New Mexico Behavioral Health Purchasing Collaborative Meeting

Thursday, October 10, 2013

Human Services Department
37 Plaza la Prensa
Santa Fe, NM

**Video Conference Sites**

- Albuquerque
- Farmington
- Las Cruces
- Las Vegas
- Roswell
Thursday, October 10, 2013
37 Plaza La Prensa
Santa Fe, New Mexico
1:00 p.m. – 4:00 p.m.

AGENDA

1. 1:00 – 1:55 p.m.  Call to Order
   - Introduction of Collaborative Member/Recognize Remote Sites
   - Review/Approval of Minutes August 15, 2013 (decision item)
   - CEO Update
     o Update on transitions due to pay holds

2. 1:55 – 2:10  Behavioral Health Planning Council (BHPC) Report
   Lisa Trujillo, Chair, Behavioral Health Planning Council

3. 2:10 – 2:25  Local Collaborative Update
   Susie Kimble and Rick Vigil

4. 2:25 – 2:45  Directors Reports/Data
   Karen Meador and Geri Cassidy, HSD/Behavioral Health Collaborative

5. 2:45 – 3:30  Centennial Care Discussion
   Sidonie Squier
     - Centennial Care Amendment (decision item)
     - Update on readiness
     - Where to get information

6. 3:30 – 4:00  Public Input

7. 4:00  Adjourn
New Mexico Behavioral Health Collaborative
August 15, 2013 · 1:00–4:00 p.m. · 37 Plaza La Prensa, Santa Fe, New Mexico

Handouts: Copies of the NM Behavioral Health Purchasing Collaborative Meeting public hand-outs may be obtained from the website www.bhc.state.nm.us

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Video Conferencing Sites</td>
<td>Farmington NM, Las Vegas NM, Las Cruces NM, Roswell NM, Albuquerque NM</td>
</tr>
<tr>
<td>Present were:</td>
<td>Retta Ward/DOH, Yolanda Deines/CYFD, Diana McWilliams/BHC, Aurora Sanchez/NMCD, Gino Rinaldi/ALTSD, Arthur Allison/IAD, Rose Baca-Quesada/MFA, Daniel Roper/DVR, Annjenette Torres/PED, Patrick Simpson/AOC, Tom Clifford/DFA (by phone)</td>
</tr>
<tr>
<td></td>
<td>The meeting to order at 1:05 pm without a quorum present. The Collaborative members introduced themselves.</td>
</tr>
<tr>
<td></td>
<td><strong>Handout-CEO Update</strong></td>
</tr>
<tr>
<td></td>
<td>Diana McWilliams, CEO, Behavioral Health Collaborative reported on current issues with the behavioral health system. There was a referral of 15 agencies to the Attorney General’s office for credible accusations of fraud so there is an investigation going on. We don’t know where the AG is in that proceeding. We are making every effort to insure consumers are safe and that services are in place throughout the network. When an agency that has a pay hold in place and cannot meet payroll the State is fronting the payroll and making sure existing NM staff are getting paid. We are also making sure that organizations that can provide services that do not have a pay hold can provide services. In the case of the 12 that still have a pay hold in place for behavioral health we are in the middle of transition or have done transition, meaning also hiring staff with all but 2 agencies. Services to consumers and their safety is the State’s number one priority. The transition agencies have been hiring on average 90% of the current staff in order for consumer’s to see the practitioners that they are familiar faces and that services get rendered as they normally do. Crisis line numbers were given out.</td>
</tr>
<tr>
<td></td>
<td>Being that a quorum was now present, the meeting went on to the voting item.</td>
</tr>
<tr>
<td></td>
<td><strong>Handout-DRAFT Meeting Minutes, New Mexico Behavioral Health Collaborative Meeting – April 11, 2013 and June 13, 2013</strong></td>
</tr>
<tr>
<td></td>
<td>A MOTION was made by Gino Rinaldi and seconded by Retta Ward to approve the minutes from the April 11, 2013. Behavioral Health Collaborative Meeting. The MOTION was PASSED unanimously.</td>
</tr>
<tr>
<td></td>
<td>A MOTION was made by Gino Rinaldi and seconded by Retta Ward to approve the minutes from the June 13, 2013.</td>
</tr>
</tbody>
</table>
Behavioral Health Collaborative Meeting.
The **MOTION** was **PASSED** unanimously.

2. **Behavioral Health Planning Council Report**
   Handout: *Behavioral Health Planning Council Report 7/11/13*
   Lisa Trujillo reported on the following:
   - Audit and Response
   - Membership
   - Bylaws and Policies and Procedures
   - Block Grants
   - Training
   - Subcommittees
   - Changes
   - Local Collaborative Alliance
   - Mapping Project
   - LC Reports
   - Budget

3. **Local Collaborative Update**
   Handout: *LC s 1-18 Quarterly Reports*
   Governor Rick Vigil reported on the Local Collaboratives’ activities including the Local Collaborative Alliance. Also the following reports were submitted.
   - Quarterly reports were submitted by LCs 2, 3, 6, 10-14 and 16

4. **Directors Reports/Data**
   Handout: *Director’s Reports*
   Diana McWilliams reported that the director’s reports that will be presented at the October 10 meeting will be more reflective of FY13. Until then, the following reports were provided to the Collaborative members:
   - Consumers Served by Ethnicity Statewide
   - Consumers Served and Expeditures, by Service - Statewide
   - Consumers Served and Expenditures by Fund Statewide

5. **New Mexico Crisis and Access Line**
   Handout: *New Mexico Crisis and Access Line Bi-annual Report 7/12/2013*
   Troy Fernandez/OptumHealth; Phil Evans and Lindsay Branine/NM Crisis and Access Line
   - The New Mexico Crisis and Access Line Bi-Annual Report was presented to the Collaborative. Included was a breakdown by type for the 3,086 total calls.
   - Also clinical and demographic information was presented.
   - Last was outreach information was reported

6. **Supportive Housing**
   Handouts: *Accomplishments and Updates on New Mexico’s Supportive Housing Initiative*
   Jane McGuigan/BHSD and Joseph Montoya/MFA
   - The presenters gave an update on the supportive housing initiative. Included in the presentation:
7. **Public Input**

   Bruce Evans, representing LC1

   - Compliments to Jane McGuigan and MFA for their work on housing for consumers and families
   - Mr. Evans expressed his concern with the Medicaid redesign and feels there are gaps, particularly in the lack of consumer and family member input.
   - Mr. Evans feels that relations between executive branch and the legislature are not good.
   - What will happen when short-term contract with the entities that have taken over for providers are over?

   Diana McWilliams responded by saying that the HSD contracts with these agencies are for transition costs, primarily to cover payroll of our existing clinicians in our present provider network and operational expenses as well as leases. OptumHealth NM is also contracting with them as part of the network so they can get up with billing Medicaid as soon as possible. Also while the transition agencies are getting credentialed they are also getting approached by the Centennial Care MCOs to also be in their network. On January 1st, the transition agencies will be part of our behavioral health care system.

Martha Cooke, NAMI and LC1

- Ms. Cooke shared that there was a movie shown in Santa Fe about bi-polar disorder. There will also be a series of lectures by Ideas in Psychiatry program starting in October.
- Ms. Cooke believes that the Crisis Line is a positive accomplishment. She feels that information about the Crisis Line is not getting out. The crisis line should not be a stop gap for the crisis that the state is going through because of the provider transition.

Patrick Simpson/AOC and non-voting member of the Collaborative asked if the Public Consulting Group (PCG) contract was shared with the Collaborative. Larry Heyeck/General Counsel HSD and Diana McWilliams responded that because of the emergent nature of the situation, the Behavioral Health Collaborative Executive Committee decided that it was in the State’s best interest to find an audit company to contract with that had no relationship with New Mexico or OptumHealth. PCG was referred to the State by SAMHSA representatives. Diana McWilliams added that because of the alleged allegations of fraud that is being investigated by the Attorney General’s Office, it would be inappropriate and

8. **Adjourn**

   The meeting was adjourned at 3:31.
Tab 2
PROVIDER TRANSITIONS

This has been the largest focus of the Council and its Subcommittees for the last three months. We have been kept informed – in our Subcommittees by Robert Chavez of BHSD and the Optum staff that attend those meetings, and in the full Council meetings by Diana McWilliams and Elizabeth Martin. Access to these well-informed people has been much appreciated by our members. However, I feel that I should let you know about some of the concerns expressed by our Subcommittee and Council members.

**Continuity of Care** – Any time without care can have serious consequences for behavioral health consumers. Long gaps between appointments are especially difficult if medications are needed. Reestablishing a therapeutic relationship after an interval without care is a challenge as well.

**Workforce** – We are being informed of rehire rates at these new agencies, and are concerned about there being enough people to treat the people currently in the system as well as those who will soon be able to avail themselves of services but don’t currently have access. We are hearing about the difficulties peer specialists are having adjusting to new employers and policies.

**Consumer Choice** – Especially in the southern part of the state, many consumers will have no choice as to what agency they will be using to access services. And they are worried about it.

**Trust issues and Traumatic Effects** – Both receivers and deliverers of care have been thrown into new situations for reasons they don’t readily understand. And even those who have not been directly affected have felt distress over what they see happening. People have had to carefully reconsider who they trust and don’t trust. It is helpful for us to think about this as a traumatic event for everyone involved and we need to be cognizant of that, especially considering what we know about the effects of trauma and how a large portion of the population we are dealing with already have a lot of trauma in their life history.

CENTENNIAL CARE

We have been trying to keep some focus on the changes that will come with Centennial Care. We are developing relationships with the four MCO’s, having had them attend our Council meetings as well as our Subcommittee meetings. There are still a lot of questions being asked, and a lot of issues that our members want to know more about provider networks, formularies, value-added services, and communications.

MEMBERSHIP

At this point we are no longer compliant with state and federal mandates, as we need to have at least a 51% consumer/family representation. Again, we are concerned with maintaining a proper balance. We would like to request two additional consumer or family members to keep us in compliance with state and federal statutes. We do have one
new member, Deborah Clark, a consumer from Albuquerque, and would like to thank the Governor for her approval of this new member.

BHPC RETREAT

You might remember that we were working on a training for our members. Because of issues with the SAMHSA contractors we were working with, we dropped those plans. We are currently planning a retreat to help us work out a model consistent with the CYFD Communities of Care that could be implemented throughout the state and across all age ranges. Mary Ann Shaening will facilitate the meeting for us, and we are inviting both the Planning Council members and members of the Local Collaborative Alliance. It is scheduled for Halloween.

SUBCOMMITTEES

As described previously, our subcommittees have spent a lot of time discussing provider transitions and Centennial Care changes. Most of them have been revisiting membership rosters and priorities. Some other subcommittee efforts:

Adult/Substance Abuse and Medicaid have learned about some innovative crisis response efforts in Taos and San Juan counties and ongoing supportive housing initiatives in the state.

Children and Adolescents have learned about the J Paul Taylor task force’s efforts, and about Mental Health First Aid, including new versions aimed specifically towards youth and towards Law Enforcement being taught to various groups in the state. They have decided on a set of priorities to work on throughout the next year.

The Native American Subcommittee has been planning their annual Behavioral Health Summit on October 11th. It will have a keynote address by Mr. Gordon House and breakout sessions on Mental Health, Communities of Care, Mental Health First Aid, and Historical Trauma and Traditional Healing.
Tab 3
Tab 4
Collaborative Funding FY13
FY13 Total Expenditure Amount & Percentage
Based on Services Provided as of 6/30/2013

<table>
<thead>
<tr>
<th>Service</th>
<th>Expenditure Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$19,712,076</td>
<td>8.41%</td>
</tr>
<tr>
<td>Residential</td>
<td>$73,183,185</td>
<td>31.23%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$12,073,344</td>
<td>5.15%</td>
</tr>
<tr>
<td>Recovery</td>
<td>$40,101,402</td>
<td>17.11%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$81,534,862</td>
<td>34.79%</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>$4,785,151</td>
<td>2.04%</td>
</tr>
<tr>
<td>Outliers</td>
<td>$2,956,314</td>
<td>1.26%</td>
</tr>
<tr>
<td>Total</td>
<td>$234,346,334</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
FY13 Total Expenditure by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Expenditure Amount</th>
<th>% of Total Service Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 &amp; Over</td>
<td>$71,673,866</td>
<td>30.58%</td>
</tr>
<tr>
<td>18-20</td>
<td>$7,901,529</td>
<td>3.37%</td>
</tr>
<tr>
<td>Under 18</td>
<td>$154,770,938</td>
<td>66.04%</td>
</tr>
<tr>
<td>Total</td>
<td>$234,346,334</td>
<td>100%</td>
</tr>
<tr>
<td>Service</td>
<td>Expenditure Amount</td>
<td>Percentage</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$9,311,654</td>
<td>12.08%</td>
</tr>
<tr>
<td>Residential</td>
<td>$7,804,573</td>
<td>10.12%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$1,691,325</td>
<td>2.19%</td>
</tr>
<tr>
<td>Recovery</td>
<td>$17,017,708</td>
<td>22.07%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$37,520,664</td>
<td>48.66%</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>$1,708,756</td>
<td>2.22%</td>
</tr>
<tr>
<td>Outliers</td>
<td>$2,060,155</td>
<td>2.67%</td>
</tr>
</tbody>
</table>

Collaborative Funding FY13
FY13 Total Adult Expenditure Amount & Percentage
Based on Services Provided as of 6/30/2013

Data Source: OptumHealth NM FY13 CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 6/30/13

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Adult $&%
Collaborative Funding FY13
FY13 Child Total Expenditure Amount & Percentage
Based on Services Provided as of 6/30/2013

- Inpatient: $10,400,422 (6.61%)
- Residential: $65,378,612 (41.58%)
- Intensive Outpatient: $10,382,019 (6.60%)
- Recovery: $23,083,694 (14.68%)
- Outpatient Services: $44,014,198 (27.99%)
- Value Added Services: $3,076,395 (1.96%)
- Outliers: $896,159 (0.57%)

Total: $157,231,499 (100.00%)

Data Source: OptumHealth NM FY13 CI-09 Report

Reviewed by: R. Buser, MD
Review Date: 06/30/13
Collaborative Funding FY13
Total Unduplicated Consumers by Age Group FY13
Based on Services Provided as of 6/30/2013

Data Source: OptumHealth NM FY13 CI-09 Report

FY13 Total Unduplicated Consumers Served By Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Unduplicated Consumers</th>
<th>% of Total Unduplicated Consumers</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 &amp; Over</td>
<td>44,567</td>
<td>51.68%</td>
</tr>
<tr>
<td>18-20</td>
<td>4,536</td>
<td>5.26%</td>
</tr>
<tr>
<td>Under 18</td>
<td>38,329</td>
<td>44.45%</td>
</tr>
<tr>
<td>Total*</td>
<td>86,229</td>
<td></td>
</tr>
</tbody>
</table>

*Total represents distinct consumers and may not equal the sum of the column.
### Behavioral Health Collaborative Directors’ Report

**Report Title: Consumers Served and Expenditures, by Service, (Yellow) - Statewide**

**Reporting Period:** 7/1/2012 - 06/30/2013  
**Service Dates:** 7/1/2012 - 06/30/2013  
**Report Submission Date:** 07/30/2013

The table below summarizes paid claims by specific services. This is not inclusive of all services covered by the Collaborative funding agencies. This report is based upon CI-09 data. This data is subject to change following final review and verification.

