provider network access to service standards. The CONTRACTOR's request for exception(s) must demonstrate best efforts by the CONTRACTOR to meet the standards and be approved in writing by HCA.

4.8.8.2 The CONTRACTOR shall have written policies and procedures describing how Members and Contract Providers access services, including prior authorization and referral requirements for various types of medical and surgical treatments, emergency room services, Behavioral Health, and LTC services. The policies and procedures must be approved by HCA and shall be made available in an accessible format upon request to HCA, Providers, and Members.

4.8.8.3 The CONTRACTOR shall submit a Network Adequacy Report as directed by HCA.

4.8.8.4 Provider to Member Ratios

4.8.8.4.1 The CONTRACTOR shall ensure that Member caseload of any PCP does not exceed one-thousand, five-hundred (1,500) Members per MCO. Any exception to the PCP caseload ratio requires HCA's prior written approval.

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4.8.8.4.2 The CONTRACTOR must establish caseload ratios for specialty Providers to ensure that Members have adequate access to specialty Providers. The CONTRACTOR must comply with HCA-required specialist to Member ratios for specialty Providers if HCA establishes such ratios.

4.8.8.5 Distance Requirements

4.8.8.5.1 The CONTRACTOR shall ensure that the following distance standards are met:

4.8.8.5.1.1 For PCPs, including internal medicine, general practice, and family practice provider types, offer Members a choice of at least two (2) PCPs accepting new patients that meet the following distance requirements:

4.8.8.5.1.1.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles;

4.8.8.5.1.1.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles; and

4.8.8.5.1.1.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.8.5.1.2 For pharmacies, including twenty-four (24) hours a day, seven (7) days-a-week pharmacies where such are available, at least one (1) pharmacy that meets the following distance requirements:

4.8.8.5.1.2.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles;

4.8.8.5.1.2.2 Ninety percent (90%) of Rural Members shall travel no farther than forty-five (45) miles; and

4.8.8.5.1.2.3 Ninety percent (90%) of Frontier Members shall travel no farther than sixty (60) miles.

4.8.8.5.1.3 For the Providers described in Attachment 5: Providers with Distance Requirements to the Contract:

4.8.8.5.1.3.1 Ninety percent (90%) of Urban Members shall travel no farther than thirty (30) miles;

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4.8.8.5.1.3.2 Ninety percent (90%) of Rural Members shall travel no farther than sixty (60) miles, unless this type of Provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HCA; and

4.8.8.5.1.3.3 Ninety percent (90%) of Frontier Members shall travel no farther than ninety (90) miles, unless this type of Provider is not physically present in the prescribed radius or unless otherwise exempted as approved by HCA.

4.8.8.6 The CONTRACTOR shall ensure that the following appointment standards are met:

4.8.8.6.1 For Asymptomatic/Routine, Member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than thirty (30) Calendar Days, unless the Member requests a later time;

4.8.8.6.2 For Asymptomatic/Routine Member-initiated dental appointments, the request to appointment time shall be no more than sixty (60) Calendar Days unless the Member requests a later date;

4.8.8.6.3 For symptomatic, Member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than fourteen (14) Calendar Days, unless the Member requests a later time;

4.8.8.6.4 For non-urgent Behavioral Health care, the request-to-appointment time for an initial assessment shall be no more than seven (7) Calendar Days, unless the Member requests a later time. The request-to-appointment time for Behavioral Health care following an initial assessment shall be no more than seven (7) Calendar Days, unless the Member requests a later time. All non-urgent Behavioral Health care follow-up appointment shall be available within thirty (30) Calendar Days of the request;

4.8.8.6.5 Primary medical, dental, and Behavioral Health care outpatient appointments for urgent conditions shall be available within twenty-four (24) hours;

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4.8.8.6.6 For specialty outpatient referral and consultation appointments, excluding Behavioral Health, the request-to-appointment time shall be consistent with the clinical urgency, but no more than twenty-four (24) hours for urgent appointments, fourteen (14) Calendar Days for symptomatic appointments, and forty-five (45) Calendar Days for routine Asymptomatic appointments, unless the Member requests a later time;

4.8.8.6.7 For maternity care appointments, the request-to-appointment time shall be no more than twenty-four (24) hours for urgent appointments. For routine prenatal care appointments, within fourteen (14) Calendar Days of the request during the first trimester, within seven (7) Calendar Days of the request during the second trimester, and within three (3) Business Days of the request during the third trimester;

4.8.8.6.8 For routine outpatient diagnostic laboratory, diagnostic imaging, and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than fourteen (14) Calendar Days, unless the Member requests a later time;

4.8.8.6.9 For outpatient diagnostic laboratory, diagnostic imaging, and other testing, if a “walk-in” rather than an appointment system is used, the Member wait time shall be consistent with severity of the clinical need;

4.8.8.6.10 For urgent outpatient diagnostic laboratory, diagnostic imaging, and other testing, the request-to-appointment time shall be consistent with the clinical urgency, but no longer than forty-eight (48) hours;

4.8.8.6.11 The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes from the time of request. A prescription phoned in or electronically submitted by a practitioner shall be filled within ninety (90) minutes from the time of request;

4.8.8.6.12 The timing of scheduled follow-up outpatient visits with practitioners from the request, excluding Behavioral Health, shall be consistent with the clinical need;

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4.8.8.6.13 For Behavioral Health crisis services, face-to-face appointments shall be available within ninety (90) minutes of the request; and

4.8.8.6.14 Non-Emergency Medical Transportation (NEMT)

4.8.8.6.14.1 Appointment Arrival and Pick-Up. The CONTRACTOR and its Major Subcontractors shall ensure the Member arrives on time for the appointment but no sooner than one (1) hour before the appointment and is not dropped off before the facility/office is open. Scheduled pick-up shall occur within fifteen minutes prior to or after the scheduled pick-up time.

4.8.8.6.14.2 Critical Care Appointments. Critical care appointments, for the purposes of applicable NEMT standards, are defined as: chemotherapy, radiation, dialysis, pre-op or post-op appointments, surgery, high-risk pregnancy-related appointments, the comprehensive well child checkup required within 30-days of the child coming into state custody, and/or Urgent Care. The CONTRACTOR and all Major Subcontractors shall ensure that ninety-five percent (95%) of all one-way trips requested for critical care appointments per month are scheduled for service and driver-related no shows or cancellations are less than five percent (<5 %).

4.8.8.6.14.3 Pharmacy Access for Justice Involved Individuals. The CONTRACTOR is directed to cover NEMT for justice-involved members who are transitioning out of prison or jail. NEMT to the pharmacy will be allowed within the first seven days after release from prison or jail when the Medicaid-enrolled member has a current and valid prescription that has not been filled. The member may be transported to a domicile or residence within the same city limits as their originating pickup point.

4.8.8.6.14.4 Wheelchair-Accessible NEMT Access. The CONTRACTOR and all Major Subcontractors shall ensure an adequate number of operational wheelchair-accessible vehicles sufficient to provide, at minimum, no less access than (i.e. the percentage of requested one-way trips that

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could be scheduled and percentage of driver-related no shows or cancellations) provided to its overall Members requiring NEMT each month.

4.8.8.6.14.5 Failure of the CONTRACTOR or Major Subcontractor to meet performance standards will result, at HCA's discretion, in sanctions (including, but not limited to, the specific monetary penalties and/or other penalties described in Section 7.3 of the Agreement).

4.8.8.7 The CONTRACTOR shall conduct "secret shopper" surveys for all Provider types and specialties, including Behavioral Health, on a quarterly basis to monitor appointment timeliness. The CONTRACTOR shall submit survey results to HCA on January 31, April 30, July 31, and October 31 of each year.

4.8.8.7.1 The surveys shall be conducted with a random sample of each of the specified provider types and specialties (PCPs, Behavioral Health providers, dental providers, maternity care providers, outpatient laboratories, etc.) in Frontier, Rural, and Urban regions across the State to monitor the appointment standards for different the types of visits specified in Section 4.8.8.6 of this Agreement (routine, urgent, etc.) for children and adults.

4.8.8.7.2 The random sample size shall be statistically significant; however, must consist of a minimum of thirty (30) surveys for each of the following provider types: PCPs, Behavioral Health Clinics and Agencies, Substance Use Disorder Providers, Behavioral Health Facilities, and specialty care Providers. The surveys must address appointment availability for the following types of appointments: Asymptomatic/Routine, symptomatic, urgent, and maternity.

4.8.8.7.3 The CONTRACTOR shall submit the survey scripts to HCA for prior written approval, allowing HCA no less than thirty (30) days to review and approve the scripts.

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4.8.9 Specialty Providers

4.8.9.1 The CONTRACTOR shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of Members are met within the CONTRACTOR's provider network.

4.8.9.2 The CONTRACTOR shall have a system to refer Members to Non-Contract Providers if Providers with the necessary qualifications or certifications do not participate in the CONTRACTOR's network. The CONTRACTOR and non-Contract Providers must coordinate with respect to payment. The CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the CONTRACTOR's network.

4.8.10 Special Provisions for the State Teaching Hospital

4.8.10.1 The CONTRACTOR shall make good faith efforts to contract with the State teaching hospital for all services provided by the State teaching hospital, including inpatient, outpatient, and physician specialty services. Agreements for a limited scope of inpatient, outpatient, or physician specialty services are not considered to be a contract for the purposes of this Section.

4.8.10.2 If the CONTRACTOR and the State teaching hospital are unsuccessful after making good faith efforts to enter into an agreement the following shall apply:

4.8.10.2.1 The CONTRACTOR shall supply HCA with all materials related to the CONTRACTOR's proposed terms and conditions, including all proposed reimbursement schedules presented to the State teaching hospital, including the proposed relativity to the Medicaid fee schedule (including the enhanced safety net care hospital reimbursement rate). When responding to a records request for this information, to the fullest extent possible, HCA will assert the exceptions and exemptions available under applicable laws, including, but not necessarily limited to, the New Mexico Inspection of Public Records Act;

4.8.10.2.2 HCA may adjust the CONTRACTOR's Capitation Rates outlined in Section 6 of this Agreement to reflect the exclusion of the State teaching hospital

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experience from the CONTRACTOR's Capitation Rates and Capitation Payments; and

4.8.10.2.3 If a Member requires treatment and/or care that is medically necessary and unique to the State teaching hospital and cannot be provided from any of the CONTRACTOR's Contract Providers operating in the State of New Mexico, the CONTRACTOR shall identify an out-of-state Provider for treatment within forty eight (48) hours of receiving notification of the Member's treatment and/or care needs. The CONTRACTOR shall execute a single-case agreement with the out-of-state Provider that is able to perform the necessary treatment and/or care. Notification of the Member's treatment and/or care needs include the following:

4.8.10.2.3.1 The Member or authorized representative contacts the CONTRACTOR's Member services representatives via telephone, facsimile, or via e-mail to inform the CONTRACTOR of the Member's treatment and/or care needs;

4.8.10.2.3.2 The referring Contract Provider notifies the CONTRACTOR of the need for treatment and/or care only available in New Mexico at the State teaching hospital via telephone, facsimile, e-mail or through the process established between the referring Contract Provider and the CONTRACTOR; or

4.8.10.2.3.3 The Member, authorized representative, or referring Contract Provider notifies the Member's care coordinator of the needed treatment and/or care that is only available in New Mexico at the State teaching hospital.

4.8.10.3 If the CONTRACTOR's good faith efforts to contract with the State teaching hospital were unsuccessful resulting in the need for the CONTRACTOR to arrange for a Member to be sent out-of-state for treatment and/or care, the CONTRACTOR shall meet the following requirements:

4.8.10.3.1 Within seven (7) Calendars Days of notification about the Member's treatment and/or care needs, the CONTRACTOR shall authorize and arrange

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for an initial consultation with the out-of-state Provider that is capable of providing the treatment and/or care;

4.8.10.3.2 Within seven (7) Calendar Days following the receipt of the treatment plan determined by the out-of-state provider the CONTRACTOR shall authorize and arrange for the treatment and/or care;

4.8.10.3.3 The CONTRACTOR shall provide HCA a weekly report as directed by HCA that includes the status of treatment arrangements with the out-of-state provider, treatment status and progress and any complications or difficulties encountered with the arrangement for out-of-state treatment; and

4.8.10.3.4 If the Member is unable to travel out-of-state, and the service is only available at the State teaching hospital, the CONTRACTOR must enter into a single case agreement with the State teaching hospital.

4.8.11 Publicly Supported Providers

4.8.11.1 Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

4.8.11.1.1 The CONTRACTOR shall make best efforts to contract with every FQHC and RHC in the State. At least one (1) FQHC shall be an FQHC that specializes in providing health care for the homeless in Bernalillo County. At least one (1) FQHC shall be an Urban Indian FQHC in Bernalillo County.

4.8.11.1.2 The CONTRACTOR shall allow its Members to access care from Non-Contract Provider FQHCs and RHCs.

4.8.11.1.3 The CONTRACTOR shall reimburse FQHCs and RHCs as specified in Section 4.10.3.2 of this Agreement.

4.8.11.2 Local Department of Health Offices

4.8.11.2.1 The CONTRACTOR shall make best efforts to contract with public health Providers for family planning services and other clinical preventive services not otherwise available in the community, such as prenatal care or perinatal case management and those defined as public health services under State law, NMSA 1978, § 24-1-1 et. seq.

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4.8.11.2.2 The CONTRACTOR may require PCPs to contract with the Vaccines for Children (VFC) program administered by the New Mexico Department of Health.

4.8.11.3 Children's Medical Services

The CONTRACTOR shall make best efforts to contract with Children's Medical Services to administer Outreach clinics at sites throughout the State.

4.8.12 Core Services Agencies (CSA) and Certified Community Behavioral Health Clinics (CCBHC)

4.8.12.1 **Core Services Agencies**

4.8.12.1.1 The CONTRACTOR shall make best efforts to contract with entities designated by the State as CSAs to manage the service delivery of Behavioral Health services, as well as provide prevention, early intervention, treatment, and recovery services related to Behavioral Health for Members. The CONTRACTOR may terminate an arrangement with a CSA for cause with prior notice to HCA and the Collaborative.

4.8.12.1.2 HCA shall designate CSAs, and, as appropriate, shall provide the CONTRACTOR with an updated list of such designated entities.

4.8.12.1.2.1 Specifically, CSAs shall provide:

4.8.12.1.2.2 Twenty-four (24) hours a day, seven (7) days a week crisis intervention;

4.8.12.1.2.3 Behavioral Health services to those Members who choose CSAs as their provider;

4.8.12.1.2.4 Access to psychiatric evaluations;

4.8.12.1.2.5 Access to medication management;

4.8.12.1.2.6 Behavioral Health out-of-home assessment and service planning;

4.8.12.1.2.7 Care coordination to Members with Serious Mental Illness (SMI) and/or Serious Emotional Disturbance (SED);

4.8.12.1.2.8 Access to a range of other clinical Behavioral Health services; and

4.8.12.1.2.9 Access to Comprehensive Community Support Services (CCSS).

4.8.12.2 Certified Community Behavioral Health Clinics (CCBHC)

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4.8.12.2.1 The CONTRACTOR shall support HCA with the implementation and expansion of CCBHCs throughout New Mexico in accordance with applicable federal authority(ies) including, but not limited to the Medicaid State Plan and/or the CCBHC demonstration per Section 223 of the Protecting Access to Medicare Act of 2014. The contractor shall:

4.8.12.2.1.1 Ensure the provision of CCBHC services to eligible members.

4.8.12.2.1.2 Contract with all State-Certified CCBHCs to deliver CCBHC services.

4.8.12.2.1.3 Reimburse CCBHCs for the clinic-specific prospective payment system rates for the provision of any covered service provided to an eligible member for that day.

4.8.12.2.1.4 Adhere to claims, data, and encounter collection and submission requirements as established by HCA.

4.8.12.2.1.5 Delegate Care Coordination under the Full Delegation Model or Shared Functions Model pursuant to Contract section 4.4.10.

4.8.12.2.1.6 Comply with all CCBHC Medicaid State Plan, CCBHC Demonstration, and state regulatory or policy requirements.

4.8.12.2.1.7 Collaborate with HCA and CCBHCs to support program implementation, troubleshoot billing issues, claims and data reporting, quality oversight and performance monitoring, and program expansion and improvement initiatives.

4.8.13 I/T/Us

4.8.13.1 The CONTRACTOR shall make best efforts to contract with all I/T/Us in the State for services, including but not limited to, transportation, Care Coordination and case management. The CONTRACTOR shall take the actions necessary to maximize the ability of the State to collect 100% federal funding for these services.

4.8.13.2 The CONTRACTOR is encouraged to use the sample I/T/U Addendum as described in 42 C.F.R. § 438.14 as a basis to develop an Addendum specific to New Mexico that may be used to establish Contract Provider agreements with I/T/Us, as such agreements include the federal protections for I/T/Us.

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4.8.13.3 The CONTRACTOR shall allow Native American Members to seek care from any I/T/U whether or not the I/T/U is a Contract Provider and shall reimburse I/T/Us as specified in Section 4.10.3.3 of this Agreement.

4.8.13.3.1 The CONTRACTOR shall permit Non-Contract I/T/Us to refer Native American Members to a Contract Provider.

4.8.13.4 The CONTRACTOR shall not prevent Native American Members from seeking care from I/T/Us or from Contract Providers due to their status as Native Americans.

4.8.13.5 The CONTRACTOR shall track and report quarterly to HCA reimbursement and utilization data related to I/T/Us.

4.8.14 Family Planning Providers

4.8.14.1 The CONTRACTOR shall give each adolescent and Adult Member the opportunity to use their own PCP or go to any family planning provider for family planning services without requiring a referral. Each Member shall also have the right to self-refer to a Contract Provider women's health specialist for Covered Services necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the Member's designated source of Primary Care if that source is not a women's health specialist. Family planning Providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CONTRACTOR for all family planning services that are Covered Services, regardless of whether they are Contract Providers. Unless otherwise negotiated, the CONTRACTOR shall reimburse Providers of family planning services pursuant to the Medicaid fee schedule. Gynecological or obstetrical ultrasounds shall be provided without requiring a prior authorization of any kind.

4.8.14.2 Pursuant to State law and regulation, Non-Contract Providers are responsible for keeping family planning information confidential in favor of the individual Member even if the Member is a minor. The CONTRACTOR is not responsible for the confidentiality of medical records maintained by Non-Contract Providers.

4.8.15 Other Provider Types

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In addition to the Provider types listed in Attachment 5: Providers with Distance Requirements of this Agreement, the CONTRACTOR shall make best efforts to contract with additional provider types, including but not limited to:

4.8.15.1 SBHC Providers pursuant to New Mexico regulations;

4.8.15.2 State operated LTC facilities;

4.8.15.3 MHV providers;

4.8.15.4 Children's Specialty Hospitals;

4.8.15.5 SBs to assist with administering the SDCB; and

4.8.15.6 Community Benefit Providers.

4.8.16 Standards for Credentialing and Recredentialing

4.8.16.1 HCA intends to implement centralized credentialing and recredentialing applicable to all MCOs during the term of this Agreement. The CONTRACTOR shall assist HCA with the transition and implementation of centralized credentialing and recredentialing and comply with all HCA requirements related thereto.

4.8.16.2 Pending the implementation of centralized credentialing and recredentialing by HCA, the CONTRACTOR shall establish and implement a documented process for credentialing and recredentialing its Contract Providers, or Providers it employs, to treat Members.

4.8.16.3 The CONTRACTOR's credentialing and recredentialing process shall adhere to NMAC 13.10.28.10 and NCQA credentialing and recredentialing standards and include, but not be limited to, (i) defining the scope of Providers covered; (ii) the criteria and the primary source verification of information used to meet the criteria; (iii) use of a single, centralized, NCQA approved CVV to process applications and perform primary source verifications; (iv) the process and time frames for making credentialing and recredentialing decisions; (v) the time frame for loading approved providers to the CONTRACTOR's claims payment system; and (vi) the extent of delegating credentialing and recredentialing arrangements.

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4.8.16.4 The CONTRACTOR's credentialing and recredentialing process shall not discriminate against providers, including those that serve high-risk populations or specialize in conditions that require costly treatment.

4.8.16.5 The CONTRACTOR shall work with all other MCOs to contract with a single, centralized and NCQA approved CVV to process credentialing applications and perform primary source verifications. The CVV's responsibilities shall include the following:

4.8.16.5.1 Receiving and processing completed applications, attestations, and primary source verification documents for current and prospective Contract Providers;

4.8.16.5.2 Offering a portal that allows providers to submit applications and upload all required documentation for the credentialing and recredentialing process online;

4.8.16.5.3 Performing credentialing verification processes on behalf of the CONTRACTOR for initial credentialing, and for recredentialing every three (3) years; and

4.8.16.5.4 Reporting credentialing and recredentialing metrics on a monthly basis to the CONTRACTOR, to include the volume of credentialing applications and recredentialing activities; time frame for processing applications; credentialing and recredentialing outcomes; and any other metrics required by HCA.

4.8.16.6 Prior to executing a contract with a CVV, the CONTRACTOR shall obtain HCA's prior written approval of the CVV and contract, and the CONTRACTOR's written policies and procedures for its credentialing and recredentialing processes.

4.8.16.7 The CONTRACTOR shall comply with the following credentialing and recredentialing requirements:

4.8.16.7.1 Develop and implement written policies and procedures for the credentialing and recredentialing process;

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4.8.16.7.2 Meet NCQA standards and State and federal regulations for credentialing and recredentialing, including NMAC 13.10.28.10, 42 C.F.R. § 455.104, § 455.105, § 455.106, § 455.107 and § 1002.3(b);

4.8.16.7.3 Collaborate with the other MCOs to define and use the same NCQA approved primary source verification sources;

4.8.16.7.4 Participate and collaborate with any statewide initiatives to streamline and standardize the credentialing/recredentialing process;

4.8.16.7.5 Use a single, standardized credentialing form developed by the Provider Workgroup and collaborate with the other MCOs to develop other standard forms used for credentialing and recredentialing;

4.8.16.7.6 Ensure credentialing/recredentialing forms require ownership and control disclosures, disclosure of business transactions, and criminal conviction information;

4.8.16.7.7 Screen and confirm, upon initial credentialing and recredentialing, the identity and the exclusion status of Providers, and any person with an ownership or control interest, or who is an agent or managing employee of a Provider against federal databases as defined in 42 C.F.R. § 455.436 to ensure Providers are not employing or contracting with excluded individuals and do not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority;

4.8.16.7.8 Designate a credentialing and recredentialing committee or other peer review body to make recommendations and decisions regarding credentialing/recredentialing issues;

4.8.16.7.9 Complete the credentialing and recredentialing process within forty-five (45) Calendar Days from the receipt of a completed application with all required primary source documentation, for all Provider types;

4.8.16.7.10 Notify Providers of credentialing decisions (approved or denied) within ten (10) Calendar Days of the credentialing committee or peer review body decision;

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4.8.16.7.11 Recredential providers at least every three (3) years;

4.8.16.7.12 Ensure and verify that Providers have appropriate licenses and certifications to perform services outlined in their respective Turquoise Care provider agreements;

4.8.16.7.13 Maintain records that verify its credentialing and recredentialing activities, including primary source verification and compliance with credentialing/recredentialing requirements; and

4.8.16.7.14 Ensure and verify hospital privileges for Providers who indicate they have privileges.

4.8.16.8 The CONTRACTOR shall enter provider specific contract information into its system(s) such that its Claims system(s) is able to recognize the provider as a Contract Provider with accuracy sufficient to pay claims no later than fifteen (15) Calendar Days after a Provider is credentialed. Credentialed providers shall be entered/loaded into the CONTRACTOR's claims payment system with an effective date no later than the date the provider was approved by the credentialing committee/peer review body or the Provider agreement effective date, whichever is later.

4.8.16.9 The CONTRACTOR shall update the rosters of agencies with a Regulation and Licensing Department (RLD) clinical supervisor designation and for provider additions related to behavioral health specialized services as required in NMAC 8.321.2. Within fifteen (15) Calendar Days of receipt of a clean roster provided to the CONTRACTOR, the CONTRACTOR shall complete the rostering updates so the CONTRACTOR's claims payment system can recognize and pay claims. The CONTRACTOR shall add rostered providers to their Provider directories.

4.8.16.10 The CONTRACTOR shall perform the following functions:

4.8.16.10.1 Credential any provider who contracts with the CONTRACTOR and maintain complete credentialing information for these Providers;

4.8.16.10.2 Identify potential and actual Contract Providers who are enrolled with HCA as Medicaid Providers;

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4.8.16.10.3 Require any Contract Provider, including Contract Providers of a Subcontractor, to be enrolled through a Provider Participation Agreement with the State Medicaid Agency as a managed care provider; and

4.8.16.10.4 Refer any Provider who notifies the CONTRACTOR of a change in their location, licensure or certification, or status to New Mexico Medicaid's Provider web portal for updating their enrollment information/status with the New Mexico Medicaid program.

4.8.16.11 The CONTRACTOR's credentialing and recredentialing process for HCBS Providers shall include assessment of each provider setting to ensure that all applicable HCB settings requirements are met.

4.8.16.12 For applicable Community Benefit Providers, EPSDT Providers, and Home Health Providers the CONTRACTOR shall ensure that its credentialing and recredentialing process includes verification of the use of EVV.

4.8.16.12.1 For a period of at least twelve (12) months following implementation of EVV for home health providers, the CONTRACTOR shall conduct monthly education and training for affected providers regarding the use of the EVV system. Such period may be extended as determined necessary by HCA.

4.8.17 Shared Responsibility Between the CONTRACTOR and Public Health Offices

4.8.17.1 The CONTRACTOR shall coordinate with the public health offices operated by the New Mexico Department of Health regarding the following services:

4.8.17.1.1 Sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations;

4.8.17.1.2 HIV prevention counseling, testing and early intervention;

4.8.17.1.3 Tuberculosis screening, diagnosis and treatment;

4.8.17.1.4 Disease outbreak prevention and management, including reporting according to State law and regulatory requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

4.8.17.1.5 Referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants and Children (WIC);

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4.8.17.1.6 Health Education services for individuals and families with a particular focus on injury prevention, including car seat use, safe sleep, domestic violence, and lifestyle issues, including tobacco use, vaping, exercise, nutrition and substance use;

4.8.17.1.7 Home visiting programs for families of newborns and other at-risk families, including the MHV program; and

4.8.17.1.8 Participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as driving while intoxicated (DWI) councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others.

4.8.17.2 The CONTRACTOR shall participate in the New Mexico Department of Health's (DOH) New Mexico State Immunization Information System to ensure the secure, electronic exchange of immunization records to support the elimination of vaccine preventable diseases.

4.8.17.3 The CONTRACTOR shall contract with the ECECD for services covered for families, and children age zero-to-five (0-5).

4.8.18 Telemedicine Requirements

4.8.18.1 In providing services under this Agreement, the CONTRACTOR shall:

4.8.18.1.1 Expand, promote, and employ broad-based utilization of statewide access to HIPAA-compliant Telemedicine service systems, including the following modalities:

4.8.18.1.1.1 Live audio/video – real-time, two-way audiovisual connection between a Member and Provider (synchronous);

4.8.18.1.1.2 Store and forward – transmission of recorded health history to a Provider (asynchronous);

4.8.18.1.1.3 Remote Member monitoring – use of electronic tools to monitor and record a Member's physiological status which then transmit the data to a Provider in a setting other than where the Member is physically located;

4.8.18.1.1.4 Other telehealth visits – any other services delivered via telehealth; and

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4.8.18.1.1.5 Telephone visits - used for limited professional services delivered by telephone without video, as permitted by HCA.

4.8.18.1.2 Follow State guidelines for Telemedicine equipment or connectivity;

4.8.18.1.3 Follow accepted HIPAA and 42 C.F.R. part 2 regulations that affect Telemedicine transmission, including but not limited to, staff and Contract Provider training, room setup, security of transmission lines, etc. The CONTRACTOR shall have and implement policies and procedures that follow all State and federal security and procedure guidelines;

4.8.18.1.4 Identify, develop and implement training for accepted Telemedicine practices;

4.8.18.1.5 Participate in the needs assessment of the organizational, developmental and programmatic requirements of Telemedicine programs;

4.8.18.1.6 Report to HCA on the Telemedicine outcomes of Telemedicine projects and submit a Telemedicine Report as directed by HCA;

4.8.18.1.7 Ensure that Telemedicine services meet the following shared values, which are ensuring: (i) competent care with regard to culture and language needs; (ii) work sites are distributed across the State, including Native American sites, for both clinical and educational purposes; and (iii) coordination of Telemedicine and technical functions at either end of network connection.

4.8.18.2 The CONTRACTOR shall participate in Project ECHO, in accordance with State prescribed requirements and standards, including but not limited to, paying its fair share of administrative costs as negotiated between the CONTRACTOR and Project ECHO and approved by HCA to support Project ECHO, and shall:

4.8.18.2.1 Work collaboratively with the University of New Mexico, HCA and Providers on Project ECHO;

4.8.18.2.2 Identify high needs, high cost, or high-risk pregnancy Members who may benefit from their Providers participating in applicable Project ECHO educational sessions;

4.8.18.2.3 Identify PCPs and OB/GYNs who serve high needs, high cost, or high-risk pregnancy Members to participate in Project ECHO;

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4.8.18.2.4 Work with Project ECHO and the UNM Section of Geriatrics (Department of Internal Medicine) to:

4.8.18.2.4.1 Create a statewide program for quality improvement in Nursing Facilities to measurably improve quality ratings over the term of the contract; and

4.8.18.2.4.2 Create a program for reduction of readmissions from Nursing Facilities to hospitals, and measurably lower readmission rates over the course of the contract;

4.8.18.2.5 Work with Project ECHO, the New Mexico Perinatal Collaborative, and the Alliance for Innovation on Maternal Health to:

4.8.18.2.5.1 Develop Care Coordination models designed to improve maternal and child health outcomes for prenatal and Postpartum Members.

4.8.18.2.5.2 Create a training program for care coordinators along with a training program for Providers on appropriate Care Coordination for pregnant women who may be experiencing a high risk pregnancy or during their Postpartum period.

4.8.18.2.6 Reimburse Primary Care clinics and any other providers caring for pregnant or Postpartum Members, including Behavioral Health Providers when presenting their patients in the Project ECHO model;

4.8.18.2.7 Provide Claims data to support evaluation of Project ECHO;

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

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

4.8.18.2.10 The CONTRACTOR shall collaborate with Project ECHO to develop a quarterly report template to report number and types of Providers trained, location of Providers by county, number of cases presented for consultation, what coordination and development activities occurred, and overall Project ECHO expenditures.

4.8.19 Emergency Planning and Response

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4.8.19.1 In the event the President of the United States declares a state of emergency under the Stafford Act or the National Emergencies Act, and the Secretary of Health and Human Services also declares a PHE in the affected area, the CONTRACTOR shall identify an emergency response team to work with HCA to address the immediate and ongoing needs of the Members. CONTRACTOR shall also provide a plan to HCA addressing the following:

4.8.19.1.1 Mechanisms for decision making and coordination;

4.8.19.1.2 Mechanisms for tracking and monitoring;

4.8.19.1.3 Nature and scope of disaster;

4.8.19.1.4 Impact on specific populations;

4.8.19.1.5 Impact on infrastructure and vital services; and

4.8.19.1.6 Continuity of Operations Plan (COOP).

4.8.19.2 In the event of a federally declared disaster, the CONTRACTOR shall coordinate with HCA and the Collaborative to locate Providers to participate in the Federal Emergency Management Agency (FEMA)- and SAMHSA-funded Immediate and Regular Service Program Crisis Counseling Services grants. The CONTRACTOR shall also serve as a flow-through entity for funding of these grants. The grants will be managed by HCA.

4.8.19.3 Emergency Planning and Response for Behavioral Health

4.8.19.3.1 The CONTRACTOR shall participate in Behavioral Health emergency planning and response in collaboration with the Collaborative. The participation of the CONTRACTOR in these activities is intended to ensure that the disaster-related emotional needs of individuals with chronic Behavioral Health disorders, other special populations, the general public and emergency responders will be addressed in a systemic and systematic fashion.

4.8.19.3.2 The CONTRACTOR shall participate in planning and training activities for statewide disaster Behavioral Health preparedness and response.

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4.8.19.3.3 The CONTRACTOR shall coordinate with the Collaborative to implement Behavioral Health response activities in the event of a local, State, or federally declared disaster.

4.8.19.3.4 The CONTRACTOR, through specific language in its provider agreements, shall require its Contract Providers to participate in disaster Behavioral Health planning efforts at their local area level.

4.8.19.4 The CONTRACTOR shall participate in other emergency planning and response as directed by HCA.

4.9 **Provider Agreements**

4.9.1 General Requirements

4.9.1.1 In order to maximize VBP initiatives and advance initiatives in Turquoise Care, the CONTRACTOR is required to enter into new contracts with provider organizations to establish its Turquoise Care provider network. In limited circumstances, HCA may consider exceptions when certain Providers and the CONTRACTOR mutually agree to forgo this requirement.

4.9.1.2 The CONTRACTOR shall submit to HCA for prior review and written approval, templates/sample provider agreements for each type of Contract Provider. Any changes to templates/sample provider agreements that may materially affect Members shall be approved by HCA in writing prior to execution by any provider.

4.9.1.3 In all provider agreements, the CONTRACTOR must comply with the requirements specified in 42 C.F.R. § 438.214 and must maintain policies and procedures that reflect these requirements.

4.9.1.4 The CONTRACTOR shall comply with 42 C.F.R. § 438.808 regarding exclusion of entities, including all statutes and regulations referenced therein.

4.9.1.5 The CONTRACTOR shall conduct background checks and similar activities as required under State or federal statues or regulations on all Providers before entering into any agreement with such provider.

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4.9.1.6 Contract Provider agreements shall be executed in accordance with all applicable State and federal statutes, regulations, and policies.

4.9.1.7 The CONTRACTOR must provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) about its Member Grievance and Appeals system to all Contract Providers at the time they enter into mutual agreement.

4.9.1.8 The CONTRACTOR may enter into single case agreements with Providers performing Covered Services who are not willing to become a part of the CONTRACTOR's provider network.

4.9.1.9 Prior to executing or renewing a provider agreement with any Community Benefit Provider, the CONTRACTOR shall verify that the Provider is compliant with all applicable HCB settings requirements (see 42 C.F.R. § 441.301(c)(4)-(5)).

4.9.2 Minimum Requirements for Contract Provider Agreements

Contract Provider agreements shall contain at least the following provisions, as applicable to the provider type:

4.9.2.1 Identify the parties of the agreement and their legal basis of operation in the State of New Mexico unless the Provider is an out-of-state provider;

4.9.2.2 Include the procedures and specific criteria for terminating the agreement, including provisions for termination for any violation of applicable State or federal statutes and regulations;

4.9.2.3 Identify the services, activities and report responsibilities to be performed by the Contract Provider. Contract Provider agreements shall include provision(s) describing how Covered Services provided under the terms of the contract are accessed by Members;

4.9.2.4 Require that all Contract Providers abide by the Member rights and responsibilities as outlined in Section 4.15.4 of this Agreement;

4.9.2.5 Provide that Emergency Services be rendered without the requirement of prior authorization of any kind;

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4.9.2.6 Specify the Contract Provider's responsibilities and prohibited activities regarding cost sharing as directed by HCA such as, without limitation, no cost sharing for Native Americans as set forth in Section 4.5.12 of this Agreement;

4.9.2.7 Include the reimbursement rates and risk assumption, if applicable;

4.9.2.8 Address how gross receipts tax (GRT) will be accounted for when reimbursing providers (i.e., whether the GRT will be built into the negotiated contract rate or paid separately and identify the amount of GRT that will be paid on Medicaid claims);

4.9.2.9 Require Contract Providers to maintain all records relating to services provided to Members for a ten (10) year period and to make all Member medical records or other service records available for the purpose of quality review conducted by HCA, or their designated agents both during and after the term of the Contract Provider agreement. Such records shall be provided to HCA within two (2) to ten (10) Business Days after the date of HCA's request in accordance with NMSA 1978, § 27-11- 4(B);

4.9.2.10 Require that Member information be kept confidential, as defined by State and federal statutes or regulations;

4.9.2.11 Include a provision that authorized representatives of HCA, the Collaborative or other State and federal agencies shall have reasonable access to facilities and records for financial and medical audit purposes both during and after the term of the Contract Provider agreement;

4.9.2.12 Include a provision for the Contract Provider to release to the CONTRACTOR any information necessary to perform any of its obligations and that the CONTRACTOR shall be monitoring the Contract Provider's performance on an ongoing basis and subjecting the Contract Provider to formal periodic review;

4.9.2.13 State that the Contract Provider shall accept payment from the CONTRACTOR as payment for any services performed, and cannot request payment from HCA or the Member, unless the Member is required to pay a copayment;

4.9.2.14 State that if the contract includes Primary Care, provisions for compliance with PCP requirements delineated in this Agreement shall apply;

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4.9.2.15 Require the Contract Provider to comply with all applicable State and federal statutes and regulations;

4.9.2.16 Not prohibit a Contract Provider from entering into a contractual relationship with another MCO;

4.9.2.17 Not include any incentive or disincentive that encourages a Contract Provider not to enter into a contractual relationship with another MCO;

4.9.2.18 Not contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act, 42 C.F.R. § 438.102 or in contravention of NMSA 1978, § 59A-57-1 to 59A-57- 11;

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

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

4.9.2.21 Provide for the provider's participation and cooperation in any internal and external QM/QI monitoring, utilization review, peer review and/or Appeal procedures established by the CONTRACTOR and/or HCA;

4.9.2.22 Provide for CONTRACTOR monitoring of the quality of services delivered under the Contract Provider agreement, and specify initial corrective action that will be taken where necessary to improve quality of care, in accordance with that level of medical, Behavioral Health or LTC that is recognized as acceptable professional practices and/or the standards established by HCA;

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

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

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

4.9.2.26 Provide for payment to the Contract Provider upon approval of a Clean Claim properly submitted by the Contract Provider within the required time frames (see Section 4.20.1.6 of this Agreement);

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4.9.2.27 Specify the Contract Provider shall accept payment or appropriate denial made by the CONTRACTOR (or, if applicable, payment by the CONTRACTOR that is supplementary to the Member's third party payer) plus the amount of any applicable Member cost-sharing responsibilities, as payment in full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable cost-sharing responsibilities;

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

4.9.2.29 Include provisions that allow the CONTRACTOR to suspend, deny, refuse to renew or terminate any Contract Provider agreement in accordance with the terms of this Agreement and applicable statutes and regulations;

4.9.2.30 Specify that HCA reserves the right to direct the CONTRACTOR to terminate or modify the Contract Provider agreement when HCA determines it to be in the best interest of the State;

4.9.2.31 Specify that both parties recognize that in the event of termination of this Agreement, the Contract Provider shall immediately make available, to HCA or its designated representative in a usable form, any or all records, whether medical or financial, related to the Contract Provider's activities undertaken pursuant to the Contract Provider agreement. The provision of such records shall be at no expense to HCA.

4.9.2.32 Include a gratuities clause as stated in Section 7.23 of this Agreement, a lobbying clause as stated in Section 7.24 of this Agreement and a conflict of interest clause as stated in Section 7.25 of this Agreement;

4.9.2.33 Specify that at all times during the term of the Contract Provider agreement, the Contract Provider shall indemnify and hold HCA harmless from all Claims, losses, or suits relating to activities undertaken by the Contract Provider pursuant to this Agreement;

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4.9.2.34 Specify that the Contract Provider is not a third party beneficiary to this Agreement and that the Contract Provider is an independent contractor performing services as outlined in this Agreement;

4.9.2.35 Require that the Contract Provider display notices of the Member's right to Appeal Adverse Benefit Determinations affecting services in public areas of the Contract Provider's facility(s) in accordance with State and federal regulations;

4.9.2.36 Include that if any requirement in the Contract Provider agreement is determined by HCA to conflict with this Agreement, such requirement shall be null and void, and all other provisions shall remain in full force and effect;

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

4.9.2.38 Require Contract Providers to comply with Section 7.14 of this Agreement, as applicable;

4.9.2.39 Include a provision requiring, as a condition of receiving any amount of payment, that the Contract Provider comply with Section 4.17 of this Agreement;

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

4.9.2.41 Require NF Providers to promptly notify the CONTRACTOR of: (i) a Member's admission, or request for admission to the NF regardless of payor source for the NF stay; (ii) a change in a Member's known circumstances; and (iii) a Member's pending discharge;

4.9.2.42 Require NF Providers to notify the Member and/or the Member's Representative in writing prior to discharge in accordance with State and federal requirements;

4.9.2.43 Require Providers to notify the Member's care coordinator of any change in a Member's medical or functional condition that could impact the Member's level of care determination;

4.9.2.44 Require Agency-Based Community Benefit Providers to provide at least thirty (30) Calendar Days advance notice to the CONTRACTOR when the provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate Providers;

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4.9.2.45 Specify that reimbursement of a Community Benefit Provider shall be contingent upon the provision of services to an eligible Member in accordance with applicable State and federal requirements and the Member's CCP as authorized by the CONTRACTOR;

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

4.9.2.47 Require all Contract Providers to (i) 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 (ii) to not employ or contract with Providers excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority;

4.9.2.48 Require Community Benefit Providers to comply with all applicable HCB settings requirements;

4.9.2.49 Include a provision, as applicable to the CCSS and HFW Provider types and services, for no reject and no eject in identified Behavioral Health Provider agreements for Members who are CISC;

4.9.2.49.1 No reject means that the Provider must accept the referral for eligibility and medical necessity determination. If the Member is Medicaid eligible, meets the Serious Emotional Disturbance (SED) criteria, and meets medical necessity, the Provider must coordinate all needed services through CCSS and HFW service providers for CISC. A Provider will not discriminate against nor use any policy or practice that has the effect of discrimination against an individual on the basis of health status or need for services.

4.9.2.49.2 No eject means that the Provider must continue to coordinate services and assist Members in accessing appropriate services and supports.

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4.9.2.50 Include a provision in applicable Behavioral Health Provider agreements for Members who are CISC that requires Contract Providers to deliver staff training on the following topics:

4.9.2.50.1 Trauma-responsive training as approved by HCA; and

4.9.2.50.2 No reject and no eject provision for Members who are CISC; and

4.9.2.51 In order to assess if the no reject, no eject provision is effective for other Provider types, the CONTRACTOR shall include a provision for in-state accredited residential treatment centers (ARTCs), residential treatment centers (RTCs), group homes, and treatment foster care (TFC) Provider Agreements that requires these Providers to inform the CONTRACTOR if a CISC Member is not accepted into service(s) or if a CISC Member is prematurely discharged. The CONTRACTOR, with State oversight, shall review all cases to determine the validity of each action and evaluate the efficacy of the provision quarterly. In all cases, the CONTRACTOR shall provide training, education, and/or take other appropriate measures if it is determined Providers are not accepting, or are prematurely discharging CISC Members for reasons other than medical necessity or other exclusionary criteria, such as age, gender, provider specialty, and bed availability. The CONTRACTOR shall capture and report data to HCA and CYFD on a quarterly basis regarding denial of services for CISC Members.

4.10 **Provider Payments**

4.10.1 Timely Payments to All Providers:

The CONTRACTOR and any of its Major Subcontractors and Subcontractors shall make timely payments to any Provider or entity that furnished covered benefits as defined in Section 4.20 of this Agreement. The CONTRACTOR and any of its Major Subcontractors or Providers paying Claims are required to maintain Claims processing capabilities to comply with all State and federal regulations.

4.10.1.1 The CONTRACTOR shall ensure its Claims processing system and provider payments are compliant with ICD-10.

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4.10.1.2 The CONTRACTOR shall implement rate changes within thirty (30) Calendar Days after receiving the final, signed Capitation Rates.

4.10.2 Claim Payment Requirements.

4.10.2.1 The Contractor shall comply with NMSA 1978, § 27-2.12.37 (effective Jan. 1, 2026).

4.10.2.2 No later than 14 days after each claim is paid, in addition to the amount of the claim paid, the Contractor shall issue payment of the gross-receipts amount applicable to the claims payment under state law based on service location. MCOs shall comply with the timing requirement of this provision by timely paying gross receipts tax on at least 90% of claims annually as determined by a reasonable sample.

4.10.2.3 Concurrent with payment of gross receipts tax to a health care provider, the Contractor shall deliver documentation to the provider specific to each and every claim which differentiates the base service payment from the gross receipts amount for that claim.

4.10.2.4 Encounters submitted to the State shall separately report the base service payment and the gross-receipts amount, in the format specified by HCA. Until HCA enables a separate gross-receipts field in the encounter file (target Q3 2026), the Contractor shall provide an interim file, on the same cadence as encounters, that for each paid claim or equivalent transaction shows the base service payment and the gross-receipts amount and links the record to the corresponding encounter. Once the field is enabled, the separate gross-receipts amount shall be included in encounter submissions prospectively, on the implementation date set by HCA.

4.10.2.5 With reasonable advance notice and giving due regard to implementation Contractor costs, HCA may, from time to time, specify the form, content, manner, timing, and delivery method for provider payment documentation and for encounter data submissions.

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4.10.2.6 Upon request, with reasonable advance notice, the Contractor shall provide such deliverables as specified by HCA, after giving due regard to Contractor costs, to demonstrate compliance with this section.

4.10.2.7 This section is limited to claim-specific payment composition and documentation and does not address any provider liabilities outside the paid claim.

4.10.3. Special Reimbursement Requirements

4.10.3.1. All Providers

4.10.3.1.1. Unless otherwise noted in Section 4.10.3 of this Agreement, the CONTRACTOR shall reimburse all providers at or above the State Plan approved fee schedule for all services reimbursed at a fee-for-service payment methodology exclusive of applicable taxes and negotiated amounts under 4.10.2. For VBP, APM, and risk-based reimbursements, the CONTRACTOR must incorporate the "at or above" State Plan approved fee schedule into the CONTRACTOR's payment methodology and be able to account for the respective utilization and payment to ensure that the requirement is met.

4.10.3.2. FQHC and RHCs

The CONTRACTOR shall reimburse both Contract and Non-Contract FQHCs and RHCs at a minimum of the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the Social Security Act.

4.10.3.3. CCBHCs

The CONTRACTOR shall reimburse state-certified CCBHCs at the clinic-specific PPS rate for the provision of any covered service provided to an eligible Member for that day.

4.10.3.4. I/T/Us

The CONTRACTOR shall reimburse both Contract and Non-Contract Provider I/T/Us at a minimum of one hundred percent

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(100%) of the rate currently established for the Indian Health Services (IHS) facilities or federally-leased facilities by the Office of Management and Budget (OMB). If a rate is not established by OMB for any particular service, then reimbursement shall be at an amount not less than the Medicaid fee schedule. Services provided within I/T/Us are not subject to prior authorization requirements.

4.10.3.5. Family Planning Non-Contract Providers

The CONTRACTOR shall reimburse family planning Non-Contract Providers for the provision of services to Members at a rate set by HCA.

4.10.3.6. Intentionally Blank

4.10.3.7. Non-Contract Providers for Women in the Third Trimester of Pregnancy

If a pregnant woman in the third trimester of pregnancy has an established relationship with an obstetrical provider and desires to continue that relationship, and the Provider is not a Contract Provider, the CONTRACTOR shall reimburse the Non-Contract Provider in accordance with the applicable Medicaid fee schedule appropriate to the provider type.

4.10.3.8. Reimbursement for Members Who Disenroll or Whose Enrollment is Suspended While Hospitalized

4.10.3.8.1. If a Member is hospitalized at the time of enrollment or disenrollment, the payor at the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, non-psychiatric specialty unit, or hospitals as designated by the DOH until the date of discharge. Upon discharge, the Member becomes the financial responsibility of HCA or the MCO receiving Capitation Payments during the month in which the Member is enrolled.

4.10.3.8.2. Discharge, for the purposes of this Agreement, shall mean: (i) when a Member is moved from or to a PPS exempt unit (such as a

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rehabilitation or psychiatric unit) within an acute care hospital; (ii) when a Member is moved from or to a specialty hospital as designated by DOH or HCA; (iii) when a Member is moved from or to a PPS exempt hospital (such as a psychiatric or rehabilitation hospital); (iv) when a Member leaves the acute care hospital setting to a community setting; and (v) when a Member leaves the acute care hospital setting to an institutional setting. For (v), the "discharge" date is based upon approval of the abstract and/or approval by HCA.

4.10.3.8.3. It is not a "discharge" when a Member is moved from one (1) acute care facility to another acute care facility, including out-of-State acute care facilities.

4.10.3.8.4. If a Member is hospitalized and is disenrolled from a MCO due to a loss in Medicaid coverage, the MCO is only financially liable for the inpatient hospitalization and associated professional services until such time that the Member is determined to be ineligible for Medicaid.

4.10.3.8.5. If a Member is in a NF at the time of disenrollment (not including loss of Medicaid eligibility) the CONTRACTOR shall be responsible for the payment of all Covered Services until the date of discharge or the date of disenrollment, whichever occurs first.

4.10.3.9. State-Operated LTC Facilities

The CONTRACTOR shall negotiate rate(s) and enter into agreements with DOH for State-operated LTC facilities.

4.10.3.10. Compensation for UM Activities

The CONTRACTOR shall ensure that, consistent with 42 C.F.R. § 438.3(i) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services to any Member.

4.10.3.11. Pharmacy Services

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4.10.3.11.1. The CONTRACTOR shall make its Formulary available to its Providers and Members through electronic prescribing tools and as a link on the CONTRACTOR's website.

4.10.3.11.2. The CONRACTOR shall ensure that Native American Members accessing the pharmacy benefit at I/T/Us are exempt from the CONTRACTOR's formulary or the agency's Preferred Drug List (PDL).

4.10.3.11.2.1. The CONTRACTOR is required to cover select multi-source generic over-the-counter (OTC) items as identified by MCO contracted Indian Health Services (I.H.S.) and Tribal 638 outpatient pharmacies. Coverage of the OTC items is restricted to those prescribed by a practitioner for which the item is an economical or preferred therapeutic alternative to a Federal Legend drug.

4.10.3.11.2.2. The All Inclusive Rate (AIR) for pharmacy drug services including prescribed OTCs may be billed in addition to billing an I.H.S. or Tribal 638 physical health, behavorial health, or dental encounter that is provided on the same day. The I.H.S or Tribal 638 outpatient phamacies will continue to bill the MCO's or agency's assigned pharmacy benefit manger (PBM). Excluded from this reimbursement change are durable medical equipment, medical supplies, and OTC orthotic and prosthetic items.

4.10.3.11.2.3. MCOs are required to have their PBMs update their claims processing systems to allow payment of the annual AIR per the Federal Register on outpatient pharmacy drug claims, Federal Legend and Over-the-Counter drug claims, effective for dates of services beginning July 1, 2024 of the Turquoise Care contract.

4.10.3.11.3. The CONTRACTOR must comply with requirements related to "grandfathering," utilization management, and excluded therapeutic classes as specified in the Managed Care Policy Manual.

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4.10.3.11.4. The CONTRACTOR may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement.

4.10.3.11.4.1. In accordance with the Public Assistance Act, NMSA 1978, § Section 27-2-12.34, the CONTRACTOR shall ensure that community-based pharmacy providers that provide services to Medicaid recipients are reimbursed as follows: for the ingredient cost of a drug at a value that is at least equal to the national average drug acquisition cost of the prescription drug at the time that the drug is administered or dispensed, or if data for the national average drug acquisition is unavailable, the wholesale acquisition cost of the drug; and professional dispensing fee. The professional dispensing fee reimbursed to community-based pharmacy providers shall be no less than the professional dispensing fee reimbursed to community-based pharmacy providers for covered outpatient drugs in the Medicaid fee-for-service program.

4.10.3.11.4.2. The CONTRACTOR shall ensure payment to chain and other community-based pharmacies not identified as independent pharmacies is based on the Maximum Allowed Cost (MAC) for ingredient cost generic drugs and is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the National Drug Code (NDC) for the drug item. Dispensing fees will be paid in accordance with the terms of the applicable pharmacies' contracts. When NADAC is not available, the MAC must be no lower than the published Wholesaler's Average Cost (WAC) listed for the NDC + 6%, The WAC must come from a published national pharmacy pricing source such as Medi-Span or First Data Bank that is not associated with the CONTRACTOR or the CONTRACTOR's PBM.

4.10.3.11.5. The CONTRACTOR shall cover outpatient drugs as defined in section 1927(k)(2) of the Social Security Act and comply with the

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requirements outlined in 42 C.F.R. § 438.3(s)(1). “Outpatient drugs” are defined as drugs which are dispensed through a prescription order for the purposes of section 1905(a)(12) of the Social Security Act.

4.10.3.11.5.1. The CONTRACTOR must adhere to the agency's Preferred Drug List (PDL), including preferred/nonpreferred status, prior authorization status, and all clinical criteria developed by the State's Pharmacy and Therapeutrics (P&T) Committee.

4.10.3.11.5.2. The CONTRACTOR shall not impose additional prior authorization requirements for drugs and products included on the PDL and quantity limits can not be more restrictive than the State's quantity limits.

4.10.3.11.5.3. The CONTRACTOR shall not negotiate any drug rebates with pharmaceutical manufactures for drugs on the PDL.

4.10.3.11.5.4. The CONTRACTOR shall not require members to obtain specialty medications, that appear on the Agency’s designated speciality-exeption list listed on the Agency's website, through a specialty pharmacy

4.10.3.11.6. The CONTRACTOR is required to cover select multi-source generic over-the-counter items as identified by HCA and posted on the HCA website. Coverage of over-the-counter items is restricted to those prescribed by a practitioner for which the item is an economical or preferred therapeutic alternative to a Federal Legend drug.

4.10.3.11.7. The CONTRACTOR shall cover brand name drugs and drug items not generally on the CONTRACTOR’s Formulary when determined to be medically necessary by the CONTRACTOR or through a Fair Hearing process.

4.10.3.11.8. The CONTRACTOR shall not include on the CONTRACTOR’s Formulary items excluded from coverage, including but not limited to: medication supplied by state mental hospitals to a Member on convalescent leave from the center; methadone for use in drug treatment

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programs except as part of a MAD-approved MAT program; personal care items, such as non-prescription shampoos and soaps; cosmetic items, such as Retin-A for aging skin and Rogaine for hair loss; drug items that are not eligible for federal financial participation (FFP), including drugs not approved as effective by the FDA, known as DESI (drug efficacy study implementation) drugs; fertility drugs; antitubercular drug items available from the New Mexico department of health (DOH) or the United States public health service; drug items used to treat sexual dysfunction; compounded drug items which lack an ingredient approved by the FDA for the indication for which the drug is intended; compounded drug items for which the therapeutic ingredient does not have an assigned national drug code and is not approved by the FDA for human use; and cough and cold preparations for a Member under the age of four.

4.10.3.11.9. The CONTRACTOR shall have an open formulary for all Behavioral Health Drugs as identified by HCA (see Attachment 7: List of Behavioral Health Drugs) This list is not all inclusive of brand names and formulations, or all Behavioral Health medications. All brands and formulations are to be covered. New FDA medications approved to market are automatically included in this list. If the prescriber certifies medical necessity in writing by noting “brand medically necessary” or “brand necessary” on the prescription and maintains supporting documentation in the Member’s medical record indicating that a generic or alternative medication does not meet the therapeutic needs of the Member, then prior authorization is not necessary for use of a brand drug. Additionally, under these circumstances, neither a demonstration of fail first, nor step therapy, will be required.

4.10.3.11.10. The CONTRACTOR shall ensure that Native American Members accessing the pharmacy benefit at I/T/Us are exempt from the CONTRACTOR’s Formulary.

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4.10.3.11.11. The CONTRACTOR shall reimburse family planning clinics, SBHCs, and DOH public health clinics for contraceptive agents and emergency contraceptives when dispensed to Members and billed using HCPC codes and CMS 1500 forms.

4.10.3.11.12. The CONTRACTOR shall meet all State and federal requirements related to pharmacy rebates and submit all necessary information as directed by HCA no later than forty-five (45) Calendar Days after the end of each quarterly rebate period.

4.10.3.11.13. The CONTRACTOR shall take part in a Drug Utilization Review (DUR) program that complies with the requirements set forth in 42 C.F.R. § 438.3(s) and 42 C.F.R. part 456, subpart K, section 1927(g) of the Social Security Act, and Attachment 9: SUPPORT Act Requirements (SUPPORT Act Requirements), to assure that prescriptions are appropriate, medically necessary, and minimize the potential for adverse medical results.

4.10.3.11.14. The CONTRACTOR's representation at the Medicaid DUR Board shall consist of one (1) physician or one (1) pharmacist.

4.10.3.11.15. When the CONTRACTOR removes drugs from its Formulary, or adds prior authorizations, quantity limits and/or step therapy restrictions on a drug, the CONTRACTOR shall provide Members with at least sixty (60) Calendar Day notice before the effective date of the change.

4.10.3.11.16. The CONTRACTOR shall ensure that contractual reimbursement methodologies between the CONTRACTOR and its pharmacy benefit manager use Pass-Through Pricing methodology.

4.10.3.11.16.1. Any agreement between the CONTRACTOR and a pharmacy benefits manager shall include provisions prohibiting the pharmacy benefit manager or representative of the pharmacy benefit manager from conducting Spread Pricing or retaining rebates with regards to the CONTRACTOR's MCO.

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4.10.3.11.16.2. If the CONTRACTOR's pharmacy benefit manager conducts a retrospective reimbursement reconciliation that results in additional payment to the pharmacy or a clawback of funds paid to the pharmacy, the result of the reconciliation must be reported to the CONTRACTOR. Any funds clawed back from the pharmacy payment must be passed through to the CONTRACTOR and shall not be retained by the pharmacy benefit manager.

4.10.3.11.16.3. Any rebate or manufacturer administrative fees collected by the CONTRACTOR's pharmacy benefit manager must be passed through to the CONTRACTOR and shall not be retained by the pharmacy benefit manager.

4.10.3.11.16.4. The CONTRACTOR shall submit its policies and procedures, and any revisions, for development of network pharmacy payment methodology to HCA for prior written approval. HCA shall review all changes to pharmacy payment methodology prior to implementation of changes.

4.10.3.11.16.5. The CONTRACTOR shall report the administrative fee paid to the pharmacy benefit manager as an "administrative cost" outlined in Section 7.2.7.1.38 of this Agreement.

4.10.3.11.17. The CONTRACTOR, Major Subcontractor and Subcontractor shall comply with the Pharmacy Benefit Manager Regulation Act.

4.10.3.11.17.1. Sections 59A-61-7, NMSA 1978 for pharmacy benefit managers operating in the state of New Mexico.

4.10.3.11.17.2. Section 59A-22-53.1 NMSA 1978 for step therapy protocols for prescription drug coverage.

4.10.3.11.18. The CONTRACTOR shall monitor the use of controlled substances retrospectively in order to detect potential Abuse or overuse and to assure the appropriate use of the drugs as the CONTRACTOR would for all drug items with diversion potential, and provide HCA with

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the oversight and monitoring programs for the utilization of controlled substances, including opioids, on a quarterly asis.

4.10.3.11.18.1. The CONTRACTOR shall work with the other MCOs to convene a task force to develop a standard monitoring program for controlled substance utilization.

4.10.3.11.18.2. The program, at a minimum, must include how monitoring will be conducted; the frequency of monitoring; indicators and thresholds for suspicious utilization and suspicious prescribing patterns; actions that will be taken when suspicious utilization and prescribing patterns are identified; and plans for an on-going CONTRACTOR controlled substance oversight group that reports regularly to HCA and the Collaborative.

4.10.3.11.19. The CONTRACTOR shall monitor the use of opioid drugs and poly-drug use retrospectively in order to detect the potential for drug overdose to assure appropriate use of the drugs as the CONTRACTOR would for all drug items.

4.10.3.11.20. The CONTRACTOR's Formulary shall, at a minimum, include all or substantially all FDA-approved antiretroviral drugs in the class existing in the standard classification systems such as those from U.S. Pharmacopeia and American Hospital Formulary As new antiretroviral drugs or newly approved uses for the antiretroviral drugs become available the CONTRACTOR shall expedite their P&T committee review to make a decision within 90 days to add these drugs to their formulary. The CONTRACTOR shall monitor use of antiretroviral drugs retrospectively in order to detect the potential for duplication of therapy or under-utilization to assure appropriate use of the drugs as the CONTRACTOR would for all drugs items.

4.10.3.11.21. The CONTRACTOR shall cover all FDA approved rescue medications indicated for the emergency treatment of known or suspected opioid (natural or synthetic) overdose without requiring prior

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authorization or quantity limits provided by any legally authorized and allowable prescriber/dispenser and shall require their Contract Providers to comply with all aspects of the Pain Relief Act, NMSA 1978, § 24-2D, including but not limited to offering overdose counseling education.

4.10.3.11.21.1. As new naloxone forms of administration become available, the CONTRACTOR shall cover brand name naloxone not generally on the CONTRACTOR's Formulary when determined to be medically necessary by the CONTRACTOR, unless otherwise specified by HCA's PDL.

4.10.3.11.22. The CONTRACTOR shall adhere to all requirements in the Audit of Pharmacy Records Act (NMSA 1978 § 61-11-18.2) when auditing pharmacies.

4.10.3.11.22.1. The CONTRACTOR shall not require more than one prior authorization per policy period for any single drug or category of item for diabetes treatment or its complications when prescribed as medically necessary by the covered Member's health care prescriber: (1) blood glucose monitors, including those for persons with disabilities, including the legally blind; (2) test strips for blood glucose monitors; 3) visual reading urine and ketone strips; (4) lancets and lancet devices; (5) insulin; (6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind; (7) syringes; (8) prescriptive oral agents for controlling blood sugar levels; (9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; (10) glucagon emergency kits.

4.10.3.11.22.2. The CONTRACTOR shall not require step therapy or prior authorizations for FDA approved medications to treat autoimmune

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disorders, cancer, substance use disorders, and rare conditions when prescribed by a medical professional as medically necessary, except in cases in which a biosimilar, interchangeable biologic or generic version is available. Medical necessity determinations shall be automatically approved within seven days and within 24 hours for emergent cases where a delay in treatment can cause harm to the eligible member.

4.10.3.12. The CONTRACTOR shall develop reimbursement strategies (e.g., VBP) to support its Population Health Management plan as described in Section 4.12.1.

4.10.3.13. The CONTRACTOR shall develop reimbursement strategies that focus on improvements in maternal and child health outcomes. Reimbursement strategies shall include at a minimum:

4.10.3.13.1.1. Incentives to Providers to add perinatal services to their practice and in particular, medically complex perinatal Members, such as those experiencing substance use disorders; and

4.10.3.13.1.2. Incentives to facilities that have received the Baby-Friendly designation.

4.10.3.14. Emergency Services

4.10.3.14.1. Any provider of Emergency Services that is a Non-Contract Provider must accept, as payment in full, no more than the amount established by HCA for such services. This requirement applies whether or not the Non-Contract Provider is within the State.

4.10.3.14.2. The CONTRACTOR shall reimburse acute general hospitals for Emergency Services, which they are required to provide because of federal mandates such as the "anti-dumping" law in the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 and 42 U.S.C. § 1395(dd) and Section 1867 of the Social Security Act.

4.10.3.14.3. The CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the

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Member, if the screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition exists. The CONTRACTOR may not refuse to cover Emergency Services based on an emergency room provider, hospital, or fiscal agent not notifying the Member's PCP or the CONTRACTOR of the Member's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services. If the screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition exists, the CONTRACTOR shall pay for both the services involved in the screening examination and the services required to stabilize the Member. The Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member, as provided in 42 C.F.R. § 438.114(d).

4.10.3.14.4. The CONTRACTOR shall pay for all Emergency Services and Post- Stabilization care that are Medically Necessary Services until the Emergency Medical Condition is stabilized and maintained.

4.10.3.14.5. If the screening examination leads to a clinical determination by the examining physician that an actual Emergency Medical Condition does not exist, then the determining factor for payment liability is whether the Member had acute symptoms of sufficient severity at the time of presentation. In these cases, the CONTRACTOR shall review the presenting symptoms of the Member and shall pay for all services involved in the screening examination where the presenting symptoms (including severe pain) were of sufficient severity to have warranted emergency attention under the prudent layperson standard. The CONTRACTOR may not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. If the Member believes that a Claim for Emergency Services has been inappropriately

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denied by the CONTRACTOR, the Member may seek recourse through the Appeal and Fair Hearing process.

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

4.10.3.14.7. The attending emergency physician or the Provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the entities identified in 42 C.F.R. § 438.114(b) as responsible for coverage and payment. In addition, the CONTRACTOR is financially responsible for Post-Stabilization services administered to maintain, improve or resolve the Member's stabilized condition if: (i) the CONTRACTOR does not respond to a request for pre-approval within one (1) hour; (ii) the CONTRACTOR cannot be contacted; or (iii) the CONTRACTOR's representative and the treating physician cannot reach an agreement concerning the Member's care and a CONTRACTOR physician is not available for consultation. In this situation, the CONTRACTOR must give the treating physician the opportunity to consult with a CONTRACTOR physician and the treating physician may continue with care of the Member until a CONTRACTOR physician is reached or one (1) of the criteria of 42 C.F.R. § 422.113(c)(3) is met.

4.10.3.14.8. The CONTRACTOR is financially responsible for Post-Stabilization Services obtained within or outside the CONTRACTOR's network that are pre-approved by the CONTRACTOR. The CONTRACTOR's financial responsibility for Post-Stabilization Services that have not been pre-approved shall end when: (i) a Contract Provider with privileges at the treating hospital assumes responsibility for the Member's care; (ii) a Contract Provider assumes responsibility for the Member's care through transfer; (iii) a representative of the

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CONTRACTOR and the treating physician reach an agreement concerning the Member's care; or (iv) the Member is discharged.

4.10.3.14.9. The CONTRACTOR must limit charges to Members for Post-Stabilization Services received from Non-Contract Providers to an amount no greater than what the CONTRACTOR would have charged the Member if he or she obtained the services from a Contract Provider.

4.10.3.15. Treat First Providers

4.10.3.15.1. For certain Providers that have been designated by HCA as Treat First Providers, Outpatient Behavioral Health therapy and all specialty services can be initiated and billed before a psychiatric diagnostic evaluation has been completed. The specification of a diagnosis may be deferred until after the fourth session where upon a diagnosis will then be established and appropriately documented in the medical record and on all subsequent billed Claims. There will always be a "provisional diagnosis" on any Claim through the fourth encounter if the diagnostic evaluation has not yet been completed. This shall include all appropriate ICD 10 classified external causes of morbidity (V, X, and Y diagnosis codes) and factors influencing health status (Z diagnosis codes). In addition, CCSS can be initiated by the Treat First Providers without a designation of SMI, SED, or SUD. After four (4) encounters, if continuing CCSS, a qualifying diagnosis within the SMI, SED, or SUD designation must be entered on the claim.

4.10.3.16. Nursing Facilities

4.10.3.16.1. The CONTRACTOR is responsible for paying claims for short-term NF stays for its Members. The CONTRACTOR is required to conduct a NF LOC assessment to authorize a short-term NF stay, if the Member meets the NF LOC criteria. This includes payment for short-term NF stays for Dual Eligible Members and retro-enrollment periods. A SOC for a short-term NF stay should not be submitted to HCA.

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4.10.3.16.2. For Members who are Medicaid only, the CONTRACTOR is responsible for paying the full amount of the short-term NF stay.

4.10.3.16.3. Related to Medicare crossover claims, CONTRACTOR payments to NFs after payments by Medicare or a Medicare Advantage Plan cannot be less than the sum of the co-insurance, deductible, and copayment amounts calculated by Medicare or the Medicare Advantage Plan, less any applicable Member pay amount.

4.10.3.16.4. For Members who are Dual Eligibles, Medicare will pay a portion of a short-term NF stay leaving the remainder of the claim to be paid by the CONTRACTOR.

4.10.3.17. The CONTRACTOR shall participate in the SBHC long-acting reversible contraceptives (LARC) as directed by HCA with the goal of ensuring same-day access to LARC devices/products for Members served by SBHCs and FQHCs. Funding provided to SBHCs under this requirement does not preclude the CONTRACTOR's obligation to ensure the Member's freedom to choose their method of family planning, in accordance with 42 C.F.R. § 441.20.

4.10.3.18. The CONTRACTOR shall collaborate to develop and implement a FQHC residency pilot program for HCA written approval.

4.10.4. Non-Contract Providers

4.10.4.1. 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:

4.10.4.1.1. Non-Contract Providers ninety-five percent (95%) of the Medicaid fee schedule rate for the Covered Services provided; and

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

4.10.5. Provider-Preventable Conditions, Including Health Care-Acquired Conditions

In accordance with Section 2702 of the PPACA, the CONTRACTOR must have mechanisms in place to preclude payment to Providers for Provider-Preventable

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Conditions. The CONTRACTOR shall require Provider self-reporting through Claims. The CONTRACTOR shall track the Provider-Preventable Conditions data and report these data to HCA via Encounter Data. To ensure Member access to care, any reductions in payment to Providers must be limited to the added costs resulting from the Provider-Preventable Conditions consistent with 42 C.F.R. § 447.26 and § 438.3(g). The CONTRACTOR must use existing Claims systems as the platform for Provider self-reporting and report to HCA via Encounter Data.

4.10.6. Physician Incentive Plans

The CONTRACTOR may operate a physician incentive plan in accordance with 42 C.F.R. § 438.3(i), § 422.208 and § 422.210. If the CONTRACTOR implements a physician incentive plan, it must submit the plan annually to HCA at the beginning of each year of the Agreement.

4.10.7. Value-Based Purchasing

4.10.7.1. General VBP Requirements

4.10.7.1.1. Provider payments in VBP programs must be based upon improved Member health care outcomes and/or quality scores. The CONTRACTOR must demonstrate how VBP programs improve Member outcomes/quality scores and not solely administrative efficiencies to qualify as a VBP program.

4.10.7.1.2. VBP Arrangements must include provisions whereby providers are held accountable to quality goals via performance measures (PMs) and savings are passed directly to the front-line providers and teams making the necessary interventions to improve quality. When selecting PMs for VBP contracts, the CONTRACTOR must adhere to any PM requirements promulgated by HCA, and the New Mexico Primary Care Council for Primary Care VBP targets.

4.10.7.1.3. In order to be counted towards the CONTRACTOR's total VBP Delivery System Improvement Performance Targets (DSIPT) goals, VBP arrangements applicable to Primary Care must adhere to requirements defined by HCA and the New Mexico Primary Care Council.

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4.10.7.1.4. The CONTRACTOR shall develop a VBP plan for achieving the requirements of Attachment 2, DSIPT and meeting the general expectation to reward Providers based on achieving quality and outcomes. The CONTRACTOR's plan shall be submitted to HCA annually by April 1. Upon written approval from HCA, the CONTRACTOR shall implement its plan. The VBP plan, at a minimum, shall include the following:

4.10.7.1.4.1. Initiatives, goals, targets, and strategies;

4.10.7.1.4.2. Baseline period; and

4.10.7.1.4.3. Data sharing arrangements established with Contract Providers under VBP arrangements.

4.10.7.1.5. The CONTRACTOR shall submit updates to the evaluation plan to HCA quarterly that include status, supportive data, and other pertinent information to the delivery system improvement.

4.10.7.1.6. The CONTRACTOR shall submit quarterly DSIPT reports on templates provided by HCA.

4.10.7.1.7. The CONTRACTOR shall share performance and Claims data and lists of attributed Members with Providers on a quarterly basis for the membership that is attributed to the provider in VBP arrangements. This data shall include sufficient information on all services provided to attributed Members, not just those delivered by the Contract Provider.

4.10.7.1.8. The CONTRACTOR shall share performance and/or claims data with Providers considering entering into VBP arrangements. This data shall be sufficient to allow Providers to make informed decisions about potential contracts.

4.10.7.1.9. The CONTRACTOR shall provide technical assistance opportunities to current and potential VBP Contract Providers.

4.10.7.1.10. HCA contemplates designing and implementing VBP or other payment models focused on the unique needs of CISC Members to

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incentivize a health care delivery system that provides high-quality services and optimal outcomes for CISC Members and their Caregivers.

4.10.7.1.10.1. The CONTRACTOR shall assist HCA and CYFD as directed by HCA the design and implementation of VBP or other payment model strategies that benefit CISC Members and their Caregivers.

4.10.7.1.10.2. The CONTRACTOR shall support Provider readiness and innovation in preparation for CISC-focused VBP or other payment models that reward quality care and outcomes over volume of services.

4.10.7.1.10.3. The CONTRACTOR shall comply with all requirements identified by HCA associated with the implementation of CISC-focused VBP or other payment model strategies, including but not limited to quality measures, performance metrics, and reporting requirements.

4.10.7.2. Primary Care VBP Requirements

4.10.7.2.1. The New Mexico Primary Care Council was established to identify ways primary care investment can increase access to primary care services, improve the quality of primary care services, address the shortage of primary care Providers, and reduce overall health care costs. The mission of the New Mexico Primary Care Council is to revolutionize primary care into inter-professional, sustainable teams delivering high-quality, accessible, equitable health care across New Mexico through partnerships with patients, families, and communities. The goals of the New Mexico Primary Care Council are to move away from volume-based "sick-care" to value-based care, to integrate "whole-person wellness", and to reduce Provider burden while strengthening the network. The collective efforts of the New Mexico Primary Care Council are referenced in this Agreement as Primary Care Payment Reform (PCPR).

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4.10.7.2.2. The CONTRACTOR shall execute and facilitate all components of the PCPR payment model, including standardized metrics, reporting, payment structures, patient attribution, data intermediary capabilities, technical assistance, and practice transformation support. The CONTRACTOR shall implement PCPR as outlined in the in the Turquoise Care Primary Care VBP Guidebook document due to be released fall of 2023. The CONTRACTOR shall use Provider metrics (access to care, equity, HEDIS, and patient satisfaction) as outlined by HCA and the New Mexico Primary Care Council.

4.10.7.2.3. The CONTRACTOR shall provide technical assistance to educate Primary Care Providers about the benefits of the PCPR model, train Providers on data reporting and the payment structure, and provide support to Providers as they progress through the PCPR payment continuum.

4.10.7.2.4. The CONTRACTOR shall adhere to any Primary Care VBP target recommendations intended to measure PCBR implementation, adherence, and outcomes as endorsed by the Primary Care Council and promulgated by HCA.

4.10.7.2.5. The CONTRACTOR shall deliver an aligned approach across all CONTRACTORS to the Provider-Facing processes of the model designed to promote inter-professional team collaboration and reduce administrative burden including, but not limited to: forms, processing, training, technical assistance, data submission, and reporting.

4.10.7.2.6. The CONTRACTOR shall report and share PCPR and Primary Care VBP data and information with Providers, HCA, and other Turquoise Care MCOs, as directed by HCA.

4.10.7.2.7. The CONTRACTOR shall partner with all other MCO CONTRACTORS to utilize the state selected single VBP data intermediary. The HCA CONTRACTOR and all other MCO CONTRACTORS shall collaborate with each other to direct the data

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intermediary to provide necessary capabilities of the Primary Care VBP as outlined by HCA and the Primary Care Council and as stated in the Turquoise Care Primary Care VBP Guidebook document due to be released in the Fall of 2023.

4.10.7.2.8. The CONTRACTOR shall provide PCPR and Primary Care VBP reporting as directed by HCA. Reporting shall include but is not limited to the CONTRACTOR's percentage of total healthcare spending for primary care using the New Mexico Primary Care Council's definition of primary care, provided upon request.

4.10.7.2.9. The CONTRACTOR shall increase the percentage of primary care spend as a proportion of total healthcare spending, subject to evidence-informed recommendations from the New Mexico Primary Care Council. The New Mexico Primary Care Council will take into account market and workforce feasibility.

4.10.8. Safety-Net Care Pool Hospitals

4.10.8.1. The CONTRACTOR shall make best efforts to contract with the Providers listed in Attachment 3: Safety Net Care Pool Hospitals.

4.10.8.2. The CONTRACTOR shall pay Providers included in Attachment 3: Safety Net Care Pool Hospitals at or above the Medicaid fee schedule for inpatient hospital services.

4.10.9. The CONTRACTOR is prohibited from using federal Medicaid funding to pay 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. State Medicaid funding may be used in accordance with the End-of-life Options Act (N.M. Stat. § 30-2-4).

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

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has provided the State with a surety bond as specified in Section 1861(o)(7) of the Social Security Act.

4.10.12. Directed Payments

4.10.12.1. The CONTRACTOR shall comply with Directed Payments established by HCA and approved by CMS. All assurances specified in 42 C.F.R. § 438.6(c)(2)(ii)-(iii) applicable to the type of Directed Payment, as defined in 42 C.F.R. § 438.6(c)(1)(i)-(iii), and made by HCA part of the approval process for Directed Payments are restated and reaffirmed.

4.10.12.2. HCA shall communicate the requirements of the Directed Payment to the CONTRACTOR through a Letter of Direction.

4.10.12.3. The Directed Payments listed in Attachment 10: Directed Payments are required of the CONTRACTOR, subject to annual approval by CMS unless otherwise specified.

4.10.13. Non-Risk Arrangements

4.10.13.1. The CONTRACTOR shall comply with non-risk arrangements established by HCA and approved by CMS.

4.10.13.2. HCA shall communicate the requirements of the non-risk arrangement to the CONTRACTOR through a Letter of Direction or via changes to the Managed Care Policy Manual.

4.10.13.3. The non-risk arrangements comply with the upper payment limits specified in 42 C.F.R. § 447.362.

4.10.13.4. The non-risk arrangements listed in Attachment 11: Non-Risk Arrangements are required of the CONTRACTOR.

4.11 **Provider Services**

4.11.1 Provider Handbook

4.11.1.1 The CONTRACTOR shall issue a provider handbook to all Contract Providers. The CONTRACTOR may distribute the Provider handbook electronically (e.g., via its website) as long as Providers are notified about how to obtain the electronic copy and how to request a hard copy at no charge to the Provider.

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4.11.1.2 At a minimum, the Provider handbook shall include the following information:

4.11.1.2.1 A table of contents;

4.11.1.2.2 Description of Turquoise Care, including eligibility, enrollment, and Member assessment information;

4.11.1.2.3 Information about CISC Members and the CISC CONTRACTOR;

4.11.1.2.4 Covered Services;

4.11.1.2.5 Description of the role of care coordinators;

4.11.1.2.6 Cultural competency and cultural humility;

4.11.1.2.7 How the Provider can access language interpretation and specialized communication services;

4.11.1.2.8 Description of the SDCB and the Agency-Based Community Benefit;

4.11.1.2.9 Emergency Services responsibilities;

4.11.1.2.10 Information on Member Grievance and Appeal rights and processes, including Fair Hearings;

4.11.1.2.11 Policies and procedures of the provider grievance and appeal complaint system;

4.11.1.2.12 Medically Necessary Service standards and clinical practice guidelines;

4.11.1.2.13 PCP responsibilities;

4.11.1.2.14 Member lock in standards and requirements;

4.11.1.2.15 The CONTRACTOR's Fraud and Abuse policies and procedures, including how to report suspected Fraud and/or Abuse;

4.11.1.2.16 Coordination with other Providers, Major Subcontractors, or HCA contractors;

4.11.1.2.17 Requirements regarding background checks;

4.11.1.2.18 Information on identifying and reporting suspected Abuse, neglect, and exploitation of Members;

4.11.1.2.19 Prior authorization, referral, and other Utilization Management requirements and procedures;

4.11.1.2.20 Protocol for Encounter Data reporting and records;

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4.11.1.2.21 Claims submission protocols and standards, including instructions and all information necessary for Clean Claims;

4.11.1.2.22 Payment policies;

4.11.1.2.23 Credentialing and recredentialing requirements;

4.11.1.2.24 Confidentiality and HIPAA requirements with which the Provider must comply;

4.11.1.2.25 Member rights and responsibilities;

4.11.1.2.26 The telephone number for the Provider services line; and

4.11.1.2.27 A separate section and/or addendum that specifically address the ABP services and ABP Exempt Members.

4.11.1.3 The CONTRACTOR shall disseminate bulletins as needed to incorporate any necessary changes to the provider handbook.

4.11.2 Provider Services Call Center

4.11.2.1 The CONTRACTOR shall operate a provider services call center with a separate toll-free telephone line to respond to Provider questions, comments, inquiries, and requests for service authorizations. This call center and its staff must be located and operated in the State of New Mexico. At its discretion, HCA may allow specialty units such as pharmacy, dental, and vision to be located out-of-state. Any exceptions must be prior approved by HCA.

4.11.2.2 The CONTRACTOR shall develop provider service line policies and procedures that address staffing, training, hours of operation, access, and response standards, monitoring of calls via recording or other means and compliance with standards.

4.11.2.3 The CONTRACTOR shall ensure that the provider service line is staffed adequately to respond to Providers' questions at a minimum from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, except for New Year's Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving Day and Christmas Day.

4.11.2.4 The CONTRACTOR shall have an automated system available during non-business hours. This automated system shall include, at a minimum, information on how to obtain after hours service authorization requests and a voice mailbox

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for callers to leave messages. The CONTRACTOR shall ensure that the automated system has adequate capacity to receive all messages. The CONTRACTOR shall return messages on the next Business Day.

4.11.2.5 The provider service line shall also be adequately staffed to provide appropriate and timely responses regarding authorization requests as described in Section 4.12 of this Agreement. The CONTRACTOR may meet this requirement by having a separate Utilization Management line.

4.11.2.6 The call center staff shall have access to electronic documentation from previous calls made by a Provider.

4.11.2.7 The CONTRACTOR shall adequately staff the provider service line to ensure that the line and the Utilization Management line/queue, meet the following performance standards independently on a monthly basis:

4.11.2.7.1 Less than five percent (5%) call abandonment rate;

4.11.2.7.2 Ninety percent (90%) of calls are answered by a live voice within thirty (30) seconds;

4.11.2.7.3 Average wait time for assistance does not exceed thirty (30) seconds;

4.11.2.7.4 Seventy percent (70%) of all calls are resolved during the first call; and

4.11.2.7.5 One hundred percent (100%) of voicemails returned by next Business Day.

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

4.11.3 Provider Website

4.11.3.1 The CONTRACTOR shall have a Provider page on its website that is accessible to Providers and the general public without any log-in requirements. The Provider page shall include all pertinent information prominently placed on the Provider page, including but not limited to, alerts of any changes to the CONTRACTOR's coverage policies or procedures, a link to the Provider directory, the Provider manual, sample Provider agreements, updated newsletters and notifications, and information about how to contact the CONTRACTOR's Provider services department.

4.11.3.2 The CONTRACTOR must ensure its website is Americans with Disabilities Act Section 508 compliant and meets health equity requirements.

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4.11.3.3 The CONTRACTOR must have a mobile version of the MCO's Provider website content.

4.11.3.4 The CONTRACTOR must ensure that all Provider information is located on the MCO's website in a manner that Providers can easily find and navigate to and from the MCO's home page.

4.11.3.5 The CONTRACTOR shall have a secure Provider portal that includes the functionality to allow Providers to:

4.11.3.5.1 Make inquiries, submit documentation, and receive responses from the CONTRACTOR regarding care for Members and payment, including electronic prior authorization request and approval, electronic claims submission and tracking, and electronic submission of Provider grievances and appeals complaints;

4.11.3.5.2 Access relevant Member information, including real-time eligibility and enrollment and claims and utilization history; and

4.11.3.5.3 Access relevant Provider information, including the information provided on the public Provider page and Provider-specific information (e.g., Provider profiles, geographic regions where Providers are located, including satellite office locations).

4.11.3.6 Upon HCA direction, the CONTRACTOR shall integrate its Provider portal with the HCA Unified Portal.

4.11.3.7 The CONTRACTOR shall have policies and procedures in place to ensure the Provider public page and secure portal are updated regularly and contains accurate and up-to-date information.

4.11.4 Provider Workgroup

4.11.4.1 The CONTRACTOR shall participate in the Provider Workgroup, consisting of representation from each Turquoise Care MCO, HCA, and Providers, for purposes of streamlining documents and processes for Providers. The CONTRACTOR shall consult with HCA prior to appointing Providers to the Provider Workgroup.

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4.11.4.2 The Provider Workgroup shall collaborate throughout the term of the Agreement to reduce the administrative burdens on Providers.

4.11.4.3 Specifically, the Provider Workgroup will develop, among other things, forms and templates related to: (i) credentialing; (ii) Provider audits; (iii) reporting; (iv) authorizations; (v) Grievances and Appeal System; and (vi) forms for level of care determinations.

4.11.5 Provider Education, Training and Technical Assistance

4.11.5.1 The CONTRACTOR shall develop and implement a Provider Training and Outreach Plan annually to educate Contract Providers on Turquoise Care requirements and the CONTRACTOR's processes and procedures. The CONTRACTOR shall also submit a Provider Training and Outreach Evaluation Report as directed by HCA.

4.11.5.2 The CONTRACTOR shall collaborate with Counties, State agencies, and local governments to provide direct technical assistance regarding contracting, billing, and reimbursement for Covered Services.

4.11.5.3 The CONTRACTOR shall establish and maintain policies and procedures to implement the Provider Training and Outreach Plan and the Provider Training and Outreach Evaluation Report that address the following, including but not limited to:

4.11.5.3.1 The development and distribution of education and informational materials to its Contract Providers;

4.11.5.3.2 A formal process for Provider education regarding the Turquoise Care program, the conditions of participation in the program, and the Contract Provider’s responsibilities to the CONTRACTOR and its Members;

4.11.5.3.3 Contract Provider education and training, which must be provided throughout the Agreement term to address clinical issues and improve the service delivery system, including but not limited to, assessments, treatment or service plans, person-centered planning, timely access requirements, continuous quality improvement processes, discharge plans, evidence-based

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practices, models of care, such as integrated care and Trauma-informed care; and

4.11.5.3.4 Training shall be offered throughout the State and at different times of the day in order to accommodate Contract Providers' schedules.

4.11.5.4 The CONTRACTOR shall provide the following information in Contract Provider trainings and educational materials and shall make such information available upon request of a Contract Provider:

4.11.5.4.1 Conditions of participation with the CONTRACTOR;

4.11.5.4.2 Providers' responsibilities to the CONTRACTOR and to Members;

4.11.5.4.3 Integrated care for Physical Health, Behavioral Health, and LTC services;

4.11.5.4.4 The CONTRACTOR's Care Coordination process and systems, including policies and procedures regarding addressing the needs of and service delivery for persons with special health care needs;

4.11.5.4.5 The CONTRACTOR's definition of high volume Provider and whether or not a Provider meets that definition;

4.11.5.4.6 Billing requirements and rate structures and amounts;

4.11.5.4.7 Cultural and linguistic competency and how to access educational opportunities for Providers and their staff on cultural and linguistic competency;

4.11.5.4.8 The credentialing and recredentialing process;

4.11.5.4.9 The prior authorization and referral processes, and how to request and obtain a second opinion for Members;

4.11.5.4.10 The delivery of the federally mandated EPSDT services;

4.11.5.4.11 Information on the CONTRACTOR's internal Provider grievance and appeals complaint process;

4.11.5.4.12 Providers' responsibility to report Critical Incident information and the mechanism to report such information;

4.11.5.4.13 The delivery of services to CISC or children in Tribal custody, including but not limited to, issues related to consent, progress reporting and potential for court testimony;

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4.11.5.4.14 The provisions and limitations of the ABP;

4.11.5.4.15 Provider identification of SUD and SMI;

4.11.5.4.16 Trauma Responsive Training, approved by HCA; and

4.11.5.4.17 Provider trainings specific to the no reject and no eject provision for CISC.

4.11.5.5 The CONTRACTOR's training program shall include the methods the CONTRACTOR will use to ensure that Providers of all types receive education and training about delivering culturally and linguistically appropriate services to Members. The CONTRACTOR shall ensure this education and training is provided on an ongoing basis, but not less than annually.

4.11.5.5.1 The CONTRACTOR shall include an annual calendar of Provider training that fully describes the training topics and delivery modalities in the CONTRACTOR's CHP and/or shared with HCA.

4.11.5.5.2 The CONTRACTOR shall regularly evaluate the training needs of the Providers and update the training programs, when appropriate.

4.11.5.5.3 Training must go beyond race/ethnicity to include health disparities and health care needs of priority populations.

4.11.5.6 The CONTRACTOR shall maintain a record of its training and technical assistance activities, which it shall make available to HCA and/or other State agencies upon request.

4.11.5.7 The CONTRACTOR shall provide to HCA, upon request, documentation that Contract Provider education and training is met.

4.11.5.8 The CONTRACTOR shall provide technical assistance to Contract Providers as determined necessary by the CONTRACTOR or HCA, including one-on-one meetings with Providers. This technical assistance shall be provided in a culturally competent manner.

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

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

4.12 **Population Health Management and Quality Assurance**

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4.12.1 Standards for Population Health Management

The CONTRACTOR shall develop and implement a Population Health Management plan that documents the CONTRACTOR's strategies and targeted interventions to improve the well-being and health outcomes of Members by providing person-centered care, identifying and mitigating health disparities, and addressing Members' Physical Health, Behavioral Health, LTC, and social needs. The CONTRACTOR's Population Health Management plan must address all activities that support Population Health and align with HCA's Quality Strategy. The CONTRACTOR shall submit an annual Population Health Management plan for HCA review and approval. The CONTRACTOR's annual Population Health Management plan must describe the following core components:

4.12.1.1 The CONTRACTOR's identification and stratification of populations targeted for Population Health Management strategies.

4.12.1.1.1 The CONTRACTOR's targeted populations must align with HCA-identified priority populations:

4.12.1.1.1.1 Pregnant and Postpartum Members and young children, including CISC;

4.12.1.1.1.2 Seniors and Members with LTSS needs;

4.12.1.1.1.3 Members with Behavioral Health conditions;

4.12.1.1.1.4 Native American Members; and

4.12.1.1.1.5 Justice-involved Members.

4.12.1.1.2 The CONTRACTOR's process and criteria for conducting risk stratification within targeted populations, as well as the process the CONTRACTOR will follow to change a Member's risk stratification when there is a significant change to the Member's needs or circumstances. The CONTRACTOR must describe how risk stratification for identified populations relates to assessments used for the purpose of identifying an appropriate level of Care Coordination as described in Section 4.4.4.

4.12.1.1.2.1 In addition to the acuity and chronicity of the Member's Behavioral Health and Physical Health condition(s), the CONTRACTOR's risk

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stratification criteria must include contributing factors, such as health equity, safety, Trauma, and HRSN.

4.12.1.2 The CONTRACTOR's Population Health Management identification of goals, strategies, and targeted interventions for each population that are designed to meet the varying level and type of needs of Members within each risk stratification, including the following types of internal and external resources to support Population Health:

4.12.1.2.1 Health education and wellness programs;

4.12.1.2.2 Care Coordination and Disease Management programs;

4.12.1.2.3 Patient-centered initiatives, such as PCMHs;

4.12.1.2.4 Value-added benefits;

4.12.1.2.5 Community organizations that offer resources that may address needs associated with HRSN (e.g., housing resources, vocational programs, food banks, support groups);

4.12.1.2.6 Cross-agency collaboration with other Member-serving agencies and organizations (e.g., justice system, schools, CYFD);

4.12.1.2.7 Advisory boards and other mechanisms for stakeholder input;

4.12.1.2.8 Utilization Management;

4.12.1.2.9 Practice guidelines;

4.12.1.2.10 QM/QI activities, including CHP and initiatives to address health disparities; and

4.12.1.2.11 VBP and/or other reimbursement strategies.

4.12.1.3 The CONTRACTOR's organizational resources that will be used to support Population Health Management strategies and targeted interventions, including:

4.12.1.3.1 Population Health leadership, staffing resources, and structures; and

4.12.1.3.2 Information systems to integrate and analyze data to inform population identification, risk stratification, individual and population needs, track referrals to external community resources, and to monitor and evaluate the effectiveness of the CONTRACTOR's Population Health Management strategies and targeted interventions.

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4.12.1.4 The CONTRACTOR's process for continuous monitoring and evaluating the effectiveness of its Population Health Management strategies and targeted interventions, including:

4.12.1.4.1 Staff with health equity expertise responsible for monitoring and evaluating the effectiveness of Population Health Management strategies and targeted interventions;

4.12.1.4.2 Type and sources of data and information, and how the data and information will be synthesized to monitor and evaluate the effectiveness of its Population Health Management strategies and targeted interventions; and

4.12.1.4.3 How the CONTRACTOR will use its QM/QI program (e.g., stratified PMs, TMs, and/or other quality metrics by priority and targeted populations) to monitor and evaluate the impact of Population Health Management strategies and targeted interventions.

4.12.1.5 The CONTRACTOR's subsequent submissions of the annual Population Health Management plan following the initial submission must be made at the beginning of each year and additionally include:

4.12.1.5.1 A summary of the effectiveness of the strategies to meet the goals and objectives in the CONTRACTOR's Population Health Management plan; and

4.12.1.5.2 How the CONTRACTOR's prospective strategies have been informed by the analysis of the effectiveness of the previous year's strategies and targeted interventions.

4.12.2 Standards for Quality Management and Quality Improvement (QM/QI)

The CONTRACTOR shall comply with State and federal standards for quality management and quality improvement. The CONTRACTOR shall:

4.12.2.1 Establish QM/QI program based on a model of continuous quality improvement using clinically sound, nationally developed, and accepted criteria;

4.12.2.2 Recognize that opportunities for improvement are unlimited; that the QM/QI process shall be data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements; requiring re-measurement

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of effectiveness and continuing development and implementation of improvements as appropriate; and, shall reflect Member and Contract Provider input;

4.12.2.3 Have a QM/QI annual program description that includes goals, objectives, structure, and policies and procedures that shall result in continuous quality improvement. The QM/QI annual program description, goals and objectives must include and support the CONTRACTOR's Population Health Management plan as described in this Section 4.12 and HCA's Quality Strategy;

4.12.2.4 Review outcome data at least quarterly for performance improvement, recommendations, and interventions;

4.12.2.5 Have a mechanism in place to detect under-and-over utilization of services;

4.12.2.6 Have access to, and the ability to collect, manage, and report to HCA data necessary to support the QM/QI activities and may be used to inform Population Health Management strategies;

4.12.2.7 Establish a committee to oversee and implement all policies and procedures;

4.12.2.8 Ensure that the ultimate responsibility for QM/QI is with the CONTRACTOR and shall not be delegated to its Subcontractors;

4.12.2.9 Have an annual QM/QI work plan to be submitted at the beginning of each year of the Agreement, approved by HCA that includes, at a minimum, immediate objectives for each Agreement year and long-term objectives for the entire term of this Agreement. The QM/QI work plan shall contain the scope, objectives, planned activities, time frames, and data indicators for tracking performance and other relevant QM/QI information, including quality improvement projects identified by HCA.

4.12.2.10 At a minimum, implement Performance Improvement Projects (PIPs) in the following areas:

4.12.2.10.1 One (1) Expand access to Assisted Living for Medicaid Members

4.12.2.10.2 One (1) Enhanced Services for an entire 12 Months for Prenatal and Postpartum Mothers with SUD;

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4.12.2.10.3 One (1) Expanding /Enhancing the States OB/GYN provider network (targeting OB deserts Rural and Frontier);

4.12.2.10.4 One (1) Improving Well Visits and Immunizations for children and adolescents; and

4.12.2.10.5 One (1) Hep C. Treatments (access to medications).

4.12.2.10.6 PIP work plans and activities must be consistent with PIPs as required by State and federal statutes and regulations, including the Quality Assessment and Performance Improvement Program requirements pursuant to 42 C.F.R. § 438.330. For more detailed information refer, to the EQR protocols available at ;

4.12.2.10.7 HCA reserves the right to select performance indicators, establish targets, and require the CONTRACTOR to include specific interventions in its PIP design.

4.12.2.11 Have the ability to design sound quality studies, apply statistical analysis to data, and derive meaning from the statistical analysis;

4.12.2.12 Submit an annual QM/QI written evaluation to HCA that includes, but is not limited to:

4.12.2.12.1 A description of ongoing and completed QM/QI activities;

4.12.2.12.2 Measures that are trended to assess performance;

4.12.2.12.3 Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of clinical care and service;

4.12.2.12.4 Developing future work plans based on the incorporation of previous year findings of overall effectiveness of the QM/QI program;

4.12.2.12.5 Demonstrating that active processes are implemented that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention’s effectiveness;

4.12.2.12.6 Demonstrating that the results of QM/QI projects and reviews are incorporated in the QM/QI program;

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4.12.2.12.7 Reporting on all federally required PMs related to HCBS waiver assurances, including details on remediation or systemic improvement based on performance as necessary. Current HCBS waiver assurances are available on the CMS website;

4.12.2.12.8 Incorporating annual HEDIS results including ECDS in the following year's plan as applicable to HCA-specific programs and quality measures; and

4.12.2.12.9 Communicating with appropriate Contract Providers the results of QM/QI activities and Provider reviews and using this information to improve the performance of the Contract Providers, including technical assistance, corrective action plans, and follow-up activities as necessary; and

4.12.2.13 Upon request, present the Behavioral Health aspects of the CONTRACTOR's annual QM/QI work plan during a quarterly meeting of the Collaborative.

4.12.3 Advisory Boards

4.12.3.1 Native American Advisory Board (NAAB)

4.12.3.1.1 The CONTRACTOR shall participate in meetings with the NAAB. At a minimum, such meetings will occur quarterly. NAAB Members shall serve to advise the CONTRACTOR on any issues pertaining to Native Americans, including but not limited to, issues concerning operations, service delivery, and quality of all Covered Services (e.g., Behavioral Health, Physical Health, and LTC), Member rights and responsibilities, the resolution of Member Grievances and Appeals, and Claims processing and reimbursement issues.

4.12.3.2 Member Advisory Board

4.12.3.2.1 The CONTRACTOR shall include a Member receiving Community Benefits on the CONTRACTOR's Member Advisory Board and shall include Community Benefits as a standing agenda item for all Member Advisory Board meetings.

4.12.3.2.2 The Member Advisory Board shall consist of members representing all populations served by the CONTRACTOR, family members and Providers. The CONTRACTOR shall have a diversity of representation of its Members

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in terms of race, ethnicity, gender, other cultural characteristics, special populations, and New Mexico's geographic areas.

4.12.3.2.3 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 HCA.

4.12.3.2.4 The CONTRACTOR shall hold quarterly, centrally located Member Advisory Board meetings throughout the term of the Agreement. The CONTRACTOR shall advise HCA ten (10) Calendar Days in advance of meetings to be held.

4.12.3.2.5 In addition to the quarterly meetings, the CONTRACTOR shall hold at least two (2) additional statewide Member Advisory Board meetings each contract year that focus on Member issues to help ensure that Member issues and concerns are heard and addressed. Attendance rosters and minutes for these two (2) statewide meetings shall be made available to HCA within ten (10) Calendar Days following the meeting date.

4.12.3.2.6 The CONTRACTOR shall ensure that all Member Advisory Board members actively participate in deliberations and that no one Board member dominates proceedings in order to foster an inclusive meeting environment.

4.12.4 Member Satisfaction Survey

4.12.4.1 As part of its QM/QI program, the CONTRACTOR shall conduct an annual survey that assesses Member satisfaction with the quality, availability, and accessibility of care. The CONTRACTOR shall implement the CAHPS survey. The CAHPS survey shall be administered to a statistically valid sample of the CONTRACTOR's Members who have at least six (6) months of continuous enrollment, including Members who have requested to change their PCPs. The CONTRACTOR shall follow all State and federal confidentiality statutes and regulations in conducting this Member Satisfaction Survey.

4.12.4.2 The CONTRACTOR shall administer the CAHPS survey in accordance with NCQA guidelines and the requirements described below:

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4.12.4.2.1 Establish policies and procedures for conducting relevant Member surveys and, if the Member is a minor or unable to act on their behalf, to survey the Member's Representative as permitted under applicable privacy statutes;

4.12.4.2.2 Use the most recent version of the CAHPS Adult and Child Survey Instruments, including the Children with Chronic Conditions (CCC) survey, to assess Member satisfaction as part of the HEDIS requirements and report the results of the CAHPS survey to HCA.

4.12.4.2.3 Utilize the annual CAHPS results in the CONTRACTOR's internal QM/QI program and Population Health Management plan by using areas of decreased satisfaction as areas for targeted improvement;

4.12.4.2.4 Include the HCA required supplemental survey questions approved by NCQA in its CAHPS that are listed in Attachment 8: CAHPS Supplemental Questions;

4.12.4.2.5 Make available results of the Member Satisfaction Surveys to Providers, HCA, and Members and families/Caregivers;

4.12.4.2.6 Demonstrate consistent and sustainable patterns of acceptable performance and/or improvement from year to year in the overall Member Satisfaction Survey results;

4.12.4.2.7 Have mechanisms in place to incorporate survey results in the CONTRACTOR's QM/QI plan for program and systems improvements; and

4.12.4.2.8 Report annual CAHPS survey data into the AHRQ CAHPS Database and authorize state-level reporting. Guidance for AHRQ CAHPS Database registration and reporting can be found at: https://cahpsdatabase.ahrq.gov/HPSurveyGuidance.aspx.

4.12.4.3 Additionally, in conjunction with the Collaborative, the CONTRACTOR shall implement the Mental Health Statistics Improvement Program (MHSIP) for Members identified as having Behavioral Health needs. This reporting is separate and distinct from AHRQ CAHPS reporting.

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4.12.4.4 Additionally, the CONTRACTOR shall participate on the steering committee for the Consumer, Family-Caregiver and Youth Satisfaction Project (C/F/YSP). CONTRACTOR shall also:

4.12.4.4.1 Each calendar year upon request from HCA, identify and assign a staff member who is directly involved with its peer/family engagement or recovery and resiliency activities as its representative on the Steering Committee.

4.12.4.4.2 Complete data collection by September 1 of each calendar year.

4.12.4.4.3 4.12.4.4.3 Contract with the consumer-run/family-driven organizations determined by the steering committee to conduct the annual Consumer Satisfaction Surveys.

4.12.4.4.4 Contract directly with consumer-run/family-driven organizations determined by the steering committee to complete the surveys.

4.12.4.4.5 Retain financial responsibility for annual survey administration.

4.12.4.4.6 Submit a work plan and timetable for successful collection of the data to the Steering Committee.

4.12.4.4.7 Monitor the contract with the consumer-run/family-driven organizations to ensure all deliverables are met within timelines established by the Steering Committee.

4.12.4.4.8 Assist in the development and updating of a Survey Procedure Manual to document survey procedures and protocols that will be used in training the consumer and family/caregiver surveyors conducting telephonic and face-to-face surveys of consumers and family members. A full documentation manual of the training will be developed that can be used for reference or for new hires.

4.12.4.4.8.1 Any electronic and hard copies of the manual will be retained by the participating surveyor organization, the Steering Committee and HCA.

4.12.4.4.8.2 The CONTRACTOR will be responsible for the cost of the training and documentation. In subsequent years, if the training material changes, the CONTRACTOR would be responsible for modifying the existing

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manual and providing the new version to the participating organizations, the Steering Committee and HCA.

4.12.4.4.9 Apply findings from the surveys to the QM and QI plans for program and systems improvement.

4.12.4.4.10 Make the results of the surveys available to members, families, caregivers, and providers.

4.12.4.4.11 HCA will develop and maintain the database tool used for collection, storage, and reporting of survey data.

4.12.4.4.11.1 HCA and CONTRACTOR will provide annual training to the consumer-run/family-driven organizations on survey data collection specific to the use of the database tool. Included in this training is a Survey Data Collection Instruction Manual, specific to the use of the database tool.

4.12.4.4.11.2 HCA shall analyze and compile the results of the survey into an appendix.

4.12.4.4.11.3 HCA shall write and publish an annual Consumer Satisfaction Project Report.

4.12.4.4.11.4 HCA shall populate five Uniform Reporting System (URS) tables with the results of the C/F/YSP as per the Substance Abuse and Mental Health Services Administration (SAMHSA) requirements.

4.12.4.4.11.5 HCA shall provide the CONTRACTOR with the survey instruments:

4.12.4.4.11.5.1 Adult

4.12.4.4.11.5.2 Family/Caregiver

4.12.4.4.12 The CONTRACTOR shall administer an annual HCBS CAHPS survey and provide results to HCA. The CONTRACTOR is directed to apply the CMS approved survey questions and instructions located on the Medicaid.Gov website.

4.12.5 <u>Provider Satisfaction Survey</u>

The CONTRACTOR shall conduct at least one (1) annual Provider Satisfaction Survey that covers Contract Providers as directed in the Managed Care Policy Manual

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and follows NCQA guidelines to the extent applicable. The CONTRACTOR shall provide results to HCA as directed by the HCA. 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 CONTRACTOR's QM/QI plan and Population Health Management plan for program and systems improvements.

4.12.6 Practice Guidelines

The CONTRACTOR shall:

4.12.6.1 Adopt practice guidelines that meet the following requirements:

4.12.6.1.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

4.12.6.1.2 Consider the needs of the Members;

4.12.6.1.3 Are adopted in consultation with Contract Providers; and

4.12.6.1.4 Are reviewed and updated every two (2) years.

4.12.6.2 Disseminate the guidelines to all affected Contract Providers and, upon request, to Members; and

4.12.6.3 Ensure that decisions for Utilization Management, Member education, coverage of services, and other applicable areas are consistent with the guidelines.

4.12.7 Performance Measures (PMs)

4.12.7.1 All PMs and targets shall be based on HEDIS technical specifications for the current reporting year. In the event that NCQA alters the measure or technical specifications for the PMs listed, the CONTRACTOR will follow relevant and current NCQA standards. PMs and targets shall be reasonable and based on industry standards that are applicable to substantially similar populations. The CONTRACTOR shall meet performance targets specified by HCA. The PMs and targets for Calendar Year (CY) 2025, 2026, and 2027 are detailed in Attachment 12: Turquoise Care PMs and TMs Table 12a: PMs of this agreement.

4.12.7.1.1 The CONTRACTOR will be required to collect, track, trend, and report PMs quarterly as directed by HCA and/or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HCA/or its designee.

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4.12.7.1.2 Reporting elements and data are to be provided to HCA in the same format as the template provided by HCA as directed by HCA. The reporting period is based upon one (1) quarter of a Calendar Year (e.g., Q1 Total= January – March) and data is to be reported cumulatively as follows: Quarter 1 (Q1) = January – March, Quarter 2 (Q2) = January – June, Quarter 3 (Q3) = January – September, and Quarter 4 (Q4) = January – December. For the measurement period and reporting elements for each measure, please refer to the relevant technical specifications. The report must be submitted within twenty (20) Calendar Days from the end of each reporting period. If the twentieth Calendar Day is not a Business Day, then the report must be submitted the following Business Day. If HCA requests any revisions to reports previously submitted by the CONTRACTOR, the CONTRACTOR shall make the changes and re-submit the reports according to the time frame set forth by HCA. The naming convention for this report is: MCO.HCAPMQXCYXX.vX. If the proper naming convention is not used, the report will be rejected by HCA.

4.12.7.2 The Turquoise Care PMs identified in Attachment 12: Turquoise Care PMs and TMs shall be evaluated. Each CY target is a result of the CY22 NCQA Quality Compass National Average, calculating an average increase for each CY until reaching the CY22 Quality Compass National Average plus one percentage point.

4.12.8 Tracking Measures (TMs)

4.12.8.1 The CONTRACTOR shall report on the Turquoise Care TMs included in Attachment 12: Turquoise Care PMs and TMs as directed by HCA.

4.12.8.1.1 All TMs shall be based on HCA directed technical specifications for the current reporting year. The CONTRACTOR shall be required to collect, track, trend, and report TMs quarterly as directed by HCA and/or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HCA and/or its designee.

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4.12.8.1.2 Reporting elements and data are to be provided to HCA in the same format as the template provided by HCA as directed by HCA. If HCA requests any revisions to reports previously submitted by the CONTRACTOR, the CONTRACTOR shall make the changes and re-submit the reports according to the time frame set forth by HCA. The naming convention for this report is: MCO.HCATMQXCYXX.vX. If the proper naming convention is not used, the report will be rejected by HCA.

4.12.8.2 The TM reports included in this Section 4.12.8 are subject to sanctions in Section 7.3.3 of this Agreement.

4.12.9 Critical Incident Management Effective 10/31/25, MCOs are not required to submit CI reports to the MAD CI Portal for the Emergency Services, Law Enforcement, and Environmental Hazard incident categories. However, MCOs must continue to internally track these incidents and must make documentation available to HCA upon request. The MCO will establish their own internal processes for tracking. The process must be robust enough to provide information regarding the MCO's follow-up to HCA upon request. MCOs must also internally track insufficient staffing incidents that will no longer be reportable to the MAD CI Portal.

4.12.9.1 The CONTRACTOR shall adhere to all State requirements for Critical Incident management and reporting as defined in NMAC 8.308.21.13. The CONTRACTOR shall develop policies and procedures to address and respond to incidents, report incidents to the appropriate entities per required time frames, and track and analyze incidents. The CONTRACTOR shall use this information to identify trends and patterns both case-specific and systemic, identify opportunities for improvement, and develop and implement appropriate strategies to reduce the occurrence of incidents and improve the quality of care.

4.12.9.1.1 The CONTRACTOR shall use this information and the data to conduct an annual evaluation of its Critical Incident management system. The CONTRACTOR shall include the results of its evaluation as part of the CONTRACTOR's QM/QI work plan submitted to HCA as outlined in Section 4.12.2.9 of this Agreement.

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4.12.9.2 The CONTRACTOR shall require its staff and Contract Providers to complete a reassessment of risk and update the CCP to address potential gaps in the Member's care, to mitigate assessed risks and to prevent occurrence of further incidents.

4.12.9.3 The CONTRACTOR shall have policies to address and respond to new PCS authorizations. The CONTRACTOR shall be responsible to verify Contract Providers have sufficient staff to provide services, assure Contract Providers assigned have initiated care and initiate procedures in place when services have not begun within five (5) calendar days.

4.12.9.4 The CONTRACTOR shall require its staff and Contract Providers to collaborate with any investigation conducted by the CONTRACTOR or outside agencies (e.g., HCA, the Collaborative, the DOH, CYFD, APS, and law enforcement). The CONTRACTOR shall also require its staff and Contract Providers to report, respond to, and document Critical Incidents and the resulting follow-up activities, as specified by the CONTRACTOR. The CONTRACTOR shall require its staff and Contract Providers to document the initiated action(s) and all follow-up activities related to the intervention(s) implemented as a result of the incident and enter the information into the HCA MAD Critical Incident Reporting Portal until the established intervention(s) demonstrate the Member's health, safety, and welfare are no longer issues of concern. Follow-up action(s) include actions taken as a result of reviewing a Critical Incident that:

4.12.9.4.1 Require investigation or intervention for issues of health and safety;

4.12.9.4.2 Include a referral request for additional information to internal or external staff or agencies; and

4.12.9.4.3 Include any change in the CONTRACTOR's activities, including but not limited to a Care Coordination visit, a Care Coordination investigation, an intervention, and/or a reassessment or change in CCP.

4.12.9.5 The CONTRACTOR shall provide appropriate training and take corrective action as needed to ensure Provider compliance with Critical Incident requirements such as provisions describing how services provided under the

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terms of the contract are accessed by Members and to provide at least thirty (30) Calendar days advance notice to the CONTRACTOR when the Contracted Provider is no longer willing or able to provide services to a Member, including the reason for the decision and to cooperate with the Members care coordinator to facilitate a seamless transition to alternate Contracted Provider. The CONTRACTOR shall ensure that training is provided upon a Contracted Provider entering into a contract, upon hire of employees, and upon enrollment in the SDBC. The CONTRACTOR shall ensure that training be provided at least annually thereafter.

4.12.9.6 The CONTRACTOR shall follow the required processes and instruct Physical Health, Behavioral Health , and Home and Community Based Service programs Providers (including long-term care Providers) annually on the required processes for reporting Critical Incidents as required by the agency or department that has oversight of the report, including but not limited to: HCAMAD, DOH, HCA Division of Health Improvement (DHI), CYFD, and Aging & Long-Term Services Department. For recipients of Adult Behavioral Health services who are non-Medicaid recipients, all Critical Incident Reports shall be reported to the State of New Mexico Interagency Behavioral Health Purchasing Collaborative at bh.qualityteam@hca.nm.gov or fax number 505- 476-9272.

4.12.9.7 The CONTRACTOR shall establish a Critical Incident review committee as defined in NMAC 8.308.21.15.B

4.12.9.7.1 The CONTRACTOR shall ensure that the Critical Incident review committee meets on a monthly basis.

4.12.9.8 Upon transition of a Member to another MCO CONTRACTOR, the CONTRACTOR shall identify whether the Member is associated with an unresolved Critical Incident Report in the HCA MAD Critical Incident Reporting Portal. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved Critical Incidents for Members who were part of the CONTRACTOR's membership at the time the incident was filed.

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4.12.9.9 Upon termination of this Agreement by HCA or the CONTRACTOR, the CONTRACTOR shall submit a report of outstanding Critical Incidents and death investigations pending receipt of the findings from the Office of the Medical Investigator, for Members who were enrolled with the CONTRACTOR prior to termination of this Agreement. HCA will provide to the CONTRACTOR a template for the report. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved Critical Incidents for Members who were part of the CONTRACTOR's membership at the time the incident was filed.

4.12.9.9.1 The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting, for the outstanding Critical Incidents and pending death investigations associated with Members who were enrolled with the CONTRACTOR prior to termination of this Agreement. This requirement will apply even when Members have transferred to another CONTRACTOR. The CONTRACTOR shall be responsible for completing all follow-up activities, such as investigations and final reporting of unresolved Critical Incidents for Members who were part of the CONTRACTOR's membership at the time the incident was filed.

4.12.9.10 The CONTRACTOR shall report on Critical Incident PMs as directed by HCA.

4.12.9.10.1 The CONTRACTOR shall report on the following PMs quarterly:

4.12.9.10.1.1 Critical Incident Performance Measure #1: The percentage of Critical Incidents reported Within 1 Business Day (1BD);

4.12.9.10.1.2 Critical Incident Performance Measure #2: The percentage of Critical Incident Follow-Up Actions Completed (FUP);

4.12.9.10.1.3 Critical Incident Performance Measure #3: The percentage of Critical Incident Preventative Follow-Up Actions Completed Within 30 Calendar Days (PRV30);

4.12.9.10.1.4 Critical Incident Performance Measure #4: The percentage Critical Incident Reporting Training Completed (TRN);

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4.12.9.10.1.5 Critical Incident Performance Measure #5: The percentage of CIR Follow-Up for Members who Transitioned to Another MCO (TRFU); and;

4.12.9.10.1.6 Critical Incident Performance Measure #6: The percentage of Restrictive Interventions Incidents that Received a Clinical Review Within 10 Calendar Days (RI10).

4.12.9.11 Critical Incidents may include but are not limited to the incident types that are reportable in the HCA MAD Critical Incident Portal below.

4.12.9.11.1 Abuse/Self-Abuse

4.12.9.11.1.1 Knowingly, intentionally and without justifiable cause inflicting physical pain, injury or mental anguish;

4.12.9.11.1.2 Intentional deprivation by a caretake or other person of services necessary to maintain the mental and physical health of a person;

4.12.9.11.1.3 Sexual abuse, including criminal sexual contact, incest and criminal sexual penetration;

4.12.9.11.1.4 Verbal abuse, including profane, threatening, derogatory, or demeaning language, spoken or conveyed with the intent to cause mental anguish; and

4.12.9.11.1.5 Self-injury and/or attempted suicide;

4.12.9.11.2. Neglect/Self-Neglect causes or is likely to cause harm to a person and includes;

4.12.9.11.2.1 Failure of the caretaker to provide basic needs of a person, such as clothing, food, shelter, supervision and care for the physical and mental health of that person, including when an agency is insufficiently staffed;

4.12.9.11.2.2 Refusing services and/or goods, including but not limited to food, prescribed medications, proper hygiene, plan of care;

4.12.9.11.2.3 Misuse of prescribed medications and/or engaging in substance abuse or dangerous behaviors;

4.12.9.11.2.4 Missing, wandering, and elopement;

4.12.9.11.3. Exploitation;

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4.12.9.11.2.5 Taking advantage of a member for personal gain through manipulation, intimidation, threats, or coercion;

4.12.9.11.2.6 The wrongful use of a member's belongings (including medications) or money without their consent;

4.12.9.11.2.7 Misuse or unauthorized use of restrictive interventions or seclusion;

4.12.9.11.2.8 Physical, chemical, or mechanical restraints that immobilize or reduce the ability of a member to move their arms, legs, body, or head freely;

4.12.9.11.2.9 A chemical restraint is a drug or medication used as a restriction to manage a member's behavior or restrict their freedom of movement and is not a standard treatment or dosage for their condition;

4.12.9.11.2.10 Medication error by a provider resulting in a telephone call to, or a consultation with, a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death.

4.12.9.11.2.11 Death including but not limited to natural/expected, unexpected, suicide, homicide, and a death caused by abuse or neglect.

4.12.10 External Quality Review Organization (EQRO)

4.12.10.1 HCA shall retain the services of an EQRO in accordance with 42 C.F.R. § 438.354. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Turquoise Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR's compliance with HCA managed care requirements and quality standards as set forth in federal regulation, this Agreement, State law and regulations, and HCA policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

4.12.10.2 The EQRO shall conduct all mandatory and optional activities related to EQR in accordance with 42 C.F.R. § 438.358 and CMS quality standards of the EQR protocol criteria. The CONTRACTOR shall cooperate fully with the EQRO. Required EQRO activities shall include, but not limited to:

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4.12.10.2.1 EQR Protocol 1: Mandatory validation of performance improvement projects set forth in 42 C.F.R. § 438.330 (b)(i) that were underway during the preceding twelve (12) months;

4.12.10.2.2 EQR Protocol 2: Mandatory validation of PMs specified by the State and set forth in 42 C.F.R. § 438.330(b)(ii) ;

4.12.10.2.3 EQR Protocol 3: Mandatory review of compliance with Medicaid managed care regulations and standards set forth in 42 C.F.R. § 438.358 (b)(iii); and

4.12.10.2.4 EQR Protocol 4: Mandatory validation of network adequacy as set forth in 42 C.F.R. § 438.358.

4.12.10.3 The CONTRACTOR shall participate with the EQRO in various other tasks, audits and projects identified by HCA to gauge performance in a variety of areas, including Care Coordination, long term services and supports, and treatment of special populations.

4.12.10.4 The EQRO retained by HCA shall not be a competitor of the CONTRACTOR and shall comply with 42 C.F.R. § 438.354.

4.13 **Patient-Centered Initiatives**

The CONTRACTOR shall comply and cooperate with all HCA patient-centered initiatives. The purpose of the patient-centered initiatives is to support HCA's commitment to improving individual and Population Health status, achieving superior clinical outcomes, and improving service delivery, while reducing administrative burdens.

4.13.1 PCMH

4.13.1.1 The CONTRACTOR shall work with PCP Contract Providers to implement PCMH programs. PCMHs are not required to have NCQA or Joint Commission recognition but are encouraged to achieve recognition as soon as possible. PCMHs shall incorporate the following principles:

4.13.1.1.1 Every Member has a selected PCP;

4.13.1.1.2 Care is provided by a physician-directed team that collectively cares for the Member;

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4.13.1.1.3 The PCMH: (i) performs Care Coordination functions in accordance with Section 4.4 of this Agreement or (ii) is engaged with the Member's assigned care coordinator, as applicable, provided by the CONTRACTOR in arranging and coordinating services; and

4.13.1.1.4 Care is coordinated and/or integrated across all aspects of health care and reduces health care disparities to improve Population Health.

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

4.13.1.2.1 Screening/identification and targeting of PCMH participants, including but not limited to: (i) Members with an identified disease state/condition aligned with the CONTRACTOR's DM programs; and (ii) Members identified with a higher level of need for continuity of care, such as those with a Behavioral Health diagnosis, including substance abuse that adversely effects the Member's life, co-morbid health conditions or Members receiving NF LOC;

4.13.1.2.2 Continuous, accessible, comprehensive, and Coordinated Care using community-based resources as appropriate, enhanced access, including but not limited to, extended office hours outside of 8:00 AM to 5:00 PM Mountain Time, open scheduling and alternative communication models, such as web-based or telephonic options;

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

4.13.1.2.4 Using access and quality measures (HEDIS and surveys), as defined by HCA;

4.13.1.2.5 Demonstrating improved health status and outcomes for Members as defined by HCA;

4.13.1.2.6 Using measures to analyze the delivery of patient-centered services and quality of care, over and underutilization of services, DM strategies and outcomes of care;

4.13.1.2.7 Promoting adoption of all use of Health Information Technology (HIT) and supporting integration between Primary Care and other Providers of Covered

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Services through Care Coordination, as well as electronic data exchange; specifically, data that may be used to support decision making and continuous quality improvement, which may include the release of CONTRACTOR's authorization data as directed by HCA; and

4.13.1.2.8 Promoting integration between Primary Care and other Providers of Covered Services through Care Coordination, as well as data exchange; specifically, data that may be used to support decision making and continuous quality improvement, which may include the release of Medicaid Claims/Encounter Data, CONTRACTOR's Claims/Encounter Data and CONTRACTOR's authorization data as directed by HCA.

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

4.13.1.4 Any amounts expended by the CONTRACTOR implementing or operating the PCMH initiative shall be counted as direct medical expenses as defined in Section 7.2 of this Agreement.

4.13.2 Health Homes

4.13.2.1 The CONTRACTOR shall comply and cooperate with HCA's Health Home initiative for developing Behavioral Health Homes and Physical Health Homes as authorized under Section 2703 of the PPACA.

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

4.13.2.3 The CONTRACTOR shall make best efforts to contract with all Health Home Providers designated by HCA and the CareLink New Mexico Steering Committee.

4.13.2.4 The CONTRACTOR shall refer all eligible Members who meet the CareLink New Mexico Health Home criteria and who are not participating in a Full Delegation of Care Coordination model to one (1) of the CareLink New Mexico Health Homes and document all such referrals. The CONTRACTOR shall also

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maintain a record of any Member choice to opt in or out of the Health Home or to select a different CareLink New Mexico Provider.

4.13.2.5 The CONTRACTOR shall ensure that Health Home Providers provide Care Coordination functions for Members enrolled with the Health Home.

4.13.2.6 The CONTRACTOR shall maintain administrative responsibility and oversight of Care Coordination and reporting as required by HCA according to this Agreement.

4.13.2.7 The CONTRACTOR shall issue monthly payments to Health Home Provider(s) when the Health Home Provider has submitted Claims to the CONTRACTOR documenting the utilization of Health Home services by a Member per the CareLink New Mexico Provider Policy Manual. The costs associated with Health Homes are included in the CONTRACTOR's Capitation Rate.

4.13.2.7.1 The payment shall be an amount based on the CONTRACTOR's Turquoise Care membership enrolled in the Health Home and billed by the Health Home Provider for that month using a PMPM set by HCA.

4.13.2.7.2 The payment shall be made in accordance with Section 4.20 of this Agreement, Claims Management.

4.13.3 New Mexico’s HIE and HIT

4.13.3.1 The CONTRACTOR shall contract with the New Mexico’s HIE, a non-profit organization that provides a secure network for the exchange of clinical health information. The CONTRACTOR shall sign a participation agreement with the HIE to ensure the CONTRACTOR has access to the HIE for any permitted uses as described in the HIE Participation Agreement. To further the integration of technology-based solutions and the promotion of interoperability of EHRs within the system of care, HCA will increase opportunities for Providers and Turquoise Care MCOs to utilize technological functions for processes that are necessary to meet the requirements of this Agreement. Expanding the adoption and use of HIT may reduce total spending on health care by diminishing the number of inappropriate tests and procedures, reducing paperwork and administrative

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overhead, and decreasing the number of adverse events resulting from medical errors.

4.13.3.2 The CONTRACTOR shall actively participate in offering information and providing support and education to Providers to further expand Provider adoption and use of HIT. The CONTRACTOR shall review operational processes to reduce Provider hassle factors by implementing technological solutions for those Providers utilizing electronic health records and incentivize Providers to implement and meaningfully use HIT as a standard of doing business with the Turquoise Care program.

4.13.3.3 HCA anticipates establishing minimum HIT standards, goals, and requirements related to operational areas where improved efficiencies or effectiveness could be achieved. The CONTRACTOR shall comply with established standards, goals, and requirements as directed by HCA.

4.13.3.4 The CONTRACTOR shall accelerate statewide HIE participation by all Medicaid Providers and Turquoise Care MCOs by:

4.13.3.4.1 Requiring that Behavioral Health and Physical Health Providers use the HIE for the secure sharing of clinical information between Physical and Behavioral Health Providers;

4.13.3.4.2 Ensuring Providers utilize alerts to facilitate timely follow up with Members after admission or discharge from hospitals and emergency rooms;

4.13.3.4.3 Joining the HIE's board of directors and advisory councils to enable and provide input into governance and policy making, and the availability of information technology service offerings; and

4.13.3.4.4 Identifying VBP opportunities that link with a Provider's adoption and use of HIT.

4.13.3.4.5 The CONTRACTOR shall encourage Providers that are participating in the Medicaid Promoting Interoperability Program (formerly the EHR Incentive Program) (i.e., eligible hospitals and eligible professionals) to continue to promote interoperability and accelerate the participation of other provider types in their network to participate in the Medicaid Promoting

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Interoperability Program. The CONTRACTOR shall encourage Providers to participate in planning activities that will result in improved care coordination and health care delivery for Members.

4.13.3.5 The CONTRACTOR shall collaborate with HCA and the HIE to support projects and initiatives in areas where HIT and HIE can bring significant change and progress, including efforts focused on:

4.13.3.5.1 Coordinating the secure sharing of clinical health information between Providers and across the continuum of care.

4.13.3.5.2 Identifying partnerships for integrated care among other health care delivery participants.

4.13.3.5.3 Identifying and implementing strategies that improves Care Coordination and health outcomes for high-needs/high-cost Members.

4.13.3.5.4 Coordinating care for Members who are enrolled in the New Mexico Medicaid FFS plan.

4.13.3.5.5 Coordinating care for Members who are transitioning between the CONTRACTOR and Qualified Health Plans.

4.13.3.5.6 Coordinating care for justice-involved Members.

4.13.3.5.7 Improving Care Coordination and Member care transitions between Providers.

4.13.3.5.8 Improving pharmacy management.

4.13.3.5.9 Participating in quality and Population Health activities and reporting as identified by the CONTRACTOR or HCA.

4.13.3.5.10 Other activities as identified by HCA and that are allowed under the Permitted Use Policy of the HIE. To increase the number of Providers participating in the HIE, the CONTRACTOR shall develop, with the HIE, a recruitment plan that can achieve an increase in the number of Providers that join the HIE.

4.13.3.6 The CONTRACTOR shall make its health information available to the HIE and use the HIE to exchange electronic health information with Providers, MCOs, and health plans in accordance with applicable State and federal law.

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4.13.3.7 The CONTRACTOR shall issue monthly payments to the New Mexico Health Information Collaborative (NMHIC), or its successor, as operator of the HIE. The costs associated with the HIE or its successor are included in the CONTRACTOR's Capitation Rate.

4.13.3.7.1 The payment shall be an amount based on the CONTRACTOR's Turquoise Care membership for that month using a PMPM set by HCA.

4.13.3.7.2 The payment shall be made no later than ten (10) Calendar Days, or at HCA's discretion, following the CONTRACTOR's receipt of the monthly Capitation Payment for its membership from HCA.

4.14 **MHV Program**

4.14.1 The CONTRACTOR shall contract with MHV program agencies in any county where services are provided through the evidence-based early childhood home visiting delivery program model. The program will be voluntary for Turquoise Care Members.

4.14.2 The CONTRACTOR shall include methods to incentivize Member participation in the MHV Program.

4.14.3 The CONTRACTOR shall:

4.14.3.1.1 Ensure Contracted MHV Providers are delivering a defined set of Medicaid-reimbursable services as defined in the MHV policy guidance;

4.14.3.1.2 Assist MHV Providers with timely enrollment in Medicaid and credentialing;

4.14.3.1.3 Enter/load credentialed MHV Providers into the CONTRACTOR's claims payment system in a timely manner;

4.14.3.1.4 Provide training to MHV Providers on billing requirements and best practices;

4.14.3.1.5 Provide education to Members on the benefits of MHV;

4.14.3.1.6 Contact every pregnant Member within 2 months of the positive pregnancy test, educate the Member on the benefits of MHV and suggest referral. Care coordination and MHV shall have separate referral pathways. Refusal to engage in care coordination shall not affect a Member's education and

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referral to MHV. Refer pregnant and Postpartum Members to MHV Providers; and

4.14.3.1.7 Ensure the quality of care provided by MHV Providers aligns with the evidence-based model requirements, including ongoing training requirements.

4.14.4 The CONTRACTOR shall work collaboratively with New Mexico ECECD and HCA to sustain the MHV program, develop workforce and provider capacity to serve Members eligible to participate in the MHV program, improve the referral process, improve the health of pregnant women and their infants, and promote parenting skills and child development. The CONTRACTOR shall be the single point of contact to resolve concerns related to its Providers participating in the MHV program.

4.14.5 The CONTRACTOR shall provide appropriate oversight of all contracted services and monitor the program fidelity of MHV program and model delivery based on agreed upon criteria.

4.14.6 The CONTRACTOR shall be responsible for submitting MHV program reporting as determined by HCA.

4.15 **Member Materials**

4.15.1 Prior Approval Process

4.15.1.1 The CONTRACTOR shall submit to HCA for review and prior written approval all materials that will be distributed to Members (referred to as Member Materials). This includes, but is not limited to, Member handbooks, Provider directories, Member newsletters, Member identification (ID) cards and, upon request, any other additional, but not required, materials and information provided to Members designed to promote health and/or educate Members.