![Report Description](image)

### Table: Consumers Served and Expenditures, by Service, (Yellow) - Statewide

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit Type</th>
<th>Units</th>
<th>Consumers Served</th>
<th>Funds Expended</th>
</tr>
</thead>
<tbody>
<tr>
<td>01) Supported Employment</td>
<td>15 Minutes</td>
<td>5991</td>
<td>285</td>
<td>$101,201.00</td>
</tr>
<tr>
<td>02) Residential Detoxification (Adults)</td>
<td>Per Diem</td>
<td>1538</td>
<td>204</td>
<td>$307,400.00</td>
</tr>
<tr>
<td>03) Inpatient Hospitalization Psychiatric (all inpt services)</td>
<td>Varied</td>
<td>60429</td>
<td>3728</td>
<td>$17,349,185.66</td>
</tr>
<tr>
<td>04) Transitional Living Services</td>
<td>Per Diem</td>
<td>13511</td>
<td>289</td>
<td>$1,619,160.00</td>
</tr>
<tr>
<td>05) Residential Treatment Services (Non-Accredited)</td>
<td>Per Diem</td>
<td>16244</td>
<td>140</td>
<td>$4,695,016.00</td>
</tr>
<tr>
<td>06) Residential Treatment Services (Accredited)</td>
<td>Per Diem</td>
<td>64394</td>
<td>640</td>
<td>$21,148,044.85</td>
</tr>
<tr>
<td>07) Adult Residential Services</td>
<td>Per Diem</td>
<td>17965</td>
<td>698</td>
<td>$3,918,894.08</td>
</tr>
<tr>
<td>08) Foster Care Therapeutic TFC I</td>
<td>Per Diem</td>
<td>102585</td>
<td>776</td>
<td>$16,991,467.99</td>
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<tr>
<td>09) Foster Care Therapeutic TFC II</td>
<td>Per Diem</td>
<td>53457</td>
<td>522</td>
<td>$6,551,506.95</td>
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<tr>
<td>10) Group Home</td>
<td>Per Diem</td>
<td>22155</td>
<td>263</td>
<td>$2,955,217.50</td>
</tr>
<tr>
<td>11) Crisis Intervention</td>
<td>15 Minutes</td>
<td>11786</td>
<td>2553</td>
<td>$251,805.68</td>
</tr>
<tr>
<td>12) BH Day Treatment</td>
<td>Per Hour</td>
<td>158255</td>
<td>436</td>
<td>$2,829,339.90</td>
</tr>
<tr>
<td>13) Skills Training &amp; Development (BMS)</td>
<td>15 Minutes</td>
<td>1956804</td>
<td>2158</td>
<td>$15,175,020.84</td>
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<tr>
<td>14) Psychosocial Rehab Services (PSR) Individual, Grp, or Classroom - Adults</td>
<td>15 Minutes</td>
<td>1599486</td>
<td>2338</td>
<td>$8,966,583.34</td>
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<tr>
<td>15) Intensive Outpatient Program SA</td>
<td>Per Diem</td>
<td>38445</td>
<td>1023</td>
<td>$1,745,594.49</td>
</tr>
<tr>
<td>16) Intensive Outpatient Program MH</td>
<td>Per Diem</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>17) Assertive Community Treatment (ACT)</td>
<td>15 Minutes</td>
<td>121505</td>
<td>288</td>
<td>$4,507,325.04</td>
</tr>
<tr>
<td>18) Multi-Systemic Therapy (MST)</td>
<td>15 Minutes</td>
<td>55331</td>
<td>252</td>
<td>$1,941,555.00</td>
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<tr>
<td>19) Psychosocial Rehab (LIFE SKILLS) - Youth</td>
<td>30 Minutes</td>
<td>13252</td>
<td>167</td>
<td>$67,452.68</td>
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<tr>
<td>20) Infant Mental Health Services</td>
<td>15 Minutes</td>
<td>12</td>
<td>1</td>
<td>$248.64</td>
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<tr>
<td>21) Home Based Services (Family Stabilization)</td>
<td>15 Minutes</td>
<td>10376</td>
<td>102</td>
<td>$154,505.00</td>
</tr>
<tr>
<td>22) Comprehensive Community Support Services</td>
<td>15 Minutes</td>
<td>994944</td>
<td>16129</td>
<td>$15,489,305.19</td>
</tr>
<tr>
<td>23) Respite Care</td>
<td>15 Minutes</td>
<td>20435</td>
<td>52</td>
<td>$101,605.00</td>
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<tr>
<td>24) Methadone Maintenance</td>
<td>Each</td>
<td>144888</td>
<td>806</td>
<td>$3,007,023.78</td>
</tr>
<tr>
<td>25) Shelter Care</td>
<td>Per Diem</td>
<td>3044</td>
<td>1076</td>
<td>$2,931,018.00</td>
</tr>
<tr>
<td>26) Indian Health Services - Inpatient Services</td>
<td>Per Diem</td>
<td>913</td>
<td>18</td>
<td>$1,976,966.00</td>
</tr>
<tr>
<td>27) Indian Health Services - Outpatient Services</td>
<td>Per Diem</td>
<td>15616</td>
<td>3033</td>
<td>$4,820,158.03</td>
</tr>
<tr>
<td>28) Traditional Healing Services</td>
<td>Each</td>
<td>8465</td>
<td>185</td>
<td>$209,490.00</td>
</tr>
<tr>
<td>29) Telehealth Services</td>
<td>Varied</td>
<td>8202</td>
<td>2796</td>
<td>$611,353.60</td>
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<tr>
<td>30) Activity Therapy</td>
<td>15 Minutes</td>
<td>7306</td>
<td>319</td>
<td>$97,044.12</td>
</tr>
<tr>
<td>31) Medication Management/Monitoring</td>
<td>Varied</td>
<td>80915</td>
<td>19407</td>
<td>$4,428,945.74</td>
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<tr>
<td>32) Outpatient Services</td>
<td>Varied</td>
<td>936583</td>
<td>73513</td>
<td>$61,511,796.76</td>
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<tr>
<td>33) Outliers</td>
<td>Varied</td>
<td>725009</td>
<td>11683</td>
<td>$28,860,102.88</td>
</tr>
</tbody>
</table>

**Total**                                                                 |                      |          |                  | $234,346,334       |

**Unduplicated Consumers**                                                |                      |          |                  | 86,229             |
### Behavioral Health Collaborative Directors' Report

**Report Title:** DRLC-02 Consumers Served and Expenditures by Fund (Green) Statewide  
**Reporting Period:** 07/01/2012 - 6/30/2013 (Q4FY13)  
**Service Dates:** 07/01/2012 - 6/30/2013  
**Paid Thru:** 6/30/2013  
**Report Submission Date:** 07/30/2013

<table>
<thead>
<tr>
<th>Contract Direct Service Dollar Amount</th>
<th>Under 18</th>
<th>Amount</th>
<th>18 - 20</th>
<th>Amount</th>
<th>21 - 64</th>
<th>Amount</th>
<th>65 and over</th>
<th>Amount</th>
<th>TOTAL Consumers</th>
<th>Claims &amp; Encounters</th>
<th>Pharmacy</th>
<th>Total Direct Service Amount Paid or Projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Managed Care</td>
<td>$244,324,980</td>
<td>$32,284</td>
<td>$131,172,416</td>
<td>$2,793</td>
<td>$5,778,760</td>
<td>$19,120</td>
<td>$35,532,596</td>
<td>$855</td>
<td>$1,320,825</td>
<td>$54,998</td>
<td>$175,804,797</td>
<td>$25,006,429</td>
</tr>
<tr>
<td>Medicaid Fee-for-Service</td>
<td>$27,782,000</td>
<td>$5,407</td>
<td>$15,760,362</td>
<td>$668</td>
<td>$749,690</td>
<td>$4,665</td>
<td>$4,060,800</td>
<td>$95</td>
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<td>$31,036</td>
<td>$3,423</td>
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| TOTAL AMOUNT                         | $317,239,287 | $154,770,938 | $7,901,529 | $69,380,489 | $2,937,377 | $234,364,334 | $26,060,259 | $18,952,469 | $279,359,061 |

**TOTAL Unduplicated Consumers (1)**  
4,536  
42,902  
1,791  
86,229  

**ATR Consumers**  
50  
544  
1  
595  

**Sexual Assault Consumers (2)**  
4,185

**Total Estimated Consumers including ATR & Sexual Assault**  
38,329  
4,586  
43,446  
1,780  
91,099

---

**Consumer counts within each age group are unduplicated. However, due to consumer birthdates, the consumer may be counted in another age group as a unique consumer within that age group if their birthday during the year caused them to move into another age group category and they received services within that respective age group designation. Total consumers are unduplicated. If a consumer received services in multiple age group categories, they were not counted only once as a unique consumer in the overall total. As a result, the overall total consumer column will not equal the sum total of the age categories. Total consumers are duplicated across funding streams as a consumer may receive services from multiple funding streams.**

---

1) Sexual Assault consumer data is received from Providers in the aggregate using age categories that do not match the categories in the Directors Report.

2) Sexual Assault consumer data is received from Providers in the aggregate using age categories that do not match the categories in the Directors Report.

- **HSD/BHSD consumer served are the Sexual Assault and ATR consumers. These could be duplicated consumers within the age group category.**
- **Due to privacy constraints, the SE is not able to determine if these consumers are duplicated.**

**Review Date:** 07/30/13  
**Reviewed by:** K. Northfield  
**Report Title:** DRLC-02 Consumers Served and Expenditures by Fund (Green) Statewide  
**Review Date:** 07/30/13  
**Page 1 of 1**

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**DRLC-02 Q4 FY13 Statewide**

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### Behavioral Health Collaborative Directors' Report

**Report Title:** Consumers Served by Ethnicity (Blue) Statewide  
**Reporting Period:** 07/01/2012 - 06/30/2013  
**Service Dates:** 07/01/2012 - 06/30/2013  
**Paid Thru:** 06/30/2013

**Reviewed by:** K. Northfield  
**Review Date:** 06/30/13

---

#### Statewide

<table>
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<th>Ethnicity</th>
<th>18-20 Females</th>
<th>18-20 Males</th>
<th>21-64 Females</th>
<th>21-64 Males</th>
<th>65 and over Females</th>
<th>65 and over Males</th>
<th>Total</th>
<th>Total</th>
<th>Total</th>
<th>Total Consumers</th>
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<td><strong>42,551</strong></td>
<td><strong>43,651</strong></td>
<td><strong>86,229</strong></td>
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</table>

#### Unduplicated Consumers With Unknown Gender : 27

Ethnicity is determined from enrollment ethnicity/race information or from Medicaid eligibility information. The mapping order is as follows:

1. Enrollment ethnicity of "Puerto Rican", "Mexican", "Cuban", "Other Specific Hispanic" or "Hispanic-Unknown Origin" or eligibility race of "Hispanic" are mapped to "Hispanic"
2. Enrollment race of "American Indian" or eligibility race of "American Indian" are mapped to "Native American"
3. Enrollment race of "African American" or eligibility race of "Black" are mapped to "African American"
4. Enrollment race of "Alaska Native" is mapped to "Alaskan Native"
5. Enrollment race of "Asian" or "Native Hawaiian/PI" or eligibility race of "Asian/Pacific Islander" are mapped to "Asian/Pacific Islander"
6. Enrollment race of "Two or more Races" is mapped to "Multiracial"
7. Records not previously mapped that have enrollment race of "White" or eligibility race of "Caucasian" are mapped to "White (Non-Hispanic)"
8. All records still remaining unmapped are mapped to "Unknown/Other"

**Note:** Totals represent distinct clients and may not equal sum of rows/columns. A client may receive services in two age groups because of a birthday. Medicaid eligibility may reflect different race codes at different times (e.g. Caucasian at one time and Hispanic or Unknown at another time). Gender is based upon sex code entered on claims. An insignificant number of anomalies have been known to occur where a client may be coded with different gender codes. Totals may differ slightly from other report, however, the difference is insignificant.
Tab 5
AMENDMENT NO. 1

This Amendment No. 1 to PSC: XX-XXXX-XXXX-XXXX is made and entered into by and between the New Mexico Human Services Department (“HSD”) and ______________________________ (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

WHEREAS, the Special Terms and Conditions for New Mexico’s Section 1115 waiver between the Centers for Medicare & Medicaid Services and HSD necessitate certain revisions to the Contract;

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

1) Certain definitions in Article 2 are (i) amended and restated or (ii) added to the Contract and read as follows:

**Community Benefit** means both the Agency-Based Community Benefit and the Self-Directed Community Benefit subject to an individual’s the annual allotment as determined by HSD on an annual basis.

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

**Confidential Information** means any communication or record – whether oral, written, electronically stored or transmitted, or in any other form – consisting of: (i) confidential Member information, including **HIPAA**-defined protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2; (ii) all non-public budget, expense, payment and other financial information; (iii) all privileged work product; (iv) all information designated by HSD or any other State agency as confidential, and all information designated as confidential under the laws of the State of New Mexico; and (v) information utilized, developed, received, or maintained by HSD, the Collaborative, the CONTRACTOR, or participating State agencies for the purpose of fulfilling a duty or obligation under this Agreement and that has not been disclosed publicly.

**Durable Medical Equipment** (DME) means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to individuals in the absence of an illness or injury or physical disability and is appropriate for use at home.
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 Community Committee for Quality Assurance.

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.

IADL means instrumental activities of daily living.