4.15.1.2 All Member Materials must be submitted to HCA in paper and electronic file media in the format prescribed by HCA. The CONTRACTOR shall submit the reading level and the methodology used to measure it concurrent with all submissions of Member Materials and include a plan that describes the CONTRACTOR’s intent for the use of the Member Materials.

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

4.15.1.4 Prior to modifying any approved Member Material(s), the CONTRACTOR shall submit to HCA for prior written approval a detailed description of the proposed modifications in accordance with this section.

4.15.1.5 HCA reserves the right to notify the CONTRACTOR to discontinue or modify Member Materials after approval.

4.15.2 Written Member Material Guidelines

4.15.2.1 The CONTRACTOR shall maintain written policies and procedures governing the development and distribution of Member Materials, including how the CONTRACTOR will meet the requirements in this section. The CONTRACTOR shall, at a minimum, have policies and procedures regarding the process for developing/creating, proofing, approving, publishing, and mailing the: (i) Member ID card; (ii) Member handbook; (iii) Provider directory; (iv) Formulary; (v) Member newsletter; and (vi) form letters within contractual standards and time frames. The CONTRACTOR shall include a separate set of policies and procedures for each of the items listed above (i-vi).

4.15.2.2 All written Member Materials must be worded at or below a sixth grade reading level, unless otherwise approved in writing by HCA.

4.15.2.3 All written Member Materials must be clearly legible with a minimum font size of twelve (12) point with the exception of Member ID cards and unless otherwise approved in writing by HCA and must comply with all provisions in 42 C.F.R. § 438.10.

4.15.2.4 All written Member Materials must be printed with the assurance of non-discrimination.

4.15.2.5 All written Member Materials shall be available in English and the prevalent languages spoken by approximately five percent (5%) or more of the population, with the exception of Native American languages, for which there are not written forms and/or for which the State has not obtained consent from Tribal leadership to use the language. The CONTRACTOR shall certify that the translation of the

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information into the different languages has been reviewed by a qualified individual for accuracy. The CONTRACTOR does not need to submit the translated Member Materials to HCA; however, the CONTRACTOR shall submit the certification that the translations have been reviewed by a qualified individual. The CONTRACTOR shall submit the certification within thirty (30) Calendar Days of HCA's approval of the English version of materials. The CONTRACTOR is responsible for ensuring the translation is accurate and culturally appropriate. The State will identify the prevalent non-English languages spoken by Members and potential Members in the State and will provide the information to the CONTRACTOR.

4.15.2.6 All written Member Materials distributed shall include a language block that informs the Member that the document contains important information and directs the Member to call the CONTRACTOR to request the document in an alternative language or to have it orally translated at no expense to the Member. The language block shall be printed, at a minimum, in the non-English languages meeting the requirement in Section 4.15.2.5 of this Agreement.

4.15.2.7 The CONTRACTOR shall make all written Member Materials available in alternative formats and in a manner that takes into consideration the Member's special needs, including those who are visually impaired or have limited reading proficiency. The CONTRACTOR shall notify all Members and potential Members that information is available in alternative formats and how to access those formats at no expense to the Member.

4.15.2.8 Once a Member has requested Member Materials in an alternative format or language, the CONTRACTOR shall: (i) make a notation of the Member's preference in the system; and (ii) provide all subsequent Member Materials to the Member in such format unless the Member requests otherwise.

4.15.2.9 The CONTRACTOR shall provide written notice to Members of any material changes to written Member Materials previously sent at least thirty (30) Calendar Days before the effective date of the change.

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4.15.2.10 The CONTRACTOR must comply with Section 1557 of the PPACA, as codified at 45 C.F.R. part 92, with regard to nondiscrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities receiving federal financial assistance.

4.15.3 Member Handbook

4.15.3.1 The Member handbook shall be prior approved by HCA and be in a format that is easily understood. The Member handbook shall include a table of contents, HCA approved definitions for the terms specified in 42 C.F.R. § 438.10(c)(4)(i) and defined in the Agreement or as referenced in Section 3.2 of the Managed Care Policy Manual, and at a minimum comply with the following:

4.15.3.1.1 The CONTRACTOR's demographic information, including the toll-free telephone number for Member services and hours of operation;

4.15.3.1.2 Information on how to obtain services such as after-hours and Emergency Services, including the 911 telephone system or its equivalent and the triage/nurse advice line;

4.15.3.1.3 Member rights and responsibilities, pursuant to 42 C.F.R. §100 and Section 4.15.4 of this Agreement, including any restrictions on the Member's freedom of choice among Contract Providers;

4.15.3.1.4 Information pertaining to coordination of care by and with PCPs (within the CONTRACTOR's MCO) and information pertaining to transition of care (between MCOs);

4.15.3.1.5 How to obtain care in emergency and urgent conditions and that prior authorization is not required for Emergency Services, including what constitutes an Emergency Medical Condition and Emergency Services, and the Member's right to use any hospital or other setting for emergency care;

4.15.3.1.6 The amount, duration, and scope of all benefits, services, and goods included in and excluded from coverage in sufficient detail to ensure that Members understand the benefits to which they are entitled. Include a separate section and/or addendum that describes the provisions and limitations (including amount, duration, scope, and cost-sharing) of the ABP, the qualifications and

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conditions for ABP exemptions, the benefit and cost-sharing differences for an ABP Exempt Member, and the process by which a Member can self-identify as potentially an ABP Exempt Member and voluntarily opt-out of the ABP;

4.15.3.1.7 Information on accessing Behavioral Health or other specialty services, including a discussion of the Member's rights to self-refer to Contract and Non-Contract family planning Providers, a female Member's right to self-refer to a women's health specialist within the CONTRACTOR's network, and that Members may self-refer for Behavioral Health services and are not required to visit their PCP first;

4.15.3.1.8 Limitations to the receipt of care from Non-Contract Providers;

4.15.3.1.9 A list of services for which prior authorization or a referral is required and the method of obtaining both;

4.15.3.1.10 Information on Utilization Management;

4.15.3.1.11 A policy on referrals for specialty care and other benefits not furnished by the Member's PCP;

4.15.3.1.12 Information on how to access pharmacy services;

4.15.3.1.13 Information regarding Grievances, Appeals, and Fair Hearing procedures and time frames including all pertinent information provided in 42 C.F.R § 438.400 through § 438.424;

4.15.3.1.14 Information on the Member's right to terminate enrollment and the process for voluntarily disenrolling from the CONTRACTOR's MCO;

4.15.3.1.15 Information on the MCO switch process;

4.15.3.1.16 Information on how Members change their demographic information;

4.15.3.1.17 Information regarding Advance Directives as described in 42 C.F.R. part 489, subpart I and in accordance with 42 C.F.R. § 422.128 and the Mental Health Care Treatment Decisions Act, NMSA 1978, 24- 7B-1 et seq. and Section 4.5.6 of this Agreement;

4.15.3.1.18 Information regarding how to obtain a second opinion;

4.15.3.1.19 Information on cost sharing, if any;

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4.15.3.1.20 How to obtain information, upon request, determined by HCA as essential during the Member's initial contact with the CONTRACTOR, which may include a request for information regarding the CONTRACTOR's structure, operation, and physician's or senior staff's incentive plans;

4.15.3.1.21 Value Added Services and how the Member may access those benefits;

4.15.3.1.22 Information regarding the birthing option program;

4.15.3.1.23 Language that clearly explains that a Native American Member may self-refer to an I/T/U for services;

4.15.3.1.24 Information on how to report fraud, waste and Abuse;

4.15.3.1.25 Information on Member's privacy rights;

4.15.3.1.26 Information on the circumstance/situations under which a Member may be billed for services or assessed charges or fees; specifically that a Provider may not bill a Member or assess charges or fees except: (i) if a Member self-refers to a specialist or other Contract Provider without following the CONTRACTOR's procedures (e.g., without obtaining prior authorization) and the CONTRACTOR denies payment to the Provider, the Provider may bill the Member; (ii) if a Provider fails to follow the CONTRACTOR's procedures, which results in nonpayment, the Provider may not bill the Member; and (iii) if a Provider bills the Member for non-Covered Services or for self-referrals, the Proposer shall inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at the time of service;

4.15.3.1.27 Information on how to access services when out of State;

4.15.3.1.28 Include information about Care Coordination, including the role of Care Coordinators, and how to contact a Care Coordinator;

4.15.3.1.29 Information on the Member rewards program and how a Member accesses the program and earns rewards;

4.15.3.1.30 Include information on how to access all services, including but not limited to, EPSDT services, dental services, emergency and non-emergency medical

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transportation services, Behavioral Health services, including Peer Support Services, and LTC services;

4.15.3.1.31 Include information on how to select/change PCP;

4.15.3.1.32 Describe how to access language assistance services for individuals with limited English proficiency (LEP) and auxiliary aids and services, including additional information in alternative formats or languages;

4.15.3.1.33 Include information about the CISC program as required by HCA;

4.15.3.1.34 Include Health Education and Health Literacy information as specified in Section 4.15.11 of this Agreement;

4.15.3.1.35 Include how Members can access the Provider directory on the CONTRACTOR's website and instructions for how Members can request a printed copy of the Provider directory;

4.15.3.1.36 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; and

4.15.3.1.37 Include how Members can access the Formulary on the CONTRACTOR's website and instructions for how Members can request a printed copy of the Formulary.

4.15.4 Member Rights and Responsibilities

4.15.4.1 The CONTRACTOR shall provide each Member with written information in the Member handbook that encompasses all the provisions in this Section 4.15.3. The CONTRACTOR must ensure that each Member is free to exercise their rights and that the exercise of these rights does not adversely affect the way the CONTRACTOR and its Contract Providers or the State treats the Member.

4.15.4.2 The CONTRACTOR must have written policies regarding the Member's and/or Representatives' rights, including but not limited to, the guaranteed right to:

4.15.4.2.1 Be treated with respect and with due consideration for their dignity and privacy;

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4.15.4.2.2 Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand;

4.15.4.2.3 Make and have honored an Advance Directive consistent with State and federal laws;

4.15.4.2.4 Receive Covered Services in a nondiscriminatory fashion;

4.15.4.2.5 Participate in decisions regarding their health care, including the right to refuse treatment;

4.15.4.2.6 Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion;

4.15.4.2.7 Request and receive a copy of their medical records and to request that they be amended or corrected as specified in 45 C.F.R. § 164.524 and part 526;

4.15.4.2.8 Choose a Representative to be involved as appropriate in making care decisions;

4.15.4.2.9 Provide informed consent;

4.15.4.2.10 Voice Grievances about the care provided by the CONTRACTOR and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation;

4.15.4.2.11 Choose from among Contract Providers in accordance with the CONTRACTOR's prior authorization requirements;

4.15.4.2.12 Receive information about Covered Services and how to access Covered Services, and Contract Providers;

4.15.4.2.13 Be free from harassment by the CONTRACTOR or its Contract Providers in regard to contractual disputes between the CONTRACTOR and Providers; and

4.15.4.2.14 Participate in understanding Physical Health and Behavioral Health problems and developing mutually agreed-upon treatment goals.

4.15.4.3 The CONTRACTOR shall ensure that each Member (and/or as appropriate, Representative) is free to exercise their rights and that the exercise of those rights

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does not adversely affect the way the CONTRACTOR or its Contract Providers treat the Member (and/or Representative).

4.15.4.4 Members and/or Representatives, to the extent possible, have a responsibility to:

4.15.4.4.1 Provide information that the CONTRACTOR and its Contract Providers need in order to care for the Member;

4.15.4.4.2 Follow the plans and instructions for care that they have agreed upon with their Providers; and

4.15.4.4.3 Keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.

4.15.5 Provider Directory

4.15.5.1 The CONTRACTOR shall develop and maintain a general Provider directory, which must include the following for all Contract Providers: complete name and any group affiliation; specialty, as appropriate; all locations; telephone numbers; office hours; non-English languages spoken (including American Sign Language) and if the languages are spoken by the Provider or a skilled medical interpreter; identification of Contract Providers accepting new patients (closed or open panels); weekend and after-hours availability; website URL, as appropriate; whether the Provider's office/facility has accommodations for Members with physical disabilities, including offices, exam room(s), and equipment; whether the Provider has completed Cultural Competence training; any special populations served (e.g., individuals with disabilities or LGBTQ+); the Provider's race and/or ethnicity; and a photograph of the Provider; and hospital listings, including locations of emergency settings and Post-Stabilization Services, with the name, location, and telephone number of each facility/setting.

4.15.5.1.1 The provider directory must be indexed alphabetically and by specialty.

4.15.5.2 The CONTRACTOR shall submit its provider directory to HCA and receive for written approval by HCA prior to distribution to Members.

4.15.5.3 The CONTRACTOR shall maintain on its website an updated provider directory that includes all identified information above and is searchable by provider type, distance from Member's address, zip code and/or whether the provider is

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accepting new patients. This directory shall be updated daily and contain a disclaimer that the online provider directory is updated more frequently than the printed directory. Information on how to access this information shall be clearly stated in both the Member and Provider areas of the website.

4.15.5.4 The CONTRACTOR's online provider directory shall comply with 42 C.F.R. § 438.242 regarding a publicly-accessible standard-based Application Programming Interface (API).

4.15.5.5 Upon request, the CONTRACTOR shall provide information on the participation status of any Provider and the means for obtaining more information about Providers who participate in the CONTRACTOR's provider network, including open- and closed-panel status, which must be updated regularly and made available on the CONTRACTOR's website.

4.15.5.6 The CONTRACTOR shall conduct annual provider directory audits to evaluate accuracy of information.

4.15.6 Formulary

4.15.6.1 The CONTRACTOR shall develop and maintain a Formulary for Members that provides the following information: which covered outpatient drugs are provided (preferred drug and non-preferred drug, as appropriate) and the tier classification for each covered outpatient drug.

4.15.7 Member Handbook and Provider Directory and Distribution

4.15.7.1 The CONTRACTOR shall comply with requirements regarding the mailing of, or sending electronically of, Member enrollment materials, including Member ID cards, Member handbook and provider directory and Formulary. Member enrollment materials may not be provided electronically unless the criteria specified in the Managed Care Policy Manual are met.

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

4.15.7.3 Upon request of a Member or Recipient, the CONTRACTOR shall mail or send electronically a Provider directory, Formulary and/or Member handbook within

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ten (10) Calendar Days. The CONTRACTOR shall give the person requesting a Provider directory, Formulary and/or Member handbook the option to get the information from the CONTRACTOR's website or to receive a printed document.

4.15.7.4 The Member handbook, Provider directory, and Formulary shall be updated on the CONTRACTOR's website.

4.15.7.5 Printed copies of the Provider directory shall be updated monthly and the electronic version shall be updated no later than two (2) Business Days after the CONTRACTOR receives updated Provider information.

4.15.7.6 The CONTRACTOR shall distribute updated information to Members on a regular basis, and the Member handbook must include information about how to find the online version of the Provider directory and Formulary and how to request a printed copy.

4.15.8 Additional Information Available Upon Request

The CONTRACTOR shall provide all other information to Members as required by CMS, including but not limited to, the following information to any Member who requests such information:

4.15.8.1 Information regarding the structure and operation of the CONTRACTOR’s MCO; and

4.15.8.2 Physician incentive plans, if applicable.

4.15.9 Member Identification (ID) Cards

4.15.9.1 Each Member shall be provided an identification card identifying the Member as a participant in the Turquoise Care program within twenty (20) Calendar Days of notification of enrollment into the CONTRACTOR’s MCO.

4.15.9.2 The CONTRACTOR shall re-issue a Member ID card within ten (10) Calendar Days of notice if a Member reports a lost card or if information on the Member ID card needs to be changed.

4.15.9.3 The Member ID card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all State and federal requirements and, at a minimum, shall include:

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4.15.9.3.1 The CONTRACTOR's name and issuer identifier, with the company logo;

4.15.9.3.2 The phone number for information and/or authorizations for all Covered Services, including for Physical Health, Behavioral Health, and LTC services;

4.15.9.3.3 Descriptions of procedures to be followed for emergency or special services;

4.15.9.3.4 The Member's identification number;

4.15.9.3.5 The Member's name (first and last name and middle initial);

4.15.9.3.6 The Member's date of birth;

4.15.9.3.7 The Member's enrollment effective date;

4.15.9.3.8 The Member's PCP;

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

4.15.9.3.10 The Member's State-issued Medicaid identification number, which shall be identified on the card as the "Medicaid ID"; and

4.15.9.3.11 All applicable copayment amounts.

4.15.10 Member Website

4.15.10.1 The CONTRACTOR shall have a Member website that is available to all Members and the general public without any log-in restrictions and that contains accurate, up-to-date information about the CONTRACTOR's MCO, including the Member handbook, services provided, the Formulary, the Provider directory, frequently asked questions (FAQs), Member newsletters, contact phone numbers and e-mail addresses, and any other information required by State and federal statutes or regulations or specified by HCA.

4.15.10.2 The CONTRACTOR must ensure its website is Americans with Disabilities Act Section 508 compliant and meets health equity requirements.

4.15.10.3 The CONTRACTOR must have a mobile version of the MCO's Member website content.

4.15.10.4 The CONTRACTOR must ensure that all Member information is located on the MCO's website in a manner that Members can easily find and navigate to and from the MCO's home page.

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4.15.10.5 The CONTRACTOR must have a secure Member portal that allows Members to access the following information on a real-time basis:

4.15.10.5.1 An electronic version of the Member's identification card;

4.15.10.5.2 Authorized services;

4.15.10.5.3 The Member's current PCP;

4.15.10.5.4 The data specified in 42 C.F.R. § 438.242 and 42 C.F.R. § 431.60; and

4.15.10.5.5 Other information, as identified by the CONTRACTOR or HCA.

4.15.10.6 The CONTRACTOR's secure Member portal must have the functionality for Members to submit questions, comments, Grievances, Appeals, requests for replacement Member ID cards, and requests to change PCPs and receive a response, giving the Member the option of requesting a response by return e-mail or phone call in addition to or In Lieu of a letter. The CONTRACTOR shall respond to questions or comments received from Members via the CONTRACTOR's website or Member portal as expeditiously as the Member's question requires but no later than one (1) business day from receipt.

4.15.10.7 Upon direction from HCA, the CONTRACTOR shall integrate its Member portal with HCA's Unified Portal.

4.15.10.8 The CONTRACTOR's call center staff shall have access to the website and Member portal to provide assistance to Members with navigating the site and locating information.

4.15.10.9 Information on the CONTRACTOR's website relating to Turquoise Care shall comply with the Marketing policies and procedures and requirements for written materials described in this Agreement and all applicable State and federal law.

4.15.11 Member Health Education

4.15.11.1 The CONTRACTOR shall develop a Health Education Plan on an annual basis. The Health Education Plan shall comply with the reporting requirements as directed by HCA.

4.15.11.2 The Health Education Plan shall include a Member education program that uses classes, individual or group sessions, videotapes, written material, media campaigns, and modern technologies (e.g., mobile applications and tools). All

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instructional materials shall be provided in a manner and format that is easily understood and in keeping with requirements for Member Materials as prescribed in this Agreement.

4.15.11.3 The CONTRACTOR shall educate its Members on the importance of good health and how to achieve and maintain good health, including but not limited to:

4.15.11.3.1 The availability and benefits of preventive health care;

4.15.11.3.2 Targeted DM education;

4.15.11.3.3 The benefits of completing Advance Directives;

4.15.11.3.4 The availability and benefits of Health Home;

4.15.11.3.5 Include information about the full array of EPSDT services, the importance and availability of EPSDT services, the benefits of preventive services, federal requirements for screenings and well-child examinations and how to access services, including services not otherwise listed as Covered Services in Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services

4.15.11.3.6 ;

4.15.11.3.7 The importance of and schedules for screenings for cancer, high blood pressure, and diabetes;

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

4.15.11.3.9 The concepts of managed care;

4.15.11.3.10 The use of the PCP as the primary source of medical care; and

4.15.11.3.11 The role of the care coordinator and how to contact the Care Coordination unit.

4.15.11.4 The CONTRACTOR shall make materials available for review by HCA upon request.

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

4.15.11.6 The CONTRACTOR’s Health Education Plan shall also include how the CONTRACTOR will work with CHWs to improve Member Health Literacy.

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Specifically, the CONTRACTOR shall make CHWs available to Members to, among other things:

4.15.11.6.1 Offer interpretation and translation services;

4.15.11.6.2 Provide culturally appropriate Health Education and information;

4.15.11.6.3 Assist Members in navigating the managed care system;

4.15.11.6.4 Assist in obtaining information about and access to available community resources;

4.15.11.6.5 Provide informal counseling and guidance on health behaviors; and

4.15.11.6.6 Assist the Member and care coordinator in ensuring the Member receives all Medically Necessary Covered Services.

4.15.11.7 The CONTRACTOR shall ensure that CHWs receive training on Turquoise Care, including the integration of Physical Health and Behavioral Health, as well as long-term services and the provisions and limitations of the ABP.

4.15.11.8 The CONTRACTOR shall submit a Health Education Plan Evaluation Report as directed by HCA.

4.15.11.9 The CONTRACTOR shall, at a minimum, distribute to Members on a quarterly basis a newsletter that is intended to educate Members on the managed care system, proper utilization of services, etc. and encourage utilization of preventive care services. HCA may require the CONTRACTOR to address a specific topic in the quarterly newsletter. The CONTRACTOR shall submit the newsletter to HCA for written approval forty-five (45) Calendar Days prior to the date on which it proposes to use or distribute the newsletter.

4.16 **Member Services**

4.16.1 Member Services Call Center

4.16.1.1 The CONTRACTOR shall operate a call center with a toll-free telephone line (Member services information line) to respond to Member questions, concerns, inquiries, and complaints from the Member, Representative or the Member's Provider. The call center and its staff must be located and operated in the State of New Mexico. With prior written approval from HCA, the CONTRACTOR may

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locate specially-trained call center staff in other locations outside New Mexico so long as calls can be transferred with a Warm Transfer during the hours delineated in Sections 4.16.1.6 and 4.16.1.9 of this Agreement. With prior written approval from HCA. The CONTRACTOR may also allow Major Subcontractors that are providing Covered Services to Members to operate a call center specific to those Covered Services being provided.

4.16.1.2 The CONTRACTOR shall develop Member services information line policies and procedures that address staffing, training, hours of operation, access, and response standards, transfers/referrals, including referrals from all sources, monitoring of calls via recording or other means, translation/interpretation, and compliance with standards.

4.16.1.3 The CONTRACTOR's call center shall have the capacity for HCA or its agent to monitor calls remotely.

4.16.1.4 The Member services information line shall be equipped to handle calls from callers with LEP, as well as calls from Members who are hearing impaired.

4.16.1.5 The CONTRACTOR shall have bilingual representatives based on the threshold of a prevalent non-English language specified in Section 4.15.2.5 of this Agreement.

4.16.1.6 The CONTRACTOR shall ensure that the Member services information line is staffed adequately to respond to Members' questions and meet -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, Juneteenth, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day on the actual day on which the holiday falls.

4.16.1.7 The call center staff shall be trained to respond to Member questions in all areas, including but not limited to Covered Services, including the ABP, the Provider network, and Member enrollment issues.

4.16.1.8 The call center staff shall receive ongoing training, at least quarterly, through instructor-led trainings and staff meetings. The call center staff must receive

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training immediately following changes to service delivery and Covered Services.

4.16.1.9 The Member services information line shall be staffed twenty-four (24) hours a day, seven (7) days a week with qualified nurses to triage urgent care and emergency calls from Members and to facilitate transfer of calls to a care coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section 4.16.1.

4.16.1.10 Staff providing triage/nurse advice services must be registered nurses, physician assistants, nurse practitioners, or medical doctors. At all times there must be staff on hand equipped to handle Behavioral Health crises. The primary intent of this triage is to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with a Member's PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

4.16.1.11 The CONTRACTOR shall ensure that all calls from Members to the nurse triage/nurse advice line that require immediate attention are immediately addressed by qualified nurses or transferred to a care coordinator, whichever is most appropriate. During normal business hours, the transfer to the Care Coordination unit shall be a Warm Transfer. After normal business hours, if the CONTRACTOR cannot transfer the call to the Care Coordination unit as a Warm Transfer, the CONTRACTOR shall ensure that a care coordinator is notified about the call and returns the Member's call within thirty (30) minutes. When returning the call the care coordinator must have access to the necessary information (e.g., the Member's CCP) to resolve Member issues. The CONTRACTOR shall implement protocols, with prior written approval from HCA, that describe how calls to the nurse triage/nurse advice line from Members will be handled.

4.16.1.12 The CONTRACTOR shall implement protocols, with prior written approval from HCA, to ensure that calls to the Member services information line that

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should be transferred/referred to other CONTRACTOR staff, including but not limited to, a Member services supervisor or a care coordinator, or to an external entity, are transferred/referred appropriately.

4.16.1.13 The CONTRACTOR shall measure and monitor the accuracy of responses and phone etiquette and take corrective action, as necessary, to ensure the accuracy of responses and appropriate phone etiquette by staff.

4.16.1.14 The CONTRACTOR shall have an automated system available during non-business hours, including weekends and holidays. This automated system shall provide callers with operating instructions on what to do in case of an emergency, the option to speak directly to a nurse, and shall include, at a minimum, a voice mailbox for callers to leave messages. The CONTRACTOR shall ensure that the voice mailbox has adequate capacity to receive all messages. The CONTRACTOR shall return all messages by the next Business Day.

4.16.1.15 The call center staff shall have access to electronic documentation from previous calls made by, or on behalf of, the Member to the Member services information line, nurse triage/nurse advice line, and the Care Coordination department.

4.16.2 Performance Standards for Member Services Line/Queue

4.16.2.1 The CONTRACTOR shall adequately staff the Member services information line to ensure that the Member line and the nurse triage/nurse advice line or queue, meet the following performance standards independently on a monthly basis: less than five percent (5%) call abandonment rate; ninety percent (90%) of calls are answered by a live voice within thirty (30) seconds; average wait time for assistance does not exceed thirty (30) seconds; seventy percent (70%) of all calls are resolved during the first call; and one hundred percent (100%) of voicemails returned by next Business Day.

4.16.2.2 The CONTRACTOR’s call center systems shall have the capability to track call center metrics as identified above. Metrics shall be reported separately for the Member services information line and the nurse triage/nurse advice line/queue.

4.16.3 Interpreter and Translation Services

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4.16.3.1 The CONTRACTOR shall provide oral interpretation services to individuals with LEP and sign language services and TDD/TTY services to individuals who are hearing impaired at no cost to the individual. The CONTRACTOR shall notify its Members and potential Members of the availability of free interpreter services, sign language, and TDD/TTY services and inform them of how to access these services.

4.16.3.2 Interpreter services must be available in the form of in-person interpreters or telephonic assistance, such as the Language Line. For phone interpreters, the caller should not have to hang up or call a separate number.

4.16.3.3 The CONTRACTOR shall offer oral interpretation services to individuals with LEP regardless of whether the individual speaks a language that meets the threshold of a prevalent non-English language as set forth in Section 4.15.2.5 of this Agreement.

4.16.3.4 The CONTRACTOR shall document the offer of an interpreter and whether the individual declined or accepted the interpreter service.

4.16.3.5 The CONTRACTOR is prohibited from requiring or suggesting that Members with LEP or Members using sign language provide their own interpreters or utilize friends or family members.

4.16.4 Personal Health Records

4.16.4.1 The CONTRACTOR shall provide Members with access to electronic versions of their personal health records.

4.17 **Grievances and Appeal System**

4.17.1 General Requirements for Grievances and Appeal System

4.17.1.1 The CONTRACTOR shall have a Grievance and Appeal system in place for Members that includes a Grievance process related to the expressions of dissatisfaction and an Appeal process related to a CONTRACTOR’s Adverse Benefit Determination. A Member must first exhaust the CONTRACTOR's Grievance and Appeal system prior to requesting a State Fair Hearing. The CONTRACTOR's Ombudsman, prescribed in Section 3.3.3.27 of this

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Agreement, is separate and distinct from the CONTRACTOR's Grievance and Appeal processes.

4.17.1.2 In implementing these processes, the CONTRACTOR shall, at a minimum:

4.17.1.2.1 Adopt written policies and procedures describing how the Member may register a Grievance or an Appeal with the CONTRACTOR and how the CONTRACTOR resolves the Grievance or Appeal;

4.17.1.2.2 Provide a copy of its Grievance and Appeal policies and procedures to all Contract Providers;

4.17.1.2.3 Comply with the requirements in 42 C.F.R. § 438.406;

4.17.1.2.4 Have sufficient support staff (clerical and professional, including Behavioral Health practitioners) available to process Grievances and Appeals in accordance with HCA requirements related to an Adverse Benefit Determination affecting a Member. The CONTRACTOR shall notify HCA the names of appointed staff members and their phone numbers. Staff shall be knowledgeable about applicable State and federal law and regulations, and all court orders and consent decrees governing Grievance and Appeal procedures, as they become effective;

4.17.1.2.5 Ensure that the individuals who make decisions on Grievances and/or Appeals are not involved in any previous level of review or decision making; and

4.17.1.2.6 Ensure that punitive or retaliatory action is not taken against a Member or a Provider that files a Grievance and/or an Appeal, or against a Provider that supports a Member's Grievance and/or Appeal.

4.17.2 Grievances

A Member may file a Grievance either verbally or in writing with the CONTRACTOR at any time from the date the dissatisfaction occurred. The Representative or a Provider acting on behalf of the Member and with the Member's written consent has the right to file a Grievance on behalf of the Member.

4.17.2.1 Within five (5) Business Days of receipt of the Grievance, the CONTRACTOR shall provide the Grievant with written notice that the Grievance has been

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received and the expected date of its resolution. This acknowledgement of receipt of a Grievance must include the information specified in the Managed Care Policy Manual.

4.17.2.2 The CONTRACTOR shall complete the investigation and final resolution process for Grievances within thirty (30) Calendar Days of the date the Grievance is received by the CONTRACTOR or as expeditiously as the Member's health condition requires and shall include mailing a resolution letter to the Grievant/Member.

4.17.2.3 The CONTRACTOR may request an extension from HCA in accordance with 42 C.F.R. § 438.408(c). For any extension not requested by the Member, the CONTRACTOR shall make reasonable efforts to give the Member prompt oral notice of the delay and shall submit an extension request to HCA for approval. Upon receiving an approval of the extension request from HCA, the MCO shall give the Member written notice of the reason for the extension within two (2) Calendar Days of HCA's approval to extend the time frame and inform the Member of the right to file a grievance if he or she disagrees with that decision. The written notice of the extension shall include the information specified in the Managed Care Policy Manual.

4.17.2.4 Unless extended pursuant to the requirements in this Section 4.17, the CONTRACTOR shall mail a resolution letter to the Grievant/Member no later than thirty (30) Calendar Days after the initial date the Grievance was received by the CONTRACTOR. The resolution letter must include the information specified in the Managed Care Policy Manual.

4.17.3 Appeals

4.17.3.1 The CONTRACTOR shall mail a notice of Adverse Benefit Determination to the Member or provider in accordance with the procedures and time frames in 42 C.F.R. § 438.404 unless such time frame is prescribed in this Section 4.17.3.

4.17.3.2 The CONTRACTOR shall mail a notice of Adverse Benefit Determination within five (5) Calendar Days if probable Member Fraud has been verified.

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4.17.3.3 The CONTRACTOR may mail a notice of Adverse Benefit Determination no later than the date of the Adverse Benefit Determination for the following:

4.17.3.3.1 The CONTRACTOR has factual information confirming the death of a Member;

4.17.3.3.2 The CONTRACTOR receives a signed written Member statement requesting service termination or giving information requiring termination of Covered Services (where the Member understands that this must be the result of supplying that information);

4.17.3.3.3 The Member has been admitted to an institution where he or she is ineligible for further services;

4.17.3.3.4 The Member's address is unknown and mail directed to them has no forwarding address;

4.17.3.3.5 The Member has been accepted for Medicaid services in another state or United States territory;

4.17.3.3.6 The Member's physician prescribes a change in the level of medical care;

4.17.3.3.7 An Adverse Benefit Determination is made with regard to the preadmission screening requirements for NF admissions; and

4.17.3.3.8 In accordance with 42 C.F.R. § 483. 404(c)(1) and 42 C.F.R. § 431.211, § 431.213 and § 431.214.

4.17.3.4 A Member may file an Appeal of a CONTRACTOR's Adverse Benefit Determination either verbally or in writing within sixty (60) Calendar Days from the date on the Adverse Benefit Determination notice. The Representative or a Provider acting on behalf of the Member with the Member's written consent has the right to file an Appeal of an Adverse Benefit Determination on behalf of the Member. The CONTRACTOR shall consider the Member, Representative, or estate representative of a deceased Member as parties to the Appeal.

4.17.3.5 The CONTRACTOR has thirty (30) Calendar Days from the date the initial oral or written Appeal is received by the CONTRACTOR to resolve the Appeal. The CONTRACTOR shall appoint at least one (1) person to review the Appeal; such person shall not have been involved in the initial decision.

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4.17.3.6 The CONTRACTOR shall have a process in place that assures that an oral or written inquiry from the Member seeking to Appeal an Adverse Benefit Determination is treated as an Appeal (to establish the earliest possible filing date for the Appeal), unless the Member or the Provider requests an expedited resolution. In accordance with 42 C.F.R. § 438.402 and § 438.406, the Member is not required to submit a written, signed Appeal after an oral Appeal is submitted.

4.17.3.7 Within five (5) Business Days of receipt of the Appeal, the CONTRACTOR shall provide the Member with written notice that the Appeal has been received and of the expected date of its resolution. This acknowledgement of receipt of an Appeal must include the information specified in the Managed Care Policy Manual.

4.17.3.8 The CONTRACTOR may extend the thirty (30) Calendar Day time frame in accordance with 42 C.F.R. § 438.408(c). For any extension not requested by the Member, the CONTRACTOR must make reasonable efforts to give the Member prompt oral notice of the delay and shall submit an extension request to HCA for approval. Upon receiving an approval of the extension request from HCA, the MCO shall give the Member written notice of the extension and the reason for the extension within two (2) Calendar Days of HCA's approval to extend the time frame. The written notice of the extension shall include the information specified in the Managed Care Policy Manual.

4.17.3.9 Unless extended pursuant to the requirements in this Section 4.17, the CONTRACTOR shall provide written notice of resolution within the thirty (30) Calendar Days of the CONTRACTOR's receipt of the Appeal to the Member, the Member's Representative(s), and/or the Provider, if the Provider filed the Appeal. The written notice of the Appeal resolution shall include, but is not limited to, the information contained in 42 C.F.R. § 438.408(e) and the Managed Care Policy Manual, as applicable.

4.17.3.10 The CONTRACTOR may only have one (1) level of Appeal for Members, as specified in 42 C.F.R. § 438.402(b).

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4.17.4 Expedited Resolution of Appeals

4.17.4.1 The CONTRACTOR shall establish and maintain an expedited review process for Appeals in accordance with 42 C.F.R. § 438.410.

4.17.4.2 The CONTRACTOR shall ensure that the expedited review process is convenient and efficient for the Member.

4.17.4.3 The CONTRACTOR shall resolve the expedited Appeal within seventy-two (72) hours of CONTRACTOR's receipt of the appeal, per 42 C.F.R. § 438.408(b)(3) and (d)(2).

4.17.4.4 The CONTRACTOR may extend the time frame for an expedited Appeal in accordance with 42 C.F.R. § 438.408(c). For any extension not requested by the Member, the CONTRACTOR shall make reasonable efforts to give the Member prompt oral notice of the delay and shall submit an extension request to HCA for approval. Upon receiving an approval of the extension request from HCA, and within two (2) Calendar Days, the MCO shall give the Member a written notice of the reason for HCA's approval to extend the time frame and inform the Member of the right to file a grievance if the Member disagrees with the decision to extend the time frame. The written notice of the extension shall include the information specified in the Managed Care Policy Manual.

4.17.4.5 If the CONTRACTOR denies a request for expedited resolution of an Appeal, the CONTRACTOR shall transfer the Appeal to the time frame for standard resolution and make reasonable efforts to give the Member prompt oral notice of the denial and follow up within two (2) Calendar Days with a written notice.

4.17.4.6 The CONTRACTOR shall inform the Member of the limited time available for expedited reviews to present evidence and allegations in fact or law.

4.17.4.7 The CONTRACTOR shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

4.17.4.8 The CONTRACTOR must ensure that punitive action is not taken against a Provider who requests an expedited Appeal or supports a Member's Appeal.

4.17.5 Deemed Exhaustion of Appeal Process

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In the event the CONTRACTOR fails to adhere to the notice and timing requirements specified in Section 4.17 of this Agreement, the Member is deemed to have exhausted the Appeal process and may request a State Fair Hearing.

4.17.6 Special Rule for Certain Expedited Service Authorization Decisions

In the case of certain expedited service authorization decisions that deny or limit services, the CONTRACTOR shall, within seventy-two (72) hours of receipt of the request for service, automatically file an Appeal on behalf of the Member, make a best effort to give the Member oral notice of the decision of the automatic Appeal, and make a best effort to resolve the Appeal. For purposes of this Section 4.17.6, "expedited service authorization" is a request for urgently needed care or services.

4.17.7 If requested by the Member, the CONTRACTOR shall continue benefits while an Appeal and/or the State Fair Hearing process is pending in accordance with 42 C.F.R. § 438.420 and § 438.424.

4.17.8 State Fair Hearings for Members

4.17.8.1 A Member may request a State Fair Hearing if they are dissatisfied with an Adverse Benefit Determination that has been taken by the CONTRACTOR and the Member has exhausted the CONTRACTOR's internal Appeal process, within ninety (90) Calendar Days of the final decision by the CONTRACTOR. The Representative, the estate representative of a deceased Member, or a Provider acting on behalf of the Member and with the Member's written consent, may request a State Fair Hearing on behalf of the Member.

4.17.8.2 The CONTRACTOR shall provide the HCA/Fair Hearings Bureau, the HCA Medical Assistance Division, the Member and/or the Member's Representative(s) with a summary of evidence (SOE) within seven (7) Calendar Days after receipt of a request for hearing but no later than fifteen (15) Business Days prior to the initially scheduled hearing. The SOE must contain copies of all documentation used to make the CONTRACTOR's decision, and it must explain the reasons for the Adverse Benefit Determination and address all of the Member's concerns. The SOE must refer to all relevant State and federal statutes and regulations used to make the decision. Upon request and no later than seven

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(7) Calendar Days after receiving the request, the CONTRACTOR shall provide the Member and/or the Member's Representative (with written consent of the Member) access to the Member's case file and provide copies of documents contained therein without charge.

4.17.8.3 The CONTRACTOR shall appear with appropriate clinical personnel at all scheduled State Fair Hearings concerning its clinical determinations to present evidence as justification for its determination regarding the disputed benefits and/or services.

4.17.8.4 The CONTRACTOR shall have its legal counsel appear at all scheduled State Fair Hearings for which the CONTRACTOR has received notification that the Member has legal counsel and when HCA provides it with not less than seven (7) Calendar Days' notice that legal representation will be required.

4.17.8.5 The CONTRACTOR shall comply with all determinations rendered as a result of State Fair Hearings. Nothing in this section shall limit the remedies available to HCA or the federal government relating to any noncompliance by the CONTRACTOR with a State Fair Hearing determination or by the CONTRACTOR's refusal to provide disputed services.

4.17.8.6 The CONTRACTOR may initiate recovery procedures against the Member, if the Adverse Benefit Determination is upheld after a State Fair Hearing, to recoup the cost of any service required to be continued while the Appeal was pending.

4.17.9 Provider Complaints

The CONTRACTOR shall establish and maintain written policies and procedures for the filing of Provider complaints. A Provider shall have the right to file a complaint with the CONTRACTOR. Provider complaints shall be resolved within thirty (30) Calendar Days. If the Provider grievance or appeal complaint is not resolved within thirty (30) Calendar Days, the CONTRACTOR shall request a fourteen (14) Calendar Day extension from the Provider. If the Provider requests the extension, the extension shall be approved by the CONTRACTOR. A Provider shall have the right to file a complaint with the CONTRACTOR regarding provider payment issues, including Claims disputes, and/or Utilization Management decisions.

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4.17.9.1 When the CONTRACTOR determines the Claim(s) subject to the Claims dispute were denied/paid incorrectly, the CONTRACTOR must correct the error and reprocess and pay the Claim(s) within thirty (30) calendar days of the notice of resolution. The CONTRACTOR must also automatically reprocess and pay all other Provider Claims affected by the same issue to correctly adjudicate all other Provider Claims affected by the same issue to correctly adjudicate all other Provider Claims similarly situated.

4.17.9.2 If the CONTRACTOR upholds its action in the Provider appeal final decision, the appeal process is considered exhausted. The Provider is not eligible to request a State Fair Hearing. The loss of the Provider appeal does not make the Member liable for any payment to the provider.

4.17.10 Appeals for Excluded State-Funded Services. If the CONTRACTOR receives a grievance or appeal for Excluded State-Funded Services, the CONTRACTOR shall forward them to the State's state-funded appeals unit within one (1) business day and shall not adjudicate them under Medicaid processes.

4.18 **Program Integrity**

4.18.1 General

4.18.1.1 The CONTRACTOR, must meet Program Integrity requirements in accordance with 42 C.F.R. Part 438 Subpart H and other Program Integrity requirements as set forth in this Section 4.18.

4.18.1.2 Compliance Program

4.18.1.2.1 In accordance with 42 C.F.R. § 438.608(a)(1), the CONTRACTOR must implement and maintain a compliance program that includes, at a minimum, the following elements:

4.18.1.2.1.1 Written policies, procedures, and standards of conduct that demonstrate compliance with requirements and standards under this Agreement and all applicable federal and State requirements;

4.18.1.2.1.2 A designated Compliance Officer responsible for developing and implementing policies and procedures designed to ensure compliance

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with this Agreement and who reports directly to the CEO and the CONTRACTOR's board of directors;

4.18.1.2.1.3 The establishment of a regulatory compliance committee on the CONTRACTOR's board of directors and at the senior management level charged with overseeing the CONTRACTOR's compliance program and compliance with the requirements under this Agreement;

4.18.1.2.1.4 A system for training and education for the CONTRACTOR'S Compliance Officer, senior management, and employees for the federal and State standards and requirements under this Agreement;

4.18.1.2.1.5 Effective lines of communication between the Compliance Officer and the CONTRACTOR's employees;

4.18.1.2.1.6 Enforcement of standards through well-publicized disciplinary guidelines; and

4.18.1.2.1.7 A system of dedicated staff with established and implemented procedures for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigations of potential compliance problems identified in the course of self-evaluation and audits, prompt and thorough correction of such problems to reduce the potential for recurrence, and ongoing compliance with the requirements of this Agreement.

4.18.1.2.2 The CONTRACTOR must develop and annually submit a written compliance program description, work plan, and evaluation for HCA approval. The CONTRACTOR's compliance program description must include:

4.18.1.2.2.1 The elements of the CONTRACTOR's compliance program as set forth in this Section 4.18.1.2;

4.18.1.2.2.2 A work plan that describes clear compliance goals, objectives, targeted State and federal requirements, methods of monitoring, controls, key dates for achieving the goals and objectives, and how the CONTRACTOR will measure the effectiveness of the controls to ensure

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the CONTRACTOR is meeting State and federal requirements. Targeted requirements must include those related to the Program Integrity and Fraud, Waste, and Abuse requirements in this Section 4.18, but must also include other requirements and standards in this Agreement, particularly those at risk for non-compliance; and

4.18.1.2.2.3 A comprehensive evaluation that includes an evaluation of the overall effectiveness of the CONTRACTOR's compliance program. The review and analysis of any impact from the previous year shall be incorporated in the development of the following year's work plan.

4.18.2 Fraud, Waste, and Abuse and Other Program Integrity Requirements

4.18.2.1 The CONTRACTOR shall cooperate with the New Mexico Medicaid Fraud & Elder Abuse Division (MFEAD) and other investigatory agencies in accordance with the provisions of NMSA 1978, 27- 11-1 et seq.

4.18.2.2 The CONTRACTOR shall comply with all State and federal requirements regarding Fraud, Waste and Abuse, including but not limited to, Sections 1128, 1156, 1902(a)(68), and Section 1903(i) of the Social Security Act and the CMS Medicaid integrity program.

4.18.2.3 The CONTRACTOR shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the CONTRACTOR in preventing and detecting potential Fraud, Waste and Abuse.

4.18.2.4 The CONTRACTOR shall establish effective lines of communication between the CONTRACTOR's Compliance Officer and the CONTRACTOR's employees to facilitate the oversight of systems that monitor service utilization and Encounters for Fraud, Waste and Abuse.

4.18.2.5 The CONTRACTOR shall cooperate fully in any activity performed by HCA, MFEAD, Medicaid Recovery Audit Contractor (RAC), CMS, and CMS Audit Medicaid Integrity Contractors (MIC). The CONTRACTOR, its Subcontractors, Major Subcontractors, and Contract Providers shall, within two (2) to ten (10) Business Days after the date of request, in accordance with NMSA 1978, § 27-11- 4(B), make available to HCA, MFEAD, RAC, CMS, or MIC any and all

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administrative, financial, and medical records relating to the delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, the CONTRACTOR and its Subcontractors, Major Subcontractors, and Contract Providers shall provide HCA, MFEAD, RAC, CMS, or MIC with access during normal business hours to its respective place of business and records.

4.18.2.6 The CONTRACTOR, Major Subcontractors, Subcontractors, and Contract Providers shall comply with all program integrity provisions of the PPACA including:

4.18.2.6.1 Enhanced provider screening and enrollment, Section 6401;

4.18.2.6.2 Termination of Provider participation, Section 6501; and

4.18.2.6.3 Provider disclosure of current or previous affiliation with excluded Provider(s), Section 6401.

4.18.2.6.4 The requirements set forth in Section 4.17.1 of this Agreement shall be included in the CONTRACTOR's contracts with Major Subcontractors, Subcontractors, and Contract Providers.

4.18.2.7 The CONTRACTOR and Major Subcontractors, Subcontractors, and Contract Providers shall establish written policies and procedures for all employees, agents, or contractors that provide detailed information regarding: (i) the New Mexico False Claims Act, NMSA 1978, 27-14-1 et seq.; (ii) the New Mexico Fraud Against the Taxpayers Act, NMSA 1978, 44-9-1 et seq.; and (iii) the Federal False Claims Act established under 31U.S.C § 3729-3733, administrative remedies for false Claims established under 31 U.S.C. 3801 et seq., including but not limited to, preventing, detecting, and reporting Fraud, Waste and Abuse in federal health care programs (as defined in Section 1128B(f) of the Social Security Act and 42 C.F.R. § 438.608). Such policies and procedures shall clearly state the CONTRACTOR’s commitment to compliance with State and federal standards.

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4.18.2.8 The CONTRACTOR and all Major subcontractors, Subcontractors, and Contract Providers shall include in any employee handbook the rights of employees to be protected as "whistleblowers".

4.18.2.9 The CONTRACTOR shall make every reasonable effort to detect, recoup, and prevent Overpayments made to Contract Providers in accordance with State and federal law and regulations. The CONTRACTOR shall report Claims identified for Overpayment recoupment to HCA at a regularly scheduled interval and in a format agreed to by HCA and the CONTRACTOR and reflected on the CONTRACTOR's Encounter Data. HCA may require an HCA-contracted Medicaid RAC to review paid Claims that are over three hundred sixty (360) Calendar Days old from the CONTRACTOR paid date and pursue Overpayments for those Claims that do not indicate recovery amounts in the CONTRACTOR's Encounter Data.

4.18.2.10 The CONTRACTOR shall promptly notify HCA when it receives information about changes in a Member's circumstances that may affect the Member's eligibility, including Member moving out of State and the death of a Member.

4.18.2.11 The CONTRACTOR shall promptly notify HCA when it receives information about a change in a Contract Provider's circumstances that may affect the Contract Provider's eligibility for participation in Medicaid, including termination of the provider agreement with the CONTRACTOR.

4.18.2.12 The CONTRACTOR shall employ a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by Contract Providers were received by Members and apply this verification method on a regular basis as specified by HCA.

4.18.3 Reporting and Investigating Suspected Fraud, Waste and Abuse

4.18.3.1 The CONTRACTOR shall cooperate with all appropriate State and federal agencies in investigating Fraud, Waste and Abuse.

4.18.3.2 The CONTRACTOR shall have methods for identifying, investigating, and referring suspected Fraud cases pursuant to 42 C.F.R. § 455.13, § 455.14 and § 455.21.

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4.18.3.3 The CONTRACTOR shall report all confirmed, credible, or suspected Fraud, Waste and Abuse to HCA as follows within the time frames required by HCA.

4.18.3.3.1 Suspected Fraud, Waste and Abuse in the administration of Turquoise Care shall be reported to HCA. It shall be HCA's responsibility to report verified cases to MFEAD;

4.18.3.3.2 All confirmed, credible, or suspected provider Fraud, Waste and Abuse shall be immediately reported to HCA and shall include the information provided in 42 C.F.R. § 455.17, as applicable. It shall be HCA responsibility to report verified cases to MFEAD; and

4.18.3.3.3 All confirmed or suspected Member Fraud, Waste and Abuse shall be reported to HCA.

4.18.3.4 The CONTRACTOR shall promptly (within five [5] Business Days) make an initial report to HCA of all suspicious activities and begin conducting a preliminary investigation of all incidents of suspected and/or confirmed Fraud, Waste and/or Abuse. The CONTRACTOR shall have up to twelve (12) months from the date of the initial report of suspicious activity to complete its preliminary investigation and shall provide HCA with monthly updates. HCA may at its sole discretion, require that the CONTRACTOR complete its preliminary investigation in a shorter time frame. In addition, unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud, Waste and/or Abuse or suspected Fraud, Waste and/or Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Turquoise Care:

4.18.3.4.1 Contact the subject of the investigation about any matters related to the investigation;

4.18.3.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident; or

4.18.3.4.3 Accept any monetary or other type of consideration offered by the subject of the investigation in connection with the incident.

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4.18.3.5 The CONTRACTOR shall within the twelve (12)-month period and within ten (10) Business Days of completing the preliminary investigation, report the results to HCA where the CONTRACTOR has determined that a potential overpayment exists.

4.18.3.6 The CONTRACTOR shall notify HCA within five (5) Business Days, via e-mail, when a formal, written action is taken by the CONTRACTOR against a Contract Provider. Such action being defined for purposes of this section as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is defined in the Contract Provider's agreement with the CONTACTOR; or (ii) due to concerns other than fraud, such as integrity or quality.

4.18.3.7 The CONTRACTOR shall comply with the reporting requirements in Section 4.22 of this Agreement.

4.18.3.8 The CONTRACTOR shall have a mechanism in place to suspend payments to any Provider for which HCA, in accordance with 42 C.F.R. § 455.23, has determined that a credible allegation of fraud exists.

4.18.4 Fraud, Waste, and Abuse Plan

4.18.4.1 The CONTRACTOR shall have a written Fraud, Waste, and Abuse Plan. An electronic copy of the Fraud, Waste, and Abuse Plan shall be provided to HCA annually by July 1. HCA will 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 HCA within thirty (30) Calendar Days of a request.

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

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

4.18.4.2.2 Outline activities proposed for the next reporting year regarding employee education of State and federal law and regulations related to Medicaid program integrity and Fraud, Waste and Abuse to ensure that all of its

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officers, directors, managers, and employees know and understand the provisions of the CONTRACTOR's Fraud, Waste and Abuse Plan;

4.18.4.2.3 Outline activities proposed for the next reporting year regarding Provider education of State and federal 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;

4.18.4.2.4 Contain procedures designed to prevent and detect Fraud, Waste and Abuse in the administration and delivery of services under this Agreement;

4.18.4.2.5 Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, Waste and Abuse;

4.18.4.2.6 Contain specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating Fraud, Waste and Abuse Plan violations;

4.18.4.2.7 Ensure that no individual who reports violations by the CONTRACTOR or suspected Fraud, Waste and Abuse is retaliated against; and

4.18.4.2.8 Include work plans for conducting both announced and unannounced site visits and field audits to Contract Providers defined as high risk (Providers with cycle/auto billing activities and Providers offering DME, home health, Behavioral Health, and transportation services) to ensure services are rendered and billed correctly.

4.18.5 Recoveries of Overpayments and/or Fraud

4.18.5.1 Identification Process For Overpayments

4.18.5.1.1 The CONTRACTOR shall report to HCA all instances in which the CONTRACTOR has notified a provider of a potential Overpayment, including the date of such notification, the stated reasons, and the potential Overpayment amount. HCA may, at its sole discretion, require monthly updates as to the status of any reported potential Overpayment.

4.18.5.1.2 Providers are required to report identified Overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar

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Days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an Overpayment if the Provider has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference that an Overpayment exists.

4.18.5.2 Self-Reporting

4.18.5.2.1 For all identified Overpayments and within the time frames specified in Section 4.18.5.1.1 of this Agreement, the Provider shall send an "Overpayment Report" to the CONTRACTOR and HCA that shall include, at a minimum: (i) Provider's name; (ii) Provider's tax identification number and National Provider Number; (iii) how the Overpayment was discovered; (iv) the reason for the Overpayment; (v) the health insurance Claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid Claim control number, as appropriate; (viii) description of corrective measures taken to prevent reoccurrence or an explanation of why corrective measures are not indicated; (ix) whether the provider has a corporate integrity agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the Overpayment; (xi) whether a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to determine the Overpayment; and (xii) the refund amount, provided, however, that related Overpayments may be reported on a single "Overpayment Report."

4.18.5.3 Refunds

4.18.5.3.1 All self-reported refunds for Overpayments shall be made by the Provider to the CONTRACTOR as an intermediary and are property of the CONTRACTOR unless:

4.18.5.3.1.1 HCA, the RAC or MFEAD independently notified the Provider that an Overpayment existed;

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4.18.5.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the Claim; or

4.18.5.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the Claim.

4.18.5.3.2 The Provider may request that the CONTRACTOR permit installment payments of the refund; such request shall be agreed to by the CONTRACTOR and the Provider; or

4.18.5.3.3 In cases where HCA, the RAC or MFEAD identifies the overpayment, HCA shall seek recovery of the Overpayment in accordance with NMAC § 8.351.2.13.

4.18.5.3.4 Failure To Self-Report and/or Refund Overpayments

4.18.5.3.4.1 The CONTRACTOR shall inform all Providers that all Overpayments that have been identified by a Provider and not self-reported within the sixty (60) Calendar Day time frame may be considered false Claims and may be subject to referrals as credible allegations of fraud and subject to Section 4.18.3.3.1 of this Agreement.

4.18.5.3.5 Claims Adjustment

4.18.5.3.5.1 The CONTRACTOR shall void or adjust (as applicable) claims to reflect any identified provider overpayments, regardless of whether they have been recovered.

4.18.6 Reporting Party-in-Interest

4.18.6.1 For the purposes of this section “party-in-interest” (party) is defined as:

4.18.6.1.1 Any director, officer, partner, or employee responsible for management or administration of a CONTRACTOR, any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the CONTRACTOR, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the CONTRACTOR, and, in the case of a CONTRACTOR organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

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4.18.6.1.2 Any entity in which a person described above in Section 4.18.6.1.1:

4.18.6.1.2.1 Is an officer or director;

4.18.6.1.2.2 Is a partner (if such entity is organized as a partnership);

4.18.6.1.2.3 Has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the CONTRACTOR; or

4.18.6.1.2.4 Has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the CONTRACTOR.

4.18.6.1.3 Any person directly or indirectly controlling, controlled by, or under common control with the CONTRACTOR; and

4.18.6.1.4 Any spouse, child, or parent of an individual described above in Sections 4.18.6.1.1 through 4.18.6.1.3.

4.18.6.2 The CONTRACTOR must report to HCA and, upon request, to the Secretary of the DHHS, the Inspector General of the DHHS, the Comptroller General, and to its Members, upon reasonable request, a description of transactions between the CONTRACTOR and a party, the following transactions:

4.18.6.2.1 Any sale or exchange, or leasing of any property between the CONTRACTOR and such a party;

4.18.6.2.2 Any furnishing for consideration of goods, services (including management services), or facilities between the CONTRACTOR and such a party, but not including salaries paid to employees for services provided in the normal course of their employment; or

4.18.6.2.3 Any lending of money or other extension of credit between the CONTRACTOR and such a party.

4.18.6.3 The CONTRACTOR shall disclose transactions subject to this Section 4.18.6 annually and such disclosures shall provide the following information:

4.18.6.3.1 The name of the party for each transaction;

4.18.6.3.2 A description of each transaction and the quantity or units involved;

4.18.6.3.3 The accrued dollar value of each transaction; and

4.18.6.3.4 A justification of the reasonableness of each transaction.

4.19 **Financial Management**

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4.19.1 Initial and Ongoing Working Capital and/or Net Worth Requirements

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

If the CONTRACTOR has been providing services to New Mexico Medicaid Members for a period of less than three (3) months, the CONTRACTOR shall submit to HCA, at the Agreement execution, proof of the greater of the following:

4.19.1.1 Working capital in the form of cash or liquid assets, excluding revenues from Medicaid capitation equal to at least the first three (3) months of operating expenses;

4.19.1.2 Initial net worth of one million five hundred thousand dollars ($1,500,000); and

4.19.1.3 Insolvency Protection (Section 4.19.2 of this Agreement) and Surplus Requirement (Section 4.19.3 of this Agreement) balances may be included in the above as appropriate.

4.19.2 Insolvency Protection

The CONTRACTOR shall comply with and is subject to all applicable State and federal statutes and regulations, including those regarding solvency and risk standards. In addition to requirements imposed by State or federal law, the CONTRACTOR shall be required to meet specific Medicaid financial requirements and to present to HCA or its agent any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HCA at no cost to HCA, in reasonable time from the date of request or as specified herein.

4.19.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in the State of New Mexico. 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 Payments paid to the CONTRACTOR in the first month of the contract year as

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determined by HCA. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HCA.

4.19.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR's Turquoise Care program.

4.19.2.1.2 The CONTRACTOR must satisfy this requirement no later than sixty (60) Calendar Days after notification by HCA of the deposit amount required.

4.19.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter as determined by HCA.

4.19.2.1.4 The CONTRACTOR shall a quarterly statement of the account balance for the restricted insolvency protection account that will allow HCA to examine and confirm compliance with the Agreement. Based upon total capitation payments paid to the CONTRACTOR, the required account balance each quarter will be determined by HCA.

4.19.2.1.5 If the account balance falls below the required amounts as determined by HCA, the CONTRACTOR has thirty (30) Calendar Days, after notification from HCA to increase the account balance to an amount no less than the required amount specified by HCA direction in 4.19.2.1.3 of this Agreement.

4.19.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HCA from this account so long as the account balance after the withdrawal is not less than required amount as specified by HCA. The CONTRACTOR shall notify HCA in writing prior to withdrawal of funds from this account. Withdrawals may be made only with the prior written approval of HCA.

4.19.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors by using this account as security.

4.19.2.1.8 The CONTRACTOR shall deposit the assets with any organization or trustee, acceptable to the Superintendent of Insurance, through which a custodial or controlled account is utilized.

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4.19.2.2 In the event that a determination is made by HCA that the CONTRACTOR is insolvent under applicable state insurance law, HCA may draw upon the insolvency protection account. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HCA.

4.19.2.3 If the Agreement is terminated, expired or not continued, the account balance shall be released by HCA to the CONTRACTOR upon receipt of proof of satisfaction of all outstanding obligations incurred under this Agreement.

4.19.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HCA may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HCA including but not limited to: Overpayments made to the CONTRACTOR, monetary penalties imposed under the Agreement, or a final order related to State requirements (e.g., overturned Appeal). In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to Providers, HCA and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HCA priority over other Claims subject to applicable state insurance law.

4.19.2.5 HCA shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed by the CONTRACTOR solely for payment for Covered Services to the CONTRACTOR's Members in the event that the CONTRACTOR becomes insolvent. Funds in the insolvency protection account remains the property of the CONTRACTOR, including any interest earned, provided the requirement under Section 4.19.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its funds in the account consistent with applicable state insurance regulations and guidelines.

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4.19.2.6 Failure to maintain the insolvency protection account as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

4.19.3 Surplus Requirement

The CONTRACTOR shall maintain, at all times, in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the CONTRACTOR's domiciliary State regulator and restricted funds of deposits controlled by HCA (including the CONTRACTOR's insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars ($1,500,000), ten percent (10%) of total liabilities or two percent (2%) of the annualized amount of the CONTRACTOR's capitation revenues. In the event that the CONTRACTOR's surplus falls below the amount specified in this paragraph, HCA shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

4.19.4 Interest

Interest generated from the deposit of funds paid to the CONTRACTOR pursuant to this Agreement shall be the property of the CONTRACTOR and available for use at the CONTRACTOR’s discretion, provided requirements outlined in Section 4.19.2.1 of this Agreement have been satisfied.

4.19.5 Inspection and Audit of Financial Records

The CONTRACTOR shall meet all State and federal requirements with respect to inspection and auditing of financial records. The CONTRACTOR shall also cooperate with HCA or its designee and provide all financial records required by HCA or its designee so that they may inspect and audit the CONTRACTOR’s financial records at least annually or at HCA’s discretion.

4.19.6 Fidelity Bond

4.19.6.1 The CONTRACTOR shall secure and maintain during the life of this Agreement a blanket fidelity bond from a company doing business in the State of New Mexico on all personnel in its employment. The bond shall be issued in the

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amount of at least one million dollars ($1,000,000) per occurrence. Said bond shall protect HCA from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CONTRACTOR or its Subcontractors or Major Subcontractors.

4.19.6.2 The CONTRACTOR shall submit proof of coverage to HCA within sixty (60) Calendar Days after the execution of this Agreement or date designated by HCA.

4.19.7 Insurance

4.19.7.1 The CONTRACTOR, its successors and assignees, Major Subcontractors, and Subcontractors shall procure and maintain such insurance as is required by currently applicable State and federal law and regulation. Such insurance shall include, but not be limited to, the following:

4.19.7.1.1 Liability insurance for loss, damage, or injury (including death) of third parties arising from acts and omissions on the part of the CONTRACTOR, its agents and employees;

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

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

4.19.7.1.4 Adequate protections against financial loss due to outlier (catastrophic) cases and Member utilization that is greater than expected. The CONTRACTOR shall submit to HCA such written documentation, as is necessary, to show the existence of this protection, which includes reinsurance as specified in Section 4.19.10 of this Agreement;

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

4.19.7.1.6 Health insurance for employees as further set forth in Section 7.31 of this Agreement.

4.19.7.2 The CONTRACTOR shall provide HCA with documentation, at least annually, that the above specified insurance has been obtained, and the CONTRACTOR's Subcontractors and Major Subcontractors shall provide the same documentation to the CONTRACTOR.

4.19.8 Financial Stability

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

4.19.8.1.1 Comply with and be subject to all applicable State and federal statutes and regulations, including those regarding solvency and risk standards. In addition, the CONTRACTOR shall meet specific Medicaid financial requirements and present to HCA any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to HCA at no cost to HCA, in reasonable time from the date of the request or as specified herein; and

4.19.8.1.2 Immediately notify HCA when the CONTRACTOR has reason to consider insolvency or otherwise has reason to believe it or any Subcontractor or Major Subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the CEO or CFO to notify the CONTRACTOR's board of the potential for insolvency.

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

4.19.8.3 The CONTRACTOR shall comply with financial viability standards/performance guidelines and cooperate with HCA reviews of the ratios and financial viability standards listed below. Failure to maintain the Current Ratio (Section 4.19.8.3.1 of this Agreement) and financial viability standards may be considered a material breach of this Agreement.

4.19.8.3.1 Current Ratio: Current assets divided by current liabilities must be greater than or equal to 1.00. Current assets may include Insolvency Protection (Section 4.19.2 of this Agreement) and Surplus Requirements (Section 4.19.3 of this Agreement) balances as appropriate.

4.19.8.3.2 Defensive Interval: Must be greater than or equal to thirty (30) Calendar Days.

Defensive Interval =
(Cash + Current Investments) /
((Operating Expense – Non-Cash Expense) /
(Period Being Measured in Days))

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Non-Cash expense is any expense not paid for in cash, such as depreciation.

4.19.8.4 If the CONTRACTOR fails to maintain either the current ratio or defensive interval, then the CONTRACTOR shall submit a written plan to reestablish a positive working capital balance for approval by HCA.

4.19.8.5 HCA may take action it deems appropriate, including termination of this Agreement, if: (i) the CONTRACTOR does not propose a plan to reestablish compliance-stated ratios in Sections 4.19.8.3.1 and 4.19.8.3.2 of this Agreement within a reasonable period of time; (ii) the CONTRACTOR violates a DCAP; or (iii) HCA determines that the compliance with the stated ratios cannot be corrected within a reasonable time.