Member Rewards – The Member rewards program provides incentives to Centennial Care Members for participating in State-defined activities that promote healthy behaviors. A Member who participates in a State-defined activity that promotes healthy behaviors earns credits that are applied to a Member’s account, which will be managed by the MCO. Earned credits may be used for health related expenditures as approved under the Member Rewards program as further explained in section [4.22].

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

Pre-Admission Screening and Resident Review (PASRR) is governed by 42 C.F.R. §§438.100 through 438.138 for all individuals with mental illness or mental retardation intellectual disability who apply to, or reside in, Medicaid certified Nursing Facilities. PASRR aims to determine if a resident is appropriately placed in the least restrictive environment and whether the individual can be appropriately served in the Nursing Facility, including provision of required mental illness/mental retardation intellectual disability services.

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

TFC means therapeutic treatment foster care.

2) Section 3.3.3.12 of the Contract is amended and restated to read as follows:

3.3.3.12 A full-time staff person dedicated to this Agreement with a minimum of a master’s degree in an appropriate field 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) **Section 3 of the Contract is amended to add 3.6 which reads as follows:**

3.6 The CONTRACTOR shall work with the State’s independent consumer supports system as directed by HSD.

4) **Section 4.1.2.2 of the Contract is amended and restated to read as follows:**

4.1.2.2 The CONTRACTOR shall use the tools and processes that have been approved by HSD in conducting the nursing facility level of care evaluation. At a minimum, (i) MDS shall be used as the basis for the evaluation and (ii) The CONTRACTOR shall interface with HSD’s eligibility system for level of care in a file format prescribed and approved by HSD.

5) **Section 4.2.2 of the Contract is amended and restated to read as follows:**

4.2.2 **Current Medicaid Recipients**

Recipients who are eligible for Medicaid in the State of New Mexico and receiving services as of \( \text{October 1, 2013} \), must select a Centennial Care MCO by \( \text{December 7, 2013} \), unless excluded from mandatory enrollment in Centennial Care. Recipients required to enroll in Centennial Care who do not select an MCO by \( \text{December 7, 2013} \) will be auto assigned to an MCO in accordance with Section \( \text{4.2.4} \) of this Agreement. Recipients required to enroll in Centennial Care who become eligible after October 1, 2013 but before January 1, 2014 must select an MCO at the time of applying for Medicaid eligibility.

6) **Section 4.2.8 of the Contract is amended and restated to read as follows:**

4.2.8 **Effective Date of Enrollment**

4.2.8.1 **Current Medicaid Recipients.** The effective date of enrollment for Recipients who are enrolled in accordance with Section \( \text{4.2.2} \) of this Agreement shall be Go-Live.

4.2.8.2 **New Medicaid Recipients.** The effective date of enrollment for Recipients who are enrolled in accordance with Section \( \text{4.2.3} \) of this Agreement is the first day of the month in which the Recipient’s eligibility becomes effective, prior to the capitation process, which occurs approximately four (4) Business Days before the end of the month, shall be the first day of the month following selection or assignment of an MCO. The effective date of enrollment for Recipients who are enrolled in accordance with Section \( \text{4.2.3} \) of this Agreement during the capitation process shall be the first day of the second month following selection or assignment of an MCO.

4.2.8.3 At HSD’s discretion, the effective date of enrollment pursuant to Section \( \text{4.2.8.2} \) of this Agreement may be modified during the term of this Agreement. HSD will notify the CONTRACTOR of any changes to the effective
date of enrollment and related processes at least ninety (90) Calendar Days before implementation prior notice.

7) **Sections 4.3.2.3.5-4.3.2.3.7 of the Contract are amended and restated to read as follows:**

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

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

4.3.2.3.7 Other reasons, including but not limited to, poor quality of care, lack of access to Covered Services, or lack of access to providers experienced in dealing with the Member’s health care needs.

8) **Section 4.4.1.2.5 of the Contract is amended and restated to read as follows:**

4.4.1.2.5 Develop and implement a CCP care plan based on the Member’s individual needs and preferences in accordance with Section 4.4.9 of this Agreement;

9) **Section 4.4.1.2.6 of the Contract is amended and restated to read as follows:**

4.4.1.2.6 Deliver on-going care coordination services based on the Member’s assessed need and in accordance with the CCP care plan and contractual obligations for frequency of contact with the Member in accordance with Section 4.4.10; and

10) **Section 4.4.1.4 of the Contract is amended and restated to read as follows:**

4.4.1.4 In coordinating Members’ care, the CONTRACTOR shall ensure that each Member’s privacy is protected consistent with the State and federal
Section 4.4.2.3 of the Contract is amended and restated to read as follows:

4.4.2.3 During Steady State, the HRA shall be completed with each Member within ten (10) thirty (30) Calendar Days of the Member’s enrollment in the CONTRACTOR’s MCO.

Section 4.4.2.4 of the Contract is amended and restated to read as follows:

4.4.2.4 During the Transition Period, the HRA shall be completed as follows:

4.4.2.4.1 For all Members who become eligible for New Mexico Medicaid on January 1, 2014 or later, the CONTRACTOR shall conduct the HRA within thirty (30) Calendar Days of the Member’s enrollment. For all other Members, the CONTRACTOR shall conduct the HRA and, if required, a comprehensive needs assessment and a CCP (further described below) within thirty (30) one-hundred and eighty (180) Calendar Days following the Member’s enrollment.

4.4.2.4.2 The CONTRACTOR shall send the Member written notification within ten (10) Calendar Days of receiving the Member’s enrollment file that explains how the Member can reach the care coordination unit for assistance with concerns or questions pending the HRA and comprehensive needs assessment process.

Section 4.4.2.5.6 of the Contract is amended and restated to read as follows:

4.4.2.5.6 Request information about the Member’s medications prescriptions;

Section 4.4.2.6 of the Contract is amended and restated to read as follows:

4.4.2.6 The CONTRACTOR shall provide the following information to every Member during his or her HRA:

4.4.2.6.1 Information about the services available through care coordination;

4.4.2.6.2 Information about Notification of the levels of care coordination levels (CCLs);

4.4.2.6.3 Notification of the Member’s right to request a higher care coordination level of care coordination;
4.4.2.6.4 Requirement for an in-person comprehensive needs assessment for the purpose of providing services associated with care coordination level 2 or level 3 care coordination; and

4.4.2.6.5 Information about specific next steps for the Member.

15) **Section 4.4.3.1 of the Contract is amended and restated to read as follows:**

   4.4.3.1 The HRA shall determine whether a Member requires care coordination level 1 or requires a comprehensive needs assessment to determine whether the Member should be assigned to care coordination level 2 or level 3 care coordination.

16) **Section 4.4.3.2 of the Contract is amended and restated to read as follows:**

   4.4.3.2 Within seven (7) Calendar Days of completion of the HRA, all Members shall be informed of the care coordination level of care coordination assigned.

17) **Section 4.4.3.3.3 of the Contract is amended and restated to read as follows:**

   4.4.3.3 A timeframe during which the Member can expect to be contacted by the care coordination unit or individual care coordinator to complete the comprehensive needs assessment (based on the care coordination level assigned).

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

   4.4.3.4 *Care Coordination Level 1 Care Coordination.* Members who are assigned to care coordination level 1 care coordination will not receive a comprehensive needs assessment and are not assigned an individual care coordinator. Members assigned to care coordination level 1 shall be monitored by the care coordination unit according to the provisions in Section 4.4.4 of this Agreement.

19) **Section 4.4.3.5 of the Contract is amended and restated to read as follows:**

   4.4.3.5 *Care Coordination Level 2 and Level 3 Care Coordination.* For Members meeting one of the indicators below, the CONTRACTOR shall conduct a comprehensive needs assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3 care coordination. The Member:

20) **Section 4.4.4 of the Contract is amended and restated to read as follows:**
4.4.4 Care Coordination Requirements for Care Coordination Level 1 Care Coordination

4.4.4.1 Members in care coordination level 1 care coordination shall receive, at a minimum, the following care coordination:

4.4.4.1.1 HRA annually (according to the standards in Section 4.4.2 of this Agreement) to determine if a higher level of care coordination is needed; and

4.4.4.1.2 Review of Claims and utilization data at least quarterly to determine if the Member is in need of a comprehensive needs assessment and potentially higher level of care coordination.

21) Section 4.4.5 of the Contract is amended and restated to read as follows:

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

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

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3 care coordination at the Member’s primary residence. If the Member refuses the care coordinator access to the residence, the visit may occur in another location only with HSD approval.

23) Section 4.4.5.2 of the Contract is amended and restated to read as follows:

4.4.5.2 During Steady State for all Members and during the Transition Period for Members who become eligible for New Mexico Medicaid on January 1, 2014 or later, the CONTRACTOR shall:

4.4.5.2.1 Schedule a comprehensive needs assessment within fourteen (14) Calendar Days of the Member receiving a care coordination level 2 or 3 care coordination assignment via the HRA; and

4.4.5.2.2 Complete the comprehensive needs assessment within thirty (30) Calendar Days of the HRA.

24) Section 4.4.5.3.2 of the Contract is amended and restated to read as follows:
4.4.5.3.2 Continue providing services previously authorized by HSD or its designee in the Member’s approved HCBS care plan or Behavioral Health treatment or service plan without regard to whether such services are being provided by Contract or Non-Contract Providers and shall not reduce these services until the CONTRACTOR has conducted a comprehensive needs assessment and developed a CCP care plan in accordance with Section 4.4.9 of this Agreement;

25) Section 4.4.5.3 of the Contract is amended and restated to read as follows:

4.4.5.3 During the Transition Period, the CONTRACTOR shall:

4.4.5.3.1 Accept the Member’s nursing facility level of care determination previously determined by HSD or its designee until redetermination of the Member’s Medicaid eligibility or scheduled level of care assessment, whichever date is earlier.

4.4.5.3.2 Continue providing services previously authorized by HSD or its designee in the Member’s approved HCBS care plan or Behavioral Health treatment or service plan without regard to whether such services are being provided by Contract or Non-Contract Providers and shall not reduce these services until the CONTRACTOR has conducted a comprehensive needs assessment and developed a CCP care plan in accordance with Section 4.4.9 of this Agreement;

4.4.5.3.3 Schedule a comprehensive needs assessment within thirty (30) Calendar Days of the for Members receiving assigned to care coordination levels 2 or 3 within the timeframes identified in Section 4.4.2.4.1 care coordination assignment via the HRA;

4.4.5.3.4 Immediately conduct a comprehensive needs assessment and update the Member’s CCP care plan if at any time before conducting a comprehensive needs assessment the CONTRACTOR becomes aware of an increase in the Member’s needs, and the CONTRACTOR shall initiate the change in services within ten (10) Calendar Days of becoming aware of the change in the Member’s needs;

4.4.5.3.5 Complete the comprehensive needs assessment within ninety (90) Calendar Days of the HRA; and

4.4.5.3.6 Remind Members using the most effective means of communication regarding the scheduled date for the
Section 4.4.6 of the Contract is amended and restated to read as follows:

4.4.6 Care Coordination Requirements for Care Coordination Level 2 Care Coordination
30) **Section 4.4.6.1 of the Contract is amended and restated to read as follows:**

4.4.6.1 Based on the comprehensive needs assessment, the CONTRACTOR shall **assign care coordination** include in level 2 care coordination, at a minimum, to Members with one of the following:

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

4.4.6.2 The CONTRACTOR shall assign a **specific care coordinator** to each Member assigned to care coordination in level 2 care coordination a **specific care coordinator**.

32) **Section 4.4.6.3 of the Contract is amended and restated to read as follows:**

4.4.6.3 Care coordinators for Members in care coordination level 2 care coordination shall provide and/or arrange for the following care coordination services:

4.4.6.3.1 Development and implementation of a CCP care plan;

4.4.6.3.2 Monitoring of the CCP care plan to determine if the CCP care plan is meeting the Member’s identified needs;

4.4.6.3.3 Assessment of need for assignment to a health home;

4.4.6.3.4 Targeted Health Education, including disease management, based on the Member’s individual diagnosis (as determined by the comprehensive needs assessment);

4.4.6.3.5 Annual comprehensive needs assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP care plan is appropriate and if a higher or lower level of care coordination is needed;

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

4.4.6.3.7 Quarterly telephone contact with the Member.

33) **Section 4.4.7 of the Contract is amended and restated to read as follows:**

4.4.7 **Care Coordination Requirements for Care Coordination Level 3 Care Coordination**

34) **Section 4.4.7.1 of the Contract is amended and restated to read as follows:**
4.4.7.1 Based on the comprehensive needs assessment, the CONTRACTOR shall assign to include in care coordination level 3 care coordination, at a minimum, to Members with one the following:

35) **Section 4.4.7.2 of the Contract is amended and restated to read as follows:**

4.4.7.2 The CONTRACTOR shall assign a specific care coordinator to each Member in care coordination level 3 care coordination a specific care coordinator.

36) **Section 4.4.7.3 of the Contract is amended and restated to read as follows:**

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

37) **Section 4.4.7.3.2 of the Contract is amended and restated to read as follows:**

4.4.7.3.2 Semi-annual comprehensive needs assessment (according to the standards in Section [4.4.5] of this Agreement) to determine if the CCP care plan is appropriate and determine if a lower level of care coordination is needed;

38) **Section 4.4.8.2 of the Contract is amended and restated to read as follows:**

4.4.8.2 The CONTRACTOR shall use the following criteria, at a minimum, to identify Members for a comprehensive needs assessment either to assess or reassess the Member’s need for a higher level of care coordination:

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

4.4.8.2.6 Information from Commencement of a periodic review (at least quarterly) beginning no more than one hundred eighty (180) Calendar Days following Go-Live of the following: (i) Claims or Encounter Data; (ii) hospital admission or discharge data; (iii) pharmacy data; and (iv) data collected through UM processes.

40) **Section 4.4.8.6 of the Contract is amended and restated to read as follows:**
4.4.6 The CONTRACTOR’s shall agreement(s) with hospitals shall require the facility to notify the CONTRACTOR within one (1) Business Day of the date a Member is admitted.

41) Sections 4.4.9.1-4.4.9.6 of the Contract are amended and restated to read as follows:

4.4.9.1 The CONTRACTOR shall develop and implement CCPs care plans for Members in care coordination levels 2 and 3 care coordination. The CONTRACTOR is not required to develop and implement CCPs care plans for Members in care coordination level 1 care coordination.

4.4.9.2 During both the Transition Period and Steady State, the CONTRACTOR shall develop and authorize the CCP care plan within fourteen (14) Business Days of completion of the comprehensive needs assessment.