4.19.9 Performance Bond

4.19.9.1 The CONTRACTOR shall maintain in force a performance bond in the initial amount of one hundred percent (100%) of the first month of Capitation Payment as determined by HCA and, thereafter, in the amount set forth in Section 4.19.9.3 of this Agreement.

4.19.9.1.1 The performance bond requirement is restricted to one (1) of the methods outlined in Sections 4.19.9.1.1.1 through 4.19.9.1.1.5 of this Agreement unless the CONTRACTOR submits and receives written approval by HCA of an alternative to Section 4.19.9.1.1 of this Agreement.

4.19.9.1.1.1 Cash Deposits.

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

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

4.19.9.1.1.4 Certificate of Deposit.

4.19.9.1.1.5 Investment account with a financial institution licensed to do business in the State of New Mexico.

4.19.9.2 The performance bond must be restricted to the CONTRACTOR’s Turquoise Care program.

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4.19.9.3 If the performance bond falls below ninety percent (90%) of the average monthly capitation paid to the CONTRACTOR in the most recent quarter as determined by HCA, the CONTRACTOR has thirty (30) Calendar Days to comply with the requirements of this section and provide proof of the increased bond amount.

4.19.9.4 HCA shall have access to, and if necessary, draw upon the performance bond in the event HCA determines the CONTRACTOR to be in a material default of or failing to materially perform the activities outlined in this Agreement or if HCA determines the CONTRACTOR insolvent as outlined under the applicable state insurance law.

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

4.19.9.6 The CONTRACTOR shall purchase the performance bond within forty-five (45) Calendar Days of receipt of the first month of Capitation Payment from HCA.

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

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

4.19.9.9 Failure to maintain the performance bond as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the bond amount each month.

4.19.9.10 The CONTRACTOR shall hold the performance bond with any organization or trustee, acceptable to the Superintendent of Insurance, through which a custodial or controlled account is utilized.

4.19.10 Reinsurance

4.19.10.1 The CONTRACTOR shall have and maintain a minimum of one million dollars ($1,000,000) per occurrence or per Member per incurred year, in excess loss reinsurance protection against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HCA such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance.

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4.19.10.1.1 Excess loss reinsurance is defined as a loss sharing mechanism where an insurer pays all claims for an individual for a defined period up to a specified amount and a reinsurance company pays a portion of the excess, up to one hundred percent (100%).

4.19.10.2 HCA reserves the right to revisit reinsurance annually and to modify the reinsurance threshold amount, to be determined by HCA, if, upon review of financial and Encounter Data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by HCA.

4.19.10.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of Section 4.19.10 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the applicable state insurance regulator for approval. The CONTRACTOR must submit the pricing details of the reinsurance agreement, including the covered period, to HCA for approval.

4.19.10.4 The CONTRACTOR shall not enter into any quota share reinsurance agreements that assign financial risk as a whole or in part to a third party without prior consent of HCA.

4.19.11 Third-Party Liability

4.19.11.1 The CONTRACTOR shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and notify the agency's TPL vendor of any third-party creditable coverage discovered. Specifically, the CONTRACTOR:

4.19.11.1.1 Is responsible for identification of third-party coverage of Members and coordination of benefits with applicable third parties and shall comply with NMAC 8.302.3.12;

4.19.11.1.2 Shall inform HCA monthly regarding any Member who has other health coverage;

4.19.11.1.3 Shall provide monthly documentation to HCA, TPL Unit enabling HCA to pursue its right under State and federal statutes and regulations;

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documentation shall include payment information, collection and/or recoveries for services provided to Members as required by HCA;

4.19.11.1.4 Has the sole right of collection to recover from a third-party resource or from a Provider who has been overpaid due to a third-party resource for twelve (12) months from the date the CONTRACTOR first pays the Claim to initiate recovery and attempt to recover any third-party resources available to Members, for all services provided by the CONTRACTOR pursuant to this Agreement or any other Agreement for Medicaid services between the CONTRACTOR and HCA. Without mitigating any rights the CONTRACTOR's Provider has pursuant to federal and State law and regulations, the CONTRACTOR:

4.19.11.1.4.1 Agrees HCA has the sole right of collection from a third-party resource which the CONTRACTOR has failed to identify within twelve (12) months from the date the CONTRACTOR first pays the Claim;

4.19.11.1.4.2 Agrees HCA has the sole right of recovery from the CONTRACTOR or a CONTRACTOR's Provider who has been overpaid due to the combined payments of the CONTRACTOR and a third-party resource when the CONTRACTOR has not made a recovery within twelve (12) months from the date the CONTRACTOR first pays the Claim;

4.19.11.1.4.3 Agrees HCA has the sole right of recovery from a third-party resource, the CONTRACTOR, or the CONTRACTOR's Provider if the CONTRACTOR has identified a third-party resource but failed to initiate recovery within twelve (12) months from the date the CONTRACTOR first pays the Claim;

4.19.11.1.4.4 Agrees HCA has the sole right of recovery from a third-party resource, the CONTRACTOR, or the CONTRACTOR's Provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR

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first pays the Claim; and may permit payments to be made in accordance with state regulations; and

4.19.11.1.4.5 Agrees that the exception to this twelve (12) month period is for cases in which a capitation has been recouped from the CONTRACTOR pursuant to Section 6.2.6 of this Agreement, whereupon the CONTRACTOR shall retain the sole right of recovery for all paid Claims related to Members and months that were recouped.

4.19.11.2 Medicaid shall be the payer of last resort for Covered Services in accordance with federal statute and regulations. The CONTRACTOR has the same rights to recovery of the full value of services as HCA and shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members under this Agreement and cost avoid and/or recover any such liability from the third party. The CONTRACTOR shall develop and implement policies and procedures to meet its obligations regarding TPL when the third party (e.g., LTC insurance) pays a cash benefit to the Member, regardless of services used, or does not allow the Member to assign their benefits.

4.19.11.3 If TPL exists for part or all of the services provided by the CONTRACTOR to a Member, the CONTRACTOR shall make reasonable efforts to recover from TPL sources the value of services rendered.

4.19.11.4 If the CONTRACTOR has determined that TPL exists for part or all of the services provided to a Member by a Subcontractor or Provider, and the third party is reasonably expected to make payment within one-hundred-twenty (120) Calendar Days, the CONTRACTOR may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's allowable Claim exceeds the amount of the anticipated third-party payment; or, the CONTRACTOR may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's or Provider's allowable Claim exceeds the amount of TPL.

4.19.11.5 The CONTRACTOR may not withhold payment for services provided to a Member if TPL or the amount of liability cannot be determined or if payment

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shall not be available within one-hundred-twenty (120) Calendar Days from the date of receipt.

4.19.11.6 If the probable existence of TPL has been established at the time the Claim is filed, the CONTRACTOR must reject the Claim and return it to the Provider for a determination of the amount of any TPL.

4.19.11.7 Claims for EPSDT shall be paid at the time presented for payment by the Provider and the CONTRACTOR shall bill the responsible third party.

4.19.11.8 The CONTRACTOR shall deny payment on a Claim that has been denied by a third-party payer when the reason for denial is the Provider's or Member's failure to follow prescribed procedures, including but not limited to failure to obtain prior authorization, timely filing, etc.

4.19.11.9 The CONTRACTOR shall treat funds recovered from third parties as reductions to Claims payments. The CONTRACTOR shall report all TPL collection amounts to HCA in accordance with state and federal guidelines and as directed by HCA.

4.19.11.10 For purposes of the twelve (12) and fifteen (15) month periods set forth in Section 4.19.11 of this Agreement, third-party resources shall not include subrogation resources provided; however, HCA's TPL Contractor will seek subrogation amounts regardless of the amount believed to be available as required by federal Medicaid guidelines. HCA shall be solely responsible for subrogation recovery activities and shall retain any and all funds recovered through these activities.

4.19.11.11 Cost sharing and medical care credit responsibilities shall not be considered TPL.

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

4.19.11.13 The CONTRACTOR shall provide to HCA any third-party resource information necessary in a format and media described by HCA and shall cooperate in any manner necessary, as requested by HCA, with HCA and/or a cost recovery vendor at such time that HCA acquires said services.

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4.19.11.14 HCA may require an HCA contracted TPL vendor to review paid Claims that are over three-hundred-sixty (360) Calendar Days old and pursue TPL for those Claims that do not indicate recovery amounts in the CONTRACTOR's reported Encounter Data.

4.19.11.15 If the CONTRACTOR operates or administers any non-Medicaid MCO, health plan or other lines of business, the CONTRACTOR shall assist HCA with the identification of Members with access to other insurance.

4.19.11.16 The CONTRACTOR shall demonstrate, upon request, to HCA that reasonable effort has been made to seek, collect, and/or report third-party recoveries. HCA shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

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

4.19.12 Medical Care Credit

4.19.12.1 The CONTRACTOR shall have policies and procedures to ensure that, where applicable, Members residing in residential facilities pay their medical care credit.

4.19.12.2 HCA will notify the CONTRACTOR of any applicable medical care credit amounts for Members via the eligibility/enrollment file.

4.19.12.3 The CONTRACTOR shall delegate collection of medical care credit to the NF or community-based residential alternative facility and shall pay the facility net of the applicable medical care credit amount.

4.19.12.4 The CONTRACTOR shall submit medical care credit information associated with Claim payments to Providers in its Encounter Data submission.

4.19.12.5 HCA shall reconcile medical care credit amounts in accordance with Section 6.8.4 of this Agreement.

4.19.13 Payments by HCA

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The CONTRACTOR shall accept payments remitted by HCA in accordance with Section 6 of this Agreement as payment in full for all services required pursuant to this Agreement.

4.19.14 Reporting

4.19.14.1 The CONTRACTOR shall submit quarterly and annual insurance filings and financial statements that are specific to the operations of the CONTRACTOR's New Mexico operations rather than a parent or umbrella organization as directed by HCA.

4.19.14.2 The CONTRACTOR shall submit third-party liability recoveries, including Medicare payment information on a date of services basis as directed by HCA.

4.19.14.3 The CONTRACTOR shall submit reports on medical care credit information on a date of service basis as directed by HCA.

4.19.14.4 The CONTRACTOR shall provide an annual audited financial report to HCA, specific to its Medicaid line of business in New Mexico, conducted in accordance with generally accepted accounting and auditing principles, as directed by HCA. If the Contractor's fiscal year does not align with the contract year, the Contractor shall notify HCA and propose a methodology for aligning reporting periods to the extent practicable.

4.19.14.5 The CONTRACTOR shall submit quarterly and annual reports of all management fees, administrative service charges, or indirect allocations paid to a parent, umbrella, affiliated, or related entity. The report shall include descriptions of cost allocation methodologies and documentation sufficient to demonstrate that such charges are reasonable and allowable as directed by HCA.

4.20 **Claims Management**

4.20.1 The CONTRACTOR and any of its Major Subcontractors, Subcontractors, or Providers paying Claims are required to maintain Claims-processing capabilities to include, but not be limited to:

4.20.1.1 Accepting NPI and HIPAA-compliant formats for electronic Claims submission;

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4.20.1.2 Assigning unique identifiers for all Claims received from Providers and ensuring that any adjustments or voids either carry some part of that original Transaction Control Number (TCN) in the adjustment/void TCN or carry a related TCN field so that the original can always be linked to any adjustments and voids;

4.20.1.3 Standardizing protocols for the transfer of Claims information between the CONTRACTOR and its Major Subcontractors and Providers, audit trail activities and the communication of data transfer totals and dates;

4.20.1.4 Date-stamping all Claims in a manner that will allow determination of the calendar date of receipt;

4.20.1.5 Running a payment cycle to include all submitted Claims to date at least weekly;

4.20.1.6 Paying Clean Claims in a timely manner as follows:

4.20.1.6.1 For Claims from I/T/Us, day activity Providers, assisted living Providers, NFs and home care agencies, including Community Benefit Providers, ninety-five percent (95%) of Clean Claims must be adjudicated within a time period of no greater than fifteen (15) Calendar Days of receipt and ninety-nine percent (99%) or more of Clean Claims must be adjudicated within a time period of no greater than thirty (30) Calendar Days of receipt;

4.20.1.6.2 For all other Claims, except Claims which have undergone a prepayment review as noted in Section 7.28.11.3 of this Agreement, ninety percent (90%) of all Clean Claims must be adjudicated within thirty (30) Calendar Days of receipt and ninety-nine percent (99%) of all Clean Claims must be adjudicated within ninety (90) Calendar Days of receipt;

4.20.1.7 Paying interest as required in Paragraph one (1) of NMAC 8.308.20.9 (E);

4.20.1.8 Being at risk for any payments made in advance of Claims adjudication (i.e., forward funding) not substantiated by Claims for those services;

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

4.20.1.10 Generating remittance advice and/or electronic response files to Providers for all Claims submissions;

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

4.20.1.12 Accepting only national HIPAA-compliant standard codes and editing to ensure that the standard measure of units is billed and paid for;

4.20.1.13 Editing Claims 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 HCA-defined editing criteria and national coding standards;

4.20.1.14 Meeting all TPL requirements described in Section 4.19.11 of this Agreement;

4.20.1.15 Using the TPL file provided by HCA to coordinate benefits with other payers;

4.20.1.16 Capturing and reporting all TPL, interest, copayment, or other financial adjustments on all Claims, using HCA defined editing criteria and HIPAA standard Claim adjustment reason codes and remark codes to identify the payments and adjustments;

4.20.1.17 Developing and maintaining an NPI HIPAA-compliant electronic billing system;

4.20.1.18 Accepting and accurately paying Medicare Claims coming either as Medicare Claims from Contract Providers or as Medicaid crossover Claims submitted by the coordination of benefits agreement (COBA) contractor; ensuring the following:

4.20.1.18.1 All information on the Medicare or crossover Claim must be accepted, adjudicated and stored; including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules;

4.20.1.18.2 Any Medicare Claims paid by a Special Needs Plan (SNP) or a Medicare Advantage Plan for which there is no Medicaid obligation (no coinsurance or deductible) must be adjudicated and stored complete with all Claim adjustment reason codes explaining the difference between the Provider's billed charges and the CONTRACTOR's allowed and paid amounts;

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4.20.1.18.3 Adjudicating all Claims ensuring Medicaid is the payer of last resort as it relates to third-party coverage liability through an insurer; and

4.20.1.18.4 The CONTRACTOR having a COBA with Medicare and participating in the automated Claims crossover process;

4.20.1.18.5 Effective October 1, 2020, Medicare is no longer the primary payer for Opioid Treatment Program (OTP) services for dually eligible beneficiaries. MCO is expected to pay the Medicaid coinsurance/deductible for OTP services once the claim has crossed over from Medicare.

4.20.1.19 Maintaining adequate data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicaid Claims for all services, regardless of the method of payment for those services, to meet the Encounter Data requirements in Section 4.20.4 of this Agreement, including but not limited to:

4.20.1.19.1 Services provided under subcapitation payment arrangements;

4.20.1.19.2 Services provided as part of a bundled rate; and

4.20.1.19.3 Services performed by CONTRACTOR staff, even where no payment is made or identified for those services, such as Care Coordination activities;

4.20.1.20 Adhering to federal and state timely filing requirements;

4.20.1.21 Configuring its system to meet HCA's editing criteria;

4.20.1.22 Submitting information to the State’s all payers Claim database at a time and in a format prescribed by HCA;

4.20.2 HCA is exploring the implementation of a unified claims payment system, either within or outside of the MMIS-R platform. The CONTRACTOR must collaborate with HCA to develop and implement a unified claims payment system as directed by HCA. Upon HCA direction, all non-pharmacy Claims, regardless of the type of Claim or provider, will come from Providers, Clearinghouses, or Major Subcontractors directly into the State’s System Integrator and will be transmitted to the CONTRACTOR for adjudication. Upon HCA direction, the CONTRACTOR shall:

4.20.2.1 Adjudicate all Claims received within the same timeliness and accuracy requirements specified in this Agreement;

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4.20.2.2 Submit Claims to the System Integrator under the CONTRACTOR's provider number as MCO Administration or MCO Care Coordination for any services directly administered by the CONTRACTOR as directed by HCA;

4.20.2.3 Reject and redirect any Claims submitted by Providers directly to the CONTRACTOR that have not come through the System Integrator;

4.20.2.4 Require in its contracts with any Major Subcontractors that all services to Members be submitted on standardized electronic Claims submitted through the System Integrator, regardless of the payment method;

4.20.2.5 Transmit any COBA Claims to the Systems Integrator, if transmitted directly to the CONTRACTOR;

4.20.2.6 Generate electronic remittances to Providers and any Major Subcontractors, even if the Claims are not paid directly, but rather, through a per diem or other payment arrangement;

4.20.2.7 Communicate back to the Systems Integrator all Electronic Data Interchange (EDI) response files, including the X12 837 Post-Adjudicated Claims Data Reporting (PACDR), and all remittance files (HIPAA 835) which will, in turn, update the Claims information with the adjudicated information and pass along to the Providers;

4.20.2.8 Include in the X12 837 PACDR files all original and adjusted Claims processed, including paid, denied, suspended status at header and line levels. The 837 shall include all data elements required to fully explain the CONTRACTOR's adjudication, ensuring that the following data elements are present, where applicable:

4.20.2.8.1 Any TPL, including Medicare payment amounts;

4.20.2.8.2 All Claim Adjustment codes (CAS) applied to the Claim and Claim lines by any other payor, as well as by the CONTRACTOR;

4.20.2.8.3 Any copay, interest, or other financial adjustments; and

4.20.2.8.4 For any subcapitated services for which reimbursement is PMPM, the payment amount for individual Claims on the 837 PACDR will be reported using equivalency pricing (i.e., the reimbursement if the service would have

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been paid at the FFS rate) and the CONTRACTOR will be expected to report separately its monthly contracted costs for those services;

4.20.2.9 For any Claims for which the CONTRACTOR initiates adjustment or void, the CONTRACTOR shall submit the results of that action on an 837 PACDR submitted to the System Integrator ensuring that the original Claim number being adjusted or voided is included; and

4.20.2.10 Reconcile with HCA any Claims received by the Systems Integrator for which status has not been received via 837 PACDR or EDI response files according to the method and time line specified by HCA.

4.20.3 Monitoring Claim Denials

4.20.3.1 The CONTRACTOR shall review the eligibility file prior to denying a NF claim for timely filing.

4.20.3.2 The CONTRACTOR shall monitor, on an at least a monthly basis, the number of each Provider's denied claims and shall initiate training and technical assistance, as needed, to any Provider whose monthly volume of denied claims is 10% or more of the provider's claims. The CONTRACTOR shall review each error and the reason for denial and advise how the provider can correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

4.20.4 Encounter Requirements

4.20.4.1 HCA maintains oversight responsibility for evaluating and monitoring the volume, completeness, timeliness and quality of all Claims adjudicated by the CONTRACTOR. If the CONTRACTOR elects to contract with a Subcontractor, the CONTRACTOR must ensure that the Subcontractor complies with all Claims and Encounter requirements. Until such time that HCA notifies the CONTRACTOR otherwise, the CONTRACTOR must submit all Encounter Data for all services performed to HCA. The CONTRACTOR is responsible for the quality, accuracy, and timeliness of all Encounter Data submitted to HCA. HCA shall communicate directly with the CONTRACTOR any requirements and/or deficiencies regarding completeness, quality, accuracy, and timeliness of Encounter Data and not with any third party contractor. Failure to submit

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accurate and complete Encounter Data may result in financial penalties determined by HCA based upon HCA error, and/or the repetitive nature of the error and/or the frequency of the errors, as described in Section 7.3 of this Agreement.

4.20.4.2 With respect to Encounter submission, the CONTRACTOR shall:

4.20.4.2.1 Provide Encounter Data to HCA by electronic file transmission using the HIPAA 837 balancing rules and National Council of Prescription Drug Programs (NCPDP) formats according to HIPAA transaction and code sets and operating rules using HCA approved, standard protocols;

4.20.4.2.2 Comply with CMS and HIPAA standards for electronic transmission, security and privacy (also applies to Subcontractors and Major Subcontractors);

4.20.4.2.3 Submit to HCA all Encounters in accordance with the HIPAA Technical Review Guides, New Mexico's Medicaid MCO Companion Guides, any HIPAA operating rules that may be issued, New Mexico's procedures for successful submission for files to the translator operated by New Mexico's Medicaid fiscal agent and any specific information included in the MCO Systems Manual;

4.20.4.2.4 Make changes or corrections to any systems, processes or data transmission formats, as needed, to comply with HCA data quality standards as originally defined or subsequently amended;

4.20.4.2.5 Within five (5) Business Days of the end of a payment cycle, the CONTRACTOR shall generate Encounter Data files for that payment cycle from its Claims management system(s) and/or other sources. If the CONTRACTOR has more than one (1) payment cycle within the same calendar week, the Encounter Data files may be merged and submitted within five (5) Business Days of the end of the last payment cycle during the calendar week;

4.20.4.2.6 Submit to HCA Encounters for all adjustment/void Claims of previously reported Encounters according to the same timeliness standards as required

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of paid/denied original Claims applied to the adjustment date. Adjustment and voids of previously paid Claims must be identified as such according to instructions in the HIPAA Technical Review Guides and New Mexico's Medicaid MCO Companion Guides, including the HCA TCN of the previously paid Encounter that the adjustment/void modifies;

4.20.4.2.7 Submit to HCA Encounters for any Medicare Claims for a Member sent to the CONTRACTOR from the CONTRACTOR's Providers, as well as Medicaid crossover Claims submitted by the COBA contractor or provider; ensuring the following: (i) all information on the Medicare or Medicaid crossover Claim must be submitted as an Encounter to HCA including the Medicare allowed and paid amounts and Medicaid allowed and paid amounts with all Claim adjustment reason codes on the Claim that allow the Claim to balance as per HIPAA 837 balancing rules.

Instructions for the submission of Medicare Encounters are included in New Mexico's Medicaid MCO Companion Guides and the MCO Systems Manual; and (ii) any Medicaid crossover Claim where the CONTRACTOR either paid the Medicaid obligation, or there was no payment made on the Medicaid obligation, must be sent to HCA as a Medicaid crossover Encounter;

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

4.20.4.2.9 Have a formal monitoring and reporting system to reconcile submissions and resubmissions of Encounter Data between the CONTRACTOR and Subcontractors, Major Subcontractors, or Providers who pay Claims to assure timeliness, completeness and accuracy of their submission of Encounter Data to the CONTRACTOR;

4.20.4.2.10 Meet HCA Encounter timeliness requirements by submitting to HCA least ninety percent (90%) of its Claims, paid originals and adjustments within

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thirty (30) Calendar Days of the date of adjudication, and ninety-nine percent (99%) within sixty (60) Calendar Days of the date of adjudication in accordance with the specifications included in HIPAA Technical Review Guides, the New Mexico Medicaid MCO Companion Guide, and the MCO Systems Manual, regardless of whether the Encounter is from a Subcontractor or Major Subcontractor, subcapitated arrangement, or performed by the CONTRACTOR. The CONTRACTOR may not withhold submission of Encounters for any reason;

4.20.4.2.11 Have written contractual requirements of Subcontractors, Major Subcontractors, or Providers that pay Claims to submit Encounters to the CONTRACTOR on a timely basis, which ensures that the CONTRACTOR can meet its timeliness requirements for Encounter submission. All Subcontractors, Major Subcontractors, or Providers that pay claims must submit the actual amount paid to the Provider as an encounter to the CONTRACTOR and the CONTRACTOR, in turn, must submit this same amount paid to the Provider (not the Major Subcontractor or pharmacy benefit manager cost) on its encounter submission to HCA.

4.20.4.2.12 Meet Encounter accuracy requirements by submitting 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. HCA will monitor the CONTRACTOR's 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 HCA. 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;

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4.20.4.2.13 The CONTRACTOR shall submit a quarterly report of the number of paid Claims by adjudication type (Inpatient and Inpatient crossovers and pharmacy Encounters are adjudicated at the header level, all others are adjudicated at the line level) by date of payment and date of service as directed by HCA. This report will be compared to Encounter Data to evaluate the completeness of data submitted. Any 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 HCA.

4.20.4.2.14 Systematically edit Encounters prior to submission to prevent or decrease submission of duplicate Encounters and other types of Encounter errors. HCA will share the edits it uses in Encounter adjudication for use by the CONTRACTOR to perform its own edits to ensure optimum accuracy and completeness. The CONTRACTOR may withhold Encounters it has identified with errors through this process in order to make corrections to its system or have the Claim adjusted. However, a paid Claim with known errors must be submitted as an Encounter if, at the end of ninety (90) Calendar Days from that Claims' payment cycle, the error has not been corrected. The CONTRACTOR shall make corrections needed to resolve the error and resubmit the Encounters at such time that the error is resolved;

4.20.4.2.15 Where the CONTRACTOR has entered into subcapitated reimbursement arrangements with Contract Providers, the CONTRACTOR shall require submission of all utilization or Encounter Data to the same standards of completeness and accuracy as required for proper adjudication of FFS Medicaid Claims, as a condition of the Capitation Payment and shall make every effort to enforce this contract provision to ensure timely receipt of complete and accurate data; and

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4.20.4.2.16 The CONTRACTOR shall conduct an analysis of its submitted and accepted Encounter Data and its financial reports within the CONTRACTOR's financial reporting package, as specified by HCA.

4.20.4.3 Encounter Data Elements

Encounter Data elements are a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and MCOs, and those required by CMS or HCA for use in managed care. HCA may increase or reduce, or make mandatory or optional, data elements as it deems necessary. The CONTRACTOR will be held harmless in conversion to HIPAA coded Encounter Data when delays are the result of HIPAA implementation issues at HCA. The transition to HIPAA codes and requirements does not relieve the CONTRACTOR of timely submission of Encounter Data.

4.20.4.4 The CONTRACTOR shall submit all Encounter Data elements noted as "required" in the HIPAA Technical Review Guides and New Mexico's Medicaid Companion Guides with specific attention to the following financial information that will be used to ensure accuracy of Claims payment and to set future Capitation Rates:

4.20.4.4.1 Actual CONTRACTOR paid amount on all Claims/lines paid by the CONTRACTOR, Subcontractor, Major Subcontractor, or Provider;

4.20.4.4.2 A CONTRACTOR paid amount equivalent for any Claims/lines that do not have an actual CONTRACTOR paid amount, with a pricing process code that indicates that the amount shown is an assigned equivalent amount rather than an actually paid amount (e.g., subcapitated Providers);

4.20.4.4.3 Claim Adjustment reason codes (CAS codes) with remark codes, as needed, to designate the reasons any Claim/line is not paid (e.g., bundling);

4.20.4.4.4 Any payments by a third-party payer, copayments from the Member, or adjustments to the Claim/line's pricing reported with the appropriate Claim adjustment reason and remark codes; and

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4.20.4.4.5 Payment to IHS, FQHC, and RHC Providers using institutional Claim formats and, including the Encounter rate on one (1) line of the Claim, but including all services rendered as part of that Encounter.

4.20.4.5 Any services provided to Members directly by CONTRACTOR staff (Care Coordination, assessments, etc.) must be submitted to HCA as Encounter Data using agreed upon coding and meeting all HIPAA transaction standards.

4.20.4.6 Any incentive payments to Providers must be reported to HCA as Encounter Data using agreed upon coding and meeting all HIPAA transaction standards.

4.20.4.7 The CONTRACTOR shall populate the dispensed as written field in all pharmacy Encounter Data submissions.

4.20.4.8 The CONTRACTOR shall provide all Encounters that include dates of service for all prenatal and Postpartum visits for both FFS and bundled payment arrangements.

4.20.5 During the term of this Agreement, HCA intends to change CONTRACTOR requirements related to the submission of non-pharmacy and non-administrative Encounters. Upon HCA direction, the CONTRACTOR will no longer submit non-pharmacy and non-administrative Encounters to HCA; all MCO Claims will be captured in the State's data warehouse from the Providers' submissions and will be updated to reflect final 'Encounter' status based on the 837 PACDR and EDI response files received from the MCOs through the System Integrator.

4.20.5.1 The quarterly report of the number of paid Claims by adjudication type will no longer be required as all Claims and adjudication results will be captured directly by HCA.

4.20.5.2 The CONTRACTOR will be responsible for responding to data validation studies that HCA will perform from the CONTRACTOR's Claims (Encounters) stored in the data warehouse. These data validation studies will not mimic FFS Claims edits, but will evaluate 'Encounter' timeliness, appropriateness, and completeness.

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4.20.5.3 The CONTRACTOR will be responsible for reconciling any Claims received by HCA for which no paid, denied, or suspended status has been returned by the CONTRACTOR on an 837 PACDR or EDI response file.

4.20.5.4 The CONTRACTOR will be responsible for adjusting or voiding any Claims identified by HCA as inappropriately paid, and sanctions may be imposed for any Claims that violate timeliness and/or completeness requirements.

4.20.5.5 Claims routing for Excluded State-Funded Services.

4.20.5.5.1. Deny and redirect. The CONTRACTOR shall implement pre-adjudication edits to deny claims for Excluded State-Funded Services received through Medicaid channels, including professional, institutional, and pharmacy/NCPDP transactions, and shall return State-specified deny-and-redirect messaging instructing providers to use the State-funded billing pathway, as directed by the State through the Managed Care Policy Manual or a Letter of Direction delivered under Section 7.47 (Notices).

4.20.5.5.2. Systems configuration and updates. The CONTRACTOR shall configure systems and trading-partner connections in accordance with State direction issued through the Managed Care Policy Manual or a Letter of Direction under Section 7.47, and shall implement updates by the effective date stated in the notice.

4.20.5.5.3. Misrouted transactions. The CONTRACTOR shall identify, reverse, and purge misrouted transactions within ten business days and maintain procedures to prevent recurrence.

4.20.5.5.4. Financial corrections. If the CONTRACTOR pays a claim for an Excluded State-Funded Service under Medicaid, the CONTRACTOR shall void or adjust the transaction, recover amounts paid, and route the claim to the State-funded pathway as directed by the State. The CONTRACTOR shall not seek Medicaid reimbursement for such services.

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4.20.5.5.5. Testing. Before activation, the CONTRACTOR shall complete State-specified test scripts and submit results confirming the edits and routing are effective.

4.21 **Information Systems**

4.21.1 General System Hardware, Software, and Information Systems Requirements

4.21.1.1 The CONTRACTOR shall maintain system hardware, software, and information systems (IS) resources that comply with all applicable State and federal statutes and regulations and are sufficient to provide the capability to:

4.21.1.1.1 Accept, transmit, maintain, and store electronic data and enrollment roster files;

4.21.1.1.2 Accept, transmit, process, maintain, and report specific information necessary to the administration of the State's Turquoise Care programs, including but not limited to, data pertaining to Providers, Members, Claims, Encounters, Grievance and Appeals, disenrollment for other than loss of Medicaid eligibility, HEDIS including but not limited to all Electronic Clinical Data System Reporting (ECDS) measures, and other quality measures;

4.21.1.1.3 Comply with the most current federal standards for encryption of any data that is exchanged by the CONTRACTOR or its Subcontractors, Major Subcontractors, and Contract Providers;

4.21.1.1.4 Conduct automated Claims processing with current NPI Number for health care Providers and Federal Employer Identification Number (FEIN)/SSN numbers for atypical Providers in HIPAA compliant formats;

4.21.1.1.5 Accept and maintain the State's ten (10) digit Member Medicaid identification number to be used for all communication to HCA and be cross-walked to the CONTRACTOR's assigned universal Member number, which is used by the Member and Providers for identification, eligibility

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verification and Claims adjudication by the CONTRACTOR and all Subcontractors and Major Subcontractors;

4.21.1.1.6 Monitor and transmit electronic Encounter Data to HCA according to Encounter Data submission standards

;

4.21.1.1.7 Upon HCA direction, transmit electronic remittance (835, 837 PACDR,) and EDI response files to HCA System Integrator

;

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

4.21.1.1.9 Transmit data securely and electronically;

4.21.1.1.10 Maintain a website for sharing information to Providers and Members, and be able to receive comments electronically and respond when appropriate, including responding to Provider transactions for eligibility and Formulary information;

4.21.1.1.11 Receive data elements associated with identifying Members who are receiving ongoing services from another MCO and using the formats that HCA uses to transmit similar information to a MCO;

4.21.1.1.12 In accordance with Federal Interoperability requirements related to payer-to-payer exchange of adjudicated Claims and Encounter data and certain clinical data (specifically the U.S. Core Data for Interoperability [USCDI]), transmit to HCA or another MCO, data elements associated with Members who have been receiving ongoing services from the CONTRACTOR's MCO;

4.21.1.1.13 Comply with the requirements in 42 C.F.R. § 438.242 regarding application programming interfaces; and

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4.21.1.1.14 Have an automated access system for Providers to obtain Member eligibility and enrollment information that includes the cross-reference capability of the system to the Member's ten (10) digit Medicaid identification number designated by HCA to the Member's Social Security number as a means of identifying the Member's most current benefits, such as providing the Member's COE.

4.21.1.2 The CONTRACTOR shall submit all reports electronically to HCA's DMZ File Transfer Protocol (FTP) site, unless directed otherwise by HCA. HCA shall provide the CONTRACTOR with access to the DMZ FTP site.

4.21.1.3 The CONTRACTOR shall transmit to and receive from HCA all transactions and code sets in the appropriate standard formats as specified under HIPAA and as directed by HCA so long as HCA direction does not conflict with State or federal law.

4.21.1.4 The CONTRACTOR's systems shall conform to future federal and/or HCA specific standards for data exchange within the time frame stipulated by federal authorities or HCA, the CONTRACTOR shall partner with HCA in the management of current and future data exchange formats and methods and in the development and implementation planning of future data exchange methods not specific to HIPAA or other federal effort. Furthermore, the CONTRACTOR shall conform to these standards as stipulated in the plan to implement such standards.

4.21.1.5 The CONTRACTOR shall participate in and, as may be directed, implement any HIE (see Section 4.13.3 of this Agreement) and other initiatives (e.g., closed-loop referral system) undertaken by HCA or other entities.

4.21.1.6 The CONTRACTOR shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems and shall provide these documents to HCA upon request.

4.21.1.7 <u>Provider Network Information Requirements</u>

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The CONTRACTOR's Provider network capabilities shall include the following, in order to fulfill the Provider credentialing, recredentialing, and enrollment functions described in Section 4.8.16 of this Agreement, as further described in the MCO Systems Manual:

4.21.1.7.1 Accepting a provider master file from HCA that identifies all Medicaid enrolled Providers;

4.21.1.7.2 Transmitting a Provider network file to New Mexico Medicaid's fiscal agent that identifies by Medicaid Provider ID and NPI any Provider enrolled with New Mexico Medicaid who is a Contract Provider. Non-Contract Providers are not to be included on this file. The CONTRACTOR shall include the date on which the Provider's status as a Contract Provider is effective and when the Provider is no longer a Contract Provider, the CONTRACTOR shall include the date the Provider's status as a Contract Provider ended. The CONTRACTOR shall send this file monthly, due no later than the tenth day of each month, reflecting the Contract Providers for the previous month. This requirement may be modified or deleted with the implementation of MMIS-R. The CONTRACTOR shall adhere to all federal requirements related to the enrollment, identification, and reporting of billing, rendering, furnishing, ordering, referring, prescribing, attending and other Providers, as applicable;

4.21.1.7.3 Accepting a Provider confirmation update file from New Mexico Medicaid that contains any newly active Contract Providers or changes to Contract Providers that lists, at a minimum, the provider's NPI or FEIN/SSN, the provider's Medicaid ID, servicing location zip code, provider type, specialty, and dates of enrollment/termination;

4.21.1.7.4 Recording each Provider listed on the New Mexico Medicaid provider update confirmation file and the full provider confirmation file in the CONTRACTOR's system with the Medicaid provider ID, the assigned provider type, specialty (if applicable), and dates of enrollment/termination and using this data to edit Claims and ensure that the appropriate provider

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taxonomy and provider servicing location zip code is assigned to Encounter Claims;

4.21.1.7.5 Maintain an accurate and provide timely updates to an online Provider directory for Members as specified in Section 4.15.5 of this Agreement; and

4.21.1.7.6 Upon HCA direction, the CONTRACTOR agrees to accept a single provider master file from HCA that has all enrolled Providers. This file will be updated on a daily basis with any changes and published monthly as a full file.

4.21.1.7.7 Systems controls for Excluded State-Funded Services

4.21.1.7.7.1 Edits and routing. The Contractor shall configure systems, clearinghouse connections, payer IDs, and trading-partner profiles to prevent Excluded State-Funded Services from adjudicating under Medicaid.

4.21.1.7.7.2 Encounter suppression. The CONTRACTOR shall suppress Excluded State-Funded Services from all encounter creation and transmission processes (837I/837P and pharmacy/NCPDP).

4.21.1.7.7.3 Change management. The CONTRACTOR shall implement State-issued technical guidance, delivered through the Managed Care Policy Manual or a Letter of Direction under Section 7.47 (Notices)—including code-list updates, denial reason codes, and message text—by the effective date stated in the notice.

4.21.2 Member Information Requirements

4.21.2.1 The CONTRACTOR's Member information requirements shall include, but not be limited to accepting, maintaining, and transmitting all required Member information.

4.21.2.2 The CONTRACTOR shall receive, process, and update enrollment files sent daily by HCA.

4.21.2.3 The CONTRACTOR shall update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

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4.21.2.4 The CONTRACTOR shall be capable of uniquely identifying a distinct Member across multiple populations and systems within its span of control.

4.21.2.5 The CONTRACTOR shall be able to identify potential duplicate records for a single Member and, upon confirmation of said duplicate record by HCA, resolve the duplication such that the enrollment, service utilization and customer interaction histories of the duplicate records are linked or merged.

4.21.2.6 The CONTRACTOR shall:

4.21.2.6.1 Provide a means for Providers and Major Subcontractors to verify Member eligibility and enrollment status twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) Calendar Days a year;

4.21.2.6.2 Ensure that current and updated eligibility information received from HCA is available to all Providers via the CONTRACTOR's eligibility verification system and all Subcontractors' eligibility verification systems within twenty-four (24) hours of receipt of any and all enrollment files from HCA;

4.21.2.6.3 Assign as the key Medicaid Member ID number, the RECIP-MCD- CARD-ID-NO that is sent on the enrollment roster file and capture and store the Medicare ID, SSN and pseudo-SSN if they are included on the enrollment roster file for use in identification, eligibility verification, and Claims adjudication by the CONTRACTOR or any Subcontractor, Major Subcontractor, or Contract Provider that pay Claims. These numbers will be cross-referenced to the Member's Social Security number and any internal number used in the CONTRACTOR's system to identify Members;

4.21.2.6.4 Meet federal CMS and HIPAA standards for release of Member information (applies to Subcontractors, Major Subcontractors, and Providers as well). Standards are specified in the MCO Systems Manual and at 42 C.F.R. § 431.306(b);

4.21.2.6.5 Maintain accurate Member eligibility and demographic data to include but not be limited to, COE, CCL, population identification and risk stratification, NF LOC and SOC, Community Benefit status, copayment maximum, copayment spent amount, Medicare status, Health Home status, Behavioral

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Health needs, age, sex, race, residence county, parent/non parent status, Native American status, institutional status and disability status on its system's database consistent with HCA requirements. This requirement also applies to any Subcontractor who maintains a copy of the Member enrollment files for the purpose of distributing eligibility or enrollment information to Providers for verifying Member eligibility;

4.21.2.6.6 Upon learning of third party coverage that was previously unknown, notify HCA within fifteen (15) Calendar Days, according to the reporting process outlined in the MCO Systems Manual;

4.21.2.6.7 Exclude the Member's Social Security number from the Member's ID card;

4.21.2.6.8 Have system functionality to manage different financial fields identified as annual maximum out-of-pocket amounts, benefit maximums, and copayment amounts for different services and for Members with different copayment requirements, including effective dates of the financial fields, as they could change over time; and

4.21.2.6.9 Transmit to HCA a daily update file that contains Member information specific to NF LOC, Community Benefit status, Care Coordination Level, Health Home status, PCP assignment, disability status, and identifying information as specified in the MCO Systems Manual.

4.21.3 Electronic Visit Verification System (EVV)

4.21.3.1 The CONTRACTOR shall contract with HCA's EVV vendor to monitor Member receipt and utilization of applicable services under EPSDT, Community Benefit, and Home Health benefit to include but not be limited to PCS, respite, skilled nursing, home health aide and therapy service. The CONTRACTOR must provide the following EVV options: (i) use of the Member's landline when the Member consents to such use; or (ii) use of the Caregiver's personal cellular phone utilizing the EVV vendor's phone application with the CONTRACTOR providing a monthly stipend for such use; or (iii) use of a tablet allowing the EVV vendor's application by the Caregiver, provided by the CONTRACTOR to the PCS and Home Health agency. The CONTRACTOR shall maintain an EVV

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system capable of leveraging up-to-date technology as it emerges to improve functionality in all areas of the State, including rural areas. The CONTRACTOR is responsible for issuing devices to its Providers, as needed, and shall ensure that all contracted personal care service, respite and home health Providers are participating in the EVV system unless granted a HCA approved written exception.

4.21.3.2 The CONTRACTOR shall oversee its contracted EVV vendor to ensure the EVV system operates in compliance with this Agreement, policies and protocols established by HCA, and State and federal statute and regulations.

4.21.3.3 The CONTRACTOR shall notify HCA within five (5) Business Days of the identification of any issue affecting EVV system operation that impacts the CONTRACTOR's performance of this Agreement, including actions that will be taken by the CONTRACTOR to resolve the issue and the specific time frames within which such actions shall be completed.

4.21.3.4 For a period of at least twelve (12) months following Go-Live, the CONTRACTOR shall conduct monthly education and training for affected Providers regarding the use of the EVV system. Such period may be extended as determined necessary by HCA.

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

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

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

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

4.21.3.5.4 Match services provided to a Member with services authorized for the Member;

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

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

4.21.3.5.6 Establish a schedule of Agency Based Community Benefit PCS for each Member identifying the time at which each service is needed, as well as the amount, frequency, duration, and scope of each service and to ensure adherence to the established schedule;

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

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

4.21.3.5.9 Reconcile paid Claims with service authorizations.

4.21.3.6 The CONTRACTOR shall monitor and use information from the EVV system to verify that authorized services are provided in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized Provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a Member is receiving services, including after the CONTRACTOR's regular business hours.

4.21.3.7 The CONTRACTOR shall submit reports on its EVV system as directed by HCA.

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

4.21.4 <u>System and Information Security and Access Management Requirements</u>

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4.21.4.1 The CONTRACTOR's systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

4.21.4.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information; and

4.21.4.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified appropriate staff.

4.21.4.2 The CONTRACTOR shall make system information available to duly authorized representatives of HCA and other State and federal agencies to evaluate, through inspections, and to audits, or other means, the quality, appropriateness, and timeliness of services performed.

4.21.4.3 The CONTRACTOR's systems shall contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits by the CONTRACTOR and the results of these tests shall be made available to HCA upon request.

4.21.4.4 Audit trails shall be incorporated into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

4.21.4.4.1 Contain a unique log-on or terminal ID, the date and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

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

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

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

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

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4.21.4.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than seven (7) years and shall be retrievable within forty-eight (48) hours.

4.21.4.5 The CONTRACTOR's systems shall have functionality and audit trails that prevent the alteration or deletion of finalized records.

4.21.4.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CONTRACTOR shall provide HCA with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.

4.21.4.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

4.21.4.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

4.21.4.9 The CONTRACTOR shall put in place procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network within the CONTRACTOR's span of control. This includes, but is not limited to, no Provider or Member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.

4.21.4.10 The CONTRACTOR shall ensure that remote access users of its systems can only access said systems through multi-factor user authentication and via methods such as Virtual Private Network (VPN).

4.21.4.11 The CONTRACTOR shall comply with recognized industry standards governing security and privacy of State and federal automated data processing systems and information processing. The CONTRACTOR and any of its Major Subcontractors or Providers that adjudicate Claims must undergo a System and

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Organizational Control (SOC) 2 Type II or an alternative privacy and security systems audit that is prior approved by HCA. This audit must be completed prior to implementation and at least annually thereafter. The CONTRACTOR shall provide the results of the audit to HCA and make the audit results available to appropriate State and federal agencies upon request. The CONTRACTOR and any of its Major Subcontractors or Providers that adjudicate Claims must undergo a System and Organizational Control (SOC) 2 Type II or an alternative privacy and security systems audit that is prior approved by HCA. The audit must be completed prior to implementation and at least annually thereafter.

4.21.5 Systems Availability, Performance, and Problem Management Requirement

4.21.5.1 The CONTRACTOR shall ensure that critical Member and Provider Internet and/or telephone-based functions and information, including but not limited to, Member eligibility and enrollment systems, are available to the applicable system users twenty-four (24) hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by HCA and the CONTRACTOR.

4.21.5.2 The CONTRACTOR shall ensure that, at a minimum, all other system functions and information are available to the applicable system users between the hours of 7 a.m. and 7 p.m. Mountain Time, Monday through Friday.

4.21.5.3 In the event of a declared major failure or disaster, the CONTRACTOR's core eligibility/enrollment and Claims processing systems shall have functionality restored within seventy-two (72) hours of the failure's or disaster's occurrence.

4.21.5.4 In the event of a problem with system availability that exceeds four (4) hours, the CONTRACTOR shall notify HCA immediately and provide HCA within five (5) Business Days, with full written documentation that includes a Corrective Action Plan describing how the CONTRACTOR will prevent the problem from occurring again.

4.21.6 Business Continuity and Disaster Recovery (BC-DR) Plan

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4.21.6.1 Regardless of the architecture of its systems, the CONTRACTOR shall develop and be continually ready to invoke a BC-DR plan that has been reviewed and approved in writing by HCA.

4.21.6.2 At a minimum, the CONTRACTOR's BC-DR plan shall address the following scenarios:

4.21.6.2.1 The central computer installation and resident software are destroyed or damaged;

4.21.6.2.2 System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;

4.21.6.2.3 System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system;

4.21.6.2.4 System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability; and

4.21.6.2.5 The CONTRACTOR's system is functional but has been compromised by unauthorized access which has led to a security incident or breach; or a vulnerability is detected which could lead to a potential incident of PHI that pertains to this agreement.

4.21.6.3 The CONTRACTOR's BC-DR plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

4.21.6.4 The CONTRACTOR shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures and provide the results of this testing to HCA upon request.

4.22 **Reporting Requirements**

4.22.1 General Requirements

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4.22.1.1 The CONTRACTOR shall comply with all the reporting requirements established by HCA, including all DSIPT reports.

4.22.1.2 The CONTRACTOR agrees to submit any data requested by HCA in the time frame and format requested by HCA.

4.22.1.3 The CONTRACTOR shall adhere to HCA defined standards and templates for all reports and reporting requirements. HCA shall provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance as required. HCA may, at its discretion, change the content, format, or frequency of reports.

4.22.1.4 As directed by HCA, the CONTRACTOR shall submit reports to the Collaborative and other State agencies.

4.22.1.5 As appropriate, report templates may include specific information related to Behavioral Health services and utilization.

4.22.1.6 HCA's requirements regarding report packages (i.e., instructions, template, and review tool) for reports, report content, and frequency of submission are subject to change at any time during the term of the Agreement.

4.22.1.6.1 The CONTRACTOR shall comply with all report package (i.e., instructions, template) revisions specified in writing by HCA, after HCA has discussed such revisions with the CONTRACTOR. HCA shall notify the CONTRACTOR, in writing, of report package revisions to existing required report content, at least fourteen (14) Calendar Days prior to implementing the report package revisions. The CONTRACTOR shall only be held harmless on the first submission of the revised report, after revisions are implemented by HCA, if HCA fails to meet this notification requirement. However, the CONTRACTOR is not otherwise relieved of any penalties for the submission of late, inaccurate, or otherwise incomplete reports. The first submission of a report (i.e., template and instructions) revised by HCA to include HCA revision in data requirements or definitions will not be subject to penalty for accuracy. For minor formatting and schedule changes, the CONTRACTOR will implement changes as directed by HCA. Minor

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formatting and schedule changes shall include, but are not be limited to, items such as addition of rows in a template, unlocking certain template cells, and changes in titles.

4.22.1.6.2 HCA shall notify the CONTRACTOR, in writing, of new report packages at least forty-five (45) Calendar Days prior to implementing the new report package, excluding DSIPT reports.

4.22.1.7 The CONTRACTOR shall submit reports that are complete, timely, accurate, and in the specified format, as required by HCA. The submission of reports that are incomplete, late, inaccurate, or not in the specified format constitutes a "Failure to Report". "Timely submission" means that a complete and accurate report, in the specified format, was submitted on or before the date it was due. HCA in its sole discretion, shall determine if a report is late, inaccurate, incomplete, or in an unspecified format. "Failure to Report" may result in monetary penalties in accordance with Section 7.3 of this Agreement.

4.22.1.8 The CONTRACTOR shall not be penalized if an error in a previously submitted report is identified by the CONTRACTOR and reported to HCA prior to HCA identification of the error. Corrected reports in this type of situation will be submitted to HCA in a time frame determined by HCA after consulting with the CONTRACTOR. In such a situation, failure to comply with the agreed upon time frames for correction and resubmission may result in monetary penalties in accordance with Section 7.3 of this Agreement.

4.22.1.9 The CONTRACTOR shall, as part of its continuous improvement activities, review timeliness and accuracy of reports submitted to HCA to identify instances and patterns of noncompliance. The CONTRACTOR shall perform an analysis, identifying any patterns or issues of noncompliance, and shall implement quality improvement activities to improve overall performance and compliance.

4.22.1.10 HCA may, at its discretion, require the CONTRACTOR to submit additional reports, both ad hoc and recurring.

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4.22.1.11 If HCA requests any revisions to reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, in the time period and format directed by HCA.

4.22.1.12 HCA reserves the right to request reports more frequently during the Transition Period in order to monitor implementation of Turquoise Care.

4.22.1.13 The CONTRACTOR shall submit all reports to HCA, unless indicated otherwise in this Agreement, according to the schedule below or as otherwise directed by HCA. "Failure to Report" may result in monetary penalties in accordance with Section 7.3 of this Agreement.

DELIVERABLE	DUE DATE
Weekly Reports	Wednesday of the following week
Monthly Reports	Fifteenth Calendar Day of the following month
Quarterly Reports	Thirtieth Calendar Day of the following month*
Semi-Annual Reports	January 31 and July 31 of the Agreement year
Annual Report	As directed by HCA
Ad Hoc Reports	Time frame as determined by HCA at time of the request.
DSIPT Reports	As Directed by HCA

*Quarterly financial reports are due sixty (60) Calendar Days from the end of the first quarter, the remaining quarterly financial reports are due forty-five (45) Calendar Days from the end of the respective quarter.

4.22.1.14 If a report due date falls on a weekend or a State of New Mexico scheduled holiday, receipt of the report the next Business Day is acceptable.

4.22.1.15 Extensions to report submission dates will be considered by HCA after the CONTRACTOR has contacted the HCA designated point of contact via e-mail at least twenty-four (24) hours in advance of the report due date. Extensions for submission of reports should be under rare and unusual circumstances. If HCA grants an extension and the report is complete, accurate, in the specified format and submitted on or before the extended deadline, the report will not be subject to penalty. Failure to request an extension at least twenty-four (24) hours prior to

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the report due date is considered a “Failure to Report” and may result in monetary penalties in accordance with Section 7.3 of this Agreement.

4.22.1.16 When a report is rejected because it constitutes a “Failure to Report”, the CONTRACTOR shall resubmit the report as soon as possible once notification of the rejection is received. The length of time in Business Days it takes the CONTRACTOR to resubmit rejected reports may result in monetary penalties in accordance with items #7, #11, and #15 of Section 7.3.3.6.7 of this Agreement. If the CONTRACTOR cures the deficiency identified by HCA and resubmits an accurate report, in the specified format, within five (5) Business Days from receipt of written notification of the basis of such failure, the CONTRACTOR will only be subject to a report rejection penalty of five thousand dollars ($5,000) and not the one thousand dollars ($1,000) daily monetary penalty. This one (1)-time cure period shall apply only to the initial rejection of any report and not to subsequent rejections of the same report. If the CONTRACTOR does not cure the deficiency within five (5) Business Days of receipt of written notification, HCA may impose monetary penalties for Failure to Report, in addition to the five thousand dollars ($5,000) rejection penalty. Any monetary penalties imposed in addition to the five thousand dollars ($5,000) report rejection penalty may begin to accrue the day after the report rejection notice is uploaded to the HCA’s FTP site (the DMZ) and ending the day before the report is resubmitted to the DMZ.

4.22.1.17 The CONTRACTOR shall submit all reports electronically to HCA's DMZ FTP site, unless directed otherwise by HCA will provide the CONTRACTOR with access to the DMZ. The e-mail generated by the DMZ upload will be used as the time stamp for the submission of the report(s).

4.22.1.18 HCA shall provide an acknowledgement of receipt of the report to the CONTRACTOR within fifteen (15) Business Days from receipt of the report.

4.22.1.19 A number of reports as identified by HCA require CONTRACTOR certification. The Authorized Certifier, or an equivalent position, as delegated by the CONTRACTOR and approved by HCA shall review the accuracy of language, analysis, and data in each report prior to submitting the report to HCA. The

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Authorized Certifier shall include a signed attestation each time the report is submitted. The attestation must include a certification, based on best knowledge, information and belief, as to the accuracy, completeness, and truthfulness of the data in the report. Reports will be deemed incomplete if an attestation is not included.

4.22.1.20 Reporting for Excluded State-Funded Services.

4.22.1.20.1 Prohibition. The CONTRACTOR shall not create, include, or transmit utilization, cost, or other information relating to Excluded State-Funded Services in encounters or in any other reports or submissions prepared or transmitted under this Agreement.

4.22.1.20.1.1 Validation and certification. Before each effective date stated in a State Notice, the Contractor shall provide evidence that suppression and routing controls are active.

4.23 **Obligations Relating to Member Personal Responsibility Initiatives**

4.23.1 Member Incentives

4.23.1.1 General Expectations

4.23.1.1.1 The CONTRACTOR shall assign at least one (1) Turquoise Care Committee representative to work with the other Member Rewards Committee representatives to continue the Turquoise Care Rewards program.

4.23.1.1.2 The CONTRACTOR shall contract directly with the Turquoise Care Rewards Program vendor approved by HCA to provide incentives to Members for healthy behaviors and to provide other services as assigned by HCA.

4.23.1.1.3 Amounts expended to administer the Member rewards program shall be deemed as administrative expenses and amounts expended on the value of the rewards themselves shall be deemed as direct services for purposes of the Medical Loss Ratio (MLR) (see Section 7.2 of this Agreement).

4.23.1.2 Specific Requirements

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4.23.1.2.1 The activities and behaviors proposed to be rewarded with incentives should promote good health, Health Literacy, and continuity of care for all Members and shall be prior approved by HCA. Changes to the rewards and redemption options will be approved by HCA.

4.23.1.2.2 The following reward activities represent examples of historical activities for the Member Incentive program:

4.23.1.2.2.1 Annual dental visit for children;

4.23.1.2.2.2 Annual dental visit for adults;

4.23.1.2.2.3 Well-child PCP visit (age zero [0] to fifteen [15] months);

4.23.1.2.2.4 Well-child PCP visit (age three [3] to six [6] years);

4.23.1.2.2.5 Adolescent well-care visit;

4.23.1.2.2.6 Childhood immunizations;

4.23.1.2.2.7 Adult PCP visit;

4.23.1.2.2.8 Perinatal (first trimester, ongoing prenatal, and Postpartum visits);

4.23.1.2.2.9 Breast cancer screening;

4.23.1.2.2.10 Diabetes management (HbA1c, nephropathy, and diabetic retinopathy);

4.23.1.2.2.11 Medication management for asthma;

4.23.1.2.2.12 Medication management for bipolar disorder;

4.23.1.2.2.13 Medication management for schizophrenia;

4.23.1.2.2.14 Medication management for hypertension;

4.23.1.2.2.15 Medication management for depression;

4.23.1.2.2.16 Follow-up after hospitalization for mental illness;

4.23.1.2.2.17 New Member HRA Completion;

4.23.1.2.2.18 Step-Up Wellness Challenge;

4.23.1.2.2.19 Drink Water Wellness Challenge; and

4.23.1.2.2.20 Just Move Wellness Challenge.

4.23.1.2.3 Members shall earn points for each healthy behavior based on a schedule approved by HCA. Points may be redeemed for healthy items available through a catalog. Points may be redeemed for HCA aproved items available through a catalog or other options as directed by HCA.

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

4.23.1.3 Data Sharing and Reporting

4.23.1.3.1 Subject to HCA approval, the CONTRACTOR will work with the Turquoise Care Rewards Program vendor to follow established processes for capturing and storing the data necessary to award points for participation in qualified activities and programs. The CONTRACTOR is required to follow the data schedules established collaboratively by the MCOs and the Turquoise Care Rewards Program vendor for providing required data.

4.23.1.3.2 The points for qualified activities and programs may be tracked based on Claim submissions.

4.23.1.3.3 The points for Member rewards may be tracked and accumulated based on an alternative process, subject to agreement by all the MCOs and prior written approval by HCA. In no instance shall the methodology proposed fail to provide the points to the Members in less than forty-five (45) Calendar Days from payment of the associated Claim or receipt by the CONTRACTOR or a written request for a non-Claim based reward.

4.23.1.3.4 The CONTRACTOR shall design and operate an automated system to communicate information on the points available for each Member to the vendor retained by the Turquoise Care MCOs to administer the provider catalog fulfillment process.

4.23.2 PCP Lock Ins

The CONTRACTOR shall monitor the potential for Abuse or overuse of services and require that a Member visit a certain PCP when the CONTRACTOR has identified continuing utilization of unnecessary services. Prior to placing the Member on PCP lock in, the CONTRACTOR shall inform the Member of the intent to lock in, including the reasons for imposing the PCP lock in. The CONTRACTOR's Grievance procedure shall be made available to any Member being designated for PCP lock in. The PCP lock in shall be reviewed and documented by the CONTRACTOR and reported to HCA every quarter. The Member shall be removed

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from PCP lock in when the CONTRACTOR has determined that the utilization problems have been resolved and that recurrence of the problems is judged to be improbable. HCA shall be notified of all lock in removals.

4.23.2.1 For Members in a PCP lock in who are transitioning from one MCO to another, the CONTRACTOR shall accept Members and shall review the Member file within thirty (30) Calendar Days of the transition and determine if the Member will remain in the PCP lock in. The CONTRACTOR shall inform the Member in writing of the decision, including the reasons to remove or maintain the PCP lock in, and shall provide the Member with the CONTRACTOR's grievance procedures within fourteen (14) Calendar Days of determination.

4.23.3 Pharmacy Lock Ins

The CONTRACTOR monitors the potential for Abuse or overuse of services and requires that a Member visit a certain pharmacy provider when Member compliance or drug-seeking behavior is suspected. Prior to placing the Member on pharmacy lock in, the CONTRACTOR shall inform the Member and/or their 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 HCA 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 determined to be improbable. HCA shall be notified of all lock in removals.

4.23.3.1 For Members in a pharmacy lock in who are transitioning from one MCO to another, the CONTRACTOR shall accept Members and shall review the Member file within thirty (30) Calendar Days of the transition to determine if the Member will remain in the pharmacy lock in. The CONTRACTOR shall inform the Member in writing of the decision, including the reasons to remove or maintain the pharmacy lock in, and shall provide the Member with the CONTRACTOR's grievance procedures within fourteen (14) Calendar Days of determination.

4.24 **CISC CONTRACTOR Scope of Work**

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4.24.1 General

The CISC CONTRACTOR shall comply with the scope of work requirements in Section 4.23 of this Agreement in addition to the other Scope of Work requirements in Section 4 of this Agreement unless otherwise indicated. To the extent that requirements in Section 4.23 of this Agreement conflict with requirements elsewhere in Section 4 of this Agreement the requirements in Section 4.23 of this Agreement shall control.

4.24.2 Enrollment of CISC Recipients

4.24.2.1 HCA shall mandatorily enroll all current and new CISC Recipients to the CISC CONTRACTOR, with the exception of Native American CISC Recipients. The enrollment of Native American CISC into the CISC CONTRACTOR shall be voluntary. Native American CISC Recipients may enroll with the CISC CONTRACTOR, another MCO, or receive services through HCA's FFS program.

4.24.2.2 The effective date of enrollment in the CISC CONTRACTOR shall be the first day of the month in which the child was taken into State custody.

4.24.2.3 CISC Recipients who are mandatorily enrolled in the CISC CONTRACTOR shall remain enrolled in the CISC CONTRACTOR while in State custody and shall not be provided an option to select a different MCO.

4.24.2.4 Newborns of CISC Members who are not taken into State custody will be enrolled in the CISC CONTRACTOR but not as a CISC Member. The mother shall have one (1) opportunity anytime during the three (3) months from the effective date of enrollment to change the newborn's MCO assignment.

4.24.2.5 Enrollment of newborns of CISC who are taken into State custody will follow CISC Recipient enrollment requirements.

4.24.2.6 CISC Members enrolled with the CISC CONTRACTOR who leave State custody shall be:

4.24.2.6.1 Disenrolled from the CISC program effective the last day of the month in which the CISC Member is no longer in State custody;

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4.24.2.6.2 Assigned to the CISC CONTRACTOR but not as a CISC Member effective on the first day of the month following the month in which the CISC Member is no longer in State custody; and

4.24.2.6.3 Given the opportunity to change MCOs during the first ninety (90) Calendar Days following the effective date of enrollment.

4.24.3 CISC Care Coordination

4.24.3.1 In addition to complying with the Care Coordination requirements in Section 4.4 of this Agreement, the CISC CONTRACTOR shall:

4.24.3.1.1 Establish a dedicated Care Coordination team, led by a registered nurse, with knowledge and experience providing Care Coordination for individuals with similar, complex needs as those of CISC Members (e.g., individuals with Behavioral Health conditions, multi-system involvement, Trauma);

4.24.3.1.2 Submit an annual CISC Care Coordination Staffing Plan as part of the CISC CONTRACTOR's written Care Coordination program description that addresses staffing for Care Coordination provided to CISC Members to HCA for review and prior written approval. At a minimum, the CISC Care Coordination Staffing Plan shall specify the following: (i) the number of care coordinators, Care Coordination supervisors, and other Care Coordination team members the CONTRACTOR will employ, their experience, and their credentials, as applicable; (ii) the proposed ratio of care coordinators to CISC Members and the method by which the CISC CONTRACTOR determined that such ratios are sufficient to fulfill the requirements specified in this Agreement; (iii) the method by which the CISC CONTRACTOR plans to maintain ratios approved by HCA for CISC Members; (iv) how the CISC CONTRACTOR will ensure that such ratios continue to be sufficient to fulfill the requirements specified in this Agreement; (v) the roles and responsibilities for each member of the Care Coordination team; and (vi) how the CISC CONTRACTOR will use care coordinators to meet the unique needs of CISC Members and their Caregivers; and

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4.24.3.1.3 Revise the CISC Care Coordination Staffing Plan for HCA review and approval in writing as needed, or as directed by HCA, to ensure CISC Care Coordination requirements are met as specified in this Agreement.

4.24.4 Benefits/Service Requirements and Limitations

4.24.4.1 The CISC CONTRACTOR shall obtain HCA prior approval in writing prior to applying prior authorization requirements for CISC Members.

4.24.5 Monitoring Medication Prescribing and Utilization for CISC Members

4.24.5.1 The CISC CONTRACTOR shall assist HCA and CYFD to develop, implement, and comply with medication guidelines for CISC Members, including but not limited to psychotropic medication prescribing and utilization guidelines.

4.24.5.2 The CISC CONTRACTOR shall comply with standards and reporting requirements associated with the CISC settlement agreement as identified by HCA.

4.24.5.3 The CISC CONTRACTOR shall educate its prescribing Providers about polypharmacy and the use of psychotropic medications for CISC Members as set forth in psychotropic medication prescribing and utilization guidelines.

4.24.5.4 The CISC CONTRACTOR shall routinely monitor prescribing provider practices, including facility-based prescribing providers, to identify and address outlier prescribing practices.

4.24.5.5 In addition to reviewing utilization and other data sources to identify and address prescribing trends and outlier practices, the CISC CONTRACTOR shall also review medication reports produced by CYFD on a quarterly basis. CYFD identifies outlier prescribing practices for CISC as including one (1) or more of the following:

4.24.5.5.1 The CISC Member is taking medications and does not have an assessment, including a DSM-5 diagnoses, in the child's case file.

4.24.5.5.2 The CISC Member has been on psychotropic medications for a period of three (3) to six (6) weeks and their symptoms are worsening or not improving.

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4.24.5.5.3 The CISC Member is prescribed three (3) or more psychotropic medications at the same time.

4.24.5.5.4 The CISC Member is prescribed any of the following at the same time: two (2) or more stimulants; two (2) or more alpha agonists/anti-hypertensives; more than two (2) antidepressants; more than one (1) antipsychotic; or one (1) or more mood stabilizers (including Lithium and anticonvulsants).

4.24.5.5.5 The prescribed psychotropic medication is not consistent with appropriate care for the CISC Member's diagnosed mental disorder or with documented targeted symptoms usually associated with a therapeutic response to the medication prescribed.

4.24.5.5.6 Psychotropic medications that are prescribed to very young CISC Members. Examples of age-related outlier practices for prescribing psychotropic medications include the following:

4.24.5.5.6.1 Stimulants for CISC Members less than four (4) years of age;

4.24.5.5.6.2 Alpha Agonists for CISC Members less than five (5) years of age;

4.24.5.5.6.3 Antidepressants for CISC Members less than five (5) years of age;

4.24.5.5.6.4 Mood Stabilizers for CISC Members less than twelve (12) years of age; and

4.24.5.5.6.5 Antipsychotics for CISC Members less than twelve (12) years of age.

4.24.6 Value Added Services

4.24.6.1 The CISC CONTRACTOR may offer Value Added Services to CISC Members that are not Covered Services.

4.24.6.2 Value Added Services proposed by the CISC CONTRACTOR for CISC Members shall be prior approved in writing by HCA.

4.24.6.3 The CISC CONTRACTOR is encouraged to tailor its proposed Value Added Services to reflect the unique, complex, and unmet needs of CISC Members and their Caregivers.

4.24.7 Provider Network

4.24.7.1 The CISC CONTRACTOR shall ensure continuity of care and minimize disruptions to care for CISC Members as a result of their enrollment into the

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CISC CONTRACTOR by offering Non-Contract Providers actively treating CISC Members prior to their enrollment with the CISC CONTRACTOR a Provider agreement or single case agreement. The CISC CONTRACTOR shall reimburse such Providers no less than the greater of in-network or Medicaid FFS rates.

4.24.7.2 The CISC CONTRACTOR shall expand its provider network and shape provider expertise to meet the unique and complex needs of CISC Members and maximize the availability of community-based, Trauma-responsive services to reduce the unnecessary utilization of inpatient, emergency room, and out-of-home/out-of-State services.

4.24.7.3 The CISC CONTRACTOR shall advance evidence-based practices and standards within its Provider network as identified by HCA.

4.24.7.4 The CISC CONTRACTOR shall separately describe and report the following information in its Provider Network Development and Management Plan:

4.24.7.4.1 Strategies for expanding the CISC CONTRACTOR's provider network and shaping its provider expertise (including training) to meet the unique and complex needs of CISC Members;

4.24.7.4.2 Provider network adequacy and capacity issues impacting CISC Members, the strategies and interventions to address the issues, and the targeted time frame for correction;

4.24.7.4.3 Out-of-network and out-of-state treatment and/or care for CISC Members and the analysis of this information used by the CISC CONTRACTOR to inform its assessment of network needs; and

4.24.7.4.4 Other information as directed by HCA.

4.24.7.5 In addition to the requirements in Section 4.11.5 of this Agreement, the CISC CONTRACTOR shall provide any additional CISC-related training and educational materials as required by HCA.

4.24.8 Population Health Management and Quality Assurance

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4.24.8.1 The CISC CONTRACTOR must include CISC-specific Population Health Management strategies and activities within its Population Health Management plan as described in Section 4.12.1.

4.24.8.2 The CISC CONTRACTOR shall separately describe and report CISC-specific quality goals, practice guidelines, PMs, and PIP in its QM/QI annual program description and evaluation report.

4.24.8.3 In addition to the Member Advisory Board requirements in Section 4.12.3.2 of this Agreement, the CISC CONTRACTOR's Member Advisory Board composition shall include members representing CISC Caregivers and Providers who serve CISC Members.

4.24.8.4 In addition to the PIPs required in Section 4.12.7 of this Agreement, the CISC CONTRACTOR shall implement one (1) PIP focused on improvements for CISC Members as approved or directed by HCA.

4.24.8.5 Each CONTRACTOR shall report on the CISC CONTRACTOR PMs and TMs for the CISC population included in Attachment 13: CISC CONTRACTOR PMs and TMS as directed by HCA. The CONTRACTOR shall report additional performance metrics as required by HCA and CYFD to measure system performance and change.

4.24.9 Member Materials

4.24.9.1 The CISC CONTRACTOR shall include information about the CISC program in its member handbook and website as required by HCA.

4.24.9.2 The CISC CONTRACTOR shall include health education strategies to benefit CISC Members and Caregivers in its Health Education Plan and the assessment of the effectiveness of those strategies in its Health Education Evaluation Report.

4.24.10 Value-Based Purchasing

HCA contemplates designing and implementing VBP or other payment models focused on the unique needs of CISC Members to incentivize a health care delivery system that provides high-quality services and optimal outcomes for CISC Members and their Caregivers.

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4.24.10.1 The CISC CONTRACTOR shall assist HCA and CYFD as directed by HCA in the design and implementation of VBP or other payment model strategies that benefit CISC Members and their Caregivers.

4.24.10.2 The CISC CONTRACTOR shall support Provider readiness and innovation in preparation for VBP or other payment models that reward quality care and outcomes over volume of services.

4.24.10.3 The CISC CONTRACTOR shall comply with all requirements identified by HCA associated with the implementation of VBP or other payment model strategies, including but not limited to quality measures, performance metrics, and reporting requirements.

4.25 2025 Turquoise Care 1115 Demonstration Waiver Initiatives

Starting July 1, 2025 and subject to final CMS approvals, the CONTRACTOR will offer the new benefits listed in Attachment 14, in accordance with the Turquoise Care 1115 Demonstration Special Terms and Conditions, Protocols, Implementation Plans, and other guidance documents, and as further detailed in the MCO Policy Manual.

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5 HCA's Responsibilities

5.1 HCA shall:

5.1.1 Establish and maintain Member eligibility and enrollment information and transfer eligibility and enrollment information to the CONTRACTOR to ensure appropriate enrollment in and assignment to the CONTRACTOR. This information shall be transferred electronically. The CONTRACTOR shall have the right to rely on eligibility and enrollment information transmitted to the CONTRACTOR by HCA. Each Party shall notify the other of possible errors or problems as soon as reasonably possible;

5.1.2 Support implementation deadlines by providing technical information at the required level of specificity in a timely fashion;

5.1.3 Provide the CONTRACTOR with enrollment information concerning each Member enrolled with the CONTRACTOR, including the Member's name, Social Security number, address, telephone number, date of birth, gender, the availability of third-party coverage, rate category, and the State-assigned identification number;

5.1.4 Compensate the CONTRACTOR as specified in Section 6 of this Agreement;

5.1.5 Provide a mechanism for Fair Hearings;

5.1.6 Conduct review and monitoring activities, as needed, to meet CMS, SAMHSA or other federal requirements for State oversight responsibilities;

5.1.7 Monitor the effectiveness of the CONTRACTOR's QM/QI programs;

5.1.8 Review the CONTRACTOR's Grievance files, as necessary;

5.1.9 Provide Members with specific information about services, benefits, MCOs from which to choose, and Member enrollment;

5.1.10 Provide the content, format, and schedule for the CONTRACTOR's report submissions;

5.1.11 Provide the CONTRACTOR with specifications related to data reporting requirements;

5.1.12 Ensure that no requirement or specification established or provided by HCA under this section conflicts with requirements or specifications established pursuant to

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HIPAA and the regulations promulgated there under. All requirements and specifications established or provided by HCA under this section shall comply with the requirements of Section 5.2 of this Agreement; and

5.1.13 Cooperate with the CONTRACTOR in the CONTRACTOR's efforts to achieve compliance with HIPAA requirements. The CONTRACTOR shall be held harmless for implementation delays when the CONTRACTOR bears no responsibility for the cause of the delay.

5.2 HCA and/or its fiscal agent shall implement electronic data standards for transactions related to managed health care. In the event that HCA and/or its fiscal agent requests that the CONTRACTOR, or its Subcontractors, Major Subcontractors, or Contract Providers deviate from or provide information in addition to the information called for in required and optional fields included in the standard transaction code sets established under HIPAA, such request shall be made by amendment to this Agreement in accordance with the provisions of Section 7.7 of this Agreement.

5.3 Performance by the CONTRACTOR shall not be contingent upon time availability of State personnel or resources, with the exception of specific responsibilities stated in the RFP or this Agreement and the normal cooperation that can be expected in such an Agreement. The CONTRACTOR's access to State personnel shall be granted as freely as possible. However, the competency/sufficiency of State staff shall not be reason for relieving the CONTRACTOR of any responsibility for failing to meet required deadlines or producing unacceptable deliverables.

5.4 To the extent the CONTRACTOR is unable to perform any obligation or meet any deadline under this Agreement because of the failure of HCA to perform its specific responsibilities under the Agreement, the CONTRACTOR's performance shall be excused or delayed, as appropriate. The CONTRACTOR shall provide HCA written notice, as soon as possible, but in no event later than the expiration of any deadline or date for performance, that identifies the specific responsibility that HCA has failed to meet, as well as the reason HCA's failure impacts the CONTRACTOR's ability to meet its performance obligations under the Agreement.

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5.5 Within three (3) Business Days of becoming aware of any Claim or information that may impact the CONTRACTOR or the services to be performed by the CONTRACTOR under this Agreement, HCA shall provide the CONTRACTOR with written notice of such Claim or information.

6 Payments to CONTRACTOR

6.1 General Requirements

6.1.1 The Parties understand and agree that the compensation and payment reimbursement for services delivered under this Agreement are dependent upon State and federal funding and regulatory approvals.

6.1.2 HCA shall compensate the CONTRACTOR for work performed under this Agreement based on the Capitation Rates shown on the rate sheets for the rating period. The CONTRACTOR shall accept payments remitted by HCA payment in full for all services required pursuant to this Agreement.

6.1.3 HCA shall make monthly Capitation Payments to the CONTRACTOR for all Members enrolled with the CONTRACTOR on or before the second Friday of each month. HCA shall not make partial month or daily Capitation Payments.

6.1.4 The CONTRACTOR shall comply with all requirements stated in NMAC 8.308.20. HCA shall make Capitation Payments that are developed in accordance with 42 C.F.R. § 438.4. All Capitation Payments and all risk-sharing mechanisms must be actuarially sound and approved by CMS.

6.1.4.1 To meet the requirement for actuarial soundness, all Capitation Rates must be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles, as set forth in the standards of practice established by the Actuarial Standards Board. Accordingly, HCA's offer of all Capitation Rates and related risk-sharing arrangements is contingent on both certifications by HCA actuary and final approval by CMS, prior to becoming effective for payment purposes. In the event such certification or approval is not obtained for any or all Capitation Rates subject to this regulation, HCA reserves the right to modify these Capitation

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Rates. HCA's decision to modify the Capitation Rates under the circumstances described above is binding on the CONTRACTOR.

6.1.5 To the extent it is determined by the appropriate taxing authority that the performance of this Agreement by the CONTRACTOR is subject to taxation, the Capitation Payments paid by HCA to the CONTRACTOR under this Agreement shall include such tax(es) and no additional amount shall be due from HCA therefore, the Capitation Payments paid by HCA 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. HCA shall pay a monthly Capitation Payment amount to the CONTRACTOR for the provision of Covered Services.

6.1.6 Capitation Rates determined through discussion between the Parties are considered confidential.

6.1.7 Members shall be held harmless against any liability for debts of a CONTRACTOR that are incurred within the Agreement in providing Covered Services to the Medicaid Member.

6.2 Payments for Services

6.2.1 HCA shall make a full monthly Capitation Payment to the CONTRACTOR for the month in which the Member is enrolled with the CONTRACTOR. The CONTRACTOR shall be responsible for Covered Services (Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services

6.2.2 for ABP Members) provided to the Member in any month for which HCA paid the CONTRACTOR for the Member's care under the terms of this Agreement.

6.2.3 The CONTRACTOR is at risk of incurring losses if its expenses for providing the Covered Services and performing the requirements of the Agreement exceed its Capitation Payment. HCA shall not provide a retroactive payment adjustment to the CONTRACTOR to reflect the cost of services actually furnished by the CONTRACTOR. The CONTRACTOR may retain its underwriting gain subject to

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the limitations set forth in Section 7.2 of this Agreement. HCA makes no guarantee of underwriting gain to the CONTRACTOR.

6.2.4 The CONTRACTOR remains ultimately liable to HCA for the services rendered under the terms of this Agreement. The CONTRACTOR is required to obtain reinsurance as outlined in Section 4.19.10 of this Agreement and shall provide a copy of its reinsurance agreement to HCA annually, beginning with the effective date of this Agreement.

6.2.5 If a Member loses eligibility for any reason and is reinstated as eligible by HCA before the end of the month, the CONTRACTOR must accept a retro Capitation Payment for that month of eligibility and assume financial responsibility for all services supplied to the Member.

6.2.6 Retro Capitation Payments may not be issued for Members for the same coverage month in which FFS Claims have already been paid by Medicaid, except in special situations determined by HCA. When retro Capitation Payments are not issued for a particular month, the Member will remain enrolled with FFS for that month.

6.2.7 HCA shall have the discretion to recoup Capitation Payments made by HCA pursuant to this Agreement for the following:

6.2.7.1 Members incorrectly enrolled with more than one (1) MCO;

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

6.2.7.3 Members whom HCA later determines were not eligible for Medicaid during the enrollment month for which Capitation Payment was made. HCA acknowledges and agrees that in the event of any recoupment pursuant to this section, the CONTRACTOR shall have the right to recoup from Providers or other persons to whom CONTRACTOR has made payment during this period of time; however, the CONTRACTOR may not recoup payments for any Value Added Services provided. Any payments that are recouped from Providers or other persons must be reflected in the Encounter Data as outlined in Section 4.20.4 of this Agreement; and

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6.2.7.4 Members with a mental health length of stay in an IMD that exceeds fifteen (15) Calendar Days within the Calendar Month as specified in Section 4.5.14 of this Agreement.

6.2.8 HCA shall have the discretion to recoup Capitation Payments for a non-Dual Rate Cohort and reissue a Dual Rate Cohort for Members who are retroactively determined to have Medicare coverage and do not exceed the time period that the CONTRACTOR can retroactively adjust Claims payment to Providers for those services for which Medicare would be the primary payer.

6.2.9 For Recipients who were enrolled with more than one (1) MCO, the MCO from whom the Capitation Payment is recouped shall have the right to recoup payments made to Providers for the delivery of Covered Services. The MCO who retains the Capitation Payment shall reimburse in a timely manner any Providers from whom payments were recouped by the prior MCO.

6.2.10 In the event of an error that causes Capitation Payment(s) to the CONTRACTOR in excess of amounts specified in the Agreement, the CONTRACTOR must report to HCA any incorrect payments within sixty (60) Calendar Days of identification. The CONTRACTOR shall reimburse HCA within thirty (30) Calendar Days of written notice of such error for the full amount of the payment. Interest shall accrue at the statutory rate on any amounts determined to be due but not paid and determined to be due after the thirtieth Calendar Day following the notice. Any process that automates the recoupment procedures will be discussed in advance by HCA and the CONTRACTOR and be documented in writing prior to implementation of a new automated recoupment process. The CONTRACTOR has the right to dispute any recoupment requests in accordance with Section 7.11 of this Agreement.

6.2.11 Members shall be held harmless against any liability for debts of the CONTRACTOR that were incurred within the Agreement in providing health care to the Members, excluding any Member's liability for applicable premiums, copayment or Member's liability for an overpayment resulting from benefits paid pending the results of a Fair Hearing.

6.3 Reimbursement to CONTRACTOR for I/T/U Services

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6.3.1 HCA will pay the CONTRACTOR, via a non-risk arrangement, on a quarterly basis, for the costs of services provided at I/T/Us. This payment shall be separate from the Capitation Rates and be based upon Encounter Data provided by the CONTRACTOR to HCA that have been accepted and have cleared all systems edits in the MMIS.

6.3.2 The CONTRACTOR shall have up to two (2) years from an I/T/U Claim's first date of service to submit to HCA. I/T/U Claims not submitted within two (2) years of the first date of service are not eligible for reimbursement by HCA.

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

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

6.4 Capitation Rates

The Capitation Payments made by HCA to the CONTRACTOR are based on the Capitation Rates for the Members enrolled with the CONTRACTOR. The Rate Cohorts designate the Covered Services and/or population characteristics (age/gender/geography) of the Capitation Rate.

HCA is exploring changes to the Rate Cohort structure which may include but is not limited to: the implementation of a per-delivery maternity payment separate from monthly Capitation Payments, consolidation of existing Rate Cohorts, and/or modifications to risk adjustment.

During the term of this Agreement, HCA reserves the right to modify or change the number assigned to the Rate Cohorts described in this section, if necessary, due to HCA MMIS requirements.

6.4.1 Physical Health

6.4.1.1 The Capitation Rates for the Physical Health program include acute care Covered Services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services) and are represented by the following rate cells:

6.4.1.1.1 TANF, CYFD 0 - 2 months

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6.4.1.1.2 TANF 2 months - 20 years, CISC 2 months - 21 years

6.4.1.1.3 TANF, 21+ years

6.4.1.1.4 SSI & Waiver, 0 - 1 year

6.4.1.1.5 SSI & Waiver, 1+ years

6.4.1.1.6 Pregnant Women, 15-49

6.4.1.2 Behavioral Health services for the population enrolled in the Physical Health Rate Cohorts are covered by the Behavioral Health Rate Cohorts (see Section 6.4.4 of this Agreement).

6.4.1.3 Physical health Capitation Rates are subject to risk-adjustment, described in Section 6.4.6 of this Agreement. Members enrolled in Rate Cohorts TANF, CYFD 0 - 2 months, SSI & Waiver, 0 - 1 year, and Rate Cohort Pregnant Women, 15-49 are excluded from risk-adjustment. Certain Covered Services may also be excluded from risk-adjustment as outlined in Section 6.4.6.7 of this Agreement.

6.4.1.4 HCA may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the risk-adjusted Capitation Rates for Covered Services not subject to risk-adjustment.

6.4.1.5 During the term of this Agreement HCA reserves the right to modify the structure, type or number of add-on PMPM amounts and shall notify the CONTRACTOR about the change at least thirty (30) days prior to the effective date of the change.

6.4.1.6 HCA will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rate and any add-on PMPM rates by Rate Cohort on an annual basis or when Capitation Rates are revised during the term of this Agreement.

6.4.2 Other Adult Group

6.4.2.1 The Capitation Rates for the Other Adult Group program include acute care Covered Services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services) and/or Attachment 4: Alternative Benefit Plan Covered Services

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6.4.2.2 (ABP Covered Services) and are represented by rate cell OAG PH 19-64. Behavioral Health services for the population enrolled in the Other Adult Group Rate Cohorts are covered by the Behavioral Health Rate Cohorts (see Section 6.4.4 of this Agreement).

6.4.2.3 Other Adult Group Physical Health Capitation Rates are subject to risk-adjustment, described in Section 6.4.6 of this Agreement. Certain Covered Services may also be excluded from risk-adjustment as outlined in Section 6.4.6.7 of this Agreement.

6.4.2.4 HCA may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the risk-adjusted Capitation Rates for Covered Services not subject to risk-adjustment, including but not limited to the Agency-Based or SDCB.

6.4.2.5 During the term of this Agreement, HCA reserves the right to modify the structure, type or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least thirty (30) days prior to the effective date of the change.

6.4.2.6 HCA will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rates and any add-on PMPM rate amounts by Rate Cohort on an annual basis or when Capitation Rates are revised during the term of this Agreement.

6.4.3 Long-Term Services and Supports (LTSS)

6.4.3.1 Blended Rates

6.4.3.1.1 The Capitation Rates for the LTSS population include blended Capitation Payments for Members who are assigned to a NF or Agency-Based Community Benefit SOC. Rate Cohorts Dual Eligible - NF LOC (Region 1,3,4), Dual Eligible - NF LOC (Region 2), and Dual Eligible - NF LOC (Region 5) represent the blended Rate Cohorts for Dual Eligible Members and Rate Cohorts Medicaid Only - NF LOC (Region 1,3,4), Medicaid Only - NF LOC (Region 2), and Medicaid Only - NF LOC (Region 5) represent the blended Rate Cohorts for Medicaid only Members.

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6.4.3.1.2 The LTSS Capitation Rates outlined in Section 6.4.3.1.1 of this Agreement are developed separately for Members with a NF SOC and Members with an Agency-Based Community Benefit SOC for acute and LTC services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services). On an annual basis HCA shall evaluate the CONTRACTOR's proportion of enrollment in the NF and Agency-Based Community Benefit settings of care and make a determination of the proportion of NF and Agency-Based Community Benefit Members for the upcoming rating period. This proportion will be used to blend the NF and Agency-Based Community Benefit Capitation Rates to derive the blended Capitation Rates paid by HCA to the CONTRACTOR.

6.4.3.1.3 HCA, at its discretion, may reevaluate the proportion of the CONTRACTOR's Members with NF and Agency-Based Community Benefit SOC assumed in the blended Capitation Rates at any time during this Agreement to determine if a revision to the blended Capitation Rates are necessary.

6.4.3.1.4 The Capitation Rates for the blended LTSS cohorts are "net" of medical care credit. The Capitation Rates used for the NF SOC population are developed on a "gross" basis and reduced for the estimated average monthly amount of medical care credit.

6.4.3.1.4.1 The blended Capitation Payments are subject to medical care credit reconciliation outlined in Section 6.7 of this Agreement.

6.4.3.1.5 HCA may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the Capitation Rates for services.

6.4.3.1.6 During the term of this Agreement, HCA reserves the right to modify the structure, type, or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least thirty (30) days prior to the effective date change.

6.4.3.2 Self-Directed Community Benefit

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6.4.3.2.1 The Capitation Rates for SDCB Members include acute and SDCB services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services). SDCB Capitation Rates are represented by Rate Cohorts Dual Eligible - Self Direction and Medicaid Only - Self Direction.

6.4.3.2.2 HCA, at its discretion, may reevaluate the annual budget amounts and budget utilization for Members enrolled with the CONTRACTOR any time during the term of this Agreement.

6.4.3.2.3 HCA may include risk corridor arrangements as deemed appropriate or include an add-on PMPM to the Medicaid only SDCB (Rate Cohort Medicaid Only - Self Direction) for Covered Services.

6.4.3.2.4 During the term of this Agreement, HCA reserves the right to modify the structure, type, or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least thirty (30) days prior to the effective date change.

6.4.3.3 Healthy Dual

6.4.3.3.1 The Healthy Dual Rate Cohort Capitation Rate includes Covered Services outlined in Attachment 1: Turquoise Care Covered Services. Medicare is the primary payer for Medicare Covered Services. The Capitation Rate includes Medicaid liability for Medicare deductible and co-insurance and any Medicaid Covered Services outlined in Attachment 1: Turquoise Care Covered Services that are not covered by Medicare.

6.4.3.3.2 During the term of this Agreement, the CONTRACTOR may determine that a Member meets the NF LOC and may transition the Member into a NF or the Agency-Based Community Benefit. If the CONTRACTOR determines the effective date for the NF LOC after the first day of the month and prior to the last five (5) Business Days of the month, the Healthy Dual Capitation Payment for the month remains in effect. HCA will change the Capitation Payment to the applicable blended Rate Cohort the month following the effective date of the NF LOC.

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6.4.3.4 HCA will not retroactively adjust payments from Physical Health or Healthy Dual Rate Cohort to a LTC Rate Cohort. It is the CONTRACTOR's responsibility to ensure timely submission of correct SOC for the Member. Notwithstanding the foregoing, if the CONTRACTOR has made good faith efforts to complete the CNA and the CONTRACTOR demonstrates through Encounter Data that it has continued to provide the LTC benefits after expiration of the NF LOC determination, then retroactive payment adjustments to the appropriate LTC Cohort may be made.

6.4.3.5 HCA will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rate and any add-on PMPM rates by Rate Cohort on an annual basis or when Capitation Rates are revised during the term of this Agreement.

6.4.4 Behavioral Health

6.4.4.1 The Behavioral Health Capitation Rates include all populations (Physical Health, LTSS, and Other Adult Group) for Covered Services identified in Attachment 1: Turquoise Care Covered Services. Behavioral Health Capitation Rates are represented by the following Rate Cohorts:

6.4.4.1.1 TANF/AFDC, all ages

6.4.4.1.2 CISC, all ages

6.4.4.1.3 SSI, 0-14 years

6.4.4.1.4 SSI, 15-20 years

6.4.4.1.5 SSI, 21+ years

6.4.4.1.6 LTSS Medicaid Only

6.4.4.1.7 LTSS Dual Eligible

6.4.4.1.8 OAG BH 19-64

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

6.4.4.3 Behavioral Health Capitation Rates are not subject to risk adjustment outlined in Section 6.4.4 of this Agreement.

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6.4.4.4 HCA shall adjust the CONTRACTOR's Behavioral Health Capitation Rates to reflect the CareLink New Mexico Health Home PMPM payment for Members who enroll in the CareLink New Mexico Health Home. Capitation Rate adjustments will occur and include a reconciliation of assumed enrollment with actual enrollment, as well as an estimated enrollment and impact on the Capitation Rates.

6.4.4.5 HCA shall provide the CONTRACTOR with documentation supporting the prior reconciliation and future period estimates.

6.4.4.6 HCA will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rate and any add-on PMPM rates by Rate Cohort on an annual basis or when Capitation Rates are revised during the term of this Agreement.

6.4.5 CISC Population

6.4.5.1 The Capitation Rates for the CISC program are represented by Rate Cohort PH CISC, 0-21 years, and includes Covered Services outlined in Attachment 1: Turquoise Care Covered Services (Covered Services). Behavioral Health services for the population enrolled in the CISC Rate Cohort are represented by the Behavioral Health Rate Cohort BH CISC, 0-21 years.

6.4.5.2 CISC Capitation Rates are not subject to risk adjustment outlined in Section 6.4.5 of this Agreement.

6.4.5.3 During the term of this Agreement, HCA reserves the right to modify the structure, type, or number of add-on PMPM rate amounts and shall notify the CONTRACTOR about the change at least thirty (30) days prior to the effective date of the change.

6.4.5.4 HCA will provide the CONTRACTOR Capitation Rate signature sheets that detail the Capitation Rates and any add-on PMPM rate amounts by Rate Cohort on an annual basis or when Capitation Rates are revised during the term of this Agreement.

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6.4.6 Risk Adjustment to Capitation Rates

6.4.6.1 HCA develops risk-adjusted Capitation Rates for the Physical Health and Other Adult Group as outlined in Sections 6.4.1 and 6.4.2 of this Agreement. Add-on PMPMs described in Sections 6.4.1.4 and 6.4.2.4 of this Agreement are excluded from risk adjustment.

6.4.6.2 The risk-adjusted rate model shall meet the requirements of the 42 C.F.R. part 438 and follow guidance established by the Actuarial Standards of Practice.

6.4.6.3 HCA will use medical and pharmacy Encounter Data submitted by the CONTRACTOR to develop risk-adjusted results. The CONTRACTOR is responsible for submitting timely, accurate, and complete Encounter data.

6.4.6.4 As part of annual Capitation Rate determination or reevaluation, HCA will provide the CONTRACTOR the risk-adjusted rate methodology, the raw risk scores for the Members enrolled with the CONTRACTOR, prevalence tables and risk-adjusted rate scores.

6.4.6.5 HCA, at its discretion, may reevaluate the CONTRACTOR's enrollment used to develop the risk scores at any time during this Agreement and may modify risk-adjusted Capitation Rates on a prospective basis.

6.4.6.6 HCA reserves the right to modify the risk-adjustment methodology during the term of this Agreement.

6.4.6.7 HCA reserves the right to modify the populations and services covered under risk adjustment payment rates during the term of this Agreement.

6.4.6.8 HCA will notify the CONTRACTOR of any changes to the risk-adjustment methodology or populations included in the risk- adjustment at least thirty (30) days before the effective date of the change.

6.4.6.9 Following CMS guidelines, HCA will apply the risk-adjustment methodology in a budget neutral manner. In the case in which a material change must be made to the risk-adjusted rate results, prospectively or retrospectively, the Capitation Rates paid to the CONTRACTOR will be adjusted on a budget neutral basis.

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6.5 Capitation Rates Adjustments

6.5.1 The Capitation Rates awarded are not subject to negotiation during the term of the Agreement. HCA may, at its option, review the Capitation Rates to determine if an adjustment is needed for reasons, including but not limited to, the following:

6.5.1.1 1115(a) Waiver changes;

6.5.1.2 New or amended federal or State statutes or regulations are implemented;

6.5.1.3 Judicial decisions;

6.5.1.4 Program changes;

6.5.1.5 Legislative changes; and

6.5.1.6 Actuarial assumptions, including those described in Section 6.4 of this Agreement.

6.5.2 The CONTRACTOR is responsible to notify HCA of program and/or expenditure changes initiated by the CONTRACTOR that may result in material changes to the current or future expenses for the CONTRACTOR. These may include but are not limited to Contract Provider terminations.

6.5.3 In the event that HCA initiates change affecting Capitation Rates and Capitation Payments during the term of this Agreement, HCA shall, prior to initiating any such change, provide the CONTRACTOR with as much notice as is possible, given the circumstance, of the contemplated change and the effect it will have on Capitation Rates and Capitation Payments.

6.5.3.1 Upon notice of a change affecting Capitation Rates, the CONTRACTOR may initiate discussions for a modification of the Agreement concerning changes in Capitation Rates. Such changes and any resulting discussions and modifications shall be limited to the change in Capitation Rates s and shall not subject the entire Agreement to being reopened.

6.5.3.2 If the CONTRACTOR does not request discussion for a modification of the Agreement concerning the change in Capitation Rates within fifteen (15) Calendar Days of the notice from HCA, then the change shall be implemented and become effective, subject to the continued Actuarial Soundness of the Capitation Rates.

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6.5.4 Should any part of the scope of work under this Agreement relate to a State program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the CONTRACTOR must do no work on that part after the effective date of the loss of program authority. The state must adjust Capitation Rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the CONTRACTOR works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the CONTRACTOR will not be paid for that work. If HCA paid the CONTRACTOR in advance to work on a no-longer-authorized program or activity and under the terms of this Agreement the work was to be performed after the date the legal authority ended, the payment for that work should be returned to HCA however, if the CONTRACTOR worked on a program or activity prior to the date legal authority ended for that program or activity, and HCA included the cost of performing that work in its payments to the CONTRACTOR, the CONTRACTOR may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

6.6 **Retroactive Period Reconciliation**

6.6.1 Retroactive Period means the time between the notification date by HCA to the CONTRACTOR of a Member's enrollment and the Member's Medicaid eligibility effective date. The Retroactive Period addresses those instances when the Member is enrolled with the CONTRACTOR, but the eligibility date is effective before the CONTRACTOR is notified of enrollment. For example, instances where the CONTRACTOR is notified by HCA that the Member is enrolled after the first day of the month for the current or prior months. The Retroactive Period includes the full month in which enrollment notification is received by the CONTRACTOR. The Retroactive Period does not include (i) newborns described in Section 4.2 of this Agreement; and (ii) Members who are established with the CONTRACTOR and whose subsequent disenrollment and retroactive re-enrollment result in no gap in

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coverage by the CONTRACTOR. Newborns are only considered part of the Retroactive Period reconciliation if the mother of the newborn is not enrolled in Turquoise Care managed care at the time of delivery.

6.6.2 The CONTRACTOR is required to reimburse Providers for the medical expenses incurred by the Member during the Retroactive Period. The duration and expenditures associated with the Retroactive Period may fluctuate for each Member and are not considered in the development of the Capitation Rates.

6.6.3 HCA shall reconcile the difference between the Covered Service expenses incurred by the CONTRACTOR during the Retroactive Period supported by accepted Encounter data and the payment made by HCA to the CONTRACTOR for the Retroactive Period that may occur due to the enrollment process outlined in Section 4.2 of this Agreement.

6.6.4 HCA shall reconcile the retroactive period amounts at least annually or more frequently at HCA discretion during the term of this Agreement. The result of the reconciliation may result in recoupment from or payment to the CONTRACTOR. The reconciliation process is outlined in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

6.7 **Medical Care Credit Reconciliation**

6.7.1 Capitation Rates for the LTSS blended Rate Cohorts are “net” of medical care credit as outlined in Section 6.4.3.1.4 of this Agreement.

6.7.2 The CONTRACTOR shall delegate the collection of medical care credit to the NF or community-based residential alternative facility and shall pay the facility net of the applicable medical care credit amount.

6.7.3 The CONTRACTOR shall submit, via Encounter data submission, medical care credit information associated with Claim payments.

6.7.4 HCA shall reconcile the difference between the actual amount of medical care credit of the Members enrolled with the CONTRACTOR and the amounts assumed in the Capitation Rates.

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6.7.5 HCA shall reconcile the medical care credit amounts at least annually, or more frequently at HCA discretion, during the term of this Agreement. The result of the reconciliation may result in recoupment from or payment to the CONTRACTOR. The reconciliation process is outlined in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

6.8 High Cost Member Risk Pool Reconciliation

6.8.1 The CONTRACTOR receives a PMPM payment identified as the High Cost Member Risk Pool (HCRP) Premium, by Rate Cohort as outlined in Section 6.4 of this Agreement, in the Capitation Rates for assumed costs associated with high-cost Members. The HCRP Premium is communicated to the CONTRACTOR and included in the Capitation Rate signature sheets.

6.8.2 Members and their costs must meet certain criteria to be considered in the HCRP Premium and Reconciliation, outlined in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies. HCA reserves the right to modify the HCRP criteria for future contract years.

6.8.3 The risk pool fund is determined based on each CONTRACTOR's contribution based on actual membership for the rating period and the corresponding HCRP premium. HCA shall reconcile the difference between the actual risk pool share of eligible high-cost Member claims incurred by the CONTRACTOR and the projected risk pool share included in the Capitation Rates. The projected risk pool share will be determined as a percent of the total risk pool fund and the actual risk pool share will be determined as a percent of total eligible high-cost Member incurred expenses.

6.8.4 HCA shall reconcile the HCRP once per contract year at the aggregate level. The reconciliation will be performed utilizing Encounter Data submitted by the CONTRACTOR and accepted by HCA with twelve (12) months of run out. The reconciliation process is outlined in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

6.9 Delivery System Improvement Performance Targets (DSIPTs)

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6.9.1 Beginning January 1, 2025, HCA shall impose performance as described in section 7.3.3.6.7 (#19) of the Agreement.

6.9.2 The DSIPTs are outlined in Attachment 2.

6.9.3 The CONTRACTOR's DSIPTs will be evaluated following the performance target period and necessary time for claims runout; results shall be provided by HCA to the CONTRACTOR after the evaluation period. The evaluation shall be calculated by summing all earned points, dividing the sum by one hundred (100) points and converting to a percentage (performance penalty percentage). Points will only be awarded if the CONTRACTOR meets the performance targets as prescribed in 2 and 2A.

6.9.4 If the CONTRACTOR does not meet the DSIPTs, HCA, at HCA's sole discretion, may recoup or may direct the CONTRACTOR to expend any portion of monetary penalties for Provider network development or other program enhancements that will directly benefit Members. The CONTRACTOR's expenditures of monetary penalties are subject to the expenditure specifications, reporting, and monitoring requirements determined by HCA. Any funds remaining after the twelve (12)-month period will be recouped by HCA.

6.10 **Community Reinvestment**

6.10.1 The CONTRACTOR shall demonstrate a commitment to improving the State of New Mexico's Medicaid program by contributing five percent (5.0%) of its (up to) three percent (3.0%) of after-tax underwriting gain to community reinvestments as describe in Section 7.2.1 of this Agreement.

6.10.2 The CONTRACTOR shall submit a community reinvestment plan to HCA on an annual basis for review and written approval. The community reinvestment plan shall detail the CONTRACTOR's community reinvestment strategies, activities, and the anticipated time frame for demonstrable impact. Following the CONTRACTOR's initial submission, future community reinvestment plans shall describe and quantify the impact of the prior year's community reinvestment plan.

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6.10.3 The CONTRACTOR's community reinvestment strategies must include the CONTRACTOR's efforts to collaborate with other MCOs to attain collective impact on the area(s) of focus identified by HCA.

6.10.4 The CONTRACTOR's community reinvestment funding shall be prioritized and focused on investing in efforts to develop, expand, and retain in-state behavioral health residential providers to reduce the unnecessary utilization of inpatient, emergency room, and out-of-state services. Community reinvestment funding in excess of what can reasonably be expended to develop, expand, and retain behavioral health residential providers may be used to support Population Health, health equity, and Health Related Social Needs (HRSN), subject to HCA's approval.

6.10.5 HCA may change the community reinvestment areas of focus in subsequent years based upon HCA and the CONTRACTOR's assessment of community needs and the opportunity for maximum impact.

6.10.6 The CONTRACTOR shall not use community reinvestment funding to pay for Covered Services, Value Added Services, or CONTRACTOR administrative expenses.

6.11. **Loss Protection Risk Corridor**

6.11.1 HCA and the CONTRACTOR will share in underwriting loss outside of the risk corridor based on netcapitation revenue. HCA will be responsible for seventy-five percent (75%) of any underwriting loss within three percent (3.0%) to six percent (6.0%) of the risk corridor and ninety percent (90%) of any underwriting loss in excess of six percent (6.0%) if the risk corridor. The inclusion of this arrangement in conjunction with the Underwriting Gain Limitation outlined in Section 7.2 effectively acts as a two-sided risk corridor.

6.11.2 HCA shall measure the underwriting loss based on the CONTRACTOR's Medicaid Financial Reporting Package, as specified by HCA. Financials will be validated against encounter data and may be adjusted accordingly. The result of the reconciliation may result in a payment to the CONTRACTOR. The evaluation process is outlined in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

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7 Terms and Conditions

7.1 Limitation of Cost

In no event shall Capitation Payments or other payments provided for in this Agreement exceed upper payment limits set forth in 42 C.F.R. § 447.362. In no event shall HCA pay twice for the provision of services.

7.2 Underwriting Gain Limitation and Medical Loss Ratio

7.2.1 The CONTRACTOR is permitted to retain ninety-five percent (95%) 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. Five-percent (5.0%) of the up to three percent (3.0%) underwriting gain shall be used for community reinvestment as stated in Section 6.10 of this Agreement. The CONTRACTOR shall share fifty percent (50%) of any underwriting gain generated in excess of three-percent (3.0%) with HCA. HCA shall measure the annual underwriting gain based on the CONTRACTOR's Medicaid Financial Reporting Package, as specified by HCA. 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 exclusive of investment income and before State and federal income taxes for the New Mexico Medicaid line of business on an annual basis. Penalties related to the Delivery System Improvement Performance Targets and other monetary penalties and/or 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:
Earned capitation premium, excluding IHS supplemental revenue, less premium tax, less New Mexico Medical Insurance Pool (NMMIP) and NMHIX assessments during the annual period.

7.2.2.2 Medicaid line of business Total Medical Expense:
Medical expense incurred during the annual period, including the net cost of excess loss reinsurance (premiums less recoveries) and, including the effect of

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TPL post payment recoveries, less IHS expenditures and less expenses for Care Coordination services deemed to be administrative per Section 7.2.8.4 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 written approval has been received by the CONTRACTOR from HCA, in accordance with Section 4.5.13 of this Agreement. In Lieu of Services or Settings are alternative services, or services in settings that are not Turquoise Care Covered Services as set forth in Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services , but are medically appropriate and cost-effective substitutes. However, the CONTRACTOR may not require a Member to use In Lieu of Services or Settings arrangements as a substitute for Turquoise Care Covered Services but may offer and cover such services or settings, if approved by HCA as a means of ensuring that appropriate care is provided in a cost-effective manner.

7.2.2.3 Medicaid line of business Administrative Expense:

Administrative Expense (outlined in Section 7.2.7 of this Agreement) incurred during the annual period, including expenses for Care Coordination services deemed to be administrative per Section 7.2.8.4 of this Agreement less premium tax less NMMIP and NMHIX assessments during the annual period.

7.2.2.4 Medicaid line of business Underwriting Gain:

Underwriting Gain equals Net Capitation Revenue less Total Net Medical Expense less Administrative Expense and includes the effect of MLR remittance owed to the State as specified in Section 7.2.10.3 of this Agreement and the effect of reconciliations as specified in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

7.2.3 HCA has established the underwriting gain limit and sharing outlined in Section 7.2.1 of this Agreement; however, HCA makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

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7.2.4 HCA will utilize the CONTRACTOR's annual Medicaid Financial Reporting Package following the close of the Calendar Year and perform the final underwriting gain calculation after all final evaluations for reconciliations are completed for the Calendar Year. If underwriting gain in excess of three percent (3.0%) is realized, HCA will recoup the amount for the excess underwriting gain share outlined in Section 7.2.1 of this Agreement. UWG limitation will be calculated in one 18 month period (July 1, 2024 - December 31, 2025) before moving to a calendar year basis.

7.2.5 HCA reserves the right to examine the allocation methodologies utilized for any non-direct expenditure by the CONTRACTOR as it relates to any expenditure, including but not limited to, Administrative Expense.

7.2.6 HCA reserves the right to modify the measurement of underwriting gain based on review of allocation methodologies.

7.2.7 Administrative Expense Reporting

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

7.2.7.1.1 Network development and contracting;

7.2.7.1.2 Direct provider contracting;

7.2.7.1.3 Credentialing and recredentialing;

7.2.7.1.4 Information systems;

7.2.7.1.5 Health Information Technology;

7.2.7.1.6 Health Information Exchange;

7.2.7.1.7 Encounter Data collection and submission;

7.2.7.1.8 Claims processing;

7.2.7.1.9 Member Advisory Board and Native American Advisory Board meetings;

7.2.7.1.10 Member services;

7.2.7.1.11 Training and education for Providers and Members;

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7.2.7.1.12 Financial reporting;

7.2.7.1.13 Licenses;

7.2.7.1.14 Taxes, excluding premium tax and NMMIP and NMHIX assessments;

7.2.7.1.15 Plant expenses;

7.2.7.1.16 Staff travel;

7.2.7.1.17 Legal and risk management;

7.2.7.1.18 Recruiting and staff training;

7.2.7.1.19 Salaries and benefits to CONTRACTOR staff;

7.2.7.1.20 Non-medical supplies;

7.2.7.1.21 Purchased service, non-medical, excluding Member and attendant travel, meals and lodging costs, reinsurance expense and risks delegated to third parties with HCA's written approval;

7.2.7.1.22 Depreciation and amortization;

7.2.7.1.23 Audits;

7.2.7.1.24 Grievances and Appeal System;

7.2.7.1.25 Capital outlay;

7.2.7.1.26 Reporting and data requirements;

7.2.7.1.27 Compliance;

7.2.7.1.28 Surveys;

7.2.7.1.29 Quality assurance;

7.2.7.1.30 Quality Management/Quality Improvement;

7.2.7.1.31 Marketing;

7.2.7.1.32 Damages/penalties;

7.2.7.1.33 Project ECHO multi-disciplinary team;

7.2.7.1.34 Electronic Visit Verification;

7.2.7.1.35 Housing Specialist;

7.2.7.1.36 Justice-Involved Liaison;

7.2.7.1.37 Member Incentives (Non-Incentive costs); and

7.2.7.1.38 Administrative Fee Paid to the CONTRACTOR's Pharmacy Benefit Manager.

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7.2.7.2 The CONTRACTOR shall submit a detailed explanation of administrative agreements with parent organizations on an annual basis in a template to be prescribed by HCA that may include, but is not limited to, allocation methodology, FTEs, salary, benefits, and general administrative overhead.

7.2.8 Care Coordination Expenses

7.2.8.1 The CONTRACTOR shall provide Care Coordination services in accordance with Section 4.4 of this Agreement. The CISC CONTRACTOR shall provide Care Coordination services in accordance with Section 4.4 and Section 4.24.3 of this Agreement.

7.2.8.2 For purposes of this Agreement, the following Care Coordination functions will be deemed medical services:

7.2.8.2.1 Comprehensive Needs Assessment;

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

7.2.8.2.3 Telephonic meetings between the care coordinator and the Member;

7.2.8.2.4 Case management;

7.2.8.2.5 Discharge consultation;

7.2.8.2.6 CCP development and updates;

7.2.8.2.7 Health Education provided to the Member;

7.2.8.2.8 DM provided to the Member; and

7.2.8.2.9 Costs associated with CHW.

7.2.8.3 The CONTRACTOR shall submit Member Care Coordination activities through Encounter Data.

7.2.8.4 For purposes of this Agreement, the following Care Coordination functions will be deemed administrative services:

7.2.8.4.1 HRAs;

7.2.8.4.2 Data runs;

7.2.8.4.3 Referrals; and

7.2.8.4.4 Case assignation and scheduling.

7.2.9 HCA shall issue its final calculation, in writing, after all final evaluations for contractual reconciliations are completed for the calendar year. To the extent that the

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CONTRACTOR fails to meet the requirements set forth herein, HCA shall, at the time it issues its final calculation, advise the CONTRACTOR of this deficiency and require the CONTRACTOR to remit the overpayment to HCA, or its designee, or otherwise advise the CONTRACTOR as to how the overpayment shall be treated for purposes of compliance with this section. If the CONTRACTOR disputes HCA's final calculation, it must advise HCA within fourteen (14) Calendar Days of receipt of the final calculation. Thereafter, the Parties shall informally meet to resolve the matter; such meeting must take place within fourteen (14) Calendar Days of HCA's receipt of the CONTRACTOR's dispute. If the Parties cannot informally resolve the matter, the CONTRACTOR may exercise its rights under Section 7.11 of this Agreement.

7.2.10 Medical Loss Ratio

The CONTRACTOR shall spend no less than ninety percent (90%) of net Medicaid line of business Net Capitation Revenue on direct medical expenses on an annual basis. HCA reserves the right, in accordance with and subject to the terms of this Agreement, to reduce or increase the minimum allowable for direct medical services over the term of this Agreement provided that any such change: (i) shall only apply prospectively; (ii) shall exclude any retroactive increase to allowable direct medical services; and (iii) shall comply with State and federal law. The MLR calculation and definitions for its calculation are separate from the underwriting gain limitation outlined in Sections 7.2.1 through7.2.2.4 of this Agreement. MLR will be calculated and reported to CMS for one six-month period (July-December 2024), with 12 month periods beginning January 1, 2025. MLR remittances will be calculated in one 18 month period (July 1, 2024-December 31, 2025), before moving to a calendar year basis.

7.2.10.1 For the purposes of this requirement, the MLR calculation standards shall be consistent with 42 C.F.R. § 438.8. The CONTRACTOR shall submit annually to HCA a MLR report in the specified format, as required by HCA. This report shall be consistent with the requirements in 42 C.F.R. § 438.8(k) and will include, for each reporting year, taxes, licensing, and regulatory fees, and a

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comparison of the information reported with the CONTRACTOR's audited financial reports, specific to this Agreement. Key components of the MLR calculation are outlined below:

7.2.10.1.1 Numerator: Sum of the CONTRACTOR's incurred Claims, activities that improve health care quality and fraud prevention activities. The expenditures for fraud prevention activities shall be consistent with regulations adopted for the private market at 45 C.F.R. part 158 and not include expenses for fraud reduction efforts.

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

7.2.10.1.3 Aggregation Method: The CONTRACTOR shall calculate the medical loss ratio for Other Adult Group and Non-Other Adult Group populations.

7.2.10.1.4 Credibility Adjustment: A credibility adjustment factor will be applied to the CONTRACTOR's MLR if experience is deemed to be partially credible. The credibility adjustment factors and standards for credibility will be published by CMS for the MLR reporting year. In the event that CMS has not issued Medicaid credibility adjustment factors for the applicable MLR reporting year, the CONTRACTOR will apply the credibility adjustment factors issued by CMS for the private market.

7.2.10.2 The CONTRACTOR shall submit its MLR calculation report by the last Business Day in July following the contract year. HCA will notify the CONTRACTOR if it disputes the information and the CONTRACTOR shall work timely and collaboratively with HCA to resolve the matter. HCA will publish and post the CONTRACTOR's audited MLR report on HCA's website on an annual basis.

7.2.10.3 For the term of the Agreement, the CONTRACTOR shall owe a remittance to the State if the applicable minimum MLR specified in Section 7.2.10 of this Agreement for the MLR reporting year is not met. The amount of the remittance is based on the remittance calculation in Turquoise Care MLR Report (Report

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29) to bring the CONTRACTOR's MLR to the minimum required percentage per aggregation method category for the MLR calculation specified in Section 7.2.10.1.3 of this Agreement. The remittance shall be paid to HCA within sixty (60) Calendar Days of notification that the remittance is owed for the MLR reporting year. Report 29 is subject to audit and/or validation procedures. The remittance calculation and remittance amount will incorporate adjustments noted during audit and/or validation procedures. The remittance shall be paid to HCA within sixty (60) Calendar Days of notification that the remittance is owed for the MLR reporting year.

7.3 **Failure to Meet Agreement Requirements**

7.3.1 General

7.3.1.1 In the event that the CONTRACTOR or any person with an ownership interest in the CONTRACTOR, affiliate, parent, Subcontractor, Major Subcontractor or Contract Provider, fails to comply with this Agreement, HCA may impose, at HCA discretion, sanctions (inclusive of the specific monetary penalties and other penalties described in this Section 7.3).

7.3.1.2 Sanctions paid by the CONTRACTOR pursuant to this Section 7.3 shall be included as Administrative Expenses as described in Section 7.2 of this Agreement.

7.3.1.3 HCA retains the right to apply progressively strict sanctions against the CONTRACTOR, for failure to perform in any of the Agreement areas.

7.3.1.4 Any sanction, including the withholding of Capitation Payments, does not constitute just cause for the CONTRACTOR to interrupt providing Covered Services to Members.

7.3.1.5 HCA may impose any other administrative, contractual, or legal remedies available under State and federal law for the CONTRACTOR's noncompliance under this Agreement.

7.3.1.6 To promote transparency, HCA, at its sole discretion, may post actions (e.g., CAPS, monetary penalties, and sanctions) taken against the CONTRACTOR in

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accordance with Section 7.3, on the HCA website. HCA website post shall include the written notice of noncompliance described in Section 7.3.2.1, and a summary of the reason for the compliance action in easily understood language.

7.3.1.7 HCA will give the Collaborative written notice whenever it imposes or lifts a sanction for one (1) of the violations listed herein that relates to Behavioral Health.

7.3.1.8 HCA at its sole discretion, may direct the CONTRACTOR to expend any portion of monetary penalties for Provider network development or other program enhancements that will directly benefit Members. The CONTRACTOR's expenditures of monetary penalties are subject to the expenditure specifications, reporting, and monitoring requirements determined by HCA.

7.3.2 Corrective Action Plans

7.3.2.1 If HCA determines that the CONTRACTOR is not in compliance with one (1) or more requirements in this Agreement, HCA may issue a notice of noncompliance, identifying the deficiency(ies) and follow-up recommendations/requirements (either in the form of a Corrective Action Plan (CAP) or an HCA DCAP). A notice of noncompliance from HCA requiring a CAP or DCAP will also serve as a notice for sanctions in the event HCA determines that sanctions are also necessary.

7.3.2.2 The CONTRACTOR may dispute a notice of noncompliance in accordance with Section 7.11 of this Agreement.

7.3.2.3 The CONTRACTOR shall be required to provide CAPs to HC within fourteen (14) Calendar Days of receipt of a noncompliance notice from HCA unless otherwise directed by HCA. CAPs are subject to review and approval by HCA.

7.3.2.4 If HCA imposes a DCAP on the CONTRACTOR, the CONTRACTOR will have fourteen (14) Calendar Days, unless otherwise directed by HCA to respond to HCA.

7.3.2.5 If the CONTRACTOR does not effectively implement the CAP/DCAP within the time frame specified in the CAP/DCAP, HCA may impose additional sanctions.

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7.3.2.6 If HCA staff is required to spend ten (10) hours or more per week monitoring a CAP(s) or DCAP(s), HCA will provide notice to the CONTRACTOR that the CONTRACTOR must contract with a third party, either designated by HCA or approved by HCA, to oversee the CONTRACTOR's compliance with the CAP(s) or DCAP(s).

7.3.3 Sanctions

7.3.3.1 HCA may impose any or all of the non-monetary sanctions and monetary penalties based on determination of noncompliance as described in this section to the extent authorized by State and federal law. Nothing in this section prohibits HCA from imposing additional sanctions under State law that address areas of noncompliance specified in Section 7.3.3.1 of this Agreement, as well as additional areas of noncompliance.

7.3.3.2 Federal Basis for imposition of sanctions

HCA may impose non-monetary or monetary intermediate sanctions as specified in Sections 7.3.3.3, 7.3.3.4 and 7.3.3.5 of this Agreement, if HCA determines the CONTRACTOR acted or failed to act in the following ways.

7.3.3.2.1 Fails substantially to provide Medically Necessary services that the CONTRACTOR is required to provide, under law or under this Agreement, to a Member covered under the Agreement.

7.3.3.2.2 Imposes and/or collect Member’s premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

7.3.3.2.3 Acts to discriminate among Members on the basis of their health status or need for Covered Services. This includes CONTRACTOR-initiated transfers or refusal to re-enroll a Member, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by clients whose medical condition or history indicates probable need for substantial future Covered Services.

7.3.3.2.4 Misrepresents or falsifies information that it furnishes to CMS or to the State.

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7.3.3.2.5 Misrepresents or falsifies information that it furnishes to a Member, potential Member, or Provider.

7.3.3.2.6 Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210.

7.3.3.2.7 Distributes, directly or indirectly, through any Major Subcontractor, Subcontractor, or Contract Provider, Marketing or Member Materials that have not been approved by the State or that contain false or materially misleading information.

7.3.3.2.8 Violates any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, or any implementing regulations.

7.3.3.3 Non-monetary intermediate sanctions may include:

7.3.3.3.1 For determinations made under Section 7.3.3.2 of this Agreement, suspension of auto-assignment of Members who have not selected an MCO;

7.3.3.3.2 For determinations made under Section 7.3.3.2 of this Agreement, suspension of new enrollment with the CONTRACTOR;

7.3.3.3.3 For determinations made under Section 7.3.3.2 of this Agreement, notification to Members of their right to terminate enrollment with the CONTRACTOR, without cause, as described in 42 C.F.R. § 438.702(a)(3);

7.3.3.3.4 Disenrollment of Members by HCA;

7.3.3.3.5 For determinations made under Section 7.3.3.2 of this Agreement, suspension of payment for Members enrolled after the effective date of the sanction and until CMS or HCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

7.3.3.3.6 Rescission of Marketing consent and suspension of the CONTRACTOR's Marketing efforts;

7.3.3.3.7 Appointment of temporary management or any portion thereof as provided in 42 C.F.R. § 438.706 and the CONTRACTOR shall pay for any costs associated with the imposition of temporary management; and

7.3.3.3.8 Additional sanctions permitted under State and federal statute or regulations that address areas of noncompliance.

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7.3.3.4 Termination of the MCO Agreement

HCA may terminate the Agreement per Section 7.6 of this Agreement and enroll the CONTRACTOR's Members in other MCOs or provide their Covered Services through other options in the State Plan, if HCA determines that the CONTRACTOR has failed to carry out the substantive terms of the Agreement or has failed to meet applicable requirements of Section 1932 or 1903(m) of the Social Security Act. Prior to termination of the Agreement, HCA will provide a pre-termination hearing in accordance with 42 C.F.R. § 438.710.

7.3.3.5 Civil Monetary Penalties, as provided in 42 C.F.R. § 438.702(a), may be assessed as follows:

7.3.3.5.1 Twenty-five thousand dollars ($25,000) for each determination under Sections 7.3.3.2.1, 7.3.3.2.5, 7.3.3.2.6, or 7.3.3.2.7 of this Agreement;

7.3.3.5.2 One hundred thousand dollars ($100,000) for each determination under Sections 7.3.3.2.3 or 7.3.3.2.4 of this Agreement;

7.3.3.5.3 Fifteen thousand dollars ($15,000) for each Member, HCA determines was not enrolled because of a discriminatory practice under Section 7.3.3.2 of this Agreement; and

7.3.3.5.4 Twenty-five thousand dollars ($25,000) or double the amount of the excess charges, whichever is greater, for determinations under Section 7.3.3.2.2 of this Agreement. HCA will deduct the amount of the overcharge from the penalty and return the overcharge amount to the Member.

7.3.3.6 Other Monetary penalties may include:

7.3.3.6.1 Actual damages incurred by HCA and/or Members resulting from the CONTRACTOR' s non-performance of obligations under this Agreement;

7.3.3.6.2 Monetary penalties in an amount equal to the costs of obtaining alternative health benefits to a Member in the event of the CONTRACTOR's noncompliance in providing Covered Services. The monetary penalties shall include the difference in the Capitation Rates that would have been paid to the CONTRACTOR and the rates paid to the replacement MCO or health

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plan. HCA may withhold payment to the CONTRACTOR for damages until such damages are paid in full;

7.3.3.6.3 When HCA determines the CONTRACTOR has a deficiency in a specific area that is not improving, HCA may take certain actions to include the provision of trainings, webinars and/or on-site technical assistance until the issue is resolved. Such actions may result in a fee of up to five thousand dollars ($5,000) per day. The CONTRACTOR will be required to provide a dedicated workspace during the time that HCA is on-site;

7.3.3.6.4 Monetary penalties for noncompliance of this Agreement that may potentially involve risk or harm to Members or the integrity of the Turquoise Care program of up to five percent (5%) of the CONTRACTOR's Medicaid Capitation Payment for each month in which the penalty is assessed;

7.3.3.6.5 Other monetary penalties for failure to perform specific responsibilities or requirements as described in this Agreement are shown in the chart below; and

7.3.3.6.6 HCA reserves the right to assess a general monetary penalty of five hundred dollars ($500) per occurrence with any notice of noncompliance as outlined below:

7.3.3.6.7 Other Monetary Penalties

	PROGRAM ISSUES	PENALTY
1.	Failure to comply with Claims processing as described in Section 4.20 of this Agreement.	Up to two percent (2%) of the CONTRACTOR’s monthly Capitation Payment for each month that HCA determines that the CONTRACTOR is not in compliance with the requirements of Section 4.20 of this Agreement. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.

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	PROGRAM ISSUES	PENALTY
2.	Failure to comply with the requirements for arranging for a Member to receive care out-of-state as described in Sections 4.4.16.8, 4.8.1.5.2.3.1, and 4.8.5.3 of this Agreement.	Up to two percent (2%) of the CONTRACTOR's monthly Capitation Payment for each month that HCA determines that the CONTRACTOR is not in compliance with the requirements of Sections 4.4.16.8, 4.8.1.5.2.3.1, and 4.8.5.3. of this Agreement. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
3.	Failure to make directed payments on a timely basis as described in Attachment 10: Directed Payments of this Agreement.	Up to two percent (2%) of the CONTRACTOR's monthly Capitation Payment for each month that HCA determines that the CONTRACTOR is not in compliance with the requirements of Attachment 10: Directed Payments of this Agreement. HCA will determine the specific percentage of the capitation penalty based on the severity
4.	Failure to comply with Encounter Submission, including failure to comply with 837 PACDR upon implementation of MMIS-R, as described in Section 4.20of this Agreement.	Up to two percent (2%) of the CONTRACTOR's monthly Capitation Payment for each quarter in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
5.	Failure to assign a Member to the required Care Coordination Level (CCL0, CCL1, or CCL2) as described in Section 4.4 of this Agreement.	One thousand dollars ($1,000) per Member for which the CONTRACTOR fails to assign the Member to the required CCL.
6.	Failure to comply with the time frames for a CNA for Care Coordination Level one (1) and Level two (2) as described in Section 4.4 of this Agreement.	One thousand dollars ($1,000) per Member for which the CONTRACTOR fails to comply with the time frames for that Member.
7.	Failure to comply with Personnel Requirements as described in Sections 3.3 of this Agreement.	One thousand dollars ($1,000) per Calendar Day per position.

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	PROGRAM ISSUES	PENALTY
8.	Failure to meet performance standards for the Member services line, Provider services call center line, nurse triage/nurse advice line, and the UM line as described in Sections 4.11 and 4.16 of this Agreement.	Up to five percent (5%) of the CONTRACTOR's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.
9.	Failure to meet General Non-Emergency Medical Transportation (NEMT) minimum standards for Members to access appointments. This excludes critical care NEMT.	Up to five percent (5%) of the CONTRACTOR's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
10.	Failure to comply with Member transition of care requirements as described in Section 4.4 of this Agreement.	Five thousand dollars ($5,000) per Member in which the CONTRACTOR fails to comply with the transition of care requirements for that Member.
11.	Failure to meet appointment standards as described in Section 4.8 of this Agreement.	Up to two percent (2.0%) of the CONTRACTOR's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
12.	Failure to complete or comply with CAPs/DCAPs.	Up to two percent (2.0%) of the CONTRACTOR's monthly Capitation Payment per Calendar Day for each day the CAP is not completed or complied with as required. Up to five percent (5.0%) of the CONTRACTOR's monthly Capitation Payment per Calendar Day for each day the DCAP is not completed or complied with as required. HCA will determine the specific percentage of the capitation penalty based on the severity or frequency of the infraction.

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	PROGRAM ISSUES	PENALTY
13.	Failure to obtain approval of Member Materials as required by Section 4.15.1 of this Agreement.	Five thousand dollars ($5,000) per day for each Calendar Day that HCA determines the CONTRACTOR has distributed Member Material that has not been approved by HCA. The five thousand dollars ($5,000) per day damage amounts will double every ten (10) Calendar Days.
14.	Failure to comply with the time frame for responding to Grievances and Appeals required in Section 4.17 of this Agreement.	One thousand dollars ($1,000) per occurrence in which the CONTRACTOR fails to comply with the time frames.
15.	For every report that meets the definition for "Failure to Report" in accordance with Section 4.22 of this Agreement.	Five thousand dollars ($5,000) per report, per occurrence. With the exception of the cure period: One thousand dollars ($1,000) per report, per Calendar Day. The one thousand dollars ($1,000) per day damage amounts will double every ten (10) Calendar Days.
16.	Failure to submit timely Summary of Evidence in accordance with Section 4.17 of this Agreement.	Five thousand dollars ($5,000) per occurrence.
17.	Failure to have legal counsel appear in accordance with Section 4.17 of this Agreement.	Ten thousand dollars ($10,000) per occurrence.
18.	Failure to meet targets for the PMs described in Attachment 12: Turquoise Care PMs and TMs Table 12a PMs.	Three (3.0%) of the total capitation paid to the CONTRACTOR for the Agreement year, divided by the number of PMs specified in the Agreement year.
19.	Failure to meet DSIPTs as described in Section 6.9 and Attachment 2: Delivery System Improvement Performance Targets (DSIPTs) of this Agreement.	Two percent (2.0%) of Capitation Payments as specified in Section 6.9 of this Agreement, for failure to meet a DSIPT.
20.	Failure to pay Contract and Non-Contract Providers rates that comply with State Minimum Wage Requirements.	Up to five percent (5.0%) of the CONTRACTOR's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.

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	PROGRAM ISSUES	PENALTY
21.	HCA can modify and assess any monetary penalty if the CONTRACTOR engages in a pattern of behavior that constitutes a violation of this Agreement, or may potentially involve a risk of harm to Members or to the integrity of Turquoise Care. This may include, but is not limited to the following: Reporting metrics not met; failure to complete Care Coordination activities by the time frames specified within this Agreement; failure to report on required data elements in report submissions; for a report that has been rejected by and resubmitted by the CONTRACTOR up to three (3) times and the report still meets the definition of for "Failure to Report" in accordance with Section 4.22 of this Agreement.	Up to five percent (5.0%) of the CONTRACTOR's monthly Capitation Payment for each month in which the penalty is assessed. HCA will determine the specific percentage of the capitation penalty, taking into consideration factors reasonably related to the nature and severity of the infraction.
22.	Program Issue: Failure to meet D-SNP statewide phase in milestones in 1.10.	$500,000 for each year the CONTRACTOR does not have a D-SNP in good standing with CMS in the specified number of counties.

7.3.4 Payment of Monetary Penalties

7.3.4.1 HCA shall provide the CONTRACTOR with notice of any monetary penalties assessed at least thirty (30) Calendar Days before deducting such amounts from the monthly Capitation Payment. The collection of monetary penalties by HCA shall be made without regard to any Appeal rights the CONTRACTOR may have pursuant to this Agreement; however, in the event an Appeal by the CONTRACTOR results in a decision in favor of the CONTRACTOR, any such funds withheld by HCA will be immediately returned to the CONTRACTOR.

7.3.4.2 Monetary penalties as described in Section 7.3 of this Agreement are assessed by HCA to the CONTRACTOR and not to Major Subcontractors, Subcontractors, or Contract Providers. The CONTRACTOR shall be responsible to HCA for such monetary penalties.