4.4.9.3 For Members in care coordination levels 2 and 3 care coordination, the care coordinator shall ensure at a minimum that the Member and Representative participate in developing the CCP care plan.

4.4.9.4 The CONTRACTOR shall ensure that care coordinators consult with the Member’s PCP, specialists, Behavioral Health providers, other providers, and interdisciplinary team experts, as needed when developing the CCP care plan.

4.4.9.5 The care coordinator shall verify that all decisions made regarding the Member’s needs and services, including the Member’s choice to receive institutional care versus HCBS, are documented in a written CCP comprehensive care plan.

4.4.9.6 The developed CCP care plan shall at a minimum include:

42) Section 4.4.9.6.16 of the Contract is amended and restated to read as follows:

4.4.9.6.16 Additional information for Members who elect the Self-Directed Community Benefit, including but not limited to the Member’s self-assessment, (whether the member requires an employer of record (“EOR”)), the back-up plan and the approved Self-Directed Community Benefits as identified in the Comprehensive Needs Assessment; and whether the Member requires an employer of record or authorized agent;

43) Section 4.4.9.6.19 of the Contract is amended and restated to read as follows:

4.4.9.6.19 The Member’s eligibility begins and end date.
44) **Sections 4.4.9.7-4.4.9.10 of the Contract are amended and restated to read as follows:**

4.4.9.7 The care coordinator shall ensure that the Member* (or the Member’s Representative, if applicable)* understands, reviews, signs and dates the CCP care plan.

4.4.9.8 The care coordinator shall provide a copy of the Member’s completed CCP care plan, including any updates, to the Member and the Member’s Representative, as applicable. The care coordination team shall provide copies to other providers authorized to deliver care to the Member, as appropriate, and shall ensure that such providers who do not receive a copy of the **CCP care plan** are informed in writing of all relevant information needed (including all relevant HSD prescribed forms) to ensure the provision of quality care for the Member and to help ensure the Member’s health, safety, and welfare, including but not limited to the tasks and functions to be performed.

4.4.9.9 For Members in an institutional facility, the care coordination team shall develop the CCP care plan but may use the CCP care plan developed by the institution to supplement the CCP care plan.

4.4.9.10 Within five (5) Business Days of completing a reassessment of a Member’s needs, the care coordination team shall update the Member’s CCP care plan as appropriate, and the CONTRACTOR shall authorize and initiate services in the updated CCP care plan.

45) **Section 4.4.10.1.1 of the Contract is amended and restated to read as follows:**

4.4.10.1.1 Develop and/or update the CCP care plan as needed;

46) **Section 4.4.10.1.5 of the Contract is amended and restated to read as follows:**

4.4.10.1.5 Upon the scheduled initiation of services identified in the Member’s CCP care plan, the care coordination team (as further addressed in Section 4.4.12) shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized and that services continue to meet the Member’s needs;

47) **Section 4.4.10.1.17 of the Contract is amended and restated to read as follows:**

4.4.10.1.7 Identify, address and evaluate service gaps to determine their cause and to minimize gaps going forward to ensure that back-up plans are implemented and effectively working. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;
Section 4.4.10.1.18 of the Contract is amended and restated to read as follows:

4.4.10.1.18 As appropriate, ensure that all PASRR requirements are met prior to the Member’s admission to a Nursing Facility, including, but not limited to, 42 CFR 483.100-138;

Section 4.4.10.3 of the Contract is amended and restated to read as follows:

4.4.10.3 The CONTRACTOR shall monitor and evaluate a Member’s emergency room and Behavioral Health crisis service utilization to determine the reason for these visits. In monitoring the Member’s emergency room and Behavioral Health crisis service use, the CONTRACTOR shall evaluate whether or not lesser acute care treatment options were available to the Member at the time and place when he/she needed such services. The care coordinator shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the Member’s providers, educating the Member, conducting a comprehensive needs reassessment, and/or updating the Member’s CCP care plan to better manage the Member’s physical health or Behavioral Health condition(s).

Section 4.4.10.5 of the Contract is amended and restated to read as follows:

4.4.10.5 The CONTRACTOR shall develop policies and procedures to ensure that care coordinators are actively involved in discharge planning when a Member is hospitalized or placed in an institutional facility. The CONTRACTOR shall define circumstances that require that hospitalized Members receive an in-person visit to complete a needs reassessment and an update to the Member’s CCP care plan as needed.

Section 4.4.11.2.2 of the Contract is amended and restated to read as follows:

4.4.11.2.2 The most current CCP care plan, including the detailed plan for back-up providers in situations when regularly scheduled providers are unavailable or do not arrive as scheduled;

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

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

Section 4.4.12.2 of the Contract is amended and restated to read as follows:
4.4.12.2 The CONTRACTOR shall use local resources, such as I/T/Us, PCMHs, Health Homes, CSAs, and Tribal services to assist in performing the care coordination functions specified throughout Section [4.4] of this Agreement.

54) **Section 4.4.12.5 of the Contract is amended and restated to read as follows:**

4.4.12.5 The CONTRACTOR shall not exceed the maximum caseload per care coordinator by designated care coordination level as described in this Section [4.4.12.5] of this Agreement. To the extent the CONTRACTOR uses I/T/Us, PCMHs, Health Homes, CSAs and Community Health Workers to perform care coordination functions, such entities may be included in the ratios included in this Section [4.4.12.5].

4.4.12.5.1 Care coordination level 1 care coordination 1:750;

4.4.12.5.2 Care coordination level 2 Members not residing in a nursing facility care coordination 1:75, and care coordination level 2 Members residing in a nursing facility 1:125;

4.4.12.5.3 Care coordination level 3 Members not residing in a nursing facility care coordination 1:50; and care coordination level 3 for Members residing in a nursing facility 1:125; and

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

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

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

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

55) **Section 4.4.12.9 of the Contract is amended and restated to read as follows:**

4.4.12.9 The CONTRACTOR shall ensure that Members have a telephone number to call to directly contact (without having to disconnect or place a second call) their care coordinator or a member of their care coordination team during normal business hours (8 a.m. – 5 p.m.
Section 4.4.13.3.1 of the Contract is amended and restated to read as follows:

4.4.13.1.6 Member services, including the care coordinator, shall be handled by the care coordinator as a Warm Transfer. After normal business hours, calls that require immediate attention by a care coordinator shall be handled by the Member services/nurse advice line in accordance with Section 4.15.1.11 of this Agreement.

56) Section 4.4.12.16.2 of the Contract is amended and restated to read as follows:

4.4.12.16.2 Care coordination levels, HRAs, comprehensive needs assessment and reassessment, development of a CCP care plan, and updating the CCP care plan including training on the tools and protocols;

57) Sections 4.4.13.1.4-4.4.13.1.7 are amended and restated to read as follows:

4.4.13.1.4 CCPs Care plans are developed and updated on schedule and in compliance with this Agreement;

4.4.13.1.5 CCPs Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;

4.4.13.1.6 CCPs Care plans are appropriate and adequate to address the Member’s needs;

4.4.13.1.7 Services are delivered as described in the CCP care plan and authorized by the CONTRACTOR;

58) Section 4.4.13.3.1 of the Contract is amended and restated to read as follows:

4.4.13.3.1 The ability to capture and track key dates and timeframes specified in this Agreement, including, but not limited to, as applicable, enrollment, date of development of the CCP care plan, date of authorization of the CCP care plan, date of initial service delivery for each service in the CCP care plan, date of each level of care and needs reassessment, date of each update to the CCP care plan, and dates regarding transition from an institutional facility to the community;

59) Section 4.4.13.3.3 of the Contract is amended and restated to read as follows:

4.4.13.3.3 The ability to notify the care coordinator about key dates, e.g., eligibility end date, date for annual level of care reassessment, date of
comprehensive needs reassessment, and date to update the CCP care plan;

60) **Section 4.13.3.5 of the Contract is amended and restated to read as follows:**

4.13.3.5 The ability to capture and monitor the CCP care plan;

61) **Section 4.4.14.1.4 of the Contract is amended and restated to read as follows:**

4.4.14.1.4 Match services provided to a Member with services authorized in the Member’s CCP care plan;

62) **Section 4.4.14.2 of the Contract is amended and restated to read as follows:**

4.4.14.2 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the CCP care plan, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a Member is receiving services, including after the CONTRACTOR’s regular business hours.

63) **Section 4.4.15.1.4 of the Contract is amended and restated to read as follows:**

4.4.15.1.4 Identification of wrap-around services available in the community where the Member will reside;

64) **Section 4.4.15.2 of the Contract is amended and restated to read as follows:**

4.4.15.2 For those Members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of sixty (60) Calendar Days from the decision to pursue transition or until the transition has occurred and a new CCP care plan is in place. The transition plan shall address the Member’s transition needs including but not limited to:

65) **Section 4.4.16.1.3 of the Contract is amended and restated to read as follows:**
4.4.16.1.3 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the CCP care plan developed by the CONTRACTOR without any disruption in services.

66) **Section 4.4.16.1.8 of the Contract is amended and restated to read as follows:**

4.4.16.1.8 During the Transition Period, for Medically Necessary Covered Services, including services previously authorized by HSD in a Member’s Behavioral Health treatment or service plan and/or HSCB HCBS care plan (including Individualized Plan of Care (IPoC), being provided by a Non-Contract Provider, the CONTRACTOR shall provide continuation of such services for up to ninety one-hundred eighty (180 ‘90) Calendar Days or until the Member may be reasonably transferred without disruption to a Contract Provider, whichever is less. The CONTRACTOR may require prior authorization for continuation of services beyond thirty (30) Calendar Days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is a Non-Contract Provider.

67) **Section 4.4.16.1.10 is deleted from the Contact.**

4.4.16.1.10 The CONTRACTOR shall continue providing services previously authorized by HSD or its designee in the Member’s approved HCBS care plan or Behavioral Health treatment or service plan without regard to whether such services are being provided by Contract or Non-Contract Providers and shall not reduce these services until the Member’s care coordinator has conducted a comprehensive needs assessment and developed a care plan.

68) **Section 4.5.6.5.2 of the Contract is amended and restated to read as follows:**

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

69) **Section 4.5.7.2.1 of the Contract is amended and restated to read as follows:**

4.5.7.2.1 Members selecting the Agency-Based Community Benefit will have a choice of the consumer delegated model or consumer directed model the option to select their personal care services provider.

70) **Section 4.5.7 of the Contract is amended to add 4.5.7.5 which reads as follows:**
4.5.7.5 The maximum allowable cost of care for the Community Benefit will be tied to
the State’s cost of care for persons served in a private nursing facility, except as
described in section 4.6.1.8. However, the maximum allowable cost of care is
not an entitlement. A Member’s actual cost of care for the Community Benefit
will be determined by the comprehensive needs assessment.

4.5.7.5.1 The annual cost limitation will be determined by HSD prior to the
beginning of each annual period for this Agreement based on the
projected cost of placement in a Medicaid custodial nursing facility,
excluding State Owned Nursing Facilities for low level of care.

4.5.7.5.2 The actual amount that can be spent by a Member in his/her CCP per
year is subject to the Member’s comprehensive needs assessment.

4.5.7.5.3 The CONTRACTOR may choose to spend additional amounts but
will not be compensated by HSD for expenditures exceeding the cost
limitation developed by HSD in Section 4.5.7.5.1 and 4.6.1.8.1 of
this Agreement.

71) **Section 4.5.11.1 of the Contract is amended and restated to read as follows:**

4.5.11.1 The CONTRACTOR shall impose the maximal nominal copayments
established by HSD for non-emergency use of the emergency room in
accordance with federal regulations for individuals over 100% of the
federal poverty level.

72) **Section 4.5.12 of the Contract is amended and restated to read as follows:**

4.5.12 **Copayment for Legend Brand Name Drugs When a Generic Drug Is Available**

4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations for individuals over 100% of the federal poverty level on any prescription filled for a Member with a legend brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to legend brand name drugs that are classified as psychotropic drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall develop a copayment exception process to be prior approved by HSD for other legend brand name drugs where such drugs are not tolerated by the Member.

4.5.12.2 The CONTRACTOR may not deny services for a Member’s failure to pay the copayment amounts.
4.5.12.3 The CONTRACTOR shall not impose any copayments on Native Americans.

73) Section 4.6.1 of the Contract is amended and restated to read as follows:

4.6.1 General

4.6.1.1 The CONTRACTOR shall offer the Self-Directed Community Benefit (SDCB) to Members who meet nursing facility level of care and are determined through a comprehensive needs assessment/reassessment to need the Community Benefit. Self-direction in Centennial Care affords Members the opportunity to have choice and control over how SDCB services are provided, who provides the services and how much providers are paid for providing care in accordance with a range of rates per service established by HSD. A list of SDCB services is included in Attachment [2].

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HSD to provide assistance to members who choose the SDCB, cooperate with the FMA in administering the Self-Directed Community Benefit SDCB.

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 EOR to serve as the employer of record EOR on his or her behalf. A Member who is an emancipated minor or under guardianship cannot serve as the EOR and must designate an individual have an EOR/authorized agent to assume the functions on his or her behalf.

4.6.1.4 Reserved. A Member or his or her Representative may designate a person to provide support to the self-directed functions. Specifically, a Member/Representative may:

4.6.1.4.1 Have the Member’s power of attorney assume the SDCB responsibilities on the Member’s behalf as the EOR; or

4.6.1.4.2 Designate an Authorized Agent who does not have power of attorney but may interact on the Member's behalf, with the FMA, supports broker and care coordinator.

4.6.1.5 The EOR or an Authorized Agent, if any, must be documented in the Member’s file. The care coordinator shall also include a copy of any EOR/ and authorized agent forms in the Member’s file and provide copies to the Member, the Member’s Representative and the FMA.
4.6.1.6 The CONTRACTOR shall have a contract effective with the FMA for each of the periods covered by this Agreement and shall not terminate their agreement with the FMA during the term of this Agreement.

4.6.1.7 HSD shall include the cost of the FMA contract in the capitated payments made by HSD to the CONTRACTOR in accordance with Section 6 of this agreement.

4.6.1.8 Existing Self-Directed Community Benefit Members

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

4.6.1.8.2 Grandfathered clients while not subject to the annual Community Benefit cost limitations imposed by Section 4.5.7.5 of this Agreement will be subject to the comprehensive needs assessment and CCP development process.

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

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

4.6.1.9 New Self-Directed Community Benefit Members

4.6.1.9.1 Members who were not enrolled as self-directed or did not have an approved self-directed budget that exceeds the cost limitation described in section 4.5.7.5 prior to January 1, 2014 are subject to annual cost limitations defined by HSD in Section 4.5.7.5.1 of this Agreement.

4.6.1.9.2 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HSD for expenditures exceeding the cost limitation developed by HSD in Section 4.5.7.5.1 of this Agreement.

74) Section 4.6.2 of the Contract is amended and restated to read as follows:

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 Self-Directed Community Benefit (SDCB) and that sufficient supports are made
available to assist Members who require assistance. This includes but is not limited to the development of the annual budget amount based on the Member’s needs as identified in the annual comprehensive needs assessment. In this capacity, the CONTRACTOR shall fulfill, at a minimum, the following tasks:

4.6.2.1.1 Understand Member and employer of records roles and responsibilities;

4.6.2.1.2 Identify resources outside the Centennial Care program, including natural and informal supports that may assist in meeting the Member’s needs;

4.6.2.1.3 Understand the array of the Self-Directed Community Benefit SDCB;

4.6.2.1.4 Develop a thoughtful and comprehensive budget to determine the annual budget for the SDCB, based on the comprehensive needs assessment to address the needs of the Member in accordance with the requirements stated in this Section 4.6.4 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/authorized agent (as appropriate); finding and hiring employees and providers, and completing all documentation required by the FMA;

4.6.2.1.7 Identify and resolve issues related to the implementation of the care plan CCP budget;

4.6.2.1.8 Assist the Member with quality assurance activities to ensure implementation of the Member’s care plan budget for the Self-Directed Community Benefit SDCB care plan and utilization of the authorized budget;

4.6.2.1.9 Recognize and report Critical Incidents, including Abuse, neglect, exploitation, Emergency Services, law enforcement involvement, and environmental hazards; and

4.6.2.1.10 Monitor quality, including but not limited to, (i) the adequacy of Member-to-support broker ratios, (ii) the relationship between support brokers and care coordinators and (iii) the of services provided by Self-Directed Community Benefit providers support brokers.

4.6.2.2 The care coordinator shall work with the Member to determine the appropriate level of assistance necessary to recruit, interview and hire
Section 4.6.3 of the Contract is amended and restated to read as follows:

4.6.3 Supports Broker Functions

4.6.3.1 The CONTRACTOR shall perform, or contract with a qualified vendor to perform, the supports broker functions for Members electing the Self-Directed Community Benefit SDCB. If the functions are subcontracted, the CONTRACTOR shall be responsible for ensuring that all applicable requirements are met. At a minimum, the CONTRACTOR (either directly or through a subcontractor) shall perform the following supports broker functions:

4.6.3.1.1 Educate Members on how to use self-directed supports and services and provide information on program changes or updates;

4.6.3.1.2 Review, monitor and document progress of the Member’s Self-Directed Community Benefit SDCB services and budget care plan;

4.6.3.1.3 Assist in managing budget expenditures and complete and submit budget revisions-requests;

4.6.3.1.4 Assist with employer functions such as recruiting, hiring and supervising providers;

4.6.3.1.5 Assist with approving/processing job descriptions for direct supports;

4.6.3.1.6 Assist with completing forms related to employees;

4.6.3.1.7 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; and

4.6.3.1.8 Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;

4.6.3.1.9 Facilitate resolution of any disputes regarding payment to providers for services rendered;

4.6.3.1.10 Develop the care plan for SDCB services, based on the budget amount, and ensure that it is included in the CCP; and
4.6.3.11 Assist in completing all documentation required by the FMA.

4.6.3.2 The CONTRACTOR shall have policies and procedures in place to ensure that supports brokers and care coordinators work in a collaborative manner and do not duplicate activities or functions.

76) **Section 4.6.4.2 of the Contract is amended and restated to read as follows:**

4.6.4.2 The CONTRACTOR shall conduct initial education and training to the FMA and its staff at least ninety (90) forty-five (45) Calendar Days prior to Go-Live. This education and training shall include, but not be limited to, the following:

77) **Sections 4.6.4.2.1-4.6.4.2.2 of the Contract are amended and restated to read as follows:**

4.6.4.2.1 The role and responsibilities of the care coordinator, including, but not limited to, comprehensive needs assessment and **CCP care plan development, CCP care plan implementation and monitoring processes, including the development and activation of a back-up plan for Members participating in the Self-Directed Community Benefit SDCB;**

4.6.4.2.2 The FMA’s responsibilities for communicating with the CONTRACTOR, Members, EORs, authorized agents, providers and HSD, and the process by which to do this;

78) **Section 4.6.5 of the Contract is amended and restated to read as follows:**

4.6.5 **Self-Assessment**

4.6.5.1 The CONTRACTOR shall obtain from the Member or Member’s representation a signed statement regarding the Member’s decision to participate in the Self-Directed Community Benefit. Such statement shall be in a turn form and manner prior approved by HSD.

4.6.5.12 The care coordinator shall provide the Member with a self-assessment instrument developed by HSD. The self-assessment instrument shall be completed by the Member with assistance from the Member’s care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the Member’s file.

4.6.5.23 If, based on the results of the self-assessment, the care coordinator determines that a Member requires assistance to direct his or her services, the care coordinator shall inform the Member that he or she will need to
designate an EOR or Authorized Agent to assume the self-direction functions on his or her behalf.

79)  **Section 4.6.6 of the Contract is amended and restated to read as follows:**

4.6.6 **Back-up Plan**

4.6.6.1 The supports broker shall assist the Member/EOR/authorized agent in developing a back-up plan for the Self-Directed Community Benefit SDCB that adequately identifies how the Member/EOR/authorized agent 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 supports broker shall assess the adequacy of the Member’s back-up plan on at least an annual basis and any time there are changes in the type, amount, duration, scope of the Self-Directed Community Benefit 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.

80)  **Section 4.6.7 of the Contract is amended and restated to read as follows:**

4.6.7 **Budget**

4.6.7.1 The supports broker and Member shall work together to care coordinator shall develop a budget for the Self-Directed Community Benefit SDCB services the Member is identified to need as a result of the comprehensive needs assessment.

4.6.7.2 The supports broker and the Member shall work together to develop a plan for the SDCB services that are part of the overall CCP within the SDCB budget. The supports broker and Member shall refer to the range of rates specified by HSD in selecting payment rates for providers and vendors.

4.6.7.3 The budget for the Self-Directed Community Benefit SDCB services shall be based upon the Member’s assessed needs. The Member shall have the flexibility to negotiate provider rates within the rate range and allocated budget. A Member shall have the flexibility to choose from the range of HSD specified rates for all Self-Directed Community Benefit SDCB services.
4.6.7.4 The CONTRACTOR shall evaluate the rates selected by the Member for Self-Directed Community Benefit SDCB services for reasonableness.

4.6.7.5 The budget for the Self Directed Community Benefit 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.

4.6.7.6 The supports broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the SDCB care plan will necessitate adjustments to the budget and that the Member does not exceed his or her budget.

81) Section 4.6.9.1 of the Contract is amended and restated to read as follows:

4.6.9.1 The CONTRACTOR shall require all Members electing to enroll in the Self-Directed Community Benefit SDCB and/or their EORs/authorized agents to receive relevant training. The supports broker shall be responsible for arranging for initial and ongoing training of Members and/or EORs/authorized agents.

82) Section 4.6.9.2 of the Contract is amended and restated to read as follows:

4.6.9.2 At a minimum, self-direction training for Members and/or EORs/authorized agents shall address the following issues:

83) Section 4.6.9.2.1 of the Contract is amended and restated to read as follows:

4.6.9.2.1 Understanding the role of Members and EORs/authorized agents with the Self-Directed Community Benefit SDCB;

84) Section 4.6.9.3 of the Contract is amended and restated to read as follows:

4.6.9.3 The CONTRACTOR shall arrange for ongoing training for Members and/or EORs/authorized agents upon request and/or if a supports broker, through monitoring, determines that additional training is warranted.

85) Section 4.6.9.4.1 of the Contract is amended and restated to read as follows:

4.6.9.4.1 Overview of the Centennial Care program and the Self-Directed Community Benefit SDCB;
Section 4.6.9.7 of the Contract is amended and restated to read as follows:

4.6.9.7 Additional training and refresher components may be provided to a provider to address issues identified by the supports broker, Member and/or the EOR/authorized agent or at the request of the provider.

Section 4.6.10.1 of the Contract is amended and restated to read as follows:

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 Self-Directed Community Benefit SDCB.

Section 4.6.10.3 of the Contract is amended and restated to read as follows:

4.6.10.3 The care coordinator shall monitor a Member’s participation in the Self-Directed Community Benefit SDCB to determine, at a minimum, the success and the viability of the service delivery model for the Member. The care coordinator shall note any patterns, such as frequent turnover of EORs/authorized agents and providers that may warrant intervention by the care coordinator. If problems are identified, a care coordinator should also ask a Member to complete a self-assessment to determine what additional supports, if any (such as designating an EOR or authorized agent), could be made available to assist the Member.

Section 4.6.11 of the Contract is amended and restated to read as follows:

4.6.11 Termination from the Self-Directed Community Benefit SDCB

4.6.11.1 The CONTRACTOR may involuntarily terminate a Member from the Self-Directed Community Benefit SDCB under any of the following circumstances:

4.6.11.1.1 The Member refuses to follow HSD rules and regulations after receiving focused technical assistance on multiple occasions, support from the care coordinator or FMA, which is supported by documentation of the efforts to assist the Member;

4.6.11.1.2 There is an immediate risk to the Member’s health or safety by continued self-direction of services, i.e., the Member is in imminent risk of death or serious bodily injury. Examples include but are not limited to the following: the Member (i) refuses to include and maintain services in his or her CCP care plan that would address health and safety issues identified in his or her comprehensive needs assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, care coordination or FMA, (ii) is experiencing significant health or safety needs and, refuses to
incorporate the care coordinator’s recommendations into his or her CCP care plan, or (iii) exhibits behaviors that endanger him/her or others;

4.6.11.3 The Member misuses his or her Self-Directed Community Benefit SDCB budget following repeated and focused technical assistance and support from the care coordinator and/or FMA, which is supported by documentation;

4.6.11.4 The Member expends his/her entire SDCB budget prior to the end of the CCP year; or

4.6.11.5.4 The Member commits Medicaid Fraud.

4.6.11.2 The CONTRACTOR shall submit to HSD any requests to terminate a Member from the Self-Directed Community Benefit SDCB with sufficient documentation regarding the rationale for termination.

4.6.11.3 Upon HSD approval, the CONTRACTOR shall notify the Member regarding termination in accordance with HSD rules and regulations. The Member shall have the right to Appeal the determination by requesting a Fair Hearing.

4.6.11.4 The CONTRACTOR shall facilitate a seamless transition from the Self-Directed Community Benefit SDCB to ensure there are no interruptions or gaps in services.

4.6.11.5 Involuntary termination of a Member from the Self-Directed Community Benefit SDCB shall not affect a Member’s eligibility for Covered Services or enrollment in Centennial Care.

4.6.11.6 The CONTRACTOR shall notify the FMA within one (1) Business Day of processing the outbound enrollment file when a Member is involuntarily terminated from the Self-Directed Community Benefit SDCB and when a Member is disenrolled from Centennial Care. The notification should include the effective date of termination and/or disenrollment, as applicable.

4.6.11.7 Members who have been involuntarily terminated withdrawn may request to be reinstated in the Self-Directed Community Benefit SDCB. Such request may not be made more than once in a calendar year twelve (12) month period. The care coordinator shall work with the FMA to ensure that the issues previously identified as reasons for termination withdrawal have been adequately addressed prior to reinstatement. All Members shall be required to participate in Self-Directed Community Benefit SDCB training programs prior to re-instatement in the Self-Directed Community Benefit SDCB.
90) **Section 4.6.12.2 of the Contract is amended and restated to read as follows:**

4.6.12.2 No Self-Directed Community Benefit (SDCB) provider shall exceed forty (40) hours paid work in a consecutive seven (7) Calendar Day period.

91) **Section 4.6.12.5 of the Contract is amended and restated to read as follows:**

4.6.12.5 The CONTRACTOR shall reimburse the FMA for authorized Self-Directed Community Benefit (SDCB) services provided by providers at the appropriate rate for the self-directed HCBS, which includes applicable payroll taxes.

92) **Sections 4.8.1.1.6-4.8.1.1.8 of the Contract are amended and restated to read as follows:**

4.8.1.1.6 Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to Members; and

4.8.1.1.7 Not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or SCHIP sanctions, except for Emergency Services; and

4.8.1.1.8 Provide Members with special health care needs direct access to a specialist, as appropriate for the member’s health care condition, as specified in 42 CFR § 438.208(c)(4).

93) **Section 4.8.13.3 of the Contract is amended and restated to read as follows:**

4.8.13.3 Supports brokers to assist with administering the Self-Directed Community Benefit.

94) **Section 4.8.16.2 of the Contract is amended and restated to read as follows:**

4.8.16.2 The CONTRACTOR shall participate in Project ECHO, in accordance with State prescribed requirements and standards including but not limited to paying its fair share of administrative costs to support Project ECHO, and shall:

95) **Section 4.9.2.45 of the Contract is amended and restated to read as follows:**

4.9.2.45 Specify that reimbursement of a Community Benefit provider shall be contingent upon the provision of services to an eligible Member in accordance
with applicable federal and State requirements and the Member’s CCP care plan as authorized by the CONTRACTOR;

96) **Section 4.10.2.2 of the Contract is amended and restated to read as follows:**

4.10.2.2 I/T/Us

The CONTRACTOR shall reimburse both Contract and Non-Contract Provider I/T/Us at a minimum of one hundred percent (100%) of the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB), except for pharmacy, inpatient physician services, case management, vision appliances, nutritional services and ambulatory surgical center services. 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.