7.3.5 Waiver of Sanctions

HCA may waive the application of sanctions (including monetary penalties) at its discretion if HCA determines that such waiver is in the best interests of the Turquoise

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Care program and its Members. Such waiver shall not constitute an ongoing waiver of sanctions or penalties.

7.3.6 Federal Sanctions

Payments provided for under this Agreement will be denied for new Members when, and for so long as, payment for those Members is denied by CMS in accordance with the requirements in 42 C.F.R. § 438.730.

7.4 Agreement Term

7.4.1 This Agreement, including any amendments and any changes made by notice to adjust the Capitation Rates, shall be effective upon signature of all parties and will terminate on December 31, 2026. Thereafter, HCA reserves the right to renew this Agreement for an additional one (1)-year period(s), not to exceed eight (8) years for the total term of the Agreement.

7.4.2 HCA reserves the right to extend this Agreement for an additional period or periods of time consistent with extensions of the 1115(a) Waiver provided that HCA notifies the CONTRACTOR in writing of its intention to do so at least six (6) months prior to the Agreement expiration date. An extension of the term of this Agreement will be made effective through an amendment to the Agreement.

7.4.3 At the option of HCA, the CONTRACTOR agrees to continue services under this Agreement when HCA determines that there is a public exigency that requires the services to continue. Continuation of services pursuant to this section shall be in three (3) month increments and the total of all public exigency extensions shall not exceed twelve (12) months. Thirty (30) Calendar Days written notice shall be given by HCA before this option is exercised.

7.5 Applicable Laws and Regulations

The CONTRACTOR agrees to comply with all applicable State and federal statutes, regulations, policies, consent decrees, executive orders and court orders, including Constitutional provisions regarding due process and equal protection of the law, including but not limited to:

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7.5.1 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 (42 U.S.C. 7401 et seq.);

7.5.2 Title IV and VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d) as implemented by regulations at 45 C.F.R. part 80;

7.5.3 Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 C.F.R. part 84;

7.5.4 Age Discrimination Act of 1975, 42 U.S.C. 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance, as implemented by regulations at 45 C.F.R. part 91;

7.5.5 Titles II and III of the Americans with Disabilities Act, 42 U.SC. 12101 et seq., and regulations issued pursuant thereto, 28 C.F.R. parts 35 and 36;

7.5.6 Title IX of the Education Amendments of 1972 regarding education programs and activities;

7.5.7 Equal Employment Opportunity (EEO) provisions;

7.5.8 Byrd Anti-Lobbying Amendment;

7.5.9 Indian Child Welfare Act (ICWA), 25 U.S.C. 1901 et seq., and the Indian Health Care Improvement Act;

7.5.10 PPACA;

7.5.11 New Mexico Human Rights Act (NMSA 1978, 28-1-1 et seq.);

7.5.12 The 1115(a) Waiver and all special terms and conditions agreed to with CMS that relate to the Waiver; and

7.5.13 Any and all consent decrees, court orders, legally binding agreements, federal program improvement plans and contracts related to Behavioral Health services entered into by the State.

7.6 **Termination**

In the event of termination, it is agreed that neither Party shall be relieved from any financial obligations each may owe to the other as a result of liabilities incurred during the

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course of this Agreement. For terminations pursuant to Sections 7.6.1, 7.6.2, 7.6.3, 7.6.4, or 7.6.6 of this Agreement, HCA will assume responsibility for informing all affected Members of the reasons for their termination from the CONTRACTOR's MCO.

7.6.1 Termination Under Mutual Agreement

Under mutual agreement, HCA and the CONTRACTOR may terminate this Agreement for any reason if it is in the best interest of HCA and the CONTRACTOR. Both Parties will sign a notice of termination which shall include, inter alia, the date of termination, conditions of termination and extent to which performance of work under this Agreement is terminated.

7.6.2 Termination by HCA for Cause

7.6.2.1 The CONTRACTOR shall be deemed to have breached this Agreement if any of the following occurs:

7.6.2.1.1 The CONTRACTOR fails to perform in accordance with any term or provision of the Agreement;

7.6.2.1.2 The CONTRACTOR renders only partial performance of any term or provision of the Agreement; or

7.6.2.1.3 The CONTRACTOR engages in any act prohibited or restricted by the Agreement.

7.6.2.1.4 In the event of a Breach by the CONTRACTOR for requirements in Section 1.10 of this Agreement, HCA shall implement the remedy in 7.6.2.3.4 if the CONTRACTOR does not have a D-SNP with statewide enrollment by January 1, 2029.

7.6.2.1.5

7.6.2.2 For purposes of Section 7.6, Subsections 7.6.2.1.1 through 7.6.2.1.3 of this Agreement shall hereinafter be referred to as "Breach."

7.6.2.3 In the event of a Breach by the CONTRACTOR, HCA shall have available any one (1) or more of the following remedies in addition to, or in lieu of, any other remedies set out in this Agreement or available in law or equity:

7.6.2.3.1 Recover actual damages, including incidental and consequential damages and any other remedy available at law or equity;

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7.6.2.3.2 Require that the CONTRACTOR prepare a plan to correct the cited deficiencies immediately, unless some longer time is allowed by HCA and implement this plan;

7.6.2.3.3 Recover any and/or all monetary penalties provided in Section 7.3 of this Agreement; and

7.6.2.3.4 Declare a default and terminate this Agreement.

7.6.2.4 In the event of a conflict between any other Agreement provisions and Section 7.6.2.3 of this Agreement, Section 7.6.2.3 of this Agreement shall control.

7.6.2.5 In the event of Breach by the CONTRACTOR, HCA shall provide the CONTRACTOR written notice of the Breach and thirty (30) Calendar Days to cure the Breach described in the notice. In the event that the CONTRACTOR fails to cure the Breach within the time period provided, then HCA shall have available any and all remedies described herein and available at law.

7.6.2.6 In the event the CONTRACTOR disagrees with the determination of noncompliance or designated corrective action described in the notice, the CONTRACTOR shall nevertheless implement said corrective action, without prejudice to any rights the CONTRACTOR may have to later dispute the finding of noncompliance or designated corrective action.

7.6.3 Termination for Unavailability of Funds

In the event that federal and/or State funds to finance this Agreement become unavailable, HCA may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. The CONTRACTOR shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date for uncompensated work performed on or after Go-Live. Availability of funds shall be determined solely by HCA. HCA's decision as to whether sufficient funds are available shall be accepted by the CONTRACTOR and shall be final.

7.6.4 Termination for CONTRACTOR Financial Inviability, Insolvency, or Bankruptcy

7.6.4.1 If HCA reasonably determines that the CONTRACTOR's financial condition is not sufficient to allow the CONTRACTOR to provide the services under this

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Agreement in the manner required by HCA. HCA may terminate this Agreement in whole or in part immediately or in stages. Said termination shall not be deemed a Breach by either Party. The CONTRACTOR's financial condition shall be presumed not sufficient to allow the CONTRACTOR to provide the services described in this Agreement in the manner required by HCA if the CONTRACTOR cannot demonstrate to HCA's satisfaction that the CONTRACTOR has risk reserves and a net worth to meet the applicable net worth requirement specified in Section 4.19.1 of this Agreement.

7.6.4.2 CONTRACTOR insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy by or against a Subcontractor, Major Subcontractor or Provider or the insolvency of said Subcontractor, Major Subcontractor or Provider, the CONTRACTOR shall immediately advise HCA.

7.6.5 Termination by HCA for Convenience

HCA may terminate this Agreement for convenience and without cause upon one hundred eighty (180) Calendar Days written notice. Said termination shall not be a Breach of the Agreement by HCA and HCA shall not be responsible to the CONTRACTOR or any other party for any costs, expenses or damages occasioned by said termination, e.g., without penalty.

7.6.6 Termination Related to the 1115(a) Waiver

7.6.6.1 The provisions of this Agreement are subject to the receipt of and continuation of a federal waiver granted to the State of New Mexico by CMS. Should the waiver cease to be effective, the State shall have the right to immediately terminate this Agreement.

7.6.6.2 In the event that there is a required modification, change or interpretation in State or federal law or the 1115(a) Waiver terms, because of court order, HCA may terminate this Agreement.

7.6.6.3 A termination under Section 7.6.6 of this Agreement shall not be a breach of this Agreement by HCA, and HCA shall not be responsible to the CONTRACTOR or

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any other party for any costs, expenses or damages occasioned by said termination.

7.6.6.4 In the event of a conflict between this Section 7.6.6 of this Agreement and any other term in this Agreement, Section 7.6.6 of this Agreement shall control.

7.6.7 Termination by the CONTRACTOR

7.6.7.1 The CONTRACTOR may terminate this Agreement, on at least ninety (90) Calendar Days prior written notice, in the event HCA fails to pay any amount due the CONTRACTOR hereunder within thirty (30) Calendar Days of the date such payments are due.

7.6.8 Termination and Expiration Procedures

7.6.8.1 The Party initiating the termination shall render written notice of termination to the other Party by certified mail, return receipt requested or in person with proof of delivery. The notice of termination shall specify the provision of this Agreement giving the right to terminate, the circumstances giving rise to termination and the date on which such termination shall become effective.

7.6.8.2 Upon termination or expiration of this Agreement, HCA shall pay the CONTRACTOR all amounts due for service from Go-Live through the effective date of such termination or expiration. HCA will withhold twenty-five percent (25%) of the full last monthly capitation cycle prior to the effective date of termination or expiration plus the average of any penalties and recoupments/sanctions for the past two (2) years. This withheld amount may also include any payments due from HCA to the CONTRACTOR for items subject to reconciliations and I/T/U payment reconciliation until all transition requirements are completed and approved by HCA. HCA may deduct from amounts otherwise payable to the CONTRACTOR monies determined to be due by HCA from the CONTRACTOR. Any amounts in dispute at the time of termination or expiration shall be placed by HCA in an interest-bearing escrow account with an escrow agent mutually agreed to by HCA and the CONTRACTOR.

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7.6.8.3 Upon receipt of notice of termination, and subject to the provisions of this section, on the date and to the extent specified in the notice of termination, the CONTRACTOR shall:

7.6.8.3.1 Not incur additional financial obligations for materials, services, or facilities under this Agreement, without prior written approval of HCA;

7.6.8.3.2 Terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as HCA may direct for orderly completion and transition or as required to prevent the CONTRACTOR from being in breach of its existing contractual obligations;

7.6.8.3.3 At the point of termination, assign to HCA in the manner and extent directed by HCA all the rights, title and interest of the CONTRACTOR in the subcontracts, in which case, HCA shall have the right, in its discretion, to settle or pay any of the Claims arising out of the termination of such agreements and subcontracts;

7.6.8.3.4 Complete the performance of such part of the Agreement that shall have not been terminated under the notice of termination;

7.6.8.3.5 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement that is in possession of the CONTRACTOR and in which HCA has or may acquire an interest;

7.6.8.3.6 In the event the Agreement is terminated by HCA, continue to serve or arrange for provision of services to the Members in the CONTRACTOR's MCO for up to forty-five (45) Calendar Days from the Agreement Termination Date or until the Members can be transferred to another MCO, whichever is longer. During this transition period, HCA shall continue to make payments as specified in Section 6 of this Agreement;

7.6.8.3.7 Promptly make available to HCA, or its designated entity, any and all records, whether medical, behavioral, related to LTC services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided, at no expense, to HCA or its designated entity;

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7.6.8.3.8 Promptly supply all information necessary to HCA, or its designated entity, for reimbursement of any outstanding Claims at the time of termination;

7.6.8.3.9 HCA will provide a termination plan template to the CONTRACTOR. The CONTRACTOR's completed termination plan shall be submitted to HCA within thirty (30) Calendar Days of receipt, for HCA's review and written approval. This plan shall, at a minimum, contain the provisions in Sections 7.6.8.3.10 through 7.6.8.3.16 below. The CONTRACTOR shall agree to make revisions to the plan, as necessary, in order to obtain approval by HCA. Failure to submit a termination plan and obtain written approval of the termination plan by HCA shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly Capitation Payment;

7.6.8.3.10 Agree to maintain Claims processing functions as necessary for a minimum of twenty-four (24) months in order to complete adjudication of all Claims;

7.6.8.3.11 Agree to comply with all duties and/or obligations incurred prior to the actual termination date of the Agreement, including but not limited to, the Appeal process as described in Section 4.17.3 of this Agreement;

7.6.8.3.12 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

7.6.8.3.13 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of Members from coverage under this Agreement to coverage under any new arrangement developed by HCA;

7.6.8.3.14 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after termination, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until HCA provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled;

7.6.8.3.15 The CONTRACTOR shall be responsible to HCA for monetary penalties arising out of the CONTRACTOR's breach of this Agreement; and

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7.6.8.3.16 Upon termination of this Agreement, submit reports to HCA every thirty (30) Calendar Days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to HCA describing how the CONTRACTOR has completed its continuing obligations. HCA shall, within twenty (20) Calendar Days of receipt of this report, advise, in writing, whether HCA agrees that the CONTRACTOR has fulfilled its continuing obligations. If HCA finds the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then HCA shall require the CONTRACTOR to submit a revised final report. HCA shall, in writing, notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of HCA that the CONTRACTOR has fulfilled its continuing obligations.

7.6.8.4 In the event that HCA terminates the Agreement for cause, in full or in part, HCA may procure services similar to those terminated and the CONTRACTOR shall be liable to HCA for any excess costs for such similar services for any calendar month for which the CONTRACTOR has been paid for providing services to Members. In addition, the CONTRACTOR shall be liable to HCA for administrative costs incurred by HCA in procuring such similar services. The rights and remedies of HCA provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

7.6.8.5 Any payments advanced to the CONTRACTOR for coverage of Members for periods after the date of termination shall be promptly returned to HCA. If termination of this Agreement occurs mid-month, the Capitation Payments for that month shall be apportioned on a daily basis. The CONTRACTOR shall be entitled to Capitation Payments for the period of time prior to the date of termination, and HCA shall be entitled to a refund for the balance of the month. All terminations shall include a final accounting of Capitation Payment received and number of Members during the month in which termination is effective.

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7.6.8.6 Upon the date of expiration of this Agreement, and subject to the provisions of this section, the CONTRACTOR shall:

7.6.8.6.1 Take such action as may be necessary, or as a contracting officer may direct, for the protection of property related to this Agreement that is in possession of the CONTRACTOR and in which HCA has or may acquire an interest;

7.6.8.6.2 Promptly make available to HCA, or its designated entity, any and all records, whether medical, behavioral, related to LTC services or financial, related to the CONTRACTOR's activities undertaken pursuant to this Agreement. Such records shall be in a usable form and shall be provided, at no expense, to HCA or its designated entity;

7.6.8.6.3 HCA will provide a termination plan template to the CONTRACTOR. The CONTRACTOR's completed termination plan shall be submitted to HCA within thirty (30) Calendar Days of receipt, for HCA's review and written approval. This plan shall, at a minimum, contain the provisions in Sections 7.6.8.6.4 through 7.6.8.6.9 below. The CONTRACTOR shall agree to make revisions to the plan, as necessary, in order to obtain written approval by HCA. Failure to submit a termination plan and obtain prior written approval of the termination plan by HCA shall result in the withhold of ten percent (10%) of the CONTRACTOR's monthly Capitation Payment;

7.6.8.6.4 Agree to maintain Claims processing functions as necessary for a minimum of twenty-four (24) months in order to complete adjudication of all Claims;

7.6.8.6.5 Agree to comply with all duties and/or obligations incurred prior to the actual expiration date of the Agreement, including but not limited to, the Appeal process as described in Section 4.17.3 of this Agreement;

7.6.8.6.6 File all reports concerning the CONTRACTOR's operations during the term of the Agreement in the manner described in this Agreement;

7.6.8.6.7 Take whatever other actions are necessary in order to ensure the efficient and orderly transition of Members from coverage under this Agreement to coverage under a new agreement as required by HCA;

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7.6.8.6.8 In order to ensure that the CONTRACTOR fulfills its continuing obligations both before and after expiration of this Agreement, maintain the financial requirements (as described in this Agreement as of the CONTRACTOR's date of termination notice), fidelity bonds and insurance set forth in this Agreement until HCA provides the CONTRACTOR written notice that all continuing obligations of this Agreement have been fulfilled;

7.6.8.6.9 Submit reports to HCA every thirty (30) Calendar Days detailing the CONTRACTOR's progress in completing its continuing obligations under this Agreement. The CONTRACTOR, upon completion of these continuing obligations, shall submit a final report to HCA describing how the CONTRACTOR has completed its continuing obligations. HCA shall, within twenty (20) Calendar Days of receipt of this report, advise, in writing, whether HCA agrees that the CONTRACTOR has fulfilled its continuing obligations. If HCA finds that the final report does not evidence that the CONTRACTOR has fulfilled its continuing obligations, then HCA shall require the CONTRACTOR to submit a revised final report. HCA shall, in writing, notify the CONTRACTOR once the CONTRACTOR has submitted a revised final report evidencing to the satisfaction of HCA that the CONTRACTOR has fulfilled its continuing obligations.

7.7 **Agreement Modification/Amendments**

7.7.1 Mutual Agreement

This Agreement may be amended at any time by mutual agreement of the Parties, except for rates, which may be amended in accordance with Section 6.6 of this Agreement. The amendment must be in writing and signed by individuals with authority to bind the Parties.

7.7.2 Changes in Law or Appropriation(s)

If State and federal statutes, regulations, policies, or guidelines are adopted, promulgated, judicially interpreted or changed or changes in State and federal appropriation(s) or other circumstances require a change in the way HCA manages its

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Medicaid program, this Agreement shall be subject to modification by amendment. Such election shall be effected by HCA sending written notice to the CONTRACTOR. HCA's decision as to the requirement for change in the scope of the Medicaid program shall be final and binding.

7.7.3 Modification Process

7.7.3.1 If HCA seeks modification to the Agreement, it shall provide notice to the CONTRACTOR that specifies those modifications, which may include the rates, or other terms and conditions.

7.7.3.2 The CONTRACTOR must respond to HCA's notice of proposed modification within ten (10) Business Days of receipt unless otherwise provided by HCA if the CONTRACTOR fails to respond, HCA will consider the proposed modification(s) acceptable to the CONTRACTOR and shall implement the proposed modification(s) as soon as practicable. Upon receipt of the CONTRACTOR's response to the proposed modifications, HCA may enter into negotiations with the CONTRACTOR to arrive at mutually agreeable amendments. In the event that HCA determines that the Parties will be unable to reach agreement on mutually satisfactory modifications, HCA will provide written notice to the CONTRACTOR of its intent to terminate this Agreement or not to extend the Agreement beyond the current term.

7.7.4 CMS Approval of the State's 1115(a) Waiver

In the event that approval of the State's 1115(a) Waiver is contingent upon amendment of this Agreement, the CONTRACTOR agrees to make any necessary amendments to obtain such waiver approval, provided, however, that the CONTRACTOR shall not be required to agree whether the modification is a substantial change to the business arrangement anticipated by the CONTRACTOR in executing this Agreement. Failure of the Parties to agree upon Capitation Rates to be incorporated by amendment will be deemed a substantial change to the business arrangement anticipated by the Parties. Notwithstanding the foregoing, any material change in the cost to the CONTRACTOR of providing the Covered Services herein that is caused by CMS in granting the waiver shall be negotiated and mutually agreed

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to between the Parties. The results of the negotiation shall be made in writing and incorporated into this Agreement.

7.7.5 CMS Approval of Amendments

Amendments, modifications, and changes to this Agreement are subject to the approval of CMS.

7.7.6 Required Compliance with Amendment and Modification Procedures

No different or additional services, work or products will be authorized or performed except as authorized by this section. No waiver of any term, covenant, or condition of this Agreement will be valid unless executed in compliance with this section. The CONTRACTOR will not be entitled to payments for any services, work, or products that are not authorized by a properly executed amendment or modification.

7.8 Intellectual Property and Copyright

7.8.1 Infringement and Misappropriation

7.8.1.1 The CONTRACTOR warrants that all materials provided by the CONTRACTOR will not infringe or misappropriate any right of, and will be free of any Claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

7.8.1.2 The CONTRACTOR will, at its expense, defend with counsel approved by HCA, indemnify and hold harmless HCA, its employees, officers, directors, CONTRACTORS, and agents from and against any losses, liabilities, damages, penalties, costs, and fees from any Claim or action against HCA that is based on a Claim of breach of the warranty set forth in Section 7.8.1.1 of this Agreement. HCA will promptly notify the CONTRACTOR, in writing, of the Claim, provide the CONTRACTOR a copy of all information received by HCA with respect to the Claim and cooperate with the CONTRACTOR in defending or settling the Claim. HCA will not unreasonably withhold, delay, or condition approval of counsel selected by the CONTRACTOR.

7.8.1.3 If materials are held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted, or if a proceeding appears to the

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CONTRACTOR to be likely to be brought, the CONTRACTOR will, at its own expense, either:

7.8.1.3.1 Procure for HCA the right to continue using the materials; or

7.8.1.3.2 Modify or replace the materials to comply with this Agreement and to not violate any intellectual property rights.

7.8.2 Exceptions

7.8.2.1 The CONTRACTOR is not responsible for any Claimed breaches of the warranties set forth in Section 7.8.1, above, to the extent caused by:

7.8.2.1.1 Modifications made to the item in question by anyone other than the CONTRACTOR or its Subcontractors, or modifications made by HCA or its CONTRACTORS working at HCA direction or in accordance with the specifications;

7.8.2.1.2 The combination, operation or use of the item with other terms if the CONTRACTOR did not supply or approve for use with the item; or

7.8.2.1.3 HCA's failure to use any new or corrected versions of the item made available by the CONTRACTOR.

7.8.3 Ownership and Licenses

7.8.3.1 The Parties agree that any materials, including without limitation, the Custom Software developed by the CONTRACTOR for the State, will be the exclusive property of HCA.

7.8.3.2 HCA will own all right, title, and interest in and to its Confidential Information and the materials provided by the CONTRACTOR, including without limitation the Custom Software and associated documentation. For purposes of this section, the materials will not include the CONTRACTOR's Proprietary Software or Third Party Software. The CONTRACTOR will take all actions necessary and transfer ownership of the materials to HCA including without limitation, the Custom Software and associated documentation prior to the termination of this Agreement.

7.8.3.3 The CONTRACTOR will furnish such material, upon request of HCA, in accordance with applicable State law. All materials, in whole and in part, will be

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deemed works made for hire of HCA for all purposes of copyright law, and the copyright will belong solely to HCA. To the extent that any materials do not qualify as a work made for hire under applicable law, and to the extent that the materials include items subject to copyright, patent, trade secret, or other proprietary right protection, the CONTRACTOR agrees to assign, and hereby assigns, all right, title, and interest in and to the materials, including without limitation, all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HCA.

7.8.3.4 The CONTRACTOR will, at HCA's expense, assist HCA or its nominee to obtain copyrights, trademarks, or patents for all such materials in the United States and any other countries. The CONTRACTOR agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign copyrights and patents, and to transfer, or cause to transfer, to HCA all the right, title, and interest in and to such materials. The CONTRACTOR also agrees not to assert any moral rights under applicable copyright law with regard to such materials.

7.8.3.5 License Rights

HCA will have a royalty-free and non-exclusive license to access the CONTRACTOR's Proprietary Software and associated documentation during the term of this Agreement. HCA shall also have ownership and unlimited rights to use, disclose, duplicate or publish all information and data developed, derived, documented or furnished by the CONTRACTOR under or resulting from this Agreement. Such data will include all results, technical information and materials developed for and/or obtained by HCA for the CONTRACTOR in the performance of the services hereunder, including but not limited to, all reports, surveys, plans, charts, recordings (video and/or audio), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda and documents (whether finished or unfinished) that result from, or are prepared in conjunction with, this Agreement.

7.8.3.6 Proprietary Notices

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The CONTRACTOR will reproduce and include HCA's copyright and other proprietary notices and product identifications provided by the CONTRACTOR on such copies, in whole or in part, or on any form of the materials.

7.8.3.7 State and Federal Governments

In accordance with 45 C.F.R. § 95.617, all appropriate State and federal agencies will have a royalty-free, nonexclusive and irrevocable license to reproduce, publish, translate or otherwise use, and to authorize others to use, for federal government purposes, all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under this Agreement, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

7.9 **Appropriations**

7.9.1 The terms of this Agreement are contingent upon sufficient appropriations or authorizations being made by the New Mexico Legislature, CMS, or the U.S. Congress for the performance of this Agreement. If sufficient appropriations and authorizations are not made by the New Mexico Legislature, CMS, or the U.S. Congress, this Agreement shall be subject to termination or amendment. Subject to the provisions of Section 7.9 of this Agreement, the State's decision as to whether sufficient appropriations or authorizations exist shall be accepted by the CONTRACTOR and shall be final and binding. Any changes to the scope of work and compensation to the CONTRACTOR affected pursuant to this Section 7.9 shall be negotiated, reduced to writing and signed by the Parties in accordance with Section 7.7 of this Agreement and any other applicable State or federal statutes or regulations.

7.9.2 To the extent CMS, legislation, or congressional action impacts the amount of appropriation available for performance under this Agreement, HCA has the right to amend the CONTRACTOR's scope of work, at its discretion, which shall be effected by HCA sending written notice to the CONTRACTOR. Any changes to the scope of work and compensation to the CONTRACTOR affected pursuant to this Section 7.9

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shall be negotiated, reduced to writing and signed by the Parties in accordance with Section 7.7 of this Agreement and any other applicable State or federal statutes or regulations.

7.10 **Governing Law**

This Agreement shall be governed by the statutes of the State of New Mexico. All legal proceedings arising from unresolved disputes under this Agreement shall be brought before the First Judicial District Court in Santa Fe, New Mexico.

7.11 **Disputes**

7.11.1 The entire agreement shall consist of: (i) this Agreement, including all attachments and any amendments; (ii) the RFPs, HCA's written clarifications to the RFPs and CONTRACTOR's responses to RFP questions, where not inconsistent with the terms of this Agreement or its amendments; and (iii) the CONTRACTOR's additional responses to the RFPs, where not inconsistent with the terms of this Agreement or its amendments, all of which are incorporated herein or by reference.

7.11.2 In the event of a dispute under this Agreement, the various documents shall be referred to for the purpose of clarification or for additional detail in the order of priority and significance, specified below:

7.11.2.1 Amendments to the Agreement in reverse chronological order followed by;

7.11.2.2 The Agreements, including all attachments followed by; and

7.11.2.3 The RFPs, including attachments thereto and HCA's written responses to written questions and HCA's written clarifications, and the CONTRACTOR's response to the RFPs, including both technical and cost portions of the response (but only those portions of the CONTRACTOR's response, including both technical and cost portions of the response, that do not conflict with the terms of this Agreement and its amendments).

7.11.3 <u>Dispute Procedures for Other than Contract Termination</u>

7.11.3.1 Except for termination of this Agreement, any dispute concerning remedies, sanctions and/or damages imposed under Section 7.3 of this Agreement shall be reported, in writing, to the MAD Director within thirty (30) Calendar Days of the

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date the CONTRACTOR receives notice of the sanction. The decision of the MAD Director regarding the dispute shall be delivered to the disputing party, in writing, within sixty (60) Calendar Days of the date the MAD Director receives the written dispute. The decision shall be final and conclusive unless, within thirty (30) Calendar Days from the date the decision is received, a written Appeal is filed with the Secretary of HCA.

7.11.3.2 Any other dispute concerning performance of the Agreement shall be reported, in writing to the MAD Director within thirty (30) Calendar Days of the date the reporting Party knew of the activity or incident giving rise to the dispute. The decision of the MAD Director shall be delivered to the Parties in writing within sixty (60) Calendar Days and shall be final and conclusive unless, within thirty (30) Calendar Days from the date of the decision, either Party files with the Secretary of HCA a written Appeal of the decision of the MAD Director.

7.11.3.3 Failure to file a timely Appeal shall be deemed acceptance of the MAD Director's decision and waiver of any further Claim.

7.11.3.4 In any Appeal under this section, the CONTRACTOR and HCA shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Secretary of HCA or their designee. The Appeal is an informal hearing that shall not be recorded or transcribed and is not subject to formal rules of evidence or procedure.

7.11.3.5 The Secretary of HCA, or their designee, shall acknowledge receipt of the Appeal within thirty (30) Calendar Days and shall schedule and hold an informal hearing within one hundred twenty (120) Calendar Days of receipt of the Appeal. The Secretary of HCA or their designee, shall review the issues and evidence presented and issue a determination, in writing, within thirty (30) Calendar Days of the informal hearing that shall conclude the administrative process available to the Parties. These time frames shall be followed unless otherwise agreed to by the Parties in writing or extended by the Secretary of HCA for good cause. Either Party may Appeal to the District Court; however, the Appeal will be subject to a record rather than de novo review.

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7.11.3.6 Pending decision by the Secretary of HCA, both Parties shall proceed diligently with performance of this Agreement in accordance with the terms of this Agreement.

7.11.3.7 Failure to initiate or participate in any part of this process shall be deemed waiver of any Claim.

7.11.4 Dispute Procedures for Contract Termination

7.11.4.1 In the event HCA seeks to terminate this Agreement, the CONTRACTOR may Appeal the termination to the Secretary of HCA within ten (10) Business Days of receiving HCA's termination notice.

7.11.4.2 The Secretary of HCA will conduct a formal hearing on the termination within thirty (30) Calendar Days after receipt of the written Appeal. Either Party may Appeal to the District Court; however, the Appeal will be subject to a record rather than de novo review.

7.12 **Status of CONTRACTOR and CONTRACTOR's Personnel**

7.12.1 Status of CONTRACTOR

7.12.1.1 The CONTRACTOR is an independent contractor performing professional services for HCA and is not an employee of the State of New Mexico. The CONTRACTOR shall not accrue leave, retirement, insurance, bonding, use State vehicles, or any other benefits afforded to State employees. The CONTRACTOR acknowledges that all sums received hereunder are reportable by the CONTRACTOR for tax purposes.

7.12.1.2 The CONTRACTOR shall be solely responsible for all applicable taxes, insurance, licensing, and other costs of doing business. Should the CONTRACTOR default in these or other responsibilities, jeopardizing the CONTRACTOR's ability to perform services, this Agreement may be terminated for cause in accordance with the terms of this Agreement.

7.12.1.3 The CONTRACTOR shall not purport to bind HCA, its officers, directors, employees, or the State of New Mexico, to any obligation not expressly

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authorized herein, unless HCA has expressly given the CONTRACTOR the authority to do so, in writing.

7.12.2 No Third-Party Beneficiaries

Only the Parties to this Agreement, and their successors in interest and assigns, have any rights or remedies under, or by reason of, this Agreement.

7.12.3 Conduct of the CONTRACTOR's Personnel and Subcontractors

7.12.3.1 While performing the services required under this Agreement, the CONTRACTOR's personnel and Subcontractors must:

7.12.3.1.1 Comply with applicable State and federal statutes, regulations and program guidelines and HCA's requests regarding personal and professional conduct; and

7.12.3.1.2 Otherwise conduct themselves in a business-like and professional manner.

7.12.3.2 Notwithstanding Section 3.3 of this Agreement, if HCA determines in good faith that a particular employee or Subcontractor is not conducting themselves in accordance with this Agreement, HCA may provide the CONTRACTOR with notice and documentation concerning such conduct. Upon receipt of such notice, the CONTRACTOR shall promptly investigate the matter and take appropriate action, which may include:

7.12.3.2.1 Removing the employee or Subcontractor;

7.12.3.2.2 Providing HCA with written notice of such removal; and

7.12.3.2.3 Replacing the employee or Subcontractor with a similarly qualified individual acceptable to HCA.

7.12.3.3 The CONTRACTOR agrees that anyone employed or retained by the CONTRACTOR to fulfill the terms of this Agreement remains under the CONTRACTOR's sole direction and control.

7.12.3.4 The CONTRACTOR must have policies regarding disciplinary action for all employees who have failed to comply with State and/or federal statutes and regulations or the CONTRACTOR's standards of conduct, policies and procedures, and requirements under this Agreement. The CONTRACTOR must

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have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

7.13 **Assignment**

With the exception of provider agreements or other subcontracts expressly permitted under this Agreement, the CONTRACTOR shall not assign, transfer, or delegate any rights, obligations, duties, or other interest in this Agreement or assign any Claim for money due or to become due under this Agreement, except with the prior written consent of HCA.

7.14 **Major Subcontractors and Subcontractors**

7.14.1 Prohibited Subcontracting Relationships

7.14.1.1 The CONTRACTOR shall not subcontract the provision of Behavioral Health services to a managed, risk-bearing Behavioral Health organization.

7.14.1.2 The CONTRACTOR shall not subcontract Member Services to any other entity.

7.14.1.3 The CONTRACTOR may subcontract Utilization Management to another entity upon prior written approval of HCA. Under such an arrangement, Utilization Management must be transparent and seamless to the Members.

7.14.2 Subcontract Relationships and Delegation

7.14.2.1 If the CONTRACTOR delegates responsibilities to a Major Subcontractor or a Subcontractor, the CONTRACTOR shall ensure that the subcontracting relationship and subcontracting document(s) comply with federal requirements, including but not limited to, compliance with the applicable provisions of 42 C.F.R. § 438.230(b) through (c):

7.14.2.1.1 The CONTRACTOR shall evaluate and certify to HCA that the delegated entity has the ability to perform the activities to be delegated;

7.14.2.1.2 The CONTRACTOR shall require that the delegation be in writing and specify the delegated activities and report responsibilities and provide for revoking delegation or imposing other sanctions if the delegated entity's performance is inadequate;

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7.14.2.1.3 The CONTRACTOR shall monitor the delegated entity's performance on an ongoing basis and subject it to formal review, on at least an annual basis, consistent with NCQA standards and State MCO statutes and regulations;

7.14.2.1.4 The CONTRACTOR shall identify deficiencies or areas for improvement, and the CONTRACTOR and the delegated entity shall take corrective action as necessary. When a CONTRACTOR identifies one or more areas of noncompliance with the delegated entity, the CONTRACTOR shall notify HCA within ten (10) Calendar Days of identification; and

7.14.2.1.5 If the subcontract is with a Major Subcontractor, for purposes of providing or securing the provision of Covered Services to Members, the CONTRACTOR shall ensure that all requirements described in Section 4.9 of this Agreement are included in the subcontract and/or a separate provider agreement is executed by the appropriate Parties.

7.14.2.2 The CONTRACTOR shall have and implement policies and procedures to ensure that the delegated entity meets all standards of performance mandated by HCA for the Turquoise Care program. These include, but are not limited to, use of appropriately qualified staff, the application of clinical practice guidelines and Utilization Management, reporting capability and ensuring Members' access to care.

7.14.2.3 The CONTRACTOR shall have and implement policies and procedures for the oversight of the performance of the subcontracted functions.

7.14.2.4 The CONTRACTOR shall maintain policies and procedures for verifying that the credentials of all its Contract Providers, Major Subcontractors, and Subcontractors meet applicable standards as stated in this Agreement, including all Attachments.

7.14.2.5 The CONTRACTOR must provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) about its Grievance and Appeals system to all Major Subcontractors and Subcontractors at the time they enter into mutual contract.

7.14.2.6 The CONTRACTOR must conduct an annual evaluation of its delegated entities that includes the review of policies and procedures, an audit of applicable files or

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records, and implementation of a corrective action plan, if warranted. The CONTRACTOR shall provide HCA a copy of all annual evaluation results and applicable supporting documents by January 30 following the year of evaluation. If a delegated entity is under a corrective action plan, the CONTRACTOR must conduct the annual review on-site.

7.14.2.7 The CONTRACTOR must notify HCA, and the Collaborative to the extent Behavioral Health services are involved, if any of the delegated entities are under a CAP and provide regular updates, as directed by HCA until the CAP is closed.

7.14.2.8 HCA maintains the right to review all transactions from a delegated entity to the CONTRACTOR at any time.

7.14.3 Legal Responsibility

7.14.3.1 The CONTRACTOR is solely responsible for fulfillment of this Agreement. HCA shall make payments only to the CONTRACTOR.

7.14.3.2 In the event that any Major Subcontractor is incapable of performing the service contracted for by the CONTRACTOR, the CONTRACTOR shall assume responsibility for providing the services that the Major Subcontractor is incapable of performing. The CONTRACTOR must provide any Covered Services directly until the CONTRACTOR identifies and contracts with a Provider(s) or Major Subcontractor to provide such services.

7.14.3.3 In the event that any Subcontractor is incapable of performing any functions contracted for by the CONTRACTOR, the CONTRACTOR shall assume responsibility for the functions the Subcontractor is incapable of performing. The CONTRACTOR must perform any functions, until the CONTRACTOR identifies and contracts with an appropriate Subcontractor.

7.14.3.4 Subcontractor Compliance for Excluded State-Funded Services

7.14.3.4.1 Flow-down. The CONTRACTOR shall incorporate obligations applicable to Excluded State-Funded Services into all relevant subcontracts, including PBMs, UM vendors, clearinghouses, data integrators, and quality/reporting delegates, covering the carve-out, deny and redirect edits, encounter/MLR suppression, technical specifications, privacy, and records handling.

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7.14.3.4.2 Oversight. The CONTRACTOR remains responsible for subcontractor performance; it shall implement pre-go live validation and quarterly audits of subcontractor controls and obtain quarterly certifications of compliance.

7.14.3.4.3 Incident reporting. The CONTRACTOR shall notify the State within one (1) business day of identification of any failure of edits/suppression or misrouting involving Excluded State Funded Services and shall implement corrective action as directed by the State.

7.14.3.5

7.14.4 Prior Approval

7.14.4.1 The CONTRACTOR shall give HCA prior notice with regard to its intent to subcontract certain significant contract requirements, as specified herein or in writing by HCA including but not limited to, credentialing and Claims processing. HCA receives the right to disallow a proposed subcontracting arrangement if the proposed Subcontractor has been formally restricted from participating in a federal entitlement program (e.g., Medicare, Medicaid), for other good cause, or as otherwise determined by HCA.

7.14.4.2 The CONTRACTOR shall give HCA prior notice with regard to its intent to subcontract Covered Services to a Major Subcontractor, as specified herein or in writing by HCA including but not limited to, DME and transportation services. HCA reserves the right to disallow a proposed subcontracting arrangement if the proposed Major Subcontractor has been formally restricted from participating in a federal entitlement program (e.g., Medicare, Medicaid) for other good cause or as otherwise determined by HCA.

7.14.4.3 All subcontracts, revisions, and terminations thereto shall be approved in advance in writing by HCA. The CONTRACTOR shall not assign, transfer, or delegate any key functions to a Subcontractor or Major Subcontractor without the explicit prior written approval of HCA. The CONTRACTOR shall revise subcontracts as directed by HCA. Once a subcontract has been executed by all of the participating parties, a copy of the fully executed subcontract shall be sent to HCA within thirty (30) Calendar Days of execution. This written prior approval

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requirement does not relieve the CONTRACTOR of any responsibilities to submit all proposed material modifications of the CONTRACTOR's operations to HCA for prior review and written approval.

7.14.5 Minimum Requirements for Subcontracts

The CONTRACTOR's subcontracts shall include the following:

7.14.5.1 The requirements in Section 4.9 of this Agreement, as applicable;

7.14.5.2 The relationship between the CONTRACTOR and the Subcontractor or Major Subcontractor, including if the Subcontractor or Major Subcontractor is a subsidiary of the CONTRACTOR or within the CONTRACTOR's corporate organization;

7.14.5.3 The responsibilities of the CONTRACTOR and the Subcontractor or Major Subcontractor;

7.14.5.4 The frequency of reporting (if applicable) to the CONTRACTOR;

7.14.5.5 The process by which the CONTRACTOR evaluates the Subcontractor or Major Subcontractor;

7.14.5.6 Certification language as described in Section 7.24.3 of this Agreement;

7.14.5.7 Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 1857(h)), Section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 C.F.R. part 15);

7.14.5.8 The requirements for submission of Encounter Data, as applicable;

7.14.5.9 The remedies, including the revocation of the delegation, available to the CONTRACTOR if the delegate does not fulfill its obligations; and

7.14.5.10 That Major Subcontractors and Subcontractors agree to hold harmless the State and the CONTRACTOR's Members in the event that the CONTRACTOR cannot or shall not pay for services performed by the Major Subcontractor or Subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the CONTRACTOR and Major Subcontractor or Subcontractor agreement for authorized services rendered prior

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to the termination of the agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members.

7.14.6 Disclosure Requirements

As required by 45 C.F.R. § 76, or other applicable federal regulations, the CONTRACTOR shall require each proposed first-tier Subcontractor or Major Subcontractor whose subcontract will equal or exceed twenty-five thousand dollars ($25,000) to disclose to the CONTRACTOR, in writing, whether as of the time of award of the subcontract, the Subcontractor, Major Subcontractor or its principals, is or is not debarred, suspended, or proposed for debarment by any federal department or agency. The CONTRACTOR shall make such disclosures available to HCA when it requests Subcontractor or Major Subcontractor approval from HCA pursuant to Section 7.14.4 of this Agreement. If the Subcontractor, Major Subcontractor or its principals, is debarred, suspended, or proposed for debarment by any federal department or agency, HCA may refuse to approve the use of the Subcontractor or Major Subcontractor.

7.14.7 Notice of Subcontractor or Major Subcontractor Termination

7.14.7.1 When a subcontract related to the provision of services or subcontracted function is being terminated, the CONTRACTOR shall give at least thirty (30) Calendar Days prior written notice of the termination to HCA.

7.14.7.2 If the CONTRACTOR changes Subcontractors for a specific subcontracted function during the term of this Agreement, the CONTRACTOR shall pay an independent monitor, as selected by HCA, to determine whether the new Subcontractor is ready to perform the subcontracted function. The CONTRACTOR shall not make any payments to the new Subcontractor until the Subcontractor has been determined ready.

7.14.8 Cooperation with Other Contractors

HCA, the Collaborative, or the State may undertake or award other agreements for work related to the tasks described in this Agreement, or any portion therein. The CONTRACTOR shall fully cooperate with such other Contractors and with HCA and the State in all such cases.

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7.15 **Release**

7.15.1 Upon final payment of the amounts due under this Agreement, unless the CONTRACTOR objects, in writing, to such payment within one hundred eighty (180) Calendar Days, the CONTRACTOR shall release HCA, its officers and employees, and the State of New Mexico from all such payment obligations whatsoever under this Agreement. The CONTRACTOR agrees not to purport to bind the State of New Mexico. If the CONTRACTOR objects in a timely manner to such payment, such objection shall be addressed in accordance with the dispute provisions provided for in this Agreement.

7.15.2 Payment to the CONTRACTOR by HCA shall not constitute final release of the CONTRACTOR. Should audit or inspection of the CONTRACTOR's records or the CONTRACTOR's Member Grievances subsequently reveal outstanding CONTRACTOR liabilities or obligations, the CONTRACTOR shall remain liable to HCA for such obligations. Any payments by HCA to the CONTRACTOR shall be subject to any appropriate recoupment by the State.

Notice of any post-termination audit or investigation of complaint by HCA shall be provided to the CONTRACTOR, and such audit or investigation shall be initiated in accordance with CMS requirements. HCA shall notify the CONTRACTOR of any Claim or demand within thirty (30) Calendar Days after completion of the audit or investigation or as otherwise authorized by CMS or applicable regulations. Any payments by HCA to the CONTRACTOR shall be subject to any appropriate recoupment by the State in accordance with the provisions of Section 7.15.2 of this Agreement.

7.16 **Change in Organizational Structure**

7.16.1 The CONTRACTOR shall notify and obtain prior written approval from HCA at least one hundred and eighty (180) Calendar Days prior to the effective date of a Change in Organizational Structure.

7.16.2 The CONTRACTOR's request for approval must include a description of the proposed Change in Organizational Structure; the new entity's ability to meet the requirements of this Agreement; a detailed transition plan to ensure uninterrupted

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services to Members and Provider payments; and any other information requested by HCA to support the CONTRACTOR's request.

7.16.3 HCA may approve the CONTRACTOR's request with or without conditions, including but not limited one (1) or more of the following: (i) executing an amendment to this Agreement, (ii) participating in a readiness review conducted by HCA to ensure the new entity demonstrates readiness to perform under this Agreement, (iii) allowing for an open enrollment or disenroll without cause, or (iv) changing the auto-assignment algorithm to manage the new entity's share of enrollment.

7.16.4 HCA may deny the CONTRACTOR's request if HCA determines that the Change in Organizational Structure is not in the best interest of the State or Members.

7.16.5 If the CONTRACTOR fails to obtain prior written approval from HCA or HCA denies the CONTRACTOR's request and the CONTRACTOR moves forward with the Change in Organizational Structure, HCA may terminate this Agreement pursuant to Section 7.6 of this Agreement.

7.17 **Records and Audit**

7.17.1 Maintenance of Medical Records

The CONTRACTOR shall maintain and shall require its Subcontractors, Major Subcontractors, and Contract Providers to maintain appropriate records in accordance with State and federal statutes and regulations relating to the CONTRACTOR's performance under this Agreement. Records include but are not limited to, all Covered Services provided to Members. A separate medical record shall be maintained for each Member on paper and/or in electronic format in a manner that is legible, current, and organized and shall be produced timely as directed by HCA. Medical records must permit effective and confidential Member care and quality review.

7.17.2 Financial Records

7.17.2.1 The CONTRACTOR agrees to maintain and require its Major Subcontractors, Subcontractors, and Contract Providers to maintain records, books, documents,

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and information that are adequate to ensure that services are provided and payments are made in accordance with the requirements of this Agreement, including Encounter Data and audited financial reports, information relating to adequate provision against the risk of insolvency, the MLR report in Section 7.2 of this Agreement, and the annual report on overpayments, and including applicable State and federal requirements (e.g., 45 C.F.R. § 74.53).

7.17.2.2 The CONTRACTOR shall retain, and require its Major Subcontractors, Subcontractors, and Contract Providers to retain, records identified in Section 7.17.2.1 of this Agreement for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.17.3 Grievance and/or Appeal Files

7.17.3.1 All Member Grievance and/or Appeal and Provider complaint files shall be maintained in a secure, designated area and be accessible to HCA upon request, for review. Grievance, Appeal, and Provider complaint files shall be retained for ten (10) years following the final decision by the CONTRACTOR, HCA Judicial Appeal or closure of a file, whichever occurs later.

7.17.3.2 The CONTRACTOR will have procedures for ensuring that files contain sufficient information to identify the Grievance, Appeal, and/or Provider complaint; the date it was received; the nature of the Grievance, Appeal, and/or Provider complaint; notice to the Member of receipt of the Grievance and/or Appeal or notice to the Provider of receipt of the Provider complaint; all correspondence between the CONTRACTOR and the Member, the Member's Representative(s), and/or the Provider; the date the Grievance, Appeal, and/or Provider complaint is resolved; the resolution and notices of final decision to the Member, the Member's Representative(s) and/or Provider; and all other pertinent information.

7.17.3.3 Documentation regarding the Grievance and/or Appeal shall be made available to the Member, if requested.

7.17.4 Program Integrity Related Records, Books, and Documents

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7.17.4.1 The CONTRACTOR agrees to maintain and require its Major Subcontractors and Subcontractors to maintain, records, books, documents and information on ownership and control, as required in 42 C.F.R. § 455.104 and prohibited affiliations, as specified in 42 C.F.R. § 438.610.

7.17.4.2 The records, books, documents and information in Section 7.17.2.1 of this Agreement shall be maintained for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.17.5 Provider Network Records, Books, and Documents

7.17.5.1 The CONTRACTOR agrees to maintain and require its Contract Providers to maintain, records, books, documents and information related to the adequacy of the provider network as specified in Section 4.8.1 of this Agreement and 42 C.F.R. § 438.207.

7.17.5.2 The records, books, documents and information in Section 7.17.5 of this Agreement.1 shall be maintained for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

7.17.6 Access to Records, Books, and Documents

7.17.6.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its Subcontractors, Major Subcontractors, and Contract Providers to provide the officials and entities identified in Section 7.17.6.3 of this Agreement with reasonable and adequate access to any personnel or records that are related to the scope of work performed under this Agreement within two (2) Business Days after the date of the request, unless the records are held by a Subcontractor, Major Subcontractor, Contract Provider, agent, or satellite office, in which case the records shall be made available within ten (10) Business Days, NMSA 1978, § 27-11- 4(B) and 42 C.F.R. § 438.3(h). Failure to provide copies or to permit inspection of records requested shall constitute a violation of the Medicaid Provider and Managed Care Act.

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7.17.6.2 The CONTRACTOR and its Subcontractors and Major Subcontractors must provide the access described in this section upon HCA's request through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with 42 C.F.R. § 438.3(h), 42 C.F.R. § 438.230(c)(3)(iii), and 42 C.F.R. § 438.3(k). This request may be for, but is not limited to, the following purposes:

7.17.6.2.1 Examination;

7.17.6.2.2 Audit;

7.17.6.2.3 Investigation;

7.17.6.2.4 Agreement administration; or

7.17.6.2.5 The making of copies, excerpts, or transcripts.

7.17.6.3 The access required must be provided to the following officials and/or entities:

7.17.6.3.1 The United States Department of Health and Human Services or its designee;

7.17.6.3.2 The Comptroller General of the United States or its designee;

7.17.6.3.3 HCA personnel or its designee;

7.17.6.3.4 HCA's Office of Inspector General;

7.17.6.3.5 The Collaborative personnel or designee;

7.17.6.3.6 MFEAD or its designee;

7.17.6.3.7 Any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of HCA;

7.17.6.3.8 The Office of the State Auditor or its designee;

7.17.6.3.9 A State or federal law enforcement agency;

7.17.6.3.10 A special or general investigating committee of the New Mexico Legislature or its designee; and

7.17.6.3.11 Any other State or federal entity identified by HCA, or any other entity engaged by HCA.

7.17.6.4 The CONTRACTOR agrees to provide the access described wherever the CONTRACTOR maintains such books, records, and supporting documentation. The CONTRACTOR further agrees to provide such access in reasonable comfort

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and to provide any furnishings, equipment, or other conveniences deemed necessary to fulfill the purposes described in this section. The CONTRACTOR will require its Subcontractors, Major Subcontractors, and Contract Providers to provide comparable access and accommodations.

7.17.6.5 Upon request, the CONTRACTOR must provide copies of the information described in this section free of charge to HCA and the entities described in this section.

7.17.7 The requirements of maintaining records, books, documents, and information will include all medical, business, and financial records. All other records, books, documentation, and information resulting from this Agreement and maintained by the CONTRACTOR, Subcontractors, Major Subcontractors, or Contract Providers must be retained for a period of at least ten (10) years from the date of creation.

7.18 **Indemnification**

7.18.1 The CONTRACTOR agrees to indemnify, defend, and hold harmless the State of New Mexico, its officers, agents, and employees from any and all Claims and losses accruing or resulting from any and all CONTRACTOR employees, agents, Subcontractors or Major Subcontractors in connection with the breach or failure to perform, or erroneous or negligent acts or omissions in the performance of this Agreement, and from any and all Claims and losses accruing or resulting to any person, association, partnership, entity or corporation that may be injured or damaged by the CONTRACTOR in the performance, or failure in performance, of this Agreement resulting from such acts of omissions. The provisions of this Section 7.18.1 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, in whole or in part, the acts of omissions of the State of New Mexico or any of its officers, employees or agents.

7.18.2 The CONTRACTOR shall at all times during the term of this Agreement, indemnify and hold harmless the State against any and all liability, loss, damage, costs or expenses that the State may sustain, incur or be required to pay: (i) by reason of any Member suffering personal injury, death or property loss or damage of any kind as a

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result of the erroneous or negligent acts or omissions of the CONTRACTOR, either while participating with or receiving care or services from the CONTRACTOR, under this Agreement; or (ii) while on premises owned, leased, or operated by the CONTRACTOR or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for, or in the control of, the CONTRACTOR or any officer, agent, Subcontractor, Major Subcontractor, or employee thereof. The provisions of this section shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, or any of its officers, employees or agents. In the event that any action, suit or proceeding, except the CONTRACTOR's Appeal and grievance reviews or other administrative process, related to the services performed by the CONTRACTOR or any officer, agent, employee, servant or Subcontractor or Major Subcontractor under this Agreement is brought against the CONTRACTOR, the CONTRACTOR shall, as soon as practicable but no later than two (2) Business Days after it receives notice thereof, notify the legal counsel of HCA and the Risk Management Division of the New Mexico General Services Department by certified mail.

7.18.3 The CONTRACTOR shall agree to indemnify and hold harmless the State, its agents, and employees from any and all Claims, lawsuits, administrative proceedings, judgments, losses, or damages, including court costs and attorney fees, or causes of action, caused by reason of the CONTRACTOR's erroneous or negligent acts or omissions, including the following:

7.18.3.1 Any Claims or losses attributable to any persons or firm injured or damaged by erroneous or negligent acts, including without limitation, disregard of federal or State Medicaid regulations or statutes by the CONTRACTOR, its officers, employees, Subcontractors, or Major Subcontractors in the performance of the Agreement, regardless of whether the State knew or should have known of such erroneous or negligent acts; unless the State of New Mexico, or any of its officers, employees or agents directed in writing to the performance of such acts; and

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7.18.3.2 Any Claims or losses attributable to any person or firm injured or damaged by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement in a manner not authorized by the Agreement or by State and federal regulations or statutes, regardless of whether the State knew or should have known of such publication, translation, reproduction, delivery, performance, use, or disposition, unless the State of New Mexico, or any of its officers, employees or agents directed or affirmatively consented in writing to such publication, translation, reproduction, delivery, performance, use or disposition.

7.18.4 The provisions of this Section 7.17 shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, or any of its officers, employees, or agents and is not deemed to be a waiver of any and all of the CONTRACTOR's legal rights to pursue indemnity actions and/or disputed Claims arising from allegations involving the actions of the State and the CONTRACTOR.

7.18.5 The CONTRACTOR, including its Subcontractors and Major Subcontractors, agrees that in no event, including but not limited to, nonpayment by the CONTRACTOR, insolvency of the CONTRACTOR or breach of this Agreement, shall the CONTRACTOR or its Subcontractor or Major Subcontractor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against a Member or persons (other than the CONTRACTOR) acting on their behalf for services provided pursuant to this Agreement except for any Medicaid population required to make copayments under HCA's policy. In no case, shall HCA and/or Members be liable for any debts of the CONTRACTOR.

7.18.6 The CONTRACTOR agrees that the above indemnification provisions shall survive the termination of this Agreement, regardless of the cause giving rise to termination. This provision is not intended to apply to services provided after this Agreement has been terminated.

7.18.7 HCA shall notify the CONTRACTOR of any Claim, loss, damage, suit or action as soon as HCA reasonably believes that such Claim, loss, damage, suit or action may

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give rise to a right to indemnification under this section. The failure of HCA, however, to deliver such notice shall not relieve the CONTRACTOR of its obligation to indemnify HCA under this section. Prior to entering into any settlement for which it may seek indemnification under this section, HCA shall consult with the CONTRACTOR, but the CONTRACTOR need not approve the settlement. Nothing in this provision shall be interpreted as a waiver of the State's right to indemnification. HCA shall permit the CONTRACTOR, at the CONTRACTOR's option and expense, to assume the defense of such asserted Claim(s) using counsel acceptable to HCA and to settle or otherwise dispose of the same, by and with the consent of HCA, such consent shall not be unreasonably withheld. Failure to give prompt notice as provided herein shall not relieve the CONTRACTOR of its obligations hereunder, except to the extent that the defense of any Claim for loss is prejudiced by such failure to give timely notice.

7.19 **Liability**

7.19.1 The CONTRACTOR shall be wholly at risk for all Covered Services. No additional payment shall be made by HCA, nor shall any payment be collected from a Member, except for copayments authorized by HCA, the State statutes or regulations.

7.19.2 The CONTRACTOR is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Agreement. HCA shall accept no responsibility for refunding to the CONTRACTOR any such excess payments unless the State of New Mexico, or any of its officers, employees or agents directed such services to be rendered or payment made.

7.19.3 The CONTRACTOR, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Agreement.

7.20 **Rights to Property**

All equipment and other property provided or reimbursed to the CONTRACTOR by HCA is the property of HCA and shall be turned over to HCA at the time of termination or expiration of this Agreement, unless otherwise agreed to in writing. In addition, in regard to the performance of experimental, developmental or research done by the

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CONTRACTOR, the State shall determine the rights of the federal government and the Parties to this Agreement in any resulting invention.

7.21 **Erroneous Issuance of Payment or Benefits**

In the event of an error that causes payment(s) to the CONTRACTOR to be issued by HCA, HCA shall deduct amounts from future Capitation Payments after thirty (30) Calendar Days of written notice of such error.

7.22 **Excusable Delays**

7.22.1 The CONTRACTOR shall be excused from performance hereunder for any period that it is prevented from performing any services hereunder, in whole or in part as, a result of an act of nature, war, civil disturbance, court order or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder nor grounds for termination of the Agreement.

7.22.2 Suspensions under Force Majeure shall require the Party seeking suspension to give notification to the other Parties at least five (5) Business Days before the imposition of the suspension. The receiving Party will be deemed to have agreed to such suspension, unless having posted to mail such objection or non-consent within five (5) Business Days of receipt of request for suspension. The performance of any Party's obligations under the Agreement shall be suspended during the period that any circumstances of Force Majeure persists or for a consecutive period of ninety (90) Calendar Days, whichever is shorter, and such Party shall be granted an extension of time for performance equal to the period of suspension.

7.22.3 In addition, the CONTRACTOR shall be excused from performance hereunder for insufficient payment by HCA provided the CONTRACTOR notifies HCA in writing of its intent to suspend performance, and HCA is unable to remedy the monetary shortfall within forty-five (45) Calendar Days.

7.23 **Prohibition of Bribes, Gratuities and Kickbacks**

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7.23.1 Pursuant to the State of New Mexico statutes and regulations, the receipt or solicitation of bribes, gratuities, and kickbacks is strictly prohibited.

7.23.2 No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual employed by the State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise there from.

7.23.3 HCA may, by written notice to the CONTRACTOR, immediately terminate the right of the CONTRACTOR to proceed under the Agreement if it is found, after notice and hearing by the Secretary of HCA or their duly authorized representative, that gratuities in the form of entertainment, gifts or otherwise were offered or given by the CONTRACTOR, or any agent or representative of the CONTRACTOR, to any officer or employee of the State of New Mexico with a view toward securing the Agreement or securing favorable treatment with respect to the award or amending or making of any determinations with respect to the performing of such Agreement. In the event the Agreement is terminated as provided in this section, the State of New Mexico shall be entitled to pursue the same remedies against the CONTRACTOR as it would pursue in the event of a breach of contract by the CONTRACTOR and as a penalty in addition to any other damages to which it may be entitled by law.

7.24 **Lobbying**

7.24.1 The CONTRACTOR certifies by signing this Agreement, to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 C.F.R. § 93 and 31 U.S.C. § 1352. This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement imposed under 31 U.S.C. § 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than ten thousand dollars ($10,000) and not more than one hundred thousand dollars ($100,000) for such failure.

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7.24.2 The CONTRACTOR shall disclose any lobbying activities using non-federal funds, in accordance with 45 C.F.R. § 93.

7.24.3 The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

7.25 **Conflict of Interest**

7.25.1 The CONTRACTOR represents and warrants that it has complied with, and during the term of this Agreement, will continue to comply with, and that this Agreement complies with, all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978 and 42 C.F.R. § 438.58. Without in any way limiting the generality of the foregoing, the CONTRACTOR specifically represents and warrants that:

7.25.1.1 In accordance with NMSA 1978, § 10-16-4.3, the CONTRACTOR does not employ, has not employed and will not employ during the term of this Agreement any HCA employee while such employee was or is employed by HCA participating directly or indirectly in HCA's contracting process;

7.25.1.2 This Agreement complies with NMSA 1978, § 10-16-7(A) because:

7.25.1.2.1 The CONTRACTOR is not a public officer or employee of the State of New Mexico;

7.25.1.2.2 The CONTRACTOR is not a Member of the family of a public officer or employee of the State of New Mexico;

7.25.1.2.3 The CONTRACTOR is not a business in which a public officer or employee, or the family of a public officer or employee, of the State of New Mexico has a substantial interest; or

7.25.1.2.4 If the CONTRACTOR is a public officer or employee of the State of New Mexico, a Member of the family of a public officer, employee of the State of New Mexico or an employee of the State who has a substantial interest,

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public notice was given, as required, by NMSA 1978, § 10-16-7(A), and this Agreement was awarded pursuant to a competitive process.

7.25.1.3 In accordance with NMSA 1978, § 10-16-8(A):

7.25.1.3.1 The CONTRACTOR is not, and has not been, represented by a person who has been a public officer or employee of the State of New Mexico within the preceding year and whose official act directly resulted in this Agreement; and

7.25.1.3.2 The CONTRACTOR is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the State of New Mexico whose official act, while in State employment, directly resulted in HCA's or the Collaborative making this Agreement.

7.25.1.4 This Agreement complies with NMSA 1978, § 10-16-9(A) because:

7.25.1.4.1 The CONTRACTOR is not a legislator;

7.25.1.4.2 The CONTRACTOR is not a Member of a legislator's family;

7.25.1.4.3 The CONTRACTOR is not a business in which a legislator or a legislator's family has a substantial interest; or

7.25.1.4.4 If the CONTRACTOR is a legislator, a Member of a legislator's family, or a business in which a legislator or legislator's family has a substantial interest, disclosure has been made as required by NMSA 1978, § 10-16-9(A), this Agreement is not a sole source or small purchase contract, and this Agreement was awarded in accordance with the provisions of the Procurement Code, NMSA 1978, 13-1-28 et seq.

7.25.1.5 In accordance with NMSA 1978, § 10-16-13, the CONTRACTOR has not directly participated in the preparation of specifications, qualifications, or evaluation criteria for this Agreement or any procurement related to this Agreement.

7.25.1.6 In accordance with NMSA 1978, § 10-16-3 and 10-16-13.3, the CONTRACTOR has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of HCA.

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7.25.2 The CONTRACTOR's representation and warranties in Section 7.24 of this Agreement.1 are material representations of fact upon which HCA relied when this Agreement was entered into by the Parties. The CONTRACTOR shall provide immediate written notice to HCA, at any time during the term of this Agreement, the CONTRACTOR learns that the CONTRACTOR's representations and warranties in Section 7.24 of this Agreement were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that the CONTRACTOR's representations and warranties in Section 7.24 of this Agreement were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to HCA and notwithstanding anything in this Agreement to the contrary, HCA may immediately terminate this Agreement.

7.26 **Health Insurance Portability and Accountability Act Compliance**

7.26.1 The CONTRACTOR must comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the CONTRACTOR's management information system (MIS) complies with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. The CONTRACTOR must comply with HIPAA EDI requirements.

7.26.2 The CONTRACTOR must comply with HIPAA notification requirements, including those set forth in the HITECH Act, 45 C.F.R. § 164.410, and related regulations. The CONTRACTOR must notify HCA of all breaches or potential breaches of unencrypted protected health information, as such protected health information pertains to the Related Agreement and any amendments thereto, and as defined by the HITECH Act, without unreasonable delay. If, in HCA determination, the CONTRACTOR has not provided notice in the manner or format prescribed by the HITECH Act, and its related regulation, then HCA may require the CONTRACTOR to provide such notice.

7.26.2.1 In addition to the requirements identified in 7.25.2, the CONTRACTOR must notify HCA no later than five (5) Calendar Days after discovery of the breach or

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potential breach to include the date and circumstances of the breach or potential breach and the number of Members who might be affected. CONTRACTOR shall continue to keep HCA updated as directed by HCA.

7.26.3 Unless otherwise required by State and federal statutes or regulations, any ambiguity or inconsistency between the provisions of the Contract and the Business Associate Agreement, attached hereto as Exhibit A and incorporated herein, shall be resolved in favor of the Contract.

7.27 **Disclosure and Confidentiality of Information**

7.27.1 Confidentiality

7.27.1.1 The CONTRACTOR, its employees, agents, Subcontractors, Major Subcontractors, consultants or advisors must treat all information that is obtained through Providers performance of the services under this Agreement, including but not limited to, information relating to Members, potential recipients of HCA and the Collaborative programs, as Confidential Information to the extent that confidential treatment is provided under State and federal statute and regulations.

7.27.1.2 The CONTRACTOR is responsible for understanding the degree to which information obtained through the performance of this Agreement is confidential under State and federal statute and regulations.

7.27.1.3 The CONTRACTOR and all Subcontractors, Major Subcontractors, consultants, advisors or agents shall not use any information obtained through performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement.

7.27.1.4 Within sixty (60) Calendar Days of the effective date of this Agreement, the CONTRACTOR shall develop and provide to HCA for review and written approval, written policies and procedures for the protection of all records and all other documents deemed confidential under this Agreement.

7.27.1.5 Any disclosure or transfer of Confidential Information by the CONTRACTOR, including information required by HCA and/or the Collaborative, will be in accordance with applicable law. If the CONTRACTOR receives a request for

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information deemed confidential under this Agreement, the CONTRACTOR will immediately notify HCA of such request and will make reasonable efforts to protect the information from public disclosure.