97) **Section 4.10 of the Contract is amended to add section 4.10.8 which reads as follows:**

4.10.8 Safety-Net Care Pool Hospitals

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

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

98) **Section 4.11.2.7 of the Contract is amended and restated to read as follows:**

4.11.2.7 The CONTRACTOR shall adequately staff the provider service line to ensure that the line, including the Utilization Management line/queue, meets the following performance standards on a monthly basis:

99) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with section 1902(c)(30)(C) of the Social Security Act. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR’s compliance with HSD’s managed care regulations and quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.
100) **Sections 4.12.4.9 and 4.12.4.10 of the Contract are amended and restated to read as follows:**

4.12.4.9 Have an annual QM/QI work plan to be submitted in accordance with Attachment **1** and thereafter at the beginning of each year of the Agreement, approved by HSD that includes, at a minimum, immediate objectives for each Agreement year and long-term objectives for the entire term of this Agreement. The QM/QI work plan shall contain the scope, objectives, planned activities, timeframes and data indicators for tracking performance and other relevant QM/QI information, including adult quality improvement projects identified by HSD;

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Behavioral Health, one (1) on services to children, one (1) on Long-Term Care, and one (1) on women’s health; three (3) of the PIPs shall focus specifically on the prevention and management of diabetes, the screening/management of clinical depression as required by the Adult Medicaid Quality Grant and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). The have a PIPs work plan and activities that are consistent with federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the “EQR Managed Care Organization Protocol” available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html;

101) **Section 4.12.5.1 of the Contract is amended and restated to read as follows:**

4.12.5.1 As part of the QI program for Centennial Care, the CONTRACTOR shall conduct an annual survey that shall assess Member satisfaction with the quality, availability, and accessibility of care. The CONTRACTOR shall implement the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for all Centennial Care Members. The CAHPS survey shall provide a statistically valid sample of CONTRACTOR’s Members who must have at least six (6) months of continuous enrollment, including Members who have requested to change their PCPs. The Member surveys shall address Member receipt of educational materials, Member satisfaction with care coordination and involvement in care coordination processes, including development of the **CCP** care plan. The CONTRACTOR shall follow all federal and State confidentiality statutes and regulations in conducting this Member Satisfaction Survey.
102) **Section 4.12.8.1 of the Contract is amended and restated to read as follows:**

4.12.8.1 All performance measures (PMs) and targets shall be based on HEDIS. PMs and targets shall be reasonable and based on industry standards that are applicable to substantially similar populations. The CONTRACTOR shall meet performance targets specified by HSD. HSD considers calendar year 2014 and SFY calendar year 2015 to be a noncompetitive baseline year for performance measure thresholds and for setting future targets. The first full HEDIS audit will be expected in SFY 2016. To the extent the CONTRACTOR has yet to achieve NCQA accreditation in the State of New Mexico, the CONTRACTOR shall report on the performance measures using NCQA HEDIS methods and technical specifications as specified by HSD or its designee. The CONTRACTOR may be required to collect, track, trend and report performance measures or other measures as directed by HSD or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HSD and/or its designee.

103) **Sections 4.12.10.1.6 and 4.12.10.1.7 of the Contract are amended and restated to read as follows:**

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

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

104) **Section 4.12 of the Contract is amended to add section 4.12.17 which reads as follows:**

4.12.17 **Tracking Measures**

4.12.17.1 The CONTRACTOR shall report on the tracking measures included in this Section 4.12.17 in a format prescribed by HSD.

4.12.17.2 The tracking measures included in this Section 4.12.17 are not subject to sanctions in section 7.3.6.1. of this Agreement.

4.12.17.3 **TM#1- Fall Risk Management**

The Percentage of Medicaid Members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.
4.12.17.4 TM#2- Diabetes, Short-Term Complications Admission Rate

The number of inpatient discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18 and older.

4.12.17.5 TM#3- Screening for Clinical Depression and Follow-Up Plan

The percentage of Medicaid enrollees age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

105) Section 4.13.1.3.7 of the Contract is amended and restated to read as follows:

4.13.1.3.7 Promoting adoption of the use of Health Information Technology ("HIT") and supporting the exchange of electronic Health Information Exchange ("HIE"); and

106) Section 4.13 of the Contract is amended to add 4.13.3 which reads as follows:

4.13.3 New Mexico’s Health Information Exchange (HIE)

4.13.3.1 The CONTRACTOR shall make its Centennial Care health plan’s health information available to the HIE and use the HIE to exchange electronic health information with other providers and health plans in accordance with applicable State and Federal law.

4.13.3.2 The CONTRACTOR shall issue monthly payments to the New Mexico Health Information Collaborative (NMHIC), or its successor, as operator of the HIE.

4.13.3.2.1 The payment shall be an amount based on the CONTRACTOR’s Centennial Care membership for that month using a PMPM set by HSD.

4.13.3.2.2 The payment shall be made no later than ten (10) Calendar Days, or at HSD’s discretion, following the CONTRACTOR’s receipt of the monthly capitation payment for its membership from HSD.

107) Section 4.14.8.3.6 of the Contract is amended and restated to read as follows:

4.14.8.3.6 Third Party Liability information: Reserved;

108) Section 4.14.8.3.10 of the Contract is amended and restated to read as follows:
109) Sections 4.15.1.9-4.15.1.11 of the Contract are amended and restated to read as follows:

4.15.1.9 The Member services information line shall be staffed twenty-four (24) hours- a-day, seven (7) days-a-week with qualified nurses to triage urgent care and emergency calls from Members and to facilitate transfer of calls to a care coordinator to the extent immediate attention of a care coordinator is necessary. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section §4.15.1.

4.15.1.10 If the CONTRACTOR operates a separate nurse triage/nurse advice line, the _Staff providing triage/nurse advice services on such line_ must be registered nurses (R.N.), physician assistants, nurse practitioners, or medical doctors. At all times there must be staff on hand equipped to handle Behavioral Health crises. The primary intent of this triage is to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with a Member’s PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

4.15.1.11 The CONTRACTOR shall ensure that all calls from Members to the nurse triage/nurse advice line that require immediate attention are immediately addressed by qualified nurses or transferred to a care coordinator, whichever is most appropriate. During normal business hours, the transfer to the care coordination unit shall be a Warm Transfer. After normal business hours, if the CONTRACTOR cannot transfer the call to the care coordination unit as a Warm Transfer, the CONTRACTOR shall ensure that a care coordinator is notified about the call and returns the Member’s call within thirty (30) minutes. When returning the call and that the care coordinator has must have access to the necessary information (e.g., the Member’s CCP care plan) to resolve Member issues. The CONTRACTOR shall implement protocols, with prior approval from HSD, that describe how calls to the nurse triage/nurse advice line from Members will be handled.

110) Section 4.15.2.1 of the Contract is amended and restated to read as follows:

4.15.2.1 The CONTRACTOR shall adequately staff the Member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards on a monthly basis: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark
established by NCQA); and average wait time for assistance does not exceed two (2) minutes.

111) **Section 4.16.8 of the Contract is amended and restated to read as follows:**

4.16.8 **Provider Grievances and Appeals**

The CONTRACTOR shall establish and maintain written policies and procedures for the filing of provider Grievances and Appeals. A provider shall have the right to file a Grievance or an Appeal with the CONTRACTOR and, after exhausting the CONTRACTOR’s Appeal process, the right to file a State Fair Hearing. Provider Grievances or Appeals shall be resolved within thirty (30) Calendar Days. If the provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, the CONTRACTOR shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by the CONTRACTOR. A provider shall have the right to file an Appeal with the CONTRACTOR regarding provider payment issues and/or Utilization Management decisions and, after exhausting the CONTRACTOR’s Appeal process, the right to file a State Fair Hearing.

112) **Section 4.17.2.4 of the Contract is amended and restated to read as follows:**

4.17.2.4 The CONTRACTOR shall promptly (within two (2) five (5) Business Days) perform a preliminary investigation of all incidents of suspected and/or confirmed Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

113) **Section 4.17 of the Contract is amended to add section 4.17.4 which reads as follows:**

4.17.4 **Recoveries of Overpayments and/or Fraud**

4.17.4.1 **Identification Process For Overpayments**

4.17.4.1.1 Providers are required to report overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an overpayment if the provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment.
4.17.4.1.2 An overpayment shall be deemed to have been “identified” by a provider when:

4.17.4.1.2.1 The provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursement;

4.17.4.1.2.2 The provider learns that a patient death occurred prior to the service date on which a claim that has been submitted for payment;

4.17.4.1.2.3 The provider learns that services were provided by unlicensed or excluded individual on its behalf;

4.17.4.1.2.4 The provider performs an internal audit and discovers that an overpayment exists;

4.17.4.1.2.5 The provider is informed by a government agency of an audit that discovered a potential overpayment;

4.17.4.1.2.6 The provider is informed by the CONTRACTOR, HSD, or the RAC of an audit that discovered a potential overpayment;

4.17.4.1.2.7 The provider experiences a significant increase in Medicaid revenue and there is no apparent reason – such as a new partner added to a group practice or new focus on a particular area of medicine – for the increase;

4.17.4.1.2.8 The provider has been notified that the CONTRACTOR or a government agency has received a hotline call for email; and/or

4.17.4.1.2.9 The provider has been notified that the CONTRACTOR or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the provider submitted a claim for payment.

4.17.4.2 Self-Reporting

4.17.4.2.1 Within the timeframes specified in 4.17.4.1.1, the provider shall send an “Overpayment Report” to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider’s name; (ii) provider’s tax identification number and National Provider Number; (iii) how the overpayment was discovered; (iv) the
reason for the overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a corrective action plan to ensure the overpayment does not occur again; (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 the OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the overpayments; (xi) if a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment; and (xii) the refund amount.

4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the overpayment in accordance with NMAC §8.351.2.13.

4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud.
Sections 4.18.2.1 and 4.18.2.2 of the Contract are amended and restated to read as follows:

4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and State Insurance Code, NMSA 1978, § 59A-46-13. The CONTRACTOR shall deposit, in the form of cash or liquid assets, an amount equal to ninety percent (90%) of the total capitation payment paid to the CONTRACTOR in the first month of the Contract Year as determined by HSD, five percent (5%) of the capitation payments made by HSD each month until a maximum total of two percent (2%) of the annualized total current capitation amount is reached and maintained. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.

4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR’s Centennial Care program.

4.18.2.1.2 The CONTRACTOR must satisfy this requirement no later than thirty (30) Calendar Days after notification by HSD of the deposit amount required.

4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.

4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.

4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.

4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.

4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to
withdrawal of funds from this account as outlined in Section 4.18.2.1.6.

4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by the CONTRACTOR and two (2) representatives of HSD. If the authorized persons remain the same, the CONTRACTOR shall submit an attestation to this effect annually by April 1 of each Contract year to HSD along with a copy of the latest bank statement. All such agreements or other signature cards shall be approved in advance by HSD. The CONTRACTOR shall deposit the cash or liquid assets with the Superintendent of Insurance or, at the discretion of the Superintendent of Insurance, with any organization or trustee acceptable through which a custodial or controlled account is utilized as per NMSA 1978, § 59A-46-13.

4.18.2.4-22 In the event that a determination is made by HSD that the CONTRACTOR is insolvent or insolvent per NMSA 1978, § 59A-46, HSD may draw upon the amount, solely with the two (2) authorized signatures of representatives of the HSD and Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

4.18.2.4-3 If the Agreement is terminated, expired, or not continued, the account balance shall be released by HSD to the CONTRACTOR upon receipt of proof of satisfaction of all outstanding obligations incurred under this Agreement.

4.18.2.4-4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims.

4.18.2.4-5 HSD shall adjust this reserve requirement quarterly annually, as needed. The reserve account may be accessed solely for payment for
Covered Services to the CONTRACTOR’s Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned as long provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with the Division Office of the Superintendent of Insurance regulations and guidelines.

4.18.2.1.6 If the reserve account falls below the required amount, the CONTRACTOR shall increase the reserve account to the one hundred percent (100%) level within thirty (30) Calendar Days. Failure to maintain the reserve as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

115) **Section 4.18.3 of the Contract is amended and restated to read as follows:**

4.18.3 Surplus Start-Up Account

The CONTRACTOR, at the agreement execution, shall submit to HSD proof of working capital in the form of cash or liquid assets excluding revenues from Medicaid capitation equal to at least the first three (3) months of operating expenses. This provision shall not apply if the CONTRACTOR has been providing services to Medicaid Members for a period exceeding three (3) months.

116) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the New Mexico Division Office of the Superintendent of Insurance, and restricted funds of deposits controlled by HSD (including the CONTRACTOR’s insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars ($1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR’s prepaid revenues. In the event that the CONTRACTOR’s surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

117) **Section 4.18.7 of the Contract is amended and restated to read as follows:**

4.18.7 Fidelity Bond

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond as specified in the Insurance Code, NMSA 1978, 59A-46-6 et seq.
however HSD requires the CONTRACTOR to maintain in force a fidelity bond amount of at least one million dollars two hundred fifty-thousand dollars ($250,000 $1,000,000) as specified under the Insurance Code, NMSA 1978, 59A-46-6 et seq.

4.18.7.2 The CONTRACTOR shall secure and maintain during the life of this Agreement a blanket fidelity bond from a company doing business in the State of New Mexico on all personnel in its employment. The bond shall be issued in the amount of at least one million dollars two hundred fifty-thousand dollars ($250,000 $1,000,000) per occurrence. Said bond shall protect HSD from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CONTRACTOR and subcontractors.

4.18.7.3 The CONTRACTOR shall submit proof of coverage to HSD within sixty (60) Calendar Days after the execution of this Agreement or date designated by HSD, and prior to the delivery of health care services.

118) Section 4.18.8.3 of the Contract is deleted.

4.18.8.3 Special contract provisions as required by 42 C.F.R. § 438.6 (c)(5): Pursuant to 42 C.F.R. § 438.6(c)(5), contract provisions for reinsurance, stop loss limits or other risk sharing methodologies must be computed on an actuarially sound basis. Certification of actuarial soundness must be submitted by HSD annually or within thirty (30) Calendar Days of any change.

119) Section 4.18.9 of the Contract is amended and restated to read as follows:

4.18.9 Risk-Based Working Capital Requirements

120) Section 4.18.10.3.2 of the Contract is amended and restated to read as follows:

4.18.10.3.2 Defensive Interval: Must be greater than or equal to thirty (30) Calendar Days.

$$\text{Defensive Interval} = \frac{(\text{Cash} + \text{Current Investments})}{(\text{Operating Expense} – \text{Non-Cash Expense}) / (\text{Period Being Measured in Days})}$$
Non-Cash expense is any expense not paid for in cash such as depreciation.

121) **Section 4.18.10.3.3 of the Contract is deleted.**

4.18.10.3.3 Equity per enrolled person: To be established by HSD following the award of the Agreement.

122) **Section 4.18.11 of the Contract is amended and restated to read as follows:**

4.18.11 **Performance Bond**

4.18.11.1 The CONTRACTOR shall maintain in force a performance bond in the initial amount of one hundred percent (100%) of the first month of capitation payment as determined by HSD and thereafter in the amount set forth in Section 4.18.11.3 throughout the term of this Agreement.