7.27.1.6 In addition to the requirements expressly stated in this section, the CONTRACTOR must comply with 42 C.F.R. § 438.224, any policy, or reasonable requirement of HCA that relates to the safeguarding or disclosure of information relating to Members, the CONTRACTOR's operations or the CONTRACTOR's performance of this Agreement.

7.27.1.7 In the event of the expiration of this Agreement, or termination thereof for any reason, all Confidential Information disclosed to and all copies thereof made by the CONTRACTOR must be returned to HCA or, at HCA's option, erased or destroyed. The CONTRACTOR must provide HCA certificates evidencing such destruction.

7.27.1.8 The CONTRACTOR's contracts with practitioners and other Providers shall explicitly state expectations about the confidentiality of HCA's Confidential Information and Member records.

7.27.1.9 The CONTRACTOR shall afford Members and/or Representatives the opportunity to approve or deny the release of identifiable personal information by the CONTRACTOR to a person or entity outside of the CONTRACTOR, except to duly authorized Subcontractors, Major Subcontractors, Providers or review organizations, or when such release is required by law, regulation or quality standards.

7.27.1.10 The obligations of this section must not restrict any disclosure by the CONTRACTOR pursuant to any applicable law, or under any court or government agency, provided the CONTRACTOR must give prompt notice to HCA of such order.

7.27.2 Disclosure of HCA's Confidential Information

7.27.2.1 The CONTRACTOR shall immediately report to HCA any and all unauthorized disclosures or uses of Confidential Information of which it or its Subcontractors, Major Subcontractors, Providers, consultants or agents is aware or has

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knowledge. The CONTRACTOR acknowledges that any publication or disclosure of Confidential Information to others may cause immediate and irreparable harm to HCA and may constitute a violation of State or federal statutes. If the CONTRACTOR, its Subcontractors, Major Subcontractors, Providers, consultants or agents should publish or disclose Confidential Information to others without authorization, HCA will immediately be entitled to injunctive relief, or any other remedies to which it is entitled, under law or equity. HCA will have the right to recover from the CONTRACTOR all damages and liabilities caused by, or arising from, the CONTRACTOR's, its Subcontractors', Major Subcontractors', Providers', representatives', consultants' or agents' failure to protect Confidential Information. The CONTRACTOR will defend with counsel approved by HCA, indemnify and hold harmless HCA from all damages, costs, liabilities and expenses caused by or arising from the CONTRACTOR's, or its Subcontractors', Major Subcontractors' Providers', representatives', consultants' or agents' failure to protect Confidential Information. HCA will not unreasonably withhold approval of counsel selected by the CONTRACTOR.

7.27.2.2 The CONTRACTOR will require its Subcontractors, Major Subcontractor, Providers, consultants and agents to comply with the terms of this section.

7.27.3 Member Records

7.27.3.1 The CONTRACTOR must comply with the requirements of State and federal statutes, including the HIPAA requirements set forth in this Agreement, regarding the transfer of Member records.

7.27.3.2 The CONTRACTOR shall have an appropriate system in effect to protect substance abuse Member records from inappropriate disclosure in accordance with 42 U.S.C. § 300x-53(b) and 45 C.F.R. § 96.13(e).

7.27.3.3 If this Agreement is terminated, HCA may require the transfer of Member records, upon written notice to the CONTRACTOR, to another entity, as consistent with State and federal statutes and regulations and applicable releases.

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7.27.3.4 The term "Member record" for this section means only those administrative, enrollment, case management, and other such records maintained by the CONTRACTOR and is not intended to include Member records maintained by participating Contract Providers.

7.27.4 Requests for Public Information

7.27.4.1 When the CONTRACTOR produces reports or other forms of information that the CONTRACTOR believes consist of proprietary or otherwise Confidential Information, the CONTRACTOR must clearly mark such information as Confidential Information or provide written notice to HCA that it considers the information confidential.

7.27.4.2 If HCA receives a request, filed in accordance with the New Mexico Inspection of Public Records Act, NMSA 1978, 14-2-1 et seq. ("IPRA") seeking information that has been identified by the CONTRACTOR as proprietary or otherwise confidential, HCA will deliver a copy of the IPRA request to the CONTRACTOR.

7.27.5 Unauthorized Acts

7.27.5.1 Each Party agrees to:

7.27.5.1.1 Notify the other Parties promptly of any unauthorized possession, use, knowledge or attempt thereof, by any person or entity that may become known to it, of any Confidential Information or any information identified as confidential or proprietary;

7.27.5.1.2 Promptly furnish to the other Parties full details of the unauthorized possession, use, knowledge, or attempt thereof and use reasonable efforts to assist the other Parties in investigating or preventing the reoccurrence of any unauthorized possession, use, knowledge or attempt thereof of Confidential Information;

7.27.5.1.3 Cooperate with the other Parties in any litigation and investigation against third parties deemed necessary by such Party to protect its proprietary rights; and

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7.27.5.1.4 Promptly prevent a recurrence of any such unauthorized possession, use or knowledge of such information.

7.27.6 Information Security

7.27.6.1 The CONTRACTOR and all its Subcontractors, Major Subcontractors, Providers, consultants, representatives, Providers, and agents must comply with all applicable statutes and regulations regarding information security, including without limitation, the following:

7.27.6.1.1 Health and Human Services Enterprise Information Security Standards and Guidelines;

7.27.6.1.2 HIPAA;

7.27.6.1.3 HITECH Act; and

7.27.6.1.4 NMAC 1.12.20 et seq.

7.28 **Cooperation Regarding Fraud**

7.28.1 The CONTRACTOR shall make an initial report to HCA 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 HCA and submit any applicable evidence in support of its findings. If HCA decides to refer the matter to the MFEAD or another State or federal investigative agency, HCA will notify the CONTRACTOR within ten (10) Business Days of making the referral. The CONTRACTOR shall cooperate fully with any and all requests from MFEAD or other State or federal investigative agency for additional documentation or other types of collaboration in accordance with applicable law.

7.28.2 The CONTRACTOR shall cooperate fully in any investigation by the MFEAD, or other State or federal agency, as well as any subsequent legal action that may result from such investigation. The CONTRACTOR and its Subcontractors, Major Subcontractors, and Contract Providers shall within two (2) to ten (10) Business Days after the date of request, in accordance with NMSA 1978, § 27-11- 4(B), make

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available to the MFEAD or other State or federal agency conducting an investigation, any and all administrative, financial, and medical records relating to the delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, the MFEAD or other State or federal agency shall be allowed to have access during normal business hours to the place of business and all records of the CONTRACTOR and its Subcontractors, Major Subcontractors, and Providers, except under special circumstances when after hour's access shall be allowed. Special circumstances shall be determined by the MFEAD or other State or federal agency.

7.28.3 The CONTRACTOR shall disclose to HCA, the Collaborative, MFEAD and any other State or federal agency charged with overseeing the Turquoise Care program, full and complete information regarding ownership, significant financial transactions or financial transactions relating to or affecting the Turquoise Care program between the CONTRACTOR and persons related to the CONTRACTOR convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.

7.28.4 The CONTRACTOR shall refer any actual or potential conflict of interest to MFEAD. The CONTRACTOR also shall refer to MFEAD any instance where a financial or material benefit is given by any representative, agent, or employee of the CONTRACTOR to HCA, or any other Party with direct responsibility for this Agreement. In addition, the CONTRACTOR shall notify MFEAD if it hires or enters into any business relationship with any person who, within two (2) years previous to that hiring or contract, was employed by HCA in a capacity relating to the Turquoise Care program, the program previously known as Centennial Care, or any other Party with direct responsibility for this Agreement.

7.28.5 Any recoupment received from the CONTRACTOR by HCA pursuant to the provisions of Section 7.3 of this Agreement herein shall not preclude the Collaborative, MFEAD or any other State or federal agency from exercising its right to criminal prosecution, civil prosecution or any applicable civil penalties, administrative fines or other remedies. Any Medicaid funds identified in any action by MFEAD or other prosecutorial agency, whether the action is civil or criminal, shall be returned to HCA. The funds shall not be retained by the CONTRACTOR.

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The amount returned to HCA should be determined according to the adjudicated Claims retained from the time the suspension of payment was initiated.

7.28.6 Upon request to the CONTRACTOR, MFEAD or any other State or federal agency shall be provided with copies of all Grievances and resolutions affecting Members.

7.28.7 Should the CONTRACTOR know about or become aware of any investigation being conducted by MFEAD or another State or federal agency, the CONTRACTOR, and its representatives, agents and employees, shall maintain the confidentiality of this information.

7.28.8 The CONTRACTOR shall have in place and enforce policies and procedures to educate Members of the existence of, and role of, MFEAD.

7.28.9 The CONTRACTOR shall have in place and enforce policies and procedures for the detection and deterrence of Fraud. These policies and procedures shall include specific requirements governing who within the CONTRACTOR's organization is responsible for these activities, how these activities shall be conducted, and how the CONTRACTOR shall address cases of suspected Fraud and Abuse.

7.28.10 All documents submitted by the CONTRACTOR to HCA and/or the Collaborative, if developed or generated by the CONTRACTOR, or its agents, shall be deemed to be certified by the CONTRACTOR as submitted under penalty of perjury.

7.28.11 Referrals For Credible Allegations Of Fraud

7.28.11.1 The CONTRACTOR shall report to HCA suspected cases of Fraud whenever there are credible allegations of Fraud. The CONTRACTOR shall follow HCA direction in identifying and reporting cases of credible allegations of Fraud. HCA shall make the final determination of whether to refer such cases to MFEAD, and other law enforcement agencies, for further investigation. HCA's directions to the CONTRACTOR may include, but is not limited to:

7.28.11.1.1 At HCA's direction, the CONTRACTOR shall suspend all Medicaid payments, in whole or in part, as directed by HCA to a provider after HCA has certified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HCA may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part.

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Should HCA suspend payments in whole, upon receipt of HCA's notice, the CONTRACTOR: (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pended Claims or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HCA. Should the CONTRACTOR fail to comply with this provision, HCA may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HCA's notice;

7.28.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law;

7.28.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HCA, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HCA.

7.28.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.28.11.1.4.1 A determination by HCA, MFEAD or its Authorized Agent or designee that there is insufficient evidence of fraud by the provider;

7.28.11.1.4.2 The dismissal of all charges and/or Claims against the provider related to the provider's alleged fraud by a court of competent jurisdiction; or

7.28.11.1.4.3 For other good cause as determined solely by HCA; and

7.28.11.1.5 The CONTRACTOR shall continue the suspension of payments, in whole or in part, until further notified, in writing, by HCA to release suspended funds. The CONTRACTOR shall release funds, as directed, within fourteen (14) Business Days of the date of release authorization.

7.28.11.2 Should HCA require the CONTRACTOR’s assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract

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services review and/or staff interviews, HCA and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

7.28.11.3 Following the referral of a Provider or Subcontractor based on a determination of a credible allegation of fraud, and during the pendency of a dispute between HCA and a Provider or Subcontractor regarding an alleged overpayment, including an overpayment based in whole or in part on a credible allegation of fraud, HCA shall direct the CONTRACTOR to not suspend participation or withhold payment to the Provider or subcontractor if the Provider or Subcontractor:

7.28.11.3.1 Submits to the CONTRACTOR prepayment review of claims for ongoing services;

7.28.11.3.2 Demonstrates to the CONTRACTOR that its employees have completed remedial training or education required by HCA to prevent the submission of claims for payment to which the Medicaid Provider or Subcontractor is not entitled; and

7.28.11.3.3 Engages an independent third party approved by the CONTRACTOR to temporarily manage or provide technical assistance to the Provider or Subcontractor following the referral or during the pendency of the dispute.

7.28.11.4 The CONTRACTOR shall not unreasonably withhold approval of a third party proposed by the Medicaid Provider or Subcontractor pursuant to Section 7.28.11.3.3 of this Agreement. The CONTRACTOR shall submit evidence that the above requirements have been met to the State's OIG and the OIG will determine compliance with the requirements and report back to the CONTRACTOR.

7.28.11.4.1 A Provider or Subcontractor that has been found to have successfully complied with the above requirements shall be reimbursed for each clean claim for ongoing services within ten (10) Calendar Days of receipt if submitted electronically or thirty (30) Calendar Days if submitted manually.

7.28.12 Recovery for Fraud/False Claims

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7.28.12.1 Should MFEAD or HCA pursue what it alleges are false and/or fraudulent Claims as permitted under law and identified by the CONTRACTOR against a Provider, any recovery (either by the Provider making payment, collection on a judgment or restitution) shall be divided as follows:

7.28.12.1.1 HCA shall recoup and remit to CMS the federal share, if applicable;

7.28.12.1.2 HCA shall retain the non-federal share and be reimbursed for any and all costs associated with any program integrity or similar audit that results in the identification and/or recovery of false and/or fraudulent Claims and for HCA professional and associated costs for transitioning recipients, when applicable; and

7.28.12.1.3 For any remaining amount of the non-federal share, HCA shall remit to the CONTRACTOR for:

7.28.12.1.3.1 Aggregate Recovery in excess of twenty-five thousand dollars ($25,000) but less than one hundred thousand dollars ($100,000), forty percent (40%) of the non-federal share;

7.28.12.1.3.2 Aggregate recovery in excess of one hundred thousand dollars ($100,000) but less than two hundred and fifty thousand dollars ($250,000), thirty percent (30%) of the non-federal share; or

7.28.12.1.3.3 Aggregate recovery in excess of two hundred and fifty thousand dollars ($250,000), twenty-five percent (25%) of the non-federal share.

7.28.12.1.4 HCA and the CONTRACTOR shall work together in good faith to come to a mutually agreeable process for any remittance due the CONTRACTOR and how that remittance will be treated for purposes of the medical loss ratio.

7.28.12.1.5 HCA shall provide the CONTRACTOR with quarterly reports regarding any recovery for which the CONTRACTOR may be entitled to a remittance.

7.28.13 The CONTRACTOR is not entitled to any recovery under this subsection when MFEAD and/or HCA independently identifies and pursues false Claims and/or fraudulent Claims.

7.29 **Waivers**

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7.29.1 No term or provision of this Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing by the Party Claimed to have waived or consented.

7.29.2 A waiver by any Party hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition or agreement herein contained.

7.30 **Suspension, Debarment and Other Responsibility Matters**

7.30.1 Pursuant to either 7 C.F.R. § 3017 or 45 C.F.R. § 76, as applicable, and other applicable federal regulations, the CONTRACTOR certifies by signing this Agreement, that it and its principals, to the best of its knowledge and belief and except as otherwise disclosed in writing by the CONTRACTOR to HCA 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 7.28; (iv) have not, within a three (3) year period preceding the effective date of this Agreement, had one (1) 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

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CONTRACTOR shall not employ or have any relationship or affiliation with an individual or entity that has been excluded from participation in health care programs pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1320a- 7 and other applicable federal statutes and regulations. The CONTRACTOR shall not be an entity that must be excluded pursuant to 42 C.F.R. § 438.610 and § 438.808(b).

7.30.2 The CONTRACTOR's certification in Section 7.28.1 of this Agreement is a material representation of fact upon which HCA and the Collaborative relied when this Agreement was entered into by the Parties. The CONTRACTOR shall provide immediate written notice to HCA and the Collaborative, if, at any time during the term of this Agreement, the CONTRACTOR learns that its certification in Section 7.28.1 of this Agreement was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances. If it is later determined that the CONTRACTOR's certification in Section 7.28.1 of this Agreement was erroneous on the effective date of this Agreement or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to HCA and the Collaborative, HCA and the Collaborative may terminate the Agreement.

7.31 **New Mexico Employees' Health Coverage**

7.31.1 If the CONTRACTOR has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least twenty (20) hours per week over a six (6) month period during the term of this Agreement, the CONTRACTOR certifies, by signing this Agreement, to have in place, and agree to maintain for the term of this Agreement, health insurance for those employees and offer that health insurance to those employees.

7.31.2 The CONTRACTOR agrees to maintain a record of the number of employees who have:

7.31.2.1 Accepted health insurance;

7.31.2.2 Declined health insurance due to other health insurance coverage already in place; or

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7.31.2.3 Declined health insurance for other reasons.

7.31.3 These records are subject to review and audit by a representative of the State.

7.32 **Duty to Cooperate**

The Parties agree that they will cooperate in carrying out the intent and purpose of this Agreement. This duty includes, specifically, an obligation by the Parties to continue performance of the Agreement in the spirit it was written in the event they identify any possible errors or problems associated with the performance of their respective obligations under this Agreement.

7.33 **Entire Agreement/Merger**

This Agreement incorporates all the agreements, covenants, and understandings between the Parties hereto concerning the subject matter hereof, and all such covenants, agreements, and understandings have been merged into this written Agreement. No prior agreement or understanding, verbal or otherwise, of the Parties or their agents shall be valid or enforceable unless embodied in this Agreement. Except for those revisions required by CMS, State or federal requirements, revisions to the original Agreement shall require an amendment agreed to by both Parties.

7.34 **Penalties for Violation of Law**

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation.

7.35 **Workers' Compensation**

The CONTRACTOR agrees to comply with State statutes and regulations applicable to workers' compensation benefits for its employees.

7.36 **Severability**

If any provision of this Agreement is construed to be illegal, invalid, or unenforceable, such interpretation and/or determination will not affect the legality or validity of any other provisions. The illegal, invalid, or unenforceable provision will be deemed stricken and

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deleted to the same extent and effect as if never incorporated into this Agreement, with all other provisions remaining in full force and effect.

7.37 **Technical Assistance**

Technical assistance shall be provided to the CONTRACTOR when deemed appropriate by HCA or the Collaborative.

7.38 **Use of Data**

HCA and the Collaborative shall have unlimited, but not exclusive, rights to use, disclose, or duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by the CONTRACTOR resulting from this Agreement. However, HCA and the Collaborative shall not disclose proprietary information that is afforded confidential status by State or federal law.

7.39 **Titles/Headings**

Titles of paragraphs or section headings used in this Agreement are for the purpose of facilitating use or reference only and shall not be considered in the interpretation of this Agreement.

7.40 **Attorneys' Fees**

In the event that any Party deems it necessary to take legal action to enforce any provision of this Agreement and HCA or the Collaborative prevails, the CONTRACTOR agrees to pay all expenses of such action, including attorneys' fees and the cost of all State litigation as may be set by the court or hearing officer. Legal actions are defined to include administrative proceedings.

7.41 **Authority**

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

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7.42 **State Contract Administrator**

The Contract Administrator shall be designated by HCA. HCA shall notify the CONTRACTOR of any changes in the identity of the Contract Administrator. The Contract Administrator is empowered and authorized as the agent of HCA and the Collaborative to represent the State in all matters related to this Agreement except those reserved to other State personnel by this Agreement. Notwithstanding the foregoing, the Contract Administrator does not have the authority to amend the terms and conditions of this Agreement. All events, problems, concerns or requests affecting this Agreement shall be reported by the CONTRACTOR to the Contract Administrator.

7.43 **Survival of Terms**

Termination or expiration of this Agreement for any reason will not release any Party from any liabilities or obligations set forth in this Agreement that:

7.43.1 The Parties have expressly agreed shall survive any such termination or expiration; or

7.43.2 Remain to be performed or, by their nature, would be intended to be applicable following any such termination or expiration.

7.44 **Calculation of Time**

Any time period herein calculated by reference to “days” means Calendar Days unless further defined and provided; however, if the last day for a given act falls on a Saturday, Sunday, or a State of New Mexico holiday, the day for such act shall be the next Business Day.

7.45 **No Implied Authority**

7.45.1 The authority delegated to the CONTRACTOR by HCA and the Collaborative is limited to the terms of this Agreement. The CONTRACTOR may not rely upon implied authority and specifically is not delegated authority under this Agreement to:

7.45.1.1 Make public policy;

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7.45.1.2 Promulgate, amend, or disregard administrative regulations or program policy decisions made by the State and federal agencies responsible for administration of HCA's or the Collaborative's programs; or

7.45.1.3 Unilaterally communicate or negotiate with any State or federal agency or the New Mexico State Legislature on behalf of HCA or the Collaborative regarding HCA or the Collaborative's programs.

7.45.2 The CONTRACTOR is required to cooperate, to the fullest extent possible, to assist HCA and the Collaborative in communications and negotiations with State and federal governments and agencies as directed by HCA.

7.46 **No Waiver of Sovereign Immunity**

The Parties expressly agree that no provision of this Agreement is in any way intended to constitute a waiver by the State of any immunities from suit or from liability that the State of New Mexico may have by operation of law

7.47 **Notice**

7.47.1 A notice shall be deemed duly given upon delivery, if delivered by hand, or three (3) Calendar Days after posting, if sent by first-class mail, with proper postage affixed. Notice may also be tendered by facsimile transmission, with original to follow by first-class mail.

7.47.2 All notices required to be given to the State under this Agreement shall be sent to the following, or their designee:

Alanna Dancis, Acting Director
Medical Assistance Division
New Mexico Health Care Authority
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Or

Rose Bryan, Chief Legal Counsel
Office of General Counsel
New Mexico Health Care Authority
P.O. Box 2348

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Santa Fe, NM 87504-2348

7.47.3 All notices required to be given to the CONTRACTOR under this Agreement shall be sent to the following, or their designee:

Andrew Peterson, UHC President
UnitedHealthcare Insurance Company
609 Broadway Boulevard NE, Suite 125
Albuquerque, NM 87102

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IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of signature by all parties.

CONTRACTOR

By: DocuSigned by: Andrew E. Peterson 2137C5016E17498... Date: 12/26/2025

[CONTRACTOR REPRESENTATIVE]

STATE OF NEW MEXICO

By: DocuSigned by: Kari Armijo 1BA9EB5EAD00499... Date: 12/30/2025

Kari Armijo, Cabinet Secretary
Health Care Authority

By: Signed by: Jeanette Lujan Thornburg 44F601C65F8E48F... Date: 12/29/2025

Carolee Graham, CFO
Human Care Authority

By: Signed by: Valerie Sandoval, Acting Cabinet Secretary 9A6A5B51B90D4A0... Date: 12/29/2025

Valerie Sandoval, Acting Cabinet Secretary Designee
Children, Youth and Families Department

By: DocuSigned by: Elizabeth Groginsky 6F1D4EE86EE94C2... Date: 12/26/2025

Elizabeth Groginsky, Cabinet Secretary
Early Childhood Education and Care Department

APPROVED AS TO FORM AND LEGAL SUFFICIENCY:

By: Signed by: Rose Bryan DBBEEDEDFC9D431... Date: 12/29/2025

Rose Bryan, Chief Legal Counsel
Health Care Authority

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

TAXATION AND REVENUE DEPARTMENT

BTIN: 03-140568-00-1

By: DocuSigned by: AnnMarie Lucero ATE23200AE974AA... Date: 12/30/2025

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Attachment 1: Turquoise Care Covered Services

Non-Community Benefit Services Included Under Turquoise Care
Non-Community Benefit Services Included Under Turquoise Care[1]
Accredited Residential SUD Treatment Centers (Adult)
Accredited Residential Treatment Center Services
Applied Behavior Analysis (ABA)
Adult Psychological Rehabilitation Services
Ambulatory Surgical Center Services
Anesthesia Services
Assertive Community Treatment (ACT) Services
Bariatric Surgery[2]
Behavior Management Skills Development Services
Behavioral Health Professional Services: outpatient Behavioral Health and substance abuse services
Biomarkers Services
Case Management
Certified Community Behavioral Health Clinic (CCBHCs)
Chiropractic Services
Chronic Care Management services
Community Based Mobile Crisis
Community Health Worker and Community Health Representative Services
Community Interveners for the Deaf and Blind
Comprehensive Community Support Services
Crisis Services, including telephone, clinic, mobile, and stabilization centers
Crisis Triage Centers, including residential
Day Treatment Services
Dental Services, including fluoride varnish
Diagnostic Imaging and Therapeutic Radiology Services
Dialysis Services
Doula Services
Durable Medical Equipment and Supplies
Emergency Services (including emergency room visits and psychiatric ER)
Experimental or Investigational Procedures
Experimental or Investigational Procedures, Technology or Non-Drug Therapies[3]
Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
EPSDT Personal Care Services
EPSDT Private Duty Nursing
EPSDT Rehabilitation Services

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Non-Community Benefit Services Included Under Turquoise Care
Evidence Based Practices (EBPs)
Family Planning
Family Peer Support Services
Family Support (Behavioral Health)
Federally Qualified Health Center Services
Hearing Aids and Related Evaluations
High Fidelity Wraparound Services
Home Health Services (limitations apply)
Hospice Services
Hospital Inpatient (including Detoxification services)
Hospital Outpatient
Human Donor Milk
Inpatient Hospitalization in Freestanding Psychiatric Hospitals
Inpatient/Outpatient Services
Institutions for Mental Disease (IMD) for SUD only
Intensive Outpatient Program Services
IV Outpatient Services
Laboratory Services
Lactation Care Provider Services
Medically Tailored Meals
Medication Assisted Treatment for Opioid Dependence
Midwife Services
Mobile Response Stabilization Services (MRSS)
Multi-Systemic Therapy Services
Non-Accredited Residential Treatment Centers and Group Homes
Nursing Facility Services
Nutrition Supports for Pregnant Members
Nutritional Services
Occupational Services
Outpatient Hospital based Psychiatric Services and Partial Hospitalization
Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
Outpatient Health Care Professional Services
Peer Support Services
Pharmacy Services
Physical Health Services
Physical Therapy
Physician Visits
Podiatry Services

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Non-Community Benefit Services Included Under Turquoise Care
Preventive Services
Prosthetics and Orthotics
Psychosocial Rehabilitation Services
Qualified Clinical Trials
Radiology Facilities
Recovery Services (Behavioral Health)
Rehabilitation Option Services
Rehabilitation Services Providers
Reproductive Health Services
Respite (Behavioral Health) (annual limits may apply but may be exceeded based on the Member's health and safety needs)
Rural Health Clinics Services
School-Based Services
Screening, Brief Intervention, Referral to Treatment (SBIRT) Services
Speech and Language Therapy
Supportive Housing (limitations apply)
Swing Bed Hospital Services
Technology or Non-Drug Therapies
Telemedicine Services
Tobacco Cessation treatment and services (may include counseling, prescription medications, and products)
Tot-to-Teen Health Checks
Transplant Services
Transportation Services (medical)
Transitional Care Management services
Treatment Foster Care I
Treatment Foster Care II
Vision Care Services

Agency-Based Community Benefit Services Included Under Turquoise Care
Adult Day Health
Assisted Living
Behavior Support Consultation
Community Transition Services
Emergency Response

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Employment Supports
Environmental Modifications ($5,000 limit every five years)
Home Health Aide
Nutritional Counseling
Personal Care Services (Consumer Directed and Consumer Delegated)
Private Duty Nursing for Adults
Respite (annual limits may apply)
Skilled Maintenance Therapy Services

Self-Directed Community Benefit Services Included Under Turquoise Care
Behavior Support Consultation
Customized Community Support
Emergency Response
Employment Supports
Environmental Modifications ($5,000 limit every 5 years)
Home Health Aide
Self-Directed Personal Care (formerly Homemaker)
Start-Up Goods (For Member electing SDCB on or after January 1, 2019, one-time limit of $2000)
Nutritional Counseling
Private Duty Nursing for Adults
Related Goods (annual limits may apply)
Respite (annual limits may apply)
Skilled Maintenance Therapy Services
Specialized Therapies (annual limits may apply)
Transportation (non-medical) (annual limits may apply)

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Attachment 2: Delivery System Improvement Performance Targets (DSIPTs)

DSIPTs for Turquoise Care

DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Behavioral Health Visit	The CONTRACTOR shall increase the number of unique Members receiving outpatient Behavioral Health Services. Percentage targets are as follows: The CY25 target is twenty-five percent (25%). The CY26 target is twenty-five percent (25%). The CONTRACTOR shall provide quarterly reports to HCA with the number of unique Members receiving outpatient Behavioral Health services and an analysis of trends observed. The quarterly reports are due to HCA thirty (30) Calendar Days after the end of each quarter. The annual supplement is due to HCA May 30th of the year following the reporting period. DENOMINATOR: All Members, based on the Medicaid Enrollment Report (MER) from the last month of the reporting quarter (March, June, September, and December), and for the last day of the Calendar Year. NUMERATOR: Unique Members with an outpatient visit for Behavioral Health services provided by a Behavioral Health or a non-Behavioral Health practitioner, excluding visits occurring in the emergency room or in long-term care facilities, and with a diagnostic sequencing of a Behavioral Health diagnosis within the primary to tertiary range, during the reporting period.	25
Value-Based Purchasing	The CONTRACTOR must implement a VBP Strategy that addresses how the CONTRACTOR will meet VBP requirements in the three (3) component areas identified in Attachment 2.A. Value-Based Purchasing (VBP) Delivery System Improvement Performance Targets.	25

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DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Telemedicine	The CONTRACTOR shall increase the number of unique Members with a Telemedicine visit by twenty percent (20%) in Rural, Frontier, and Urban areas for Physical Health Specialists and Behavioral Health Specialists. July 1, 2024 – December 31, 2024 of CY24 will be a baseline period for this DSIPT. The CONTRACTOR shall submit CY24 data to HCA by April 1, 2025 to establish the baseline for the CY25 increase. The baseline for each upcoming calendar year will be the total number of unique Members with a Telemedicine visit at the end of the previous calendar year. • Members with Telemedicine visits conducted at I/T/Us are included. • UNM's Project ECHO is an educational enterprise and is not considered "Telemedicine" for the purposes of this DSIPT, nor is routine Telemedicine, such as interpretations of radiologic exams by a radiologist at a remote site. • Telemedicine may include virtual visits or e-visits and asynchronous/store-and-forward Telemedicine. If the CONTRACTOR achieves a minimum of seven percent (7%) of total membership with Telemedicine visits, as of November 30 each year, then the CONTRACTOR must maintain that same seven percent (7%) percent at the end of each calendar year in order to meet this target. The CONTRACTOR shall obtain the Medicaid enrollment data from HCA's website: https://www.hsdate.nm.us/LookingForInformation/medicaid-eligibility.aspx The CONTRACTOR shall provide quarterly reports to HCA with the number of unique Members served through Telemedicine visits and an analysis of trends observed. The quarterly reports are due to HCA thirty (30) Calendar Days after the end of each quarter.	10
Personal Care Services (PCS) Fulfillment	The CONTRACTOR shall increase the percent of agency – based authorized personal care services delivered to Members. Performance targets are as follows: • For July 1, 2024 – December 31, 2024 of CY24, eighty-eight percent (88%) of authorized personal care services shall be provided to Members.	10

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DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
	• For CY25, ninety percent (90%) of authorized personal care services shall be provided to Members. • For CY26, ninety-two percent (92%) of authorized personal care services shall be provided to Members. • For CY27, ninety-four percent (94%) of authorized personal care services shall be provided to Members. • For CY28, ninety-six percent (96%) of authorized personal care services shall be provided to Members. For purposes of this DSIPT the performance target shall be calculated as follows: • NUMERATOR: Total number of hours of agency-based personal care services provided to Members verified through Electronic Visit Verification (EVV). • DENOMINATOR: Total number of hours of authorized agency-based personal care services for Members. "Unfulfilled hours" represent hours of authorized personal care services that were not provided to Members due to both insufficient staffing and categorized as unable to locate and difficult to engage (UTL/DTE). Unfulfilled hours includes no shows and any hours missed due to tardy arrivals. The CONTRACTOR shall provide quarterly reports to HCA, including authorized hours; hours of personal care services provided; and unfulfilled hours. The CONTRACTOR shall categorize and report unfulfilled hours as follows: • Insufficient staffing; • Members traveling out-of-state or away from where services are delivered; • Members/guardians who refused personal care services; • Members in a hospital, inpatient setting, or NF; • Members who were incarcerated (outside of the suspension period); and • Members that are unable to be located (UTL) or difficult to engage (DTE) The quarterly reports shall include an analysis of trends observed. The quarterly reports are due to HCA thirty (30) Calendar Days after the end of each quarter.	

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DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Pharmacy	**Hepatitis C Treatment:** The CONTRACTOR shall submit a biannual report including data analysis on its population diagnosed with Hepatitis C, stratified by race and ethnicity, including the technical specifications for HEDIS. The biannual reports are due to HCA ninety (90) Calendar Days after the end of each six-month period. HCA will provide the CONTRACTOR with annual targets for percents of Members with Hepatitis C, as defined by a positive Hepatitis C Virus Ribonucleic Acid (HCV RNA) test within the calendar year. The annual target percent will be identified by HCA following six months of baseline data and shared with the CONTRACTOR. Hepatitis C Diagnosis is defined as a positive HCV RNA test within the past two calendar years (e.g., if the DSIPT CY is 2025, diagnosis is defined as a positive HCV RNA test within CY24 or CY25). Treatment is defined as being "successful" when a resulting negative viral load follows a positive HCV RNA test by at least three months. The data source is the Syncronys HIE, including claims data with corresponding labs, and will be collected by HCA. For purposes of this DSIPT, the CONTRACTOR shall treat an annual percent of Members with Hepatitis C, meeting the annual target as set by HCA.	10
	Support of pharmacist billing: The CONTRACTOR shall increase the percent of counseling claims submitted by pharmacists in retail pharmacy settings. For the purposes of this DSIPT, following the baseline year, the CONTRACTOR shall increase total claims (CPT 99401) for pharmacy counseling submitted by pharmacists in retail pharmacy settings by one percent (1%). For all subsequent years of the contract, the percent shall increase, at minimum, an additional one percent (1%) each calendar year. Reporting for this DSIPT will utilize claims data.	10

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DSIPT Objective	Delivery System Improvement Performance Target	Number of Points out of 100
Non-Emergency Medical Transportation (NEMT)	The CONTRACTOR shall complete ninety percent (90%) of eligible General NEMT trips upon request to and/or from medically necessary covered services annually. General NEMT is any NEMT that excludes the critical care population. An eligible NEMT trip is to and/or from a medically necessary service. For purposes of this DSIPT, CONTRACTOR performance shall be calculated and reported as follows: • NUMERATOR: Eligible NEMT trips completed to and/or from medically necessary services • DENOMINATOR: Total eligible NEMT trips to and/or from medically necessary services. • An eligible General NEMT trip is defined as each one-way trip, from one destination to another. For example, a round trip counts as two trips. The CONTRACTOR shall provide monthly reports to HCA that include the CONTRACTOR's completed NEMT trip performance and detailed information about the reasons for NEMT trips that were not completed, including, but not limited to: trips that could not be scheduled or accommodated and no-shows or cancellations by the NEMT provider. The monthly reports shall also include an analysis of trends observed. The monthly reports are due to HCA fifteen (15) Calendar Days after the end of each month.	10

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Attachment 2.A: Value-Based Purchasing (VBP) Delivery System Improvement Performance Targets

CONTRACTOR'S VBP Program and Requirements

To support Turquoise Care's VBP goals, the CONTRACTOR must implement a VBP Program that addresses 4.10.6 and demonstrates how the CONTRACTOR will meet VBP requirements in the following three (3) component areas.

1. VBP Required Components

The VBP portion of the CONTRACTOR's DSIPT is worth twenty-five (25) points but will be calculated on a thirty (30)-point achievement scale. The VBP portion of the CONTRACTOR's DSIPT consists of two (2) required components.

1. Total Points equals thirty (30) for meeting all components of VBP requirements.
2. Point Deductions:
    a. Ten (10) points for each level of provider payments target not achieved; and
    b. Two (2) point deduction for each additional requirement that the CONTRACTOR fails to meet. Refer to Table 1 for additional requirements for each Level of VBP.

2. VBP Strategy

As noted above, the CONTRACTOR must develop a VBP Strategy. The CONTRACTOR shall work with other HCA Turquoise Care MCOs when developing VBP strategies and requirements to minimize Provider burden to the extent possible. The VBP strategy must include a detailed work plan outlining all interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the entire contract period. The VBP Strategy for the contract period must be submitted to HCA during the readiness review period. In subsequent years the CONTRACTOR shall develop a VBP Annual Plan that must include a detailed work plan outlining all the interventions the CONTRACTOR is implementing to reach VBP targets in each VBP component area during the contract year, prior period experience, and changes to the VBP Strategy. The CONTRACTOR's VBP Annual Plan shall be submitted to HCA annually by April 1.

3. VBP Quarterly Report

The CONTRACTOR must submit all required quarterly VBP Reports on the template provided by HCA and shall submit narrative and quantitative updates of all VBP barriers, solutions, successes, status, supportive data and other pertinent information to the VBP. Quarterly reports are due sixty (60) Calendar Days from the end of the first

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quarter, the remaining quarterly reports are due forty-five (45) Calendar Days after the respective quarter close (or next Business Day if it falls on a weekend or holiday).

First Quarter: May 30	Second Quarter: August 15
Third Quarter: November 15	Fourth Quarter: February 15

VBP reporting requirements will be developed by HCA and will be provided to the CONTRACTOR sixty (60) Business Days prior to Go-Live of new Model Contract. HCA reserves the right to modify the reporting requirements.

Percentage of Provider Payments as a Component of a VBP Payment Arrangement

The CONTRACTOR must meet minimum targets for three (3) levels of VBP arrangements. Failure to meet minimum targets will result in deductions to the points available. Percentage of provider payments are defined as Claims paid to a provider who is actively contracted under one (1) of the three (3) levels of VBP arrangements as defined in Table 1 below. For reporting purposes, the CONTRACTOR may exclude provider payment for Dual Eligible Members, with the exception of those VBP arrangements that are with Long Term Care or Nursing Facility Providers, from the calculation. The CONTRACTOR must include payments to Behavioral Health Community Providers in calculating the percentage of overall spend in its VBP arrangements. For purposes of calculating VBP percentages for Community Benefit Providers and Nursing Facilities, the CONTRACTOR may include Dual Eligible Members within those calculations.

To meet the targets, the CONTRACTOR must have met the percentages established in Table 1 in all three (3) levels, with the following exceptions:

- MCOs with more advanced VBP strategies may substitute higher percentages in Level three (3) for lower percentages in Level two (2) and higher percentages in Level one (1) as the overall minimum percentage targets (total for Level one [1]-Level three [3]) are met for the contract year; and
- MCOs with disproportionate membership within the LTSS program may, at HCA's discretion, submit a plan to HCA for written approval that substitutes a higher percentage in Level two (2) for a lower percentage in Level three (3).

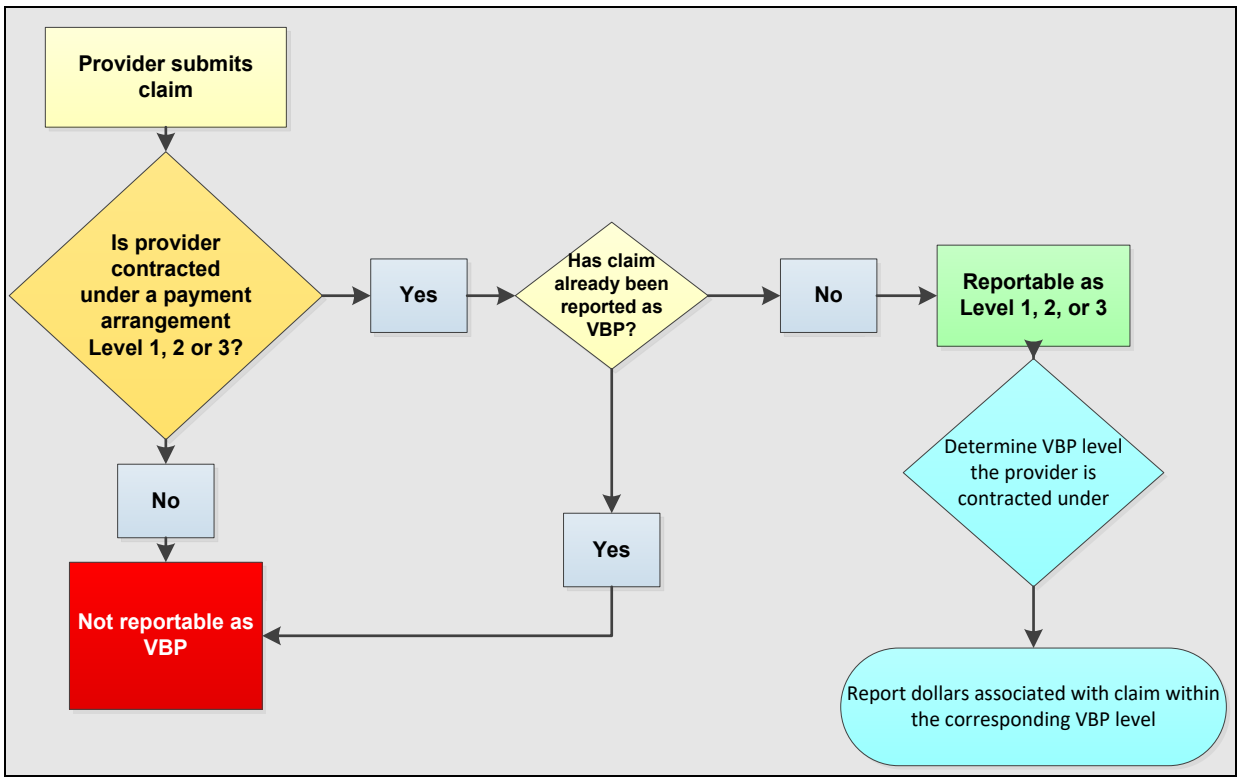
4. VBP Percentage Calculation Methodology

For purposes of calculating the VBP percentage minimums in Tables 1-3, a Claim may be counted a maximum of once and is considered a VBP Claim only if the billing provider is contracted with the CONTRACTOR under one (1) of the three (3) types of payment

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arrangements defined in Table 1. Calculation methodology is outlined in the following diagram:

Diagram 1 – Counting Claims when calculating VBP percentages:



VBP Minimum Percentage of Provider Payments Requirements

The following outlines the minimum percentage of Provider Claims that must be associated with a VBP payment arrangement for each contract year.

VBP levels and minimum requirements shall apply as follows for new CONTRACTORs selected as Turquoise Care MCOs (Table 1 requirements), and for Legacy CONTRACTORs (i.e., formerly Centennial Care 2.0 MCOs) selected as Turquoise Care MCOs (Table 2 requirements).

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Table 1 – VBP Level Minimum Requirements for New CONTRACTORs:

Aggregate VBP Targets		
Contract Year 1 (Jan 1 – Dec 31, 2025)	**Contract Year 2** (Jan 1 – Dec 31, 2026)	**Contract Year 3** (Jan 1 – Dec 31, 2027)
• Level 1: 8% • Level 2: 11% • Level 3: 5% • **Total: 24%** ***Jan 2025 begins the first year for VBP allowing six months to transition. The first six months of the contract will be used for data collection only.***	• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HCA reserves the right to modify the percentage in Year 3 increasing 5% from Contract Period 2.***

Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract year three.

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 1 – Minimum Requirements		
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.		
Contract Year 1	**Contract Year 2**	**Contract Year 3**
8%	**10%**	**11%**
• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities.	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***

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VBP Level 1 – Minimum Requirements
Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.) 1. Must include a mix of Physical Health, Behavioral Health, LTC and Nursing Facility Providers. 2. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.

VBP Level 1 Definitions:

1. Traditional Physical Health Providers are Providers whose primary services are not Behavioral Health, LTC, or nursing facilities. Traditional Physical Health Providers include FQHCs, hospitals, etc.

2. Small provider is defined as practices with one thousand (1,000) or less assigned/attributed Members or as determined by HCA prior to the start of the contract period.

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 2 – Minimum Requirements		
Level 2: Fee schedule based, upside-only shared savings-- available when outcome/quality scores meet agreed-upon targets (may include downside risk).		
Contract Year 1	**Contract Year 2**	**Contract Year 3**
11%	**13%**	**14%**
• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated providers who offer a continuum of specialty Behavioral Health services. • Actively build readiness for LTC Providers including nursing facilities.	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • Actively build readiness for LTC Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional Physical Health Providers with at least two (2) small Providers • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

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VBP Level 2 – Minimum Requirements
Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.) 1. Must include two (2) or more bundled payments for episodes of care. 2. At least five percent (5%) of the overall total Contract Year Percentages in Level 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**. 3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.
VBP Level 2 Definitions: 1. **Actively build** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTSS and NF Providers in Level 2 by Contract Year 3. 2. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top ten (10) to twenty (20) highest of contracted hospitals and serve at least one hundred (100) Members annually. 3. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR's delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment of Care Coordination needs and Care Coordination assignment and linkage.

Table 1 – VBP Level Minimum Requirements (continued):

VBP Level 3 – Minimum Requirements		
Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.		
Contract Year 1	**Contract Year 2**	**Contract Year 3**
5%	**7%**	**8%**

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VBP Level 3 – Minimum Requirements		
• Traditional Physical Health Providers. • Implement a CONTRACTOR led Behavioral Health Provider level workgroup that works with Behavioral Health Providers to design full risk model (see definitions).	• Traditional Physical Health Providers. • Develop Level 3 Behavioral Health Provider agreement model that includes providers who are primarily Behavioral Health and/or integrated Provider systems who offer a continuum of specialty Behavior Health services. • Implement a CONTRACTOR led LTC Provider (including nursing Facilities) level workgroup to design full-risk model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional Physical Health Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavior Health services. • Actively build LTC Providers (including nursing facilities) full-risk contracting model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

VBP Level 3 – Minimum Requirements

Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.)

1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
2. At least five percent (5%) of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**.
3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.

VBP Level 3 Definitions:

1. **Implement a CONTRACTOR led Behavioral Health Provider Level workgroup** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Behavioral Health Providers in Level 3 by Contract Year 3.
2. **Implement a LTC including nursing facilities provider level workgroup to design full-risk model** is defined as a CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTC including nursing facilities Providers in Level 3 by Contract Year 4, if HCA elects to renew the CONTRACTOR's Turquoise Care Agreement.
3. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top ten (10) to twenty (20) highest of contracted hospitals and serve at least one hundred (100) Members annually.
4. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR's delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment for Care Coordination needs and Care Coordination assignment and linkage.

Full Delegation of Care Coordination within Level 3 VBP arrangements are tied to Level 3 full risk Providers and with Health Homes.

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Table 2 – VBP Level Minimum Requirements for Legacy CONTRACTORS:

Aggregate VBP Targets		
Contract Year 1 (Jan 1 – Dec 31, 2024)	**Contract Year 2** (Jan 1 – Dec 31, 2025)	**Contract Year 3** (Jan 1 – Dec 31, 2026)
• Level 1: 10% • Level 2: 13% • Level 3: 7% • **Total: 30%**	• Level 1: 11% • Level 2: 14% • Level 3: 8% • **Total: 33%** ***HCA reserves the right to modify the percentage in Year 2 increasing 5% from Contract Year 1.***	• Level 1: 12% • Level 2: 15% • Level 3: 9% • **Total: 36%** ***HCA reserves the right to modify the percentage in Year 3 increasing 5% from Contract Year 2.***
Modifications will be conveyed to the CONTRACTOR at least 60 days prior to the beginning of contract year three.		

Table 2 – VBP Level Minimum Requirements (continued):

VBP Level 1 – Minimum Requirements		
Level 1: Fee schedule based with bonus or incentives and/or withhold payable only when outcome/quality scores meet agreed-upon targets.		
Contract Year 1	**Contract Year 2**	**Contract Year 3**
10%	**11%**	**12%**
• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities.	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed percentage achieved in prior year.***
Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.) 1. Must include a mix of Physical Health, Behavioral Health, LTC, and Nursing Facility Providers. 2. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.		

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VBP Level 1 – Minimum Requirements
VBP Level 1 Definitions: 1. Traditional Physical Health Providers are Providers whose primary services are not Behavioral Health, LTC, or Nursing Facilities. Traditional Physical Health Providers include FQHCs, hospitals, etc. 2. Small provider is defined as practices with one thousand (1,000) or less assigned/attributed Members or as determined by HCA prior to the start of the contract period.

Table 2 – VBP Level Minimum Requirements (continued):

VBP Level 2 – Minimum Requirements		
Level 2: Fee schedule based, upside-only shared savings-- available when outcome/quality scores meet agreed-upon targets (may include downside risk).		
Contract Year 1	**Contract Year 2**	**Contract Year 3**
13%	**14%**	**15%**
• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • Actively build readiness for LTC Providers including nursing facilities.	• Traditional Physical Health Providers with at least two (2) small Providers • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• Traditional Physical Health Providers with at least two (2) small Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavioral Health services. • LTC Providers including nursing facilities. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***
Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.) 1. Must include two (2) or more bundled payments for episodes of care. 2. At least five percent (5%) of the overall total Contract Year Percentages in Level 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**. 3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.		

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VBP Level 2 – Minimum Requirements

VBP Level 2 Definitions:

1. **Actively build** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTSS and NF Providers in Level 2 by Contract Year 2.

2. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top ten (10) to twenty (20) highest of contracted hospitals and serve at least one hundred (100) Members annually.

3. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR's delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment of Care Coordination needs and Care Coordination assignment and linkage.

Table 2 – VBP Level Minimum Requirements (continued):

VBP Level 3 – Minimum Requirements

Level 3: Fee schedule based or capitation with risk sharing (at least 5% for upside and downside risk); and/or global or capitated payments with full risk.

Contract Year 1	Contract Year 2	Contract Year 3
7%	**8%**	**9%**
• Traditional Physical Health Providers. • Develop Level 3 Behavioral Health Provider agreement model that includes providers who are primarily Behavioral Health and/or integrated Provider systems who offer a continuum of specialty Behavior Health services. • Implement a CONTRACTOR led LTC Provider (including nursing facilities) level workgroup to design full-risk model (see definitions).	• Traditional Physical Health Providers. • Behavioral Health Providers whose primary services are Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavior Health services. • Actively build LTC Providers (including nursing facilities) full-risk contracting model (see definitions). ***All included provider requirements must exceed the percentage of payments achieved in prior year.***	• 8% with traditional Physical Health Provider. • One percent (1%) with Providers who are primarily Behavioral Health and/or integrated Providers who offer a continuum of specialty Behavior Health services. • LTC Providers including nursing facilities over prior year. ***All included provider requirements must exceed the percentage of payments achieved in prior year.***

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VBP Level 3 – Minimum Requirements

Additional Requirements: (CONTRACTOR is subject to a two (2)-point deduction for each Additional Requirement that is not met during a contract year.)

1. Global or capitated payments with full risk. Arrangements with full risk for Covered Services shall include Full Delegation of Care Coordination as detailed in bullet 2 below. Full Delegation of Care Coordination within Level 3 VBP arrangements as outlined in definitions below.
2. At least five percent (5%) of the overall total Contract Year Percentages in Levels 2 and/or Level 3 VBP contracting must be with **high volume hospitals** and require **avoidable readmission reduction targets**.
3. The CONTRACTOR shall establish a process for Providers in VBP arrangements to have access to data that provides information about Members' utilization of services, including total cost of care on a quarterly basis.

VBP Level 3 Definitions:

1. **Implement a CONTRACTOR led Behavioral Health Provider Level workgroup** is defined as CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for Behavioral Health Providers in Level 3 by Contract Year 2.
2. **Implement a LTC including nursing facilities provider level workgroup to design full-risk model** is defined as a CONTRACTOR led collaboration that leads to provider readiness and development of a VBP model contracting strategy that ensures the CONTRACTOR will meet the requirement for LTC including nursing facilities Providers in Level 3 by Contract Year 3.
3. **High volume hospital** is defined as hospitals contracted with the CONTRACTOR whose readmission rates are in the top ten (10) to twenty (20) highest of contracted hospitals and serve at least one hundred (100) Members annually.
4. **Avoidable readmission targets** can be identified by CONTRACTOR utilizing the HEDIS "Plan All Cause Readmission" measure. Additionally, the CONTRACTOR shall develop transition of care requirements for all contracted inpatient facilities. The requirements must ensure that Members are effectively transitioned to home/community following an inpatient stay be based upon nationally recognized best practices in transitions of care. The transition of care model must include, at a minimum, formal hand-offs to Care Coordination either with the CONTRACTORS Care Coordinator(s) or CONTRACTOR's delegate (where Care Coordination is delegated by the CONTRACTOR), ensuring Members/representatives understand discharge instructions, follow-up appointments are made prior to discharge, appropriately linking Members to necessary services/resources, transportation barriers are addressed and a plan for medication reconciliation. For Members who are transitioned from an inpatient stay who do not have an assigned care coordinator, the process shall include how the facility will refer the Member to the CONTRACTOR for assessment for Care Coordination needs and Care Coordination assignment and linkage.

Full Delegation of Care Coordination within Level 3 VBP arrangements are tied to Level 3 full risk Providers and with Health Homes.

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Attachment 3: Safety Net Care Pool Hospitals

HOSPITAL NAME	COUNTY
Alta Vista Regional Medical Center	San Miguel
Artesia General Hospital	Eddy
Carlsbad Medical Center	Eddy
CHRISTUS St. Vincent Regional Hospital	Santa Fe
Cibola General Hospital	Cibola
Covenant Health Hobbs Hospital	Lea
Eastern New Mexico Medical Center	Chaves
Gila Regional Medical Center	Grant
Holy Cross Hospital	Taos
Lincoln County Medical Center	Lincoln
Los Alamos Medical Center	Los Alamos
Lovelace Regional Hospital-Roswell	Chaves
Memorial Medical Center	Dona Ana
Mimbres Memorial Hospital	Luna
Miners Colfax Medical Center	Colfax
Mountainview Regional Medical Center	Dona Ana
Nor- Lea General Hospital	Lea
Otero County Hospital Association (formerly Gerald Champion Medical Center)	Otero
Plains Regional Medical Center-Clovis	Curry
Presbyterian HealthCare Services dba Dan C. Trigg Memorial Hospital	Quay
-Presbyterian Healthcare Services dba Presbyterian Espanola Hospital	Rio Arriba
Presbyterian Santa Fe Medical Center	Santa Fe
Rehoboth McKinley Christian Hospital	McKinley
Roosevelt General Hospital	Roosevelt
San Juan Regional Medical Center	San Juan
Sierra Vista Hospital	Sierra
Socorro General Hospital	Socorro
The University of New Mexico Hospital	Bernalillo
Three Crosses Regional Hospital	Dona Ana
Union County General Hospital	Union

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Attachment 4: Alternative Benefit Plan Covered Services

Alternative Benefit Plan Services Included Under Turquoise Care[1]
Allergy testing and injections
Annual physical exam and consultation[2]
Applied Behavior Analysis (ABA)
Bariatric surgery[3]
Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
Cancer clinical trials
Cardiovascular rehabilitation[4]
Chemotherapy
Chiropractic Services
Chronic Care Management services
Dental services[5]
Diabetes treatment, including diabetic shoes, medical supplies, equipment and education
Dialysis
Diagnostic imaging
Disease management
Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[6]
Electroconvulsive therapy
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age nineteen (19) to twenty (20)
Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
Family planning and reproductive health services and devices, sterilization, , contraceptives, and insertion and/or removal of contraceptive devices[7]
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services
Genetic evaluation and testing[8]
Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]

[1] At minimum, the CONTRACTOR shall cover all codes included on the Medicaid fee schedule for these services.
[3] Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
[3] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight BMI and health status.
[4] Limited to short-term therapy (two consecutive months) per cardiac event.
[5] The ABP covers dental services for adults in accordance with NMAC 8.310.2. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
[6] Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.
[7] Sterilization reversal is not covered. Infertility treatment is not covered.
[8] Limited to genetic testing outlined in NMAC 8.3.10.2. Does not include random genetic screening.
[9] Limited to short-term therapy (two consecutive months) per condition.

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Alternative Benefit Plan Services Included Under Turquoise Care[1]

Hearing screening as part of a routine health exam[10]

Holter monitors and cardiac event monitors

Home health care, skilled nursing and intravenous services[11]

Hospice care services

Immunizations[12]

Inpatient physical and behavioral health hospital/medical services and surgical care[13]

Inpatient rehabilitative services/facilities[14]

Internal prosthetics

IV infusions

Lab tests, x-ray services and pathology

Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care

Medication assisted therapy for opioid addiction

Non-emergency transportation when necessary to secure covered medical services

Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity

Organ and tissue transplants[15]

Osteoporosis diagnosis, treatment and management

Outpatient surgery

Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions[16]

Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings[17]

Physician visits

Podiatry and routine foot care[18]

Prescription medicines

Primary Care to treat illness/injury and chronic disease management

Pulmonary therapy[19]

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[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for Members age 19-20. The ABP does not cover audiology services.

[11] Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.

[12] Includes ACIP-recommended vaccines.

[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.

[14] Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the Member is the eventual return home.

[15] Transplants are limited to two per lifetime.

[16] Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

[17] Includes US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.

[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

[19] Limited to short-term therapy (two consecutive months) per condition.

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Alternative Benefit Plan Services Included Under Turquoise Care[1]
Radiation therapy
Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
Skilled nursing[20]
Sleep studies[21]
Specialist visits
Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[22]
Telemedicine services
Tobacco Cessation treatment and services (may include counseling, prescription medications, and products)
Transitional Care Management services
Urgent care services/facilities
Vision care for eye injury or disease[23]
Vision hardware (eyeglasses or contact lenses)[24]

[20] Subject to the 100-visit home health limit when provided through a home health agency.
[21] Limited to diagnostic sleep studies performed by certified providers/facilities.
[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.
[23] Refraction for visual acuity and routine vision care are not covered, except for Members age 19-20.
[24] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients age 19-20 following a periodicity schedule.

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Attachment 5: Providers with Distance Requirements

A. Behavioral Health

1. Freestanding Psychiatric Hospitals
2. General Hospitals with psychiatric units
3. Partial Hospital Programs
4. Accredited Residential Treatment Centers (ARTC)
5. Non-Accredited Residential Treatment Centers (RTC) and Group Homes (GH)
6. Treatment Foster Care I & II (TFC I & II)
7. Core Service Agency (CSA)
8. Community Mental Health Centers (CMHC)
9. Certified Community Behavioral Health Clinics (CCBHCs)
10. Mobile Crisis Services
11. Indian Health Service and Tribal 638s providing Behavioral Health services
12. Outpatient Provider Agencies
13. Agencies providing Behavioral Management Services (BMS)
14. Agencies providing Day Treatment Services
15. Agencies providing Assertive Community Treatment (ACT)
16. Agencies providing Multi-Systemic Therapy (MST)
17. Agencies providing Intensive Outpatient Services
18. Methadone Clinics
19. FQHCs providing Behavioral Health Services
20. Rural Health Clinics providing Behavioral Health services
21. Psychiatrists
22. Psychologists (including Prescribing Psychologists)
23. Suboxone certified MDs
24. All other licensed Independent Behavioral Health practitioners (LISW, LPCC, LMFT, CNS and CNP with Psychiatric Certification, Independent Practices or Groups)

B. Physical Health

1. Cardiology
2. Certified Nurse Practitioner
3. Certified Midwives
4. Dermatology
5. Dental
6. Endocrinology
7. ENT
8. FQHC
9. Gastroenterology
10. Hematology/Oncology
11. Home Infusion Therapy
12. I/T/U

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13. Nephrology
14. Neurology
15. Neurosurgeon
16. OB/GYN (including certified nurse midwives)
    a. To specify providers that have capabilities for infant deliveries
17. Optometry
18. Orthopedics
19. Pediatrics
20. Physician Assistant
21. Podiatry
22. RHC
23. Rheumatology
24. Surgeons
25. Urology

C. Long-Term Care

1. Assisted Living Facilities
2. Home Health Agencies
3. Personal Care Service Agencies (PCS) - delegated
4. Personal Care Service Agencies (PCS) – directed
5. Private Duty Nursing Agencies
6. Nursing Facilities

D. Hospitals

1. General Hospitals
2. Inpatient Psychiatric Hospitals

E. Ancillary Service Providers

1. Physical Therapy
2. Occupational Therapy
3. Speech Therapy
4. Outpatient Dialysis
5. X-Rays
6. Lab

F. Transportation

1. NEMT

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Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies

The following outlines the methodologies, including data and other information, for the evaluation of the following:

1. Retroactive Period Reconciliation (Section 6.6)
2. Medical Care Credit Reconciliation (Section 6.7)
3. High Cost Member Risk Pool Reconciliation (Section 6.8)

The reconciliations outlined in this Attachment utilize Encounter Data submitted by the CONTRACTOR and accepted by HCA's MMIS system. In some circumstances, additional information may be required of the CONTRACTOR and this information may be incorporated into the evaluation. Additional information includes, but is not limited to, excess loss reinsurance expense and recoveries, pharmacy rebates, pharmacy supplemental rebates, or exclusivity pricing.

Medical Care Credit and Retroactive Reconciliation will be calculated in one 18 month period (July 1, 2024 - December 31, 2025) before moving to a calendar year basis. For the high cost risk pool (HCRP).

Retroactive Period Reconciliation

1. HCA shall reconcile the medical expenditures related to the Retroactive Period for each contract year period (January 1 to December 31 of each year of the Agreement term). The Retroactive Period may exist for some Members whose effective date of Medicaid eligibility is determined prior to HCA notification date to the CONTRACTOR outlined in Sections 4.2.9 and 6.6. Newborns are only considered part of the Retroactive Period reconciliation if the mother of the newborn is not enrolled in an MCO at the time of delivery.
2. The reconciliation for the Retroactive Period is limited to the Covered Services medical expenses defined in Attachment 1: Turquoise Care Covered Services and Attachment 4: Alternative Benefit Plan Covered Services
3. . The following expenses are excluded from the reconciliation:
    a. Indian Health Services/Tribal 638 Providers reimbursed through the supplemental process described in Section 6.3;
    b. Value Added Services;

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c. CONTRACTOR administrative expense;
d. CONTRACTOR Care Coordination expense (medical and administrative);
e. CONTRACTOR Turquoise Care Rewards expense (reward and administrative);
f. Health Insurance Exchange payments; and
g. Project ECHO payments.

4. The retroactive reconciliation will be calculated using the following information:
   a. Payments made by HCA to the CONTRACTOR for Members in the Retroactive Period;
   b. Medical expenses outlined in Retroactive Period Reconciliation item #2 and defined as covered medical expenses incurred by Members during the Retroactive Period and paid by the CONTRACTOR, including the net cost of excess loss reinsurance (premiums less recoveries), less:
      i. Pharmacy rebates, including supplemental rebates for specialty medications such as Hepatitis C; and
      ii. Applicable Member cost sharing.
5. HCA will permit the CONTRACTOR to retain five percent (5%) of the net medical expense for administrative costs (net medical expense multiplied by five percent [5.0%]).
6. HCA shall adjust the final reconciliation for applicable premium tax.
7. Net medical expense plus the administrative allowance and premium tax will be compared to the payment made by HCA to the CONTRACTOR to determine the value of recoupment from or payment to the CONTRACTOR.
8. HCA shall provide the CONTRACTOR with detailed Member level data for revenue and Encounter expenses as well as impacts of pharmacy rebates, Member cost sharing and net cost of excess loss reinsurance upon completion of the reconciliation calculations.
9. HCA makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.
10. Evaluation Periods
    a. Interim Evaluation

    HCA will perform an initial evaluation of the reconciliation starting in April in the year following the end of the contract year being measured when the evaluation includes Capitation Payment and accepted Encounter Data with three (3) months of runout. HCA

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will provide the CONTRACTOR with the results of the interim evaluation, and at HCA's discretion may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with any concerns about the capitation, Encounter Data or other factors included in the interim reconciliation within thirty (30) Calendar Days following receipt of the information. The CONTRACTOR is responsible for communicating any issues that may impact the information that HCA uses to perform the interim evaluation by no later than the last Business Day of January in the year following the end of the contract year being measured.

b. Final Evaluation

HCA will perform a final evaluation of the reconciliation starting in January in the second year following the end of the contract year being measured when the evaluation includes Capitation Payment and accepted Encounter Data with twelve (12) months of runout. HCA will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with the concerns about the capitation, Encounter Data or other factors included in the final reconciliation within thirty (30) Calendar Days following receipt of the information; otherwise, the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information HCA uses to inform the final evaluation by no later than the last Business Day of September in the year following the end of the contract year being measured.

11. Retroactive Changes to the Data Following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HCA then HCA is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract year.