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1.1 through 4.18.11.1.1.4 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1.1 Cash Deposits;

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

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

4.18.11.1.4 Certificate of Deposit

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

4.18.11.3 If the performance bond falls below ninety percent (90%) of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD the CONTRACTOR has thirty (30) Calendar Days to comply with the requirements of this Section and provide proof of the increased bond amount.

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in default of or failing to perform the activities outlined in this Agreement or if HSD
4.18.11.5 The CONTRACTOR is prohibited from using a parental guarantee to fulfill the requirements of the Performance Bond.

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

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

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

4.18.11.9 Failure to maintain the performance bond as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

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

123) Section 4.18.12 of the Contract is amended and restated to read as follows:

4.18.12 Reinsurance

4.18.12.1 The CONTRACTOR shall have and maintain a minimum of one million dollars ($1,000,000.00) per occurrence in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HSD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance. Information provided to HSD on the CONTRACTOR’s reinsurance must be computed on an actuarially sound basis.

4.18.12.2 HSD reserves the right to revisit reinsurance annually and modify the reinsurance threshold amount, to be determined by HSD, if, upon review of financial and Encounter Data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by HSD.

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the Office of the Superintendent of Insurance for approval. The CONTRACTOR must
submit the pricing details of the reinsurance agreement including the covered period to HSD as well as a copy to the Office of the Superintendent of Insurance for approval.

4.18.12.4 The CONTRACTOR shall ensure that the reinsurance agreement meets a medical loss ratio of at least 85% annually.

124) **Section 4.18.13.1 of the Contract is amended and restated to read as follows:**

4.18.13.1 The CONTRACTOR shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and notify the agency’s third-party liability vendor of any third-party creditable coverage discovered. **Specifically, the CONTRACTOR:**

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

4.18.13.1.2 Shall inform HSD within twenty (20) Calendar Days of receiving information regarding any member who has other health coverage;

4.18.13.1.3 Shall provide documentation within twenty (20) Calendar Days to HSD, Third-Party Liability Unit enabling HSD to pursue its right under federal and State law, regulations and rules; documentation shall include payment information, collection and/or recoveries for services provided to enrolled members as required by HSD; and

4.18.13.1.4 Has the sole right of collection to recover from a third-party resource or from a provider who has been overpaid due to a third-party resource for twelve (12) months from the date the CONTRACTOR first pays the claim to initiate recovery and attempt to recover any third-party resources available to Medicaid Members, for all services provided by the CONTRACTOR pursuant to this Agreement or any other Agreement for Medicaid services between the CONTRACTOR and HSD. Without mitigating any rights the CONTRACTOR’s provider has pursuant to federal and state law and regulations, the CONTRACTOR:
4.18.13.1.4.1 Agrees HSD has the sole right of collection from a third-party resource which the CONTRACTOR has failed to identify within twelve (12) months from the date the CONTRACTOR first pays the claim;

4.18.13.1.4.2 Agrees HSD has the sole right of recovery from the CONTRACTOR or a CONTRACTOR’s provider who has been overpaid due to the combined payments of the CONTRACTOR and a third-party resource when the CONTRACTOR has not made a recovery within twelve (12) months from the date the CONTRACTOR first pays the claim;

4.18.13.1.4.3 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR’s provider if the CONTRACTOR has identified a third-party resource but failed to initiate recovery within the twelve (12) month period;

4.18.13.1.4.4 Agrees has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR’s provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations

4.18.13.1.4.5 The exception to this twelve (12) month period is for cases in which a capitation has been recouped from the CONTRACTOR pursuant to Article 6.2.4, whereupon the CONTRACTOR shall retain the sole right of recovery for all paid claims related to members and months that were recouped

125) Section 4.18.14 of the Contract is amended to add 4.18.14.5 which reads as follows:

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

126) Section 4.18.16.1 of the Contract is amended and restated to read as follows:
4.18.16.1 The CONTRACTOR shall submit quarterly and annual insurance filings and financial statements that are specific to the operations of the CONTRACTOR’s New Mexico operations rather than a parent or umbrella organization in accordance with Section [4.21.12.1] of this Agreement.

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

4.19.2.2.13 Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per invoice type (837I adjudicated at the header level, 837P and 837I adjudicated at the line level, 837D, NCPDP), calculated for a month’s worth of submissions. HSD will monitor the CONTRACTOR corrections to denied Encounters for services covered under this Agreement by random sampling performed quarterly and over the term of the Agreement. The methodology for the error rates will be determined by HSD. Seventy-five percent (75%) of the denied Encounters for services covered under this Agreement included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial;

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

4.19.2.2.14 The CONTRACTOR shall submit a report of the number of denied Claims by invoice type (professional, institutional, pharmacy, dental) by date of payment and date of service in accordance with Section [4.21.11.1] of this Agreement. This report will be compared to Encounter Data to evaluate the completeness of data submitted. A variance between the CONTRACTOR’s report and the record of Encounters received cannot exceed five percent (5%) for months of payment greater than ninety (90) Calendar Days. The methodology for the variances will be determined by HSD;

129) **Section 4.19.2.2 of the Contract is amended to add section 4.19.2.2.17 which reads as follows:**

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

130) **Section 4.21.1.8 of the Contract is amended and restated to read as follows:**

4.21.1.8 Each report must include an analysis, which shall include, at a minimum: (i) identification of any changes compared to previous reporting periods as
well as trending over time; (ii) an explanation of said changes (positive or negative); (iii) an action plan or performance improvement activities addressing any negative changes; and (iv) any other additional information pertinent to the reporting period. HSD may assess liquidated damages for failure to address any of these requirements. The above data requirements may be represented in charts, graphs, tables and any other data illustrations to demonstrate findings.

131) **Section 4.21.2.1.2 of the Contract is amended and restated to read as follows:**

4.21.2.1.2 The CONTRACTOR shall, upon request, provide information regarding Member education, training and Outreach initiatives including, but not limited to, the following: (i) target audiences; (ii) location of training/event; (iii) date of training/event; (iv) topics; (v) funds expended; (vi) number and types of attendees and (vii) sign-in sheets.

132) **Section 4.21.4.4 of the Contract is amended and restated to read as follows:**

4.21.4.4 The CONTRACTOR shall submit a monthly *Call Center Report* that provides information about the Member services, provider services, and nurse advice lines. During the first 30 days of implementation the MCO must submit all call center response statistics daily. If deficiencies are found, the state and the MCO must determine how the MCO will remedy the deficiency as soon as possible. After the first 30 days, if the MCO is consistently meeting requirements, the MCO may submit weekly reports for the first 180 days of implementation. The report shall, at a minimum, include by language queue: (i) number of calls received; (ii) number of calls answered; (iii) abandonment rate; (iv) number of calls answered within thirty (30) seconds; and (v) call topics.

133) **Section 4.21.4 of the Contract is amended to add section 4.21.4.7 which reads as follows:**

4.21.4.7 The CONTRACTOR shall submit an *Activities of the Native American Advisory Board Report* ten (10) Calendar Days following each meeting pursuant to Section 4.12.1 of this Agreement. The report shall, at a minimum, include: (i) how notice of such meeting was delivered to Native American representatives that were asked to attend the meeting; (ii) meeting agenda; (iii) a list of meeting attendees; (iv) meeting minutes; (v) action items and/or recommendations to the CONTRACTOR and/or HSD and (vi) the date, time and location of the next meeting.

134) **Section 4.21.5.1.1 of the Contract is amended and restated to read as follows:**
4.21.5.1.1 The CONTRACTOR shall submit a quarterly *Network Adequacy Report* that provides the information on activities from the previous quarter broken out by month. At a minimum, the report shall include: (i) number of providers by provider type; (ii) ratios of providers (by specialty type) to Members (by age group); (iii) geographic access standards by county; and (iv) the time between a Member’s initial request for an appointment and the date of the appointment. The data may be collected using statistical sampling methods (including periodic Member or provider surveys).

135) **Section 4.21.5.1.3 of the Contract is amended and restated to read as follows:**

4.21.5.1.3 The CONTRACTOR shall submit a monthly *PCP Report* that provides the information on activities from the previous month. At a minimum, the report shall include: (i) the names of newly enrolled Members and the name of the PCP to which they are assigned or selected; (ii) the PCP to Member ratio per 2,000 Members; (iii) the percent of PCP panel slots open; (iv) the number of providers serving as PCPs stratified by type (nurse practitioners, internists, pediatricians, etc); (v) the number of PCP visits per 2,000 Members; (vi) the percent of new Members who did not select a PCP and were assigned to one; and (vii) the number of PCP change requests received and processed.

136) **Section 4.21.5.1.6 of the Contract is amended and restated to read as follows:**

4.21.5.1.6 The CONTRACTOR shall submit a quarterly *Provider Suspensions and Terminations Report* that lists by name all Contract Provider suspensions or terminations. This report shall include information on all Contract Providers. At a minimum, the report shall include: (i) each Contract Provider’s name; (ii) the Contract Provider’s specialty; (iii) the Contract Provider’s SSN, as appropriate; (iv) the Contract Provider’s NPI; (v) the Contract Provider’s primary city; (vi) reason(s) for the action taken; and (vii) the effective date of the suspension or termination. If the CONTRACTOR has taken no action against providers during the quarter this should be documented in the *Provider Suspensions and Terminations Report*.

137) **Section 4.21.6 of the Contract is amended and restated to read as follows:**

4.21.6.1 The CONTRACTOR shall submit a quarterly *Medicaid School-Based Health Centers (SBHC) Report* that provides information on all of the procedure codes being billed by each approved SBHC, by county sponsoring entity. The report shall include the number of submitted,
paid, denied, resubmitted, adjudicated, open and reversed SBHC Claims. At a minimum, the report will include (i) **county name** delivery site; (ii) Medicaid SBHC provider name; (iii) provider’s NPI, (iv) total Claims submitted, paid, denied, resubmitted, adjudicated, open and reversed; (v) funding source; (vi) YTD services by service code; (vii) YTD Claims total; (viii) YTD Claims status; and (ix) Claims denied and resubmitted.

4.21.6.2 To the extent the CONTRACTOR provides Value Added Services in accordance with Section 4.7 of this Agreement, the CONTRACTOR shall submit a quarterly **Value Added Services Report** that, at a minimum, lists: (i) the service/benefit; (ii) procedure code for each service; (iii) the number of unduplicated Members for each service; (iv) the numbers of Encounters for each service; (v) the total dollar amount expended in the quarter; (vi) the total dollar amount expended YTD; and (vii) provider name and county. Additionally, the CONTRACTOR shall provide: (i) a description of each benefit; (ii) definition; (iii) availability of the service and any service limitations; (iv) geographic locations where the service is offered; and (v) payment code; and (vi) the date the service(s) will be offered.

4.21.6.3 The CONTRACTOR shall submit a quarterly **Self-Directed Report** that, at a minimum, provides (i) information on the utilization of Self-Directed Community Benefit services and (ii) information on the Member’s utilization of the SDCB budget.

4.21.6.4 The CONTRACTOR shall submit a quarterly **Developmental Disabilities Specialty Dental Report** that, at a minimum, lists the following information: (i) Member name; (ii) provider name; (iii) date of service; and (iv) amount paid for service.

4.21.6.5 The CONTRACTOR shall submit a quarterly **Jackson Class Members Report** that provides, at a minimum, information regarding new requests for new adaptive equipment and for modifications and repairs.

4.21.6.6 The CONTRACTOR shall submit a quarterly **Facilities Readmission Report** that provides information by county regarding the number of Members who are readmitted to a facility such as, an RTC, TFC, hospital, within thirty (30) Calendar Days of a previous discharge. The report shall provide data by procedure codes and populations as specified by HSD.

4.21.6.7 The CONTRACTOR shall submit a quarterly **Member Incentive Rewards Report** that at a minimum includes: (i) the total credits available to each Medicaid household and Member; (ii) the total volume purchased with Member incentive credits for each covered item on the HSD-approved schedule; (iii) the total value of the benefits purchased with those credits by each Medicaid household and Member; and (iv) the ratio of credits earned
to items purchased for all households and Members that participate in the Member incentive program as described in Section 4.22.1 of this Agreement.

138) Sections 4.21.7.3 and 4.21.7.4 of the Contract are amended and restated to read as follows:

4.21.7.3 The CONTRACTOR shall submit a quarterly monthly Level of Care (LOC) Report that provides information regarding initial and annual nursing facility level of care determinations. The report shall, at a minimum, include information regarding number of Members who meet nursing facility level of care and compliance with timeframes associated with level of care determinations as well as their care setting.

4.21.7.4 The CONTRACTOR shall submit a quarterly Agency-Based Community Benefit Report that provides information regarding the amount of the Community Benefit used by Members stratified by level of need as directed by HSD. The report shall also provide information regarding the number of Members that have exhausted their Community Benefit.

139) Section 4.21.7 of the Contract is amended to add sections 4.21.7.10 and 4.21.7.11 which read as follows:

4.21.7.10 The CONTRACTOR shall submit a quarterly CSA Report that provides information regarding the number of CSAs assisting the MCOs’ members and the following information at a minimum for each CSA: (i) name of CSA, (ii) number of Members in CSA that are identified as CSA Members, (iii) number of Members that were admitted to an out of home placement, (iv) number of Members that were admitted to a psychiatric hospital, (v) number of Members who had a crisis incident, (vi) number of SED and SMI members served by the CSA, and (vii) the types of services provided by the CSA.

4.21.7.11 The CONTRACTOR shall submit a monthly Comprehensive Care Plan Report that provides information regarding, at a minimum (i) reductions, (ii) suspensions, (iii) denials and/or (iv) terminations of previously authorized services.

140) Section 4.21.8.4 of the Contract is amended and restated to read as follows:

4.21.8.4 Prior Authorization Report for Denied/Deferred Prior Authorization Requests that includes prior authorization information by service and by population. The report shall, at a minimum, include the following data: (i) date of request; (ii) name of the requesting provider; (iii) Member’s name and ID number; (iv) date of birth; (v) diagnoses and service/medication being requested; (vi) justification given by the provider for the Member’s
need for the service/medication; (vii) justification of the CONTRACTOR’s
denial or the reason(s) for deferral of the request; and (viii) the date and
method of notification of the provider and the Member of the
CONTRACTOR’s determination (i) the service for which a prior
authorization is being requested; (ii) the number of initial and continued
requests for each service; (iii) the number of requests approved, denied
(administrative and clinical), pended for each service (initial and continued);
and (iv) the number of terminations and reductions in service for each
service.