Medical Care Credit Reconciliation

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1. HCA shall evaluate the difference between the actual and assumed medical care credit amounts included in the LTSS blended Capitation Rates described in Section 6.4.3.1.4 and Section 6.8.
2. HCA shall evaluate the actual medical care credit amounts reflected in the CONTRACTOR's payments from the CONTRACTORS' submitted and accepted Encounter Data versus the amount included in the LTSS blended payment rates. The difference between the amounts will result in either a recoupment by HCA from the CONTRACTOR or a payment by HCA to the CONTRACTOR.
3. Evaluation Periods
   a. **Interim Evaluation**

      HCA will perform an initial evaluation of the reconciliation starting in April in the year following the end of the contract year being measured when the evaluation includes Capitation Payment and accepted Encounter Data with three (3) months of runout. HCA shall provide the CONTRACTOR with the results of the interim evaluation, and at HCA's discretion, may include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with any concerns about the capitation, Encounter Data, or other factors included in the interim reconciliation within thirty (30) Business Days following receipt of the information. The CONTRACTOR is responsible for communicating any issues that may impact the information HCA uses to perform the interim evaluation by no later than the last Business Day of January in the year following the end of the contract year being measured.

   b. **Final Evaluation**

      HCA will perform a final evaluation of the reconciliation starting in January in the second year following the end of the contract year being measured when the evaluation includes Capitation Payment and accepted Encounter Data with twelve (12) months of runout. HCA will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with HCA concerns about the capitation, Encounter Data or other factors included in the final reconciliation within

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thirty (30) Business Days following receipt of the information; otherwise, the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information HCA uses to perform the final evaluation by no later than the last Business Day of September in the year following the end of the contract year being measured.

4. Retroactive Changes to the Data Following the Final Evaluation
   In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HCA, then HCA is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract year.

High Cost Member Risk Pool Reconciliation

1. HCA shall evaluate and reconcile the HCRP for each contract year.
2. A high-cost Member is a Member who is expected to incur costs above the attachment point of one hundred seventy-five thousand dollars ($175,000) during the contract year. The CONTRACTOR will be at risk for all expenses incurred under the attachment point. For a Member that moves between CONTRACTORS during the contract year and meets the attachment point, that Member will be counted for the HCRP Reconciliation and the total HCRP expenses will be allocated based on each CONTRACTOR's share of total expenses for that Member.
3. The HCRP evaluation is limited to covered Physical Health (PH) and Other Adult Group Physical Health (OAHPH) services and Rate Cohorts. Behavioral Health (BH) services and Long Term Services and Supports (LTSS) Rate Cohorts will be excluded from the evaluation process. For a Member that moves between an included and excluded Rate Cohort during the contract year (e.g., from PH to LTSS), the expenses incurred while the Member is in the excluded Rate Cohort (e.g., LTSS) will not be included in the Member's annual costs for the HCRP Reconciliation.
4. A Member's expenses will be limited to one million dollars ($1,000,000) to account for the minimum requirement for excess loss reinsurance protection as outlined in Section 4.19.10.1.

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5. The HCRP Premium and Reconciliation will include eighty percent (80%) of expense by Member between the attachment point and the one million dollar ($1,000,000) limit. The CONTRACTOR will be at risk for the remaining twenty percent (20%) of expenses incurred by a Member above the attachment point.
6. The HCRP excludes CONTRACTOR's Member month and Encounter Data in the Retroactive Period.
7. HCA will utilize the following to evaluate the HCRP Reconciliation:
    a. Projected Risk Pool Share
        i. Capitation Rate HCRP Premium PMPM, described in Section 6.8.1, by Rate Cohort;
        ii. Member months by Rate Cohort for the evaluation period per HCA's Capitation Payments to the CONTRACTOR;
        iii. The CONTRACTOR's contribution divided by the total contribution by all CONTRACTORS results in the CONTRACTOR's projected risk pool share percentage;
        iv. The total contribution by all CONTRACTORS represents the HCRP fund that will be reconciled against actual experience for the contract year. Each CONTRACTOR will receive their appropriate share of the HCRP fund and may not be reimbursed for all incurred high-cost Member expenses. The HCRP Reconciliation will be budget neutral to HCA.
    b. Actual Risk Pool Share
        i. Encounter Data submitted by the CONTRACTOR and accepted by HCA with twelve (12) months run out;
        ii. The CONTRACTOR's incurred high-cost Member expense divided by the total high-cost Member expense incurred by all CONTRACTORS results in the CONTRACTOR's actual HCRP share percentage.
    c. The difference between the CONTRACTOR's projected HCRP share and the actual HCRP share results in the percent of the HCRP fund that is to be recouped by HCA or paid to the CONTRACTOR.
8. Upon completion of the HCRP evaluation, HCA shall provide the CONTRACTOR notification of the recoupment from or payment to the CONTRACTOR.

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9. Evaluation Periods

   a. Final Evaluation

   HCA will perform the final evaluation of the reconciliation starting in January in the second calendar year following the end of the contract year being measured when the evaluation includes Capitation Payments and accepted Encounter Data with twelve (12) months runout. HCA will provide the CONTRACTOR with the results of the final evaluation. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with any concerns regarding the source data or other factors included in the final reconciliation within thirty (30) Calendar Days following receipt of the information; otherwise, the results are considered final.

10. Retroactive Changes to the Data Following the Evaluation

    In the circumstance the capitation or enrollment information used in the evaluation of the reconciliation is adjusted by HCA, then HCA is not required to adjust the payment or recoupment if the sum of the impact of all reconciliations is less than two percent (2%) of the sum of the payment or recoupment for all reconciliations for the impacted contract year.

Reconciliations and Risk Corridor Evaluation Methodologies:

Loss Protection Risk Corridor

1. HCA and the CONTRACTOR will share in underwriting loss outside of the risk corridor based on net capitation revenue. HCA will be responsible for seventy-five percent (75%) of any underwriting loss within three percent (3.0%) to six percent (6.0%) of the risk corridor and ninety percent (90%) of any underwriting loss in excess of six percent (6.0%) if the risk corridor. HCA shall measure the underwriting loss based on the CONTRACTOR's Medicaid Financial Reporting Package, as specified by HCA.

2. For purposes of this section, "underwriting loss" is defined as negative net income exclusive of investment income and before State and federal income taxes for the New Mexico Medicaid line of business. Penalties related to the Delivery System Improvement Performance Targets and other monetary penalties and/or damages will not be considered reductions to revenue and/or countable expenses in the calculation of the underwriting loss.

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a. Medicaid line of business Net Capitation Revenue: Earned capitation premium, excluding IHS supplemental revenue, less premium tax, less New Mexico Medical Insurance Pool (NMMIP) and HIX assessments during the annual period.

b. Medicaid line of business Total Medical Expense: Medical expense incurred during the contract period, including the net cost of excess loss reinsurance (premiums less recoveries) and, including the effect of TPL post payment recoveries, less IHS expenditures and less expenses for Care Coordination services deemed to be administrative per Section 7.2.8.4 of this Agreement.

i. In Lieu of Services or Settings may be considered a Medical Expense if written approval has been received by the CONTRACTOR from HCA, in accordance with Section 4.5.13 of this Agreement. In Lieu of Services or Settings are alternative services, or services in settings that are not Turquoise Care Covered Services as set forth in Attachment 1: Turquoise Care Covered Services or Attachment 4: Alternative Benefit Plan Covered Services, but are medically appropriate and cost-effective substitutes. However, the CONTRACTOR may not require a Member to use In Lieu of Services or Settings arrangements as a substitute for Turquoise Care Covered Services but may offer and cover such services or settings, if approved by HCA as a means of ensuring that appropriate care is provided in a cost-effective manner.

c. Medicaid line of business Allowable Administrative Expense: Administrative Expense (outlined in Section 7.2.7 of this Agreement) incurred during the contract period, less premium tax less NMMIP and NMHIX assessments during the contract period. Allowable Administrative Expense will be capped at a percentage of Net Capitation Revenue based on the market share of the CONTRACTOR during the contract period.

i. If the Member market share between July 1, 2024 and December 31, 2025 is less than twenty-five percent (25.0%), then allowable administrative expenses, not to exceed 10.0% of the net capitation revenue, will be included in the risk corridor calculation.

ii. If the Member market share between July 1, 2024 and December 31, 2025 is greater than or equal to twenty-five percent (25.0%), then allowable administrative expenses, not

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to exceed 6.5% of the net capitation revenue, will be included in the risk corridor calculation.

d. Medicaid line of business Underwriting Loss: Underwriting Loss equals Net Capitation Revenue less Total Net Medical Expense less Allowable Administrative Expense and includes the effect of MLR remittance owed to the State as specified in Section 7.2.10.3 of this Agreement and the effect of reconciliations as specified in Attachment 6: Reconciliations and Risk Corridor Evaluation Methodologies.

3. HCA makes no guarantee of any level of underwriting gain to the CONTRACTOR under this Agreement.

4. HCA will utilize the CONTRACTOR's annual Medicaid Financial Reporting Package following the close of the contract period and perform the final underwriting loss calculation after all final evaluations for reconciliations are completed for the contract period. Financials will be validated against encounter data and may be adjusted accordingly. If underwriting loss in excess of three percent (3.0%) is realized, HCA will remit the amount for the excess underwriting loss share outlined in Section 6.11.1 of this Agreement.

5. HCA reserves the right to examine the allocation methodologies utilized for any non-direct expenditure by the CONTRACTOR as it relates to any expenditure, including but not limited to, Administrative Expense.

6. HCA reserves the right to modify the measurement of underwriting loss based on review of allocation methodologies.

7. HCA reserves the right to reevaluate the risk corridor prior to January 1, 2026 and modify or discontinue the arrangement as desired.

8. Evaluation Periods

a. Interim Evaluation

HCA will perform an initial evaluation of the reconciliation starting in April in the year following the end of the contract period being measured.. HCA will provide the CONTRACTOR with the results of the interim evaluation, and at HCA's discretion may

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include a partial recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with any concerns about the interim reconciliation within thirty (30) Calendar days following receipt of the information. The CONTRACTOR is responsible for communicating any issues that may impact the information that HCA uses to perform the interim evaluation by no later than the last Business Day of January in the year following the end of the contract year being measured. The first contract period will be defined as the 18-month period from July 2024 through December 2025. The evaluation will occur on a calendar year basis after the initial calculation.

b. Final Evaluation

HCA will perform a final evaluation of the reconciliation starting in January in the second year following the end of the contract period being HCA will provide the CONTRACTOR with the results of the final evaluation and shall reflect any interim recoupment or payment. The CONTRACTOR shall evaluate the information provided by HCA and provide HCA with the concerns final reconciliation within thirty (30) Calendar days following receipt of the information; otherwise, the results are considered final. The CONTRACTOR is responsible for communicating any issues that impact the information HCA uses to inform the final evaluation by no later than the last Business Day of September in the year following the end of the contract year being measured. The first contract period will be defined as the 18-month period from July 2024 through December 2025. The evaluation will occur on a calendar year basis after the initial calculation.

9. Retroactive Changes to the Data Following the Final Evaluation

In the circumstance that the capitation or enrollment information used in the final evaluation of the reconciliation is adjusted by HCA then HCA is not required to adjust the final payment or final recoupment if the sum of the impact for all reconciliations is less than two percent (2%) of the sum of the final payment or recoupment for all reconciliations and/or risk corridor for the impacted contract year.

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Attachment 7: List of Behavioral Health Drugs

GENERAL DESCRIPTION		PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names are in parentheses) **Note: This list is not all inclusive of brand names and formulations, all Behavioral Health medications. All brands and formulations are to be covered. New FDA medications approved to market are automatically included in this list.**				
Anti-Anxiety Medications (non-benzodiazepines)		Buspirone (BuSpar)				
Antidepressants		Amitriptyline (Elavil)	Amoxapine (Asendin)	Bupropion (Wellbutrin)	Citalopram (Celexa)	Clomipramine (Anafranil)
		Desipramine (Norpramin)	Desvenlafaxine (Pristiq)	Duloxetine (Cymbalta)	Doxepin (Sinequan)	Escitalopram (Lexapro)
		Fluoxetine (Prozac, Sarafem)	Fluvoxamine (Luvox)	Imipramine (Tofranil)	Maprotiline (Ludiomil)	Mirtazapine (Remeron))
		Nefazodone (Serzone)	Nortriptyline (Pamelor)	Paroxetine (Paxil, Pexeva)	Protriptyline (Vivactil)	Sertraline (Zoloft)
		Trazodone (Desyrel, Oleptro)	Trimipramine (Surmontil)	Venlafaxine (Effexor)	Vilazodone (Viibryd)	Vortioxetine (Trintellix)
		Dextromethorphan Hydrobromine/ Bupropion (Aubelity ER)				
Antipsychotics: Atypical, Second Generation, and a Phenothiazine and/or Tranquilizers		Aripiprazole (Abilify)	Asenapine (Saphris)	Brexiprazole (Rexulti)	Cariprazine (Vraylar)	Chlorpromazine (Thorazine)
		Clozapine (Clozaril)	Droperidol (Inapsie)	Fluphenazine (Prolixin)	Haloperidol (Haldol)	Fluphenazine (Prolixin)
		Haloperidol (Haldol)	Iloperidone (Fanapt)	Loxapine (Loxitane)	Lumateperone Tosylte (Caplyta)	Lurasidone (Latuda)
		Molindone (Moban*)	Olanzapine (Zyprexa)	Olanzapine/Fluoxetine (Symbyax)	Perphenazine (Trilafon)	Pimozide (Orap)
		Paliperidone (Invega)	Perphenazine (Trilafon)	Pimozide (Orap)	Quetiapine (Seroquel)	Risperidone (Risperdal)
		Thioridazine (Mellaril)	Thiothixene (Navane)	Trifluoperazine (Stelazine)	Ziprasidone (Geodon)	

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GENERAL DESCRIPTION		PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names are in parentheses) **Note: This list is not all inclusive of brand names and formulations, all Behavioral Health medications. All brands and formulations are to be covered. New FDA medications approved to market are automatically included in this list.**			
Monoamine Oxidase Inhibitors		Isocarboxazid (Marplan)	Phenelzine (Nardil)	Tranylcypromine (Parnate)	Selegiline (Emsam)
Anti-Mania Medications		Lithium carbonate (Lithobid)		Lithium Citrate	
Anticonvulsant Mood Stabilizers		Carbamazepine (Tegretol)	Divalproex sodium (Depakote)	Gabapentin (Neurontin) *for use in alcohol use disorder	Lamotrigine (Lamictal)
		Oxarbazepine (Trileptal)	Topiramate (adjunct) (Topamax)	Valproic acid (Depakene)	
ADHD Treatments		Atomoxetine (Strattera)	Clonidine (Catapres)	Amphetamine (Adzenys)	Amphetamine/ Dextroamphetamine (Adderall)
		Methylphenidate (Concerta, Ritalin)	Guanfacine (Intuniv)	Dexmethylphenidate (Focalin)	Dextroamphetamine (Dexedrine)
		Lisdexamfetamine (Vyvanse)	Methamphetamine (Desoxyn)	Viloxazine (Qelbree)	
Long Acting Injectable Antipsychotics		Aripiprazole IM (Abilify Maintena)	Aripiprazole Lauroxil IM (Aristada)	Fluphenazine Decanoate IM (Prolixin)	Haloperidol Decanoate IM (Haldol Decanoate)
		Olanzapine IM (Zypreza Relprevv)	Paliperidone Palmitate Gluteal (Invega Hafyera)	Paliperidone Palmitate IM (Invega Sustenna)	Paliperidone Palmitate ER IM (Invega Trinza)
		Risperidone IM, (Risperidal Consta)	Risperidone SQ (Perseris)		
		Acamprosate (Campral)	Buprenorphine (Sublocade) (Brixadi)	Buprenorphine/Naloxone (Suboxone, Zubsolv)	Disulfiram (Antabuse)

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GENERAL DESCRIPTION		PRIMARY EXAMPLES OF MEDICATIONS IN THE CATEGORY (brand names are in parentheses) **Note: This list is not all inclusive of brand names and formulations, all Behavioral Health medications. All brands and formulations are to be covered. New FDA medications approved to market are automatically included in this list.**			
Medication Assisted Treatment for substance use disorders		Lofexidine (Lucemyra)	Naltrexone (Vivitrol)		
Other		Liothyronine (Cytomel) *for augmentation in severe depression	Prazosin (Minipress) *for PTSD	Pramipexole (Mirapex) *for augmentation in severe depression	

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Attachment 8: CAHPS Supplement Questions

NCQA Tracking Number	Child Questions	Response Categories Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always)	If Required by State Medicaid Agency, which one?	NCQA Decision
990231	Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?	Yes; No [Insert Skip Pattern if Necessary]	New Mexico	Approved
990232	In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it?	Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months]	New Mexico	Approved
990233	In the last 6 months, how often did the help with transportation meet your needs?	Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months]	New Mexico	Approved
990234	In the last 6 months, how long did it take to get an appointment for regular or routine care? (For example, preventive care or a complete physical)	1–7 days; 8–21 days; 22–30 days; 31 days or more; My child did not need an appointment for regular or routine care	New Mexico	Approved
990235	In the last 6 months, if you had a problem getting the care, tests, or treatment you thought you needed through your health plan, what was the main problem you had?	Plan did not approve my child's care, tests, or treatment; Care, tests, or treatment delayed while waiting for plan's approval; Providers I wanted my child to see were not in plan or network; Could not get an appointment with provider at a convenient time; The cost to me for my child's care, tests, or treatment was too high; Brand name medications I wanted cost more than the generic available; The cost of my child's medications was too high; Problem	New Mexico	Approved

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		getting plan to pay claims after getting care, tests, or treatment; Problem getting a referral to a specialist; Other (Please Specify): _____; I did not have a problem getting care, tests, or treatment		
990236	In the last 6 months, if you needed non-emergency care after your doctor's office was closed, where did you get it?	I received help from my doctor's office; I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care; I did not need after hours care	New Mexico	Approved
990237	In the last 6 months, if you needed non-emergency care during doctor's office hours, and your provider was not available, where did you receive care?	I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care	New Mexico	Approved
990238	In the last 6 months, if you needed to see a mental health or substance use disorder specialist how often was it easy to get an appointment as soon as needed?	Never; Sometimes; Usually; Always; I did not see a mental health or substance use disorder specialist in the last 6 months [Insert skip pattern, if necessary]	New Mexico	Approved

NCQA Tracking Number	**Adult Questions**	**Response Categories** Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always)	**If Required by State Medicaid Agency, which one?**	**NCQA Decision**

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990239	Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?	Yes; No [Insert Skip Pattern if Necessary]	New Mexico	Approved
990240	In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it?	Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months]	New Mexico	Approved
990241	In the last 6 months, how often did the help with transportation meet your needs?	Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months]	New Mexico	Approved
990242	In the last 6 months, how long did it take to get an appointment for regular or routine care? (For example, preventive care or a complete physical)	1 – 7 days; 8 – 21 days; 22 – 30 days; 31 days or more; I did not need an appointment for regular or routine care	New Mexico	Approved
990243	In the last 6 months, if you had a problem getting the care, tests, or treatment you thought you needed through your health plan, what was the main problem you had?	Plan did not approve my care, tests, or treatment; Care, tests, or treatment delayed while waiting for plan's approval; Providers I wanted to see were not in my plan or network; Could not get an appointment with a provider at a convenient time; The cost for care, tests, or treatment was too high for me; Brand name medications I wanted cost more than the generic available; The cost of my medications was too high; Problems getting my plan to pay claims after getting care, tests, or treatment; Problems getting a referral to a specialist; Other (Please Specify):_____; I did not have a problem getting care, tests, or treatment	New Mexico	Approved

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990244	In the last 6 months, if you needed non-emergency care after your doctor's office was closed, where did you get it?	I received help from my doctor's office; I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care; I did not need after hours care	New Mexico	Approved
990245	In the last 6 months, if you needed non-emergency care during doctor's office hours, and your provider was not available, where did you receive care?	I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care	New Mexico	Approved
990246	In the last 6 months, if you needed to see a mental health or substance use disorder specialist how often was it easy to get an appointment as soon as needed?	Never; Sometimes; Usually; Always; I did not see a mental health or substance use disorder specialist in the last 6 months [Insert skip pattern, if necessary]	New Mexico	Approved

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Attachment 9: SUPPORT Act Requirements

The CONTRACTOR is required to implement the requirements of the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" or the "SUPPORT for Patients and Communities Act" into policy and procedures for all contracted Medicaid services statewide.

Opioid Claims Review

(I) A real-time prospective drug utilization review (DUR)of the sort defined in section 1927(g)(2)(A) of the Social Security Act, for each prescription that identifies potential problems at point of sale to engage both patients and prescribers about possible opioid abuse and overdose risk prior to the prescription being dispensed to the patients.

(II) An automated claim review process as a retrospective DUR of the sort defined in section 1927(g)(2)(B) of the Social Security Act, that provides for additional examination of claims data to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.

(III) Both the prospective and the retrospective DUR will be consistent with medical practice patterns in New Mexico to help meet the health care needs of the Medicaid patient population in the state. The Centers for Medicare & Medicaid Services encourage states to utilize, for example, the 2016 Centers for Disease Control and Prevention Guideline for primary care practitioners on prescribing opioids in outpatient settings for chronic pain.

(IV) **Claims Review Requirements**

1. **Safety Edits Including Early, Duplicate, and Quantity Limits**: Limitations in both prospective and retrospective DUR should include restrictions on duplicate fills, early fills, and drug quantity limitations.

2. **Maximum Daily Morphine Milligram Equivalents Safety Edits:** Both the prospective and retrospective DUR safety edits must include a morphine milligram equivalents threshold amount such as the level that is recommended in the 2016 Centers for Disease Control Guideline referenced in section (III) above.

3. **Concurrent Utilization Alerts**: Both the prospective and retrospective DUR safety edits must be able to provide alerts for concurrently prescribed opioids and benzodiazepines or opioids and antipsychotics, as well as potential complications resulting from other medications concurrently being prescribed with opioids.

4. **Care Coordination:** All safety edits will activate Care Coordination for the deliberate organization of Member care activities between all participants involved in the Member's care to facilitate the appropriate delivery of health care services.

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(V) **Exemptions** – The drug review and utilization requirements under this subsection shall not apply with respect to an individual who is receiving hospice or palliative care or treatment for cancer; or is a resident of a long-term care facility, a facility described in section 1905(d) of the Social Security Act, or of another facility for which frequently abused drugs are dispensed for residents through a contract with a single pharmacy.

(VI) **Opioid Therapy Edits** – Opioid pharmacy claims that exceed the maximum morphine milligram equivalents per day, as determined by the state, will be flagged and may be denied. If the prescriber deems that it is medically necessary for the recipient to exceed the maximum morphine milligram equivalents per day limit, the prescriber must complete the *Drug Prior Authorization Request* form and fax the completed signed form requesting to increase the maximum prescribed morphine milligram equivalents limit to the prior authorization unit of the recipient's assigned benefit plan for clinical review. If a recipient presents a new prescription to the pharmacy that exceeds a previously approved morphine milligram equivalents limit, this is considered an additional request requiring the prescriber to again submit for prior authorization. Subsequent requests by a prescriber to increase a morphine milligram equivalents limit will require the prescriber to submit a new request.

When the pharmacist cannot reach a prescriber or when the prior authorization departments are closed, the pharmacist, using his/her/their professional judgement, may deem the filling of the prescription for these edits to be an "emergency." In these emergency cases, the pharmacist must document "Emergency Prescription" in writing on the hardcopy prescription or in the pharmacy's electronic recordkeeping system and can override the pharmacy claim at point-of-sale by contacting the health plan's pharmacy help desk.

The CONTRACTOR will offer education and training to all providers on new opioid provisions to help minimize workflow disruption and to ensure that Members have continuity of care. Prior authorization may be necessary to avoid abrupt opioid withdrawal for patients that need to taper off high doses of opioids to minimize potential symptoms of withdrawal and manage their treatment regimen, while encouraging pain treatment using non-pharmacologic therapies and non-opioid medications when appropriate.

(VII) **Program To Monitor Antipsychotic Medications By Children** – The CONTRACTOR shall develop and implement a program to monitor and manage the appropriate use of antipsychotic medications by children and submit quarterly to the Health Care Authority any information as may be required on activities carried out under a monitoring program for individuals not more than the age of 18 years. See also Section 4.24.5 of this Agreement for requirements specific to CISC Members.

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(VIII) **Fraud And Abuse Identification** – The CONTRACTOR shall develop and implement a process that identifies potential fraud or abuse of controlled substances by individuals, health care providers prescribing drugs to individuals, and pharmacies dispensing drugs to individuals.

(IX) **DRUG UTILIZATION REVIEW ACTIVITIES AND REQUIREMENTS** – The CONTRACTOR must comply with the applicable provisions of 42 C.F.R. § 438.3(s)(2), § 483.3(s)(4), and § 483.3(s)(5).

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Attachment 10: Directed Payments

Directed Payments are subject to change each year, and any changes will be outlined in Letters of Direction.

Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
Health Care Quality Surcharge -Value Based Purchasing Program (HCQS-VBP)	January 1, 2020 Updated July 1, 2025	Nursing Facilities per the following classifications: I: Less than 60 beds II: 60 or more beds and less than 90,000 annual Medicaid bed days III: 60 or more beds and 90,000 or more annual Medicaid bed days	A uniform dollar increase to Nursing Facility per diem rates for the market basket index (MBI) factor and per diem add-on for each respective class of Nursing Facility as defined in New Mexico statute, §7-41-4 and §7-41-6, and Quality incentive payments incorporated in the rates as a separate payment term to Nursing Facilities for achieving performance targets across quality measures. Achievement is validated by the HCA-selected data intermediary and the MCOs distribute the earned amounts to each Nursing Facility on a quarterly basis as specified by HCA	Monthly Capitation (Per Diem and MBI) and Quarterly Separate Payment Term (Quality)	Per claim for per diem and MBI factor Quarterly for quality
University of New Mexico Medical Group (UNMMG)	January 1, 2019	The University of New Mexico Health Sciences Center clinical delivery system including: UNM Medical Group, , UNM Hospitals, and associated clinics and programs	Uniform percentage increase to contracted rates between the practice plans and the MCOs.	Quarterly Separate Payment Term based on HCA's analysis of utilization data from the MCOs.	As directed by HCA upon the MCOs' receipt of payment from HCA
Community Tribal Hospital	January 1, 2020	Community hospitals that serve a disproportionate share of Native American Members as measured relative to their total Medicaid utilization as defined in the approved preprint for the respective contract year.	Uniform percentage increase to contracted rates between the class of covered hospitals and the MCOs for inpatient hospital services.	Monthly Capitation	Per claim
University of New Mexico Hospital (UNMH)	January 1, 2020	The eligible class of providers is defined as a hospital that, pursuant to a lease agreement, has assumed a New Mexico county's perpetual contractual obligation to the United States government, through the Indian Health Service, to provide	Uniform dollar amount for inpatient and outpatient hospital services with a portion at-risk for meeting specified performance metrics. The quality incentive payment is incorporated in the rates as a separate payment term to UNMH for achieving performance targets across quality	Quarterly Separate Payment Term based on HCA's review of utilization. HCA reviews UNMH's performance on the	As directed by HCA upon the MCOs' receipt of payment for the utilization increase and for the earned quality-related funds.

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Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		guaranteed access to care for Native Americans.	measures. Quality achievement is validated by the HCA/MAD-Quality Bureau and the MCOs distribute the earned amount to UNMH on a annual basis as specified by HCA.	specified quality metrics for the rating period and distributes one (1) separate payment for this component of the directed payment.	
HealthCare Delivery Access Act (HDAA) Formerly Hospital Value Based Payment Program (HVBP) CY23 Formerly Hospital Access Program (HAP) CY2020 – CY 2022)	July 1, 2024	HDAA Hospitals ALBUQUERQUE ER AND MEDICAL HOSPITAL - COORS ALBUQUERQUE ER AND MEDICAL HOSPITAL -MONTGOMERY ALTA VISTA REGIONAL HOSPITAL ARTESIA GENERAL HOSPITAL CARLSBAD MEDICAL CENTER CIBOLA GENERAL HOSPITAL COVENANT HEALTH HOBBS HOSPITAL DR. DAN C. TRIGG MEMORIAL HOSPITAL EASTERN NEW MEXICO MEDICAL CENTER PRESBYTERIAN HEALTHCARE SERVICES (ESPANOLA HOSPITAL) OTERO COUNTY HOSPITAL ASSOCIATION (GERALD CHAMPION REGIONAL MEDICAL CENTER) GILA REGIONAL MEDICAL CENTER GUADALUPE COUNTY HOSPITAL HOLY CROSS HOSPITAL LINCOLN COUNTY MEDICAL CENTER LOS ALAMOS MEDICAL CENTER LOVELACE MEDICAL CENTER - DOWNTOWN LOVELACE REGIONAL HOSPITAL-ROSWELL LOVELACE WESTSIDE HOSPITAL LOVELACE WOMENS HOSPITAL MEMORIAL MEDICAL CENTER	A uniform dollar amount for inpatient and outpatient hospital services based on actual utilization for HDAA hospitals. Quality incentive payments are incorporated in the rates as a separate payment term to HDAA hospitals for achieving performance targets across quality measures. Achievement is validated by the HCA-selected data intermediary and the MCOs distribute the amounts earned to each HDAA hospital on an annual basis as specified by HCA	Quarterly Access Separate Payment Term Annual Quality Separate Payment Term	As directed by HCA upon the MCOs' receipt of payment from HCA Annually for quality

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Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		DEMING HOSPITAL (MIMBRES MEMORIAL HOSPITAL) MINERS COLFAX MEDICAL CENTER MOUNTAINVIEW REG MEDICAL CENTER NORLEA HOSPITAL PLAINS REGIONAL MEDICAL CENTER - CLOVIS PRESBYTERIAN HOSPITAL DOWNTOWN REHOBOTH MCKINLEY CHRISTIAN HOSPITAL ROOSEVELT GENERAL HOSPITAL SJRMC INPATIENT REHABILITATION UNIT (SAN JUAN REGIONAL MEDICAL CENTER) SANTA FE MEDICAL CENTER SIERRA VISTA HOSPITAL SOCORRO GENERAL HOSPITAL ST. VINCENT HOSPITAL THREE CROSSES REGIONAL HOSPITAL UNION COUNTY GENERAL HOSPITAL CARLSBAD MEDICAL CENTER REHABILITATION ADVANCED CARE HOSPITAL OF SOUTHERN NM (LTCH) ALBUQUERQUE - AMG SPECIALTY HOSPITAL (LTCH) SOCORRO GENERAL HOSPITAL ST. VINCENT HOSPITAL THREE CROSSES REGIONAL HOSPITAL UNION COUNTY GENERAL HOSPITAL CARLSBAD MEDICAL CENTER REHABILITATION ADVANCED CARE HOSPITAL OF SOUTHERN NM (LTCH) ALBUQUERQUE - AMG SPECIALTY HOSPITAL (LTCH) CLEARSKY REHABILITATION HOSPITAL OF RIO RANCHO			

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Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		ENCOMPASS HEALTH REHABILITATION HOSPITAL KINDRED HOSPITAL ALBUQUERQUE LOVELACE UNM REHABILITATION HOSPITAL REHABILITATION HOSPITAL OF SOUTHERN NM PRESBYTERIAN KASEMAN HOSPITAL MESILLA VALLEY HOSPITAL LLC BEHAVIORAL HEALTH SERVICES OF NEW MEXICO, LLC (CENTRAL DESERT BEHAVIORAL) HAVEN BEHAVIORAL SENIOR CARE OF ALBUQUERQUE THE PEAK HOSPITAL			
Primary Care Payment Reform Value Based Program (PCPR-VBP)	July 1, 2024	To participate in the Primary Care Payment Reform (PCPR), eligible primary care providers must: Meet the "PCPR VBP Program Criteria" detailed on the PCPR webpage (https://www.hca.nm.gov/primary-care-council/primary-care-payment-reform/), Be Medicaid-certified and contracted with at least one MCO, Provide primary care services as defined in the Turquoise Care contract, Complete the PCPR registration process, Execute required contracts and/or agreements with MCO(s),	Uniform percentage increase for eligible utilization at provider class practices, amounts incorporated in the rates as a separate payment term. Quality incentive payments are incorporated in the rates as a separate payment term to PCPR-VBP eligible providers for achieving performance targets across quality measures. Quality achievement is validated by the HCA-selected data intermediary and the MCOs distribute the earned amounts to each PCPR-VBP provider on a quarterly basis as specified by HCA	Quarterly Separate Payment Term (Quality)	Per claim and quarterly for quality

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Name of Directed Payment	Effective Date	Provider Class	Type of Directed Payment	Payment Terms to MCO	Frequency of Payments to Providers
		Submit required data, including quality metric data, to the Data Intermediary as outlined in the "New Mexico Medicaid PCPR VBP Program Implementation Guidebook for Primary Care Providers," Have Medicaid utilization during the performance period, Have a panel of attributed primary care patients.			
Ambulance Supplemental Payment Program (ASPP)	January 1, 2024	Government Owned Emergency Transport providers who submitted a cost report for the prior year, enrolled in Medicaid, and provide services to Medicaid beneficiaries.	A uniform dollar amount to EMS Providers based on per trip EMS ground ambulance encounters from MCOs	Quarterly Separate Access Payment Term	As directed by HCA upon the MCOs' receipt of payment from HCA.
Minimum Fee Schedule	July 1, 2024	Any Contract provider, Non-Contract Nursing Facility provider, or Non-Contract Hospital provider enrolled as a Medicaid provider.	Minimum fee schedule based on State Plan approved rates	Monthly Capitation	Per encounter
Non-Contract Providers Minimum Fee Schedule	July 1, 2024	Non-Contract Providers except as otherwise precluded by law and/or specified for I/T/Us, FQHCs/RHCs, family planning Providers, Emergency Service Providers, Nursing Facilities, and hospitals.	Minimum fee schedule based on 95% of State Plan approved rates	Monthly Capitation	Per Encounter
Turquoise Care 1115 Waiver Food as Medicine Meals for Pregnant Members	July 1, 2025	Providers billing for Food as Medicine Meals for Pregnant Members services.	Minimum fee schedule based on 1115 Waiver-approved rates.	Monthly Capitation	Per Encounter

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- The CONTRACTOR must comply with Section 4.10.12 Directed Payments.
- The effective dates of the directed payments are contingent on CMS approval and subject to annual renewal unless otherwise noted. Directed payments without a specified end date are anticipated to be in place for the duration of the term of this Agreement and will be removed from this Attachment if ended prior to the termination of the contract term.
- For directed payments operationalized through a Separate Payment Term, the amount of the payment each quarter will be based on emerging utilization data. The CONTRACTOR is required to submit utilization and paid amounts by procedure code, rate cohort and month in which the service occurred for each quarter. Each subsequent quarter will include a look-back period to account for claims lag.
- For directed payments operationalized through capitation, HCA may request ad hoc reporting to verify accuracy of information used to determine payment and will take action on any Provider complaints on the respective directed payment, and review and potentially reconcile the state directed payment, as needed.
- HCA will also rely on sanctions, including monetary penalties, for noncompliance as specified in Section 7.3.3 Sanctions.

Attachment 11: Non-Risk Arrangements

This attachment sets forth the services under the CONTRACT that are under a non-risk arrangement, in accordance with 42 C.F.R. § 447.362.

Non-Risk Arrangement	Services subject to the non-risk arrangement	Frequency of payment from HCA to the CONTRACTOR based on reported utilization
1. Medical Respite Services	Medical Respite Services	Quarterly
2. I/T/U Services	I/T/U Services	Quarterly

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Attachment 12: Turquoise Care PMs and TMs

Table 12.a PMs

Measure Performance Measures are based on NCQA HEDIS measure technical specifications for the current reporting year unless otherwise specified by HCA.		**Targets** Each CY target is a result of the CY22 NCQA Quality Compass National Average, calculating an average increase for each CY until reaching the CY22 Quality Compass National Average plus one percentage point.			
1	Well-Child Visits in the First 30 Months of Life (W30) (two indicators):	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	1. The percentage of members who turned 15 months old during the measurement year and had six or more well-child visits.	56.76%	54.50%	56.13%	57.76%
	2. The percentage of members who turned 30 months old during the measurement year and had two or more well-child visits.	66.74%	64.48%	66.11%	67.74%
2	Child and Adolescent Well-Care Visits (WCV) (three indicators): The percentage of members 3 - 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	1. 3-11 years of age	56.50%	54.24%	55.87%	57.50%
	2. 12-17 years of age	49.94%	47.68%	49.31%	50.94%
	3. 18-21 years of age	25.99%	23.73%	25.36%	26.99%
3	Prenatal and Postpartum Care (PPC) (two indicators):	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
	1. Timeliness of Prenatal Care: The percentage of deliveries in which members had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment.	82.95%	80.69%	82.32%	83.95%
	2. Postpartum Care: The percentage of deliveries in which members had a postpartum visit on or between seven and 84 days after delivery.	76.96%	74.70%	76.33%	77.96%
4	Oral Evaluation Dental Services (OED): The percentage of members under 21 years of age, who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.	CY22 National Average (ADV)	CY25 Target	CY26 Target	CY27 Target
		47.27%	45.01%	46.64%	48.27%

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Measure Performance Measures are based on NCQA HEDIS measure technical specifications for the current reporting year unless otherwise specified by HCA.		Targets Each CY target is a result of the CY22 NCQA Quality Compass National Average, calculating an average increase for each CY until reaching the CY22 Quality Compass National Average plus one percentage point.			
5	Follow up After Hospitalization for Mental Illness (FUH) (7 Day): The percentage of discharges for members six (6) years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnosis and who had a follow-up visit with a mental health practitioner within 7 days after discharge.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		32.18%	29.92%	31.55%	33.18%
6	Breast Cancer Screening (BCS): The percentage of members 50-74 years of age who had at least one mammogram to screen for breast cancer in the past two years.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		52.43%	50.17%	51.80%	53.43%
7	Follow-up Care for Children Prescribed ADHD Medication (ADD-E) (Initiation Phase): The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		43.62%	41.36%	42.99%	44.62%
8	Immunizations for Adolescents (IMA): The percentage of members 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus vaccine series by their 13th birthday.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		35.55%	33.29%	34.92%	36.55%
9	Pharmacotherapy for Opioid Use Disorder (POD): The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		27.48%	25.22%	26.85%	28.48%
10	Glycemic Status Assessment for Patients with Diabetes (GSD): The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9.0% (poor control) during the measurement year. (lower is better)	CY22 National Average (CDC)	CY25 Target	CY26 Target	CY27 Target
		40.34%	42.60%	40.97%	39.34%

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Measure Performance Measures are based on NCQA HEDIS measure technical specifications for the current reporting year unless otherwise specified by HCA.		Targets Each CY target is a result of the CY22 NCQA Quality Compass National Average, calculating an average increase for each CY until reaching the CY22 Quality Compass National Average plus one percentage point.			
11	Eye Exam for Patients with Diabetes (EED): The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.	CY22 National Average (CDC)	CY25 Target	CY26 Target	CY27 Target
		51.47%	49.21%	50.84%	52.47%
12	Kidney Health Evaluation for Patients with Diabetes (KED): The percentage of diabetic members 18-85 years of age who received an annual kidney health evaluation, including a blood test for kidney function (estimated glomerular filtration rate [eGFR]) and a urine test for kidney damage (urine albumin-creatinine ratio [uACR]) during the measurement year.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		34.54%	32.28%	33.91%	35.54%
13	Lead Screening in Children (LSC): The percentage of members two years of age who had one or more capillary or venous blood test for lead poisoning by their second birthday.	CY22 National Average	CY25 Target	CY26 Target	CY27 Target
		59.36%	57.10%	58.73%	60.36%

Table 12.b TMs

Measure	
1	Smoking Cessation: 1. Total number of unduplicated members receiving smoking and tobacco cessation products/services (nicotine replacement, counseling services, quit line, and medications) 2. Total number of units for smoking and tobacco cessation products and services 3. Total dollar amount for smoking and tobacco cessation products and services 4. Total of unduplicated members receiving smoking and tobacco cessation products/services, nicotine replacement, counseling services, quit line, and medications who have successfully quit smoking
2	Childhood Immunization Status (CIS) (Combination 3): The percentage of members two years of age who had the following vaccinations: (4) DTaP, (3) IPV, (1) MMR, (3) HiB, (3) HepB, (1) VZV, and (4) PCV by their second birthday.
3	Follow-Up After ED Visit for Mental Illness (FUM) (7 Day): The percentage of emergency department visits for members six years of age and older with a principal diagnosis of mental illness or intentional self-harm who received a follow-up visit for mental illness within seven days of the ED visit.
4	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (two indicators): The percentage of members 12 years of age and older who were screened for

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Measure	
	clinical depression using a standardized instrument and, if screened positive, received follow-up care. 1. 12 -17 years of age 2. 18 years of age and older
5	Cervical Cancer Screening (CCS): The percentage of women 21-64 years of age who were screened for cervical cancer.
6	Statin Therapy for Patients with Diabetes (SPD) and Cardiovascular Disease (SPC) (four indicators): The percentage of members with Diabetes and Cardiovascular Disease who received and adhered to statin therapy. 1. Diabetes (SPD) Received Statin Therapy 2. Diabetes (SPD) 80% Adherence 3. Cardiovascular disease (SPC) Received Statin Therapy 4. Cardiovascular disease (SPC) 80% Adherence
7	Contraceptive Care for Women (four indicators): The percentage of members provided most effective or moderately effective method of contraception, or a long-acting reversible method of contraception (LARC). 1. 15-20 years of age (CCW) 2. 21-44 years of age (CCW) 3. Postpartum, 15-20 years of age (CCP) 4. Postpartum, 21-44 years of age (CCP)
8	Initiation and Engagement of Substance Use Disorder (IET): 1. Initiation Phase: The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. 2. Engagement Phase: The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
9	Prenatal Depression Screening and Follow-Up (PND-E): The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.
10	Postpartum Depression Screening and Follow-up (PDS-E) The percentage of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period.
11	Diabetes Short Term Complications Admission Rate: The percentage of discharges with a principal ICD-10 diagnosis code for diabetes short-term complications (ketoacidosis, hyperosmolarity, or coma). (lower is better)

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Attachment 13: CISC CONTRACTOR PMs and TMS

Table 13.a CISC PMs

	Measure	Measurement Steward
1	Lead Screening in Children (LSC): The percentage of CISC two years of age who had one or more capillary or venous blood test for lead poisoning by their second birthday.	NCQA
2	Well-Child Visits in the First 30 Months of Life (W30): The percentage of CISC with six or more well-child visits in the first 15 months of life.	NCQA
3	Well-Child Visits in the First 30 Months of Life (W30): The percentage of CISC with two or more well-child visits at 15 months to 30 months of life.	NCQA
4	Immunizations for Adolescents (IMA): The percentage of CISC 13 years of age who had (one) dose of meningococcal vaccine, one dose of Tdap, and complete human papillomavirus vaccine series by their 13th birthday.	NCQA
5	Child and Adolescent Well-Care Visits (WCV) (two indicators): The percentage of CISC 3-17 years of age who received one or more well-care visit with a PCP or OB/GYN. 1. 3-11 years of age 2. 12-17 years of age	NCQA
6	Childhood Immunization Status (CIS) (Combination 3): The percentage of CISC two years of age who had the following vaccinations: (4) DTaP, (3) IPV, (1) MMR, (3) HiB, (3) HepB, (1) VZV, and (4) PCV.	NCQA
7	Follow-up Care for Children Prescribed ADHD Medication (ADD) (Initiation Phase): The percentage of CISC between six and 12 years of age who were diagnosed with ADHD who had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.	NCQA

Table 13.b CISC TMs

	Measure	Measurement Steward
1	Oral Evaluation Dental Services (OED)	NCQA
2	Follow up After Hospitalization for Mental Illness 6-17 – (7-Day)	NCQA
3	Follow up After Hospitalization for Mental Illness 6-17 – (30-Day)	NCQA
4	Follow up After ED Visit for Mental Illness 6-17 – (7-Day)	NCQA
5	Follow up After ED Visit for Mental Illness 6-17 – (30-Day)	NCQA
6	Hospital Readmissions Within 30 days of Discharge 2-17 years	HCA

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Measure		Measurement Steward
7	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA

Measure		Measurement Methodology
8	Rate of CISC in Out-of-State Residential Placements	Year 1 (the first complete measurement year): Report on the number of out-of-state residential placements HCA will develop the specifications for this measure for Year 2 based upon the baseline data collected in Year 1
9	Length of Stay (LOS) for Behavioral Health (BH) Inpatient Hospitals: Median LOS per utilizer for BH Inpatient Hospital stratified by service type for each quarter of the MY and annual	Methodology: Sum of LOS for each service type X/number of CISC in service type X
10	Foster Care Placement Disruptions Due to BH: Rate of CISC who had an unplanned change in foster care placement due to a BH issue per 1,000 eligible beneficiaries for each quarter of the MY and annual	Methodology: Number of enrolled CISC who had an unplanned change in placement due to a BH need/number of CISC * 1,000
11	Emergency Department (ED) Utilization: Rate of CISC with a claim for an ED encounter for BH related issue per 1,000 eligible beneficiaries for each quarter of the MY and annual	Methodology: Number of enrolled CISC with a claim for an ED encounter for BH/number of enrolled beneficiaries * 1,000

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Attachment 14: 2025 Turquoise Care 1115 Demonstration Waiver Initiatives

With the exception of Medical Respite, starting July 1, 2025, and subject to final CMS approvals, THE CONTRACTOR will offer the new benefits listed in the table below, in accordance with the Turquoise Care 1115 Demonstration Special Terms and Conditions (STC), Protocols, Implementation Plans, and other guidance documents, and as further detailed in the MCO Policy Manual and NMAC. The start date for Medical Respite is contingent on CMS approval.

Initiative Name	Initiative Description	Service Definition	Additional Information
Medical Respite	Acute and post-acute medical care for people who are homeless who are too ill to recover from sickness or injury on the street or in a shelter, but not sick enough to warrant hospital level care	Short-term post-hospitalization housing with room and board for up to six months per rolling year, only where integrated, clinically-oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing services are limited to a clinically appropriate amount of time.	See Attachment 11: Non-Risk Arrangements. Additional information on program limits, implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC.
Food is Medicine Nutrition Supports for Pregnant Members	Delivery of prepared meals or grocery boxes that provide the nutritional equivalent of up to three meals per day and will be available for up to the length of the pregnancy and up to twelve months postpartum.	Home delivered meals (medically-tailored meals) and food boxes, tailored to health risk, for pregnant individuals who meet risk and needs-based criteria.	Additional information on program limits, implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC. The Contractor will implement nutrition supports that are nutritionally tailored, culturally relevant, and that elevate local food systems and vendors. The Contractor must submit an implementation plan for HCA approval, highlighting their support of local vendors and path to meet HCA' s goals for Food is Medicine Nutrition Supports to HCA no later than June 1 , 2025 .
Food is Medicine Nutrition Supports for Community Benefit Members	Provide individuals enrolled in the Community Benefit program meeting eligibility criteria up to two meals per day.	Services to provide and deliver home delivered meals on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both	Additional information on program implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC. The Contractor will implement nutrition supports that are nutritionally tailored, culturally relevant, and that elevate local food systems and vendors.

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		health and social services needed to ensure the optimal functioning of the participant. Services are furnished consistent with the participant's person-centered service plan. Meals provided as part of these	The Contractor must submit an implementation plan for HCA approval, highlighting their support of local vendors and path to
		services shall not constitute a "full nutritional regimen" (3 meals per day).	meet HCA's goals for Food is Medicine Nutrition Supports to HCA no later than June 1, 2025 .
JUST Health Plus	The JUST Health Plus program will offer Pre-release services including but not limited to case management, medication assisted treatments and 30 days of prescription medication at release for Medicaid members in a correctional facility who are within 90 days of release. JUST Health Plus builds upon the foundation of the JUST Health programs phasing-in expansions to enhance pre-release services and post- release continuity of care. The Contractor will coordinate justice liaison and transition of care services for JUST Health Pluss and will not be at risk for pre-release medical services. JUST Health Plus will be phased in by facility. Until JUST Health Plus has been implemented in a correctional facility, the Contractor is required to follow the requirements for JUST Health as stated in the contract.	The Contractor shall follow existing Turquoise Care service definitions for the HCA-specified pre-release services.	Implementation will be phased in to select NMCD and CYFD facilities in 2025 as specified by HCA. Additional information on program implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC.

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Exhibit A
HIPAA Business Associate Agreement

This Business Associate Agreement ("BAA") is entered into between the New Mexico Health Care Authority ("HCA"), the New Mexico Behavioral Health Purchasing Collaborative (the "Collaborative") and United Healthcare Insurance Company, hereinafter referred to as "Business Associate", (the "Parties") in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), including the Standards of the Privacy of Individually Identifiable Health Information and the Security Standards at 45 C.F.R.s § 160, § 162 and § 164, as amended and other relevant laws, including subsequently adopted provisions applicable to use and disclosure of Confidential Information and applicable agency guidance.

BUSINESS ASSOCIATE, by this Professional Services Contract (PSC) 24-630-8000-0030, ("the Related Agreement") has agreed to provide services to, or on behalf of, HCA which may involve the disclosure by the HCA to the Business Associate (referred to in PSC 24-630-8000-0030 as "CONTRACTOR") of Protected Health Information. This BAA is intended to supplement and to supersede all prior Business Associate agreements between the parties and to restate the respective obligations of the HCA and the CONTRACTOR as set forth in PSC 24-630-8000-0030 and is hereby incorporated therein.

THE PARTIES acknowledge HIPAA, the HITECH Act and the U.S. Department of Health and Human Services final rule, effective March 26, 2003, modifying HIPAA and the Privacy and Security Rules ("the HIPAA Omnibus Rule") require that Department and Business Associates enter into a written agreement to establish the permitted and required uses and disclosures of Protected Health Information by the Business Associate, which Department may disclose to the Business Associate, or which may be created, received, maintained, or transmitted for a function or activity by the Business Associate on behalf of the Department during the term of their Related Agreement and after termination.

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1. Definition of Terms

a. Breach. "Breach" has the meaning assigned to the term breach under 42 U.S.C. §17921(1) [HITECH Act § 13400 (1)] and 45 C.F.R. § 164.402, as amended.

b. Business Associate. "Business Associate", herein being the same entity as the CONTRACTOR in the same or Related Agreement, shall have the same meaning as defined under the HIPAA standards as defined below, including without limitation, the CONTRACTOR acting in the capacity of a Business Associate as defined in 45 C.F.R. § 160.103, as amended.

c. Authority. "Authority" shall mean in this agreement the State of New Mexico Health Care Authority.

d. Individual. "Individual" shall have the same meaning as in 45 C.F.R. §160.103 and shall include a person who qualifies as an authorized personal representative in accordance with 45 C.F.R. §164.502 (g).

e. HIPAA Standards. "HIPAA Standards" shall mean the privacy, security and breach notification provisions applicable to a Business Associate as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009 and the regulations and policy guidance, as each may be amended over time, including without limitation:

i. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information in 45 C.F.R. § 160 and Part 164, Subparts A and E, as amended.

ii. Breach Notification Rule. "Breach Notification" shall mean the Notification in the case of Breach of Unsecured Protected Health Information, 45 C.F.R. § 164, Subparts A and D.

iii. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R.s § 160, § 162 and § 164, Subparts A and C, including the following:

a) Security Standards. "Security Standards" hereinafter shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.306.

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b) Administrative Safeguards. "Administrative Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.308.

c) Physical Safeguards. "Physical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.310.

d) Technical Safeguards. "Technical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.312.

f. Policies and Procedures and Documentation Requirements. "Policies and Procedures and Documentation Requirements" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. §164.316.

g. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as in 45 C.F.R. §160.103, limited to the information created, maintained, transmitted or received by the Business Associate, its agents or Subcontractors from, or on behalf of the HCA.

h. Required By Law. "Required By Law" shall have the same meaning as in 45 C.F.R. §164.103.

i. Secretary. "Secretary" shall mean the Secretary of the U. S. Department of Health and Human Services, or their designee.

j. Covered Entity. "Covered Entity" shall have the meaning as the term "covered entity" defined at 45 C.F.R. §160.103 and in reference to the party to this BAA, shall mean the State of New Mexico Health Care Authority.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Standards. All terms used and all statutory and regulatory references shall be as currently in effect or as subsequently amended.

2. Obligations and Activities of Business Associate

a. General Rule of PHI Use and Disclosure. The Business Associate may use or disclose PHI it creates for, receives from, maintains or transmits on behalf of, the Department to perform functions, activities or services for, or on behalf of, the Department in accordance with the specifications set forth in this BAA and in this PSC 24-630-8000-

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0030, provided that such use or disclosure would not violate the HIPAA Standards if done by the Department; or as Required By Law.

i. Any disclosures made by the Business Associate of PHI must be made in accordance with HIPAA Standards and other applicable laws.

ii. Notwithstanding any other provision herein to the contrary, the Business Associate shall limit uses and disclosures of PHI to the "minimum necessary," as set forth in the HIPAA Standards.

iii. The Business Associate agrees to use or disclose only a "limited data set" of PHI as defined in the HIPAA Standards while conducting the authorized activities herein and as delineated in PSC 24-630-8000-0030, except where a "limited data set" is not practicable in order to accomplish those activities.

iv. Except as otherwise limited by this BAA or PSC 24-630-8000-30, the Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

v. Except as otherwise limited by this BAA or PSC 24-630-8000-0030, Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that the disclosures are Required By Law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

vi. The Business Associate may use PHI to report violations of law to appropriate federal and State authorities, consistent with 45 C.F.R. § 164.502(j).

vii. The Business Associate may use PHI to provide Data Aggregation services to the Department as permitted by the HIPAA Standards.

b. Safeguards. The Business Associate agrees to implement and use appropriate Security, Administrative, Physical and Technical Safeguards and comply, where applicable, with subpart C of 45 C.F.R. § 164 to prevent use or disclosure of PHI other than as required by law or as provided for by this BAA or PSC 24-630-8000-0030. The Business Associate

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shall identify in writing upon request from the Department, the Administrative, Physical and Technical Safeguards that it uses to prevent impermissible uses or disclosures of PHI.

c. Restricted Uses and Disclosures. The Business Associate shall not use or further disclose PHI other than as permitted or required by this BAA or PSC 24-630-8000-0030, the HIPAA Standards, or otherwise as permitted or required by law. The Business Associate shall not disclose PHI in a manner that would violate any restriction which has been communicated to the Business Associate.
    i. The Business Associate shall not directly or indirectly receive remuneration in exchange for any of the PHI, unless a valid authorization has been provided to the Business Associate that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the PHI of that individual, except as provided for under the exceptions listed in 45 C.F.R. §164.502 (a)(5)(ii)(B)(2).
    ii. Unless approved by the Department, the Business Associate shall not directly or indirectly perform Marketing to individuals using PHI.
d. Agents and Subcontractors. The Business Associate shall ensure that any agents or Subcontractors that create, receive, maintain or transmit PHI on behalf of the Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and shall make that agreement available to the Department upon request. Upon the Business Associate's contracting with an agent or Subcontractor for the sharing of PHI under the Related Agreement and this BAA, the Business Associate shall provide the Department written notice of any such executed agreement.
e. Availability of Information to Individuals and the Department. The Business Associate shall provide, at the Department's request, and in a reasonable time and manner, access to PHI in a Designated Record Set (including an electronic version, if required) to the Department or, if requested by an Individual, to an Individual or the Individual's designee, in order to meet the requirements under 45 C.F.R. § 164.524.
f. Amendment of PHI. In accordance with 45 C.F.R. § 164.526, the Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Department

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directs or agrees to, at the request of the Department or an Individual, to fulfill the Department's obligations to amend PHI pursuant to the HIPAA Standards.

g. Internal Practices. The Business Associate agrees to make internal practices, books and records, including policies, procedures and PHI relating to the use and disclosure of PHI, received from, or created or received by the Business Associate, on behalf of the Department, available to the Secretary, for purposes of the Secretary's determining the Department's compliance with the HIPAA Standards.

h. PHI Disclosures Recordkeeping. The Business Associate agrees to document such disclosures of PHI and information related to such disclosures, as necessary, to satisfy the Department's obligation under 45 C.F.R. § 164.528. The Business Associate shall provide such information in the time and manner reasonably designated by the Department.

i. PHI Disclosures Accounting. The Business Associate agrees to provide to the Department or an Individual, no later than thirty (30) days of receipt of a request, information collected in accordance with Section 2 (h) of this Agreement.

j. Security Rule Provisions. As required by 42 U.S.C. § 17931 (a) [HITECH Act Section 13401(a)] , the following Sections, as they are made applicable to business associates under the HIPAA Standards, shall also apply to the Business Associate: 1) Administrative Safeguards; 2) Physical Safeguards; 3) Technical Safeguards; 4) Policies and Procedures and Documentation Requirements; and 5) Security Standards. Additionally, the Business Associate shall either implement or properly document the reasons for non-implementation of all safeguards in the above cited Sections that are designated as "addressable" as such are made applicable to Business Associates pursuant to the HIPAA Standards.

k. Civil and Criminal Penalties. The Business Associate agrees that it will comply with the HIPAA Standards, as applicable to the Business Associates, and acknowledges that it may be subject to civil and criminal penalties for its failure to do so.

l. Performance of Covered Entity's Obligations. To the extent the Business Associate is to carry out the Department's obligations under the HIPAA Standards, the Business

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Associate shall comply with the requirements of the HIPAA Standards that apply to the Department in the performance of such obligations.

3. **Business Associate Obligations for Notification, Risk Assessment and Mitigation**

During the term of this BAA or PSC 24-630-8000-0030, the Business Associate shall be required to perform the following pursuant to the Breach Notification Rule regarding Breach Notification, Risk Assessment and Mitigation:

a. Notification

i. The Business Associate agrees to report to the Department Contract Manager or HIPAA Privacy and Security Officer any use or disclosure of PHI that is the subject of the Related Agreement or this BAA not provided for by this BAA or PSC 24-630-8000-0030, and HIPAA Standards, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, as soon as it (or any employee or agent) becomes aware of the Breach, and, in no, case later than five (5) Calendar Days after it (or any employee or agent) becomes aware of the Breach, except when a government official determines that a notification would impede a criminal investigation or cause damage to national security.

ii. Business Associate shall provide the Department with the names of the individuals whose unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 C.F.R. § 164.404(c), and, if requested by the Department, provide information necessary for the Department to investigate promptly the impermissible use or disclosure. The Business Associate shall continue to provide to the Department information concerning the Breach as it becomes available to it, and shall also provide such assistance and further information as is reasonably requested by the Department.

b. Risk Assessment

i. When the Business Associate determines whether an impermissible acquisition, use or disclosure of PHI, that is the subject of the Related Agreement or this BAA, by an employee or agent, poses a low probability of the PHI being compromised, it shall document its assessment of risk in accordance with 45 C.F.R. § 164.402 (in definition

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of "Breach", 2) based on at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the protected health information or to whom the disclosure was made; (iii) whether the protected health information was actually acquired or viewed; and (iv) the extent to which the risk to the protected health information has been mitigated. Such assessment shall include: 1) the name of the person(s) making the assessment; 2) a brief summary of the facts; and 3) a brief statement of the reasons documenting the determination of risk of the PHI being compromised. When requested by the Department, the Business Associate shall make its risk assessments of PHI that is the subject of the Related Agreement or this BAA available to the Department.

ii. If the Department determines that an impermissible acquisition, access, use or disclosure of PHI, for which one of the Business Associate's employees or agents was responsible, constitutes a notice to affected individuals of such Breach, and if requested by the Department, the Business Associate shall provide notice to the affected individuals whose PHI was the subject of the Breach. When requested to provide notice, the Business Associate shall provide notice in accordance with 45 C.F.R. § 164.401 et seq. The cost of notice and related remedies shall be borne by Business Associate. The notice to affected individuals shall be provided without unreasonable delay and in no case later than sixty (60) Calendar Days after discovery of the breach of the PHI.

c. Mitigation

i. In addition to the above duties in this Section, the Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI, by the Business Associate, in violation of the requirements of this Agreement, the Related Agreement or the HIPAA Standards. The Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by the Department, the Business Associate shall make its mitigation and corrective action plans available to the Department.

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ii. The notice to affected individuals shall be written in plain language and shall include, to the extent possible: 1) a brief description of the Breach; 2) a description of the types of Unsecured PHI that were involved in the Breach; 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach; 4) a brief description of what the Business Associate and the Department are doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches; and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 C.F.R. §164.404(c).

d. Notification to Clients

i. Business Associates shall notify individuals of Breaches as specified in 45 C.F.R. §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of a State or jurisdiction, the Business Associate shall notify prominent media outlets serving such location(s), following the requirements set forth in 45 C.F.R. § 164.406.

4. Obligations of the Department to Inform Business Associate of Privacy Practices and Restrictions

a. The Department shall notify the Business Associate of any limitation(s) in the Department's Notice of Privacy Practices, implemented in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of PHI.

b. The Department shall notify the Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. The Department shall notify the Business Associate of any restriction in the use or disclosure of PHI that the Department has agreed to, in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

d. The Department shall not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule, if done by the Department.

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5. Term and Termination

a. Term. This BAA terminates concurrently with PSC 24-630-8000-0030, except that obligations of the Business Associate under this BAA related to final disposition of PHI in this Section 5, shall survive until resolved, as set forth immediately below.

b. Disposition of PHI upon Termination. Upon termination of this PSC 24-630-8000-0030and BAA for any reason, the Business Associate shall return or destroy all PHI in its possession and shall retain no copies of the PHI. In the event that the Business Associate determines that returning or destroying the PHI is not feasible, the Business Associate shall provide to the Department notification of the conditions that make return or destruction of PHI not feasible. Upon mutual agreement of the Parties that return or destruction of the PHI is infeasible, the Business Associate shall agree, and require that its agents, affiliates, subsidiaries and Subcontractors agree, to the extension of all protections, limitations and restrictions required of Business Associate hereunder, for so long as the Business Associate maintains the PHI.

c. If the Business Associate breaches any material term of this BAA, the Department may either:

   i. Provide an opportunity for the Business Associate to cure the breach and the Department may terminate this PSC 24-630-8000-0030 and BAA without liability or penalty in accordance with Section 7.6.2, Termination by HCA for Cause, of PSC 24-630-8000-0030, if the Business Associate does not cure the breach within the time specified by the Department; or,

   ii. Immediately terminate this PSC 24-630-8000-0030 without liability or penalty, if the Department determines that cure is not reasonably possible; or,

   iii. If neither termination nor cure are feasible, the Department shall report the breach of the Related Agreement and BAA to the Secretary.

The Department has the right to seek to cure any breach of this BAA by the Business Associate, and this right, regardless of whether the Business Associate cures such breach, does not lessen any right or remedy available to the Department at law, in equity, or under this BAA or PSC 24-630-8000-0030, nor does it lessen the Business Associate's responsibility for such breach of this BAA or its duty to cure such breach of this BAA.

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6. Penalties and Training

The Business Associate understands and acknowledges that violations of this BAA or PSC 24-630-8000-0030 may result in notification, by the Department, to law enforcement officials and regulatory, accreditation and licensure organizations. If requested by the Department, the Business Associate shall participate in training regarding use, confidentiality and security of PHI.

7. Miscellaneous

a. Interpretation. Any ambiguity in this BAA, or any inconsistency between the provisions of this BAA or PSC 24-630-8000-0030, shall be resolved to permit the Department to comply with the HIPAA Standards.

b. The Business Associate's Compliance with HIPAA. The Department makes no warranty or representation that compliance by the Business Associate with this BAA or the HIPAA Standards will be adequate or satisfactory for the Business Associate's own purposes or that any information in the Business Associate's possession or control, or transmitted or received by the Business Associate, is or will be secure from unauthorized use or disclosure. The Business Associate is solely responsible for all decisions made by the Business Associate regarding the safeguarding of PHI that is the subject of the Related Agreement or this BAA.

c. Change in Law. In the event there are subsequent changes or clarifications of statutes, regulations or rules relating to this BAA or PSC 24-630-8000-0030, the Department shall notify Business Associate of any actions it reasonably deems necessary to comply with such changes and the Business Associate shall promptly take such actions. In the event there is a change in federal or state laws, rules or regulations, or in the interpretation of any such laws, rules, regulations or general instructions, which may render any of the material terms of this BAA unlawful or unenforceable, or which materially affects any financial arrangement contained in this BAA, the parties shall attempt amendment of this BAA to accommodate such changes or interpretations. If the parties are unable to agree, or if amendment is not possible, the parties may terminate the BAA and PSC 24-630-8000-0030 pursuant to its termination provisions.

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d. No Third-Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Department, the Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

e. Assistance in Litigation or Administrative Proceedings. The Business Associate shall make itself and any agents, affiliates, subsidiaries, Subcontractors or workforce Members assisting the Business Associate in the fulfillment of its obligations under this BAA and PSC 24-630-8000-0030, available to the Department, at no cost to the Department, to testify as witnesses or otherwise in the event that litigation or an administrative proceeding is commenced against the Department or its employees, based upon Claimed violation of the HIPAA standards or other laws relating to security and privacy, where such Claimed violation is alleged to arise from the Business Associate's performance under this BAA or PSC 24-630-8000-0030, except where the Business Associate or its agents, affiliates, subsidiaries, Subcontractors or employees are named adverse parties.

f. Additional Obligations. The Department and the Business Associate agree that, to the extent not incorporated or referenced in any BAA between them, other requirements applicable to either or both that are required by the HIPAA Standards, those requirements are incorporated herein by reference.

g. Any ambiguity or inconsistency between the provisions of this BAA and PSC 24-630-8000-0030 shall be resolved in favor of PSC 24-630-8000-0030.