141) Section 4.21.9.1 of the Contract is amended and restated to read as follows:

4.21.9.1 The CONTRACTOR shall submit a quarterly monthly Grievances and
Appeals Report. The CONTRACTOR shall submit reports of all provider and
Member Grievances (informal and formal), Appeals, and Fair Hearings
utilizing the State-provided reporting templates and codes.

142) Section 4.21.10.2 of the Contract is amended and restated to read as follows:

4.21.10.2 The CONTRACTOR shall submit a monthly quarterly Systems
Availability and Performance Report that provides information on
availability and unavailability by major system as well as response
times for the CONTRACTOR’s confirmation of CONTRACTOR’s
enrollment and electronic Claims management functions, as measured
within the CONTRACTOR’s span of control. The report shall meet the
requirements of Section 4.21.10.4 of this Agreement.

143) Sections 4.21.11.1 and 4.21.11.2 of the Contract are amended and restated to
read as follows:

4.21.11.1 The CONTRACTOR shall submit a monthly quarterly Claims Payment
Accuracy Report. The report shall include the results of the internal audit
of the random sample of all “processed or paid” Claims and shall report on
the number and percent of Claims that are paid accurately. If the
CONTRACTOR subcontracts for the provision of any Covered Services,
and the subcontractor is responsible for processing Claims, then the
CONTRACTOR shall submit a Claims payment accuracy percentage report
for the Claims processed by the subcontractor. The report for each
subcontractor shall include the results of the internal audit conducted and
shall report on the number and percent of Claims that are paid accurately.

4.21.11.2 The CONTRACTOR shall submit a monthly Claims Activity Report. At a
minimum, this report shall identify the number of Claims received, number
of Claims denied (by reason), number of Claims paid, total amount paid by
the categories of service specified by HSD in accordance with Section
4.194 of this Agreement. During the first 180 Calendar Days of
implementation the CONTRACTOR must submit a weekly claims activity
report. After the first 180 Calendar Days, at the discretion of HSD, the CONTRACTOR may submit monthly reports.

144) Section 4.21.11 of the Contract is amended to add 4.21.11.5 which reads as follows:

4.21.11.5 The CONTRACTOR shall submit a quarterly * Encounter Processing and Submission Report* that tracks encounters paid in a reporting period and provides a cross tabulation of service delivery cost by month of service and month of payment for managed care encounters; including all inpatient, outpatient, dental and pharmacy encounters.

145) Section 4.21.12 of the Contract is amended and restated to read as follows:

4.21.12 Financial Management

4.21.12.1 By April 1 June 1 of each Agreement year, the CONTRACTOR shall submit annual *Independently Audited Financial Statements*, including, but not limited to, its income statement, statement of changes in financial condition or cash flow, and balance sheet that allow HSD to determine solvency and CMS compliance. Such financial statements shall be specific to the operations of the CONTRACTOR rather than a parent or umbrella organization.

4.21.12.2 By April 1 June 1 of each Agreement year, the CONTRACTOR shall submit a *New Mexico Medicaid Specific Audited Schedule of Revenue and Expenses report* that allow HSD to determine solvency and CMS compliance.

4.21.12.3 The CONTRACTOR shall submit a monthly, quarterly and annual *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well funds for which the CONTRACTOR does not pay a Claim due to TPL coverage or Medicare coverage. This CONTRACTOR shall calculate cost savings in categories described by HSD Reserved.

4.21.12.4 The CONTRACTOR shall submit *Medicaid Specific Unaudited Schedule of Revenue and Expenses* on a quarterly basis. The report will be used to examine and compare administrative expenditures by line of business. The report is due forty five (45) Calendar Days from the end of quarter or the fifteenth (15th) Calendar Day of the second month following the quarter. Reserved.
4.21.12.5 The CONTRACTOR shall submit quarterly and annual Division—Office of the Superintendent of Insurance Reports that allow HSD to determine solvency and CMS compliance. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement.

4.21.12.6 The CONTRACTOR shall submit quarterly and annual Patient Liability Information Reports on a date of service basis. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement. Reserved.

4.21.12.7 The CONTRACTOR shall submit the quarterly Medicaid Financial Reporting Package—Expenditures by Category of Services Report that allows HSD to determine cost efficiency. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter.

4.21.12.7.1 The CONTRACTOR shall submit the annual Medicaid Financial Reporting Package Supplement to HSD by May 15th or an alternative date established by HSD.

4.21.12.8 The CONTRACTOR shall submit a quarterly Utilization by Category of Services Report that allows HSD to determine cost efficiency. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter. Reserved.

4.21.12.9 Reserved. The CONTRACTOR shall submit quarterly EQHC/RHC Payment Reports (Check Register). The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter.

4.21.12.10 The CONTRACTOR shall submit a quarterly Payments to IHS and Tribal 638 Providers Reports that facilitate HSD’s reimbursement to the CONTRACTOR after comparison to Encounters and acceptance of the report. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter.
4.21.12.11 The CONTRACTOR shall submit a quarterly Subcapitation Expenditure and Utilization report. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter. Reserved.

4.21.12.12 The CONTRACTOR shall submit a monthly Withholding Bank Statement for Delivery System Improvements to allow HSD to verify compliance with delivery system improvement requirements in accordance with Section 6.10.1 and Attachment 3 to this Agreement. The report is due forty-five (45) Calendar Days after month end.

4.21.12.13 Initially and upon renewal, the CONTRACTOR shall submit an annual report that identifies the fidelity bond or insurance protection by amount of coverage in relation to annual payments, and allows HSD to examine and confirm solvency and CMS compliance.

4.21.12.14 Initially and upon renewal, the CONTRACTOR shall submit an annual Reinsurance Policy Report that allows HSD to assess solvency and CMS compliance.

4.21.12.15 The CONTRACTOR shall submit a quarterly Cash Reserve Statement Reports that allow HSD to examine and confirm solvency and CMS compliance. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter.

4.21.12.16 The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of five percent (5%) or more have occurred. These records shall include, but are not limited to, an updated list of names and addresses of all persons or entities having ownership interest of five percent (5%) or more. These records shall be provided no later than sixty (60) Calendar Days following the change of ownership.

4.21.12.17 By April 1 of each Agreement year, the CONTRACTOR shall submit an annual Risk Withholding Report that allows HSD to analyze risk sharing.
4.21.12.18 The CONTRACTOR shall submit a quarterly Stop Loss Protection Report that allows HSD to assess the stop loss protections of the CONTRACTOR and of its Contract Providers. Reserved.

4.21.12.19 The CONTRACTOR shall submit a quarterly HCBS Expenditure Report that allows HSD to assess the amount of services spent by the CONTRACTOR and the type of expenditure the CONTRACTOR has incurred. Reserved.

4.21.12.20 The CONTRACTOR shall submit an annual Payment Reform Pay-For-Performance Report, see Section 4.10.7.1.2 of the Agreement that allows HSD to assess the CONTRACTOR’s incentive programs that have been approved by HSD.

4.21.12.21 The CONTRACTOR shall submit a quarterly report that identifies the performance bond, insurance protection or deposit by amount of coverage in relation to HSD requirements, and allows HSD to examine and confirm the value of the performance bond in accordance with 4.18.11.

146) Section 4.22.1.1.3 of the Contract is amended and restated to read as follows:

4.22.1.1.3 Amounts expended on to administer the Member incentive rewards program shall be deemed as administrative expenses for purposes of the medical expense ratio (see Section [7.2] of this Agreement) and amounts expended on the value of the rewards themselves shall be deemed as direct services for purposes of the medical expense ratio (see Section 7.2 of this Agreement).

147) Section 4.22.1.2 of the Contract is amended and restated to read as follows:

4.22.1.2 Specific Requirements

4.22.1.2.1 The activities and behaviors proposed to be rewarded with incentives should promote good health, Health Literacy, and continuity of care for all Members and shall be prior approved by HSD. Behaviors to be rewarded will be agreed to by the CONTRACTOR, the other Centennial Care MCOs and HSD, include but are not limited to the following: (i) compliance with scheduled medical well-child visits (EPSDT); (ii) compliance with scheduled dental exams for children; (iii) compliance with scheduled office visits with the Member’s assigned PCMH or PCP, (iv) participation in weight loss programs; (v) participation in programs to support blood pressure
control; (vi) participation in programs to support blood sugar (HbA1c) control; (vii) participation in cooking and nutrition classes to support diabetes self-management; (viii) participation in exercise programs; (ix) participation in smoking cessation programs; (x) participation in Health Literacy classes; (xi) making and keeping appointments; (xii) compliance with care plans; (xiii) compliance with prenatal visits and care plans; (xiv) receiving flu shots, as applicable.

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

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

148) **Section 4.22.1.3 of the Contract is amended and restated to read as follows:**

4.22.1.3 Data Sharing and Reporting

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

4.22.1.3.2 The credits for qualified activities and programs may be tracked based on Encounter Data Claim submissions. For example, if the credit is to be awarded based on participation in a Medicaid Covered Services (e.g., a well-child visit), the schedule will recognize the qualifying activity based on the CPT code on the Encounter Claim. If the credit is to be awarded based on participation in a non-covered Medicaid activity (e.g., commercial weight loss program), the CONTRACTOR shall capture the data based on the submission of zero paid Encounter Claims.

4.22.1.3.3 The credits for Member incentives rewards may be tracked and accumulated based on an alternative process, subject to agreement by all the MCOs and prior approval by HSD. In no instance shall the methodology proposed fail to provide the credits to the Members in less than forty-five (45) thirty (30) Calendar Days from payment of the associated claim or receipt by the MCO or a written request for a non-claim based reward.
4.22.1.3.4 The CONTRACTOR shall design and operate an automated system to communicate information on the credits available to each Member to pharmacies participating in the CONTRACTOR’s provider network, the vendor retained by the Centennial Care MCOs to administer the provider catalog fulfillment process.

149) **Section 6.3 is amended and restated to read as follows:**

6.3 **Supplemental Reimbursement to CONTRACTOR for I/T/U Payments for Services to Native Americans**

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

6.6 **Changes in the Capitation Payment Rates Payment for Services**

151) **Section 6.7.1 of the Contract is amended to add section 6.7.1.4 which reads as follows:**

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

152) **Section 6.8.1 of the Contract is amended and restated to read as follows:**

6.8.1 HSD monthly capitation payments will be “net” of patient liability. The capitation payments are based on “gross” cost and will be reduced by the amount of patient responsibility each month.

153) **Section 6.8 of the Contract is amended to add section 6.8.4 of the Contract which reads as follows:**

6.8.4 HSD shall perform a reconciliation of the patient liability amounts every six months during the term of this Agreement to recoup or adjust payment based on actual enrolled member patient liability and the net capitation payment.

154) **Section 6 of the Contract is amended to add section 6.11 which reads as follows:**

6.11 **Community Benefit Reconciliation**
6.11.1 HSD shall review Members determined by the CONTRACTOR to need access to the Community Benefit. If a Member does not utilize Community Benefit services within ninety (90) Calendar Days of approval of the CCP, HSD will recoup the capitation payment for the Community Benefit from the CONTRACTOR.

155) Section 7.2 of the Contract is amended and restated to read as follows:

7.2 Limitation on Profit Underwriting Gain

156) Sections 7.2.1-7.2.6 of the Contract are amended and restated to read as follows:

7.2.1 The CONTRACTOR is permitted to retain one hundred percent (100%) of any profit underwriting gain generated under this Agreement up to three percent (3.0%) of net capitation revenue as defined in Section 7.2.2 of this Agreement generated annually under this Agreement. The CONTRACTOR shall share fifty percent (50%) of any profit underwriting gain generated in excess of three percent (3.0%) with HSD. HSD shall measure the annual profit underwriting gain based on the Medicaid Financial Reporting Package Annual Division of Insurance reports and supplemental reports that identify premium tax, NMMIP or other insurance assessments including the appropriate reporting of administrative expenses. The measurement will be performed as outlined in Section 7.2.2 of this Agreement.

7.2.2 For purposes of this Section, “profit underwriting gain” is defined as the net income before State and federal taxes for the Medicaid line of business on an annual basis. The Delivery System Improvement Fund and Liquidated Damages will not be considered reductions to revenue and/or countable expenses in the calculation of the limitation on profit underwriting gain.

Medicaid line of business Net Capitation Revenue:
Prospective capitation premium, excluding IHS supplemental revenue, less minus Premium Tax, less minus NMMIP Assessments paid during the annual period.

Medicaid line of business Total Medical Expense:
Medical Expense (net of reinsurance and TPL post payment recoveries) incurred during the annual period, less IHS expenditures and less expenses for care coordination services deemed to be administrative per care coordination services outlined in Section 7.2.9 of this Agreement, incurred during the annual period.

Medicaid Administration:

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Administrative expense (outlined in §7.2.8 of this Agreement) incurred during the annual period including expenses for care coordination services deemed to be administrative per Section 7.2.9 of this Agreement less Premium Tax less NMMIP Assessment during the annual period.

**Profit Underwriting Gain:**
Net Capitation Revenue less Medicaid line of business Total Net Medical Expense less Administrative expenses equals profit underwriting gain.

7.2.3 HSD has established the profit underwriting gain limit and sharing outlined in §7.2.1 of this Agreement; however, HSD makes no guarantee of any level of underwriting gain or profit to the CONTRACTOR under this Agreement.

7.2.4 HSD will utilize the annual Medicaid Financial Reporting Package Division of Insurance filings received on March following the close of the calendar year to calculate the underwriting gain. If underwriting gain profit in excess of three percent (3.0%) is realized, HSD will recoup make an adjustment to the prospective capitation between April and June to reduce the amount for the excess underwriting gain profit share outlined in Section §7.2.1 of this Agreement.

7.2.5 HSD reserves the right to examine the allocation methodologies utilized for any non-direct expenditure by the CONTRACTOR as it relates to any expenditure including but not limited to administrative expense that impacts net income after taxes reported.

7.2.6 HSD reserves the right to modify the measurement of profit underwriting gain based on review of allocation methodologies.

157) Section 7.2.9.2.6 of the Contract is amended and restated to read as follows:

7.2.9.2.6 CCPCare plan development and updates;

158) Section 7.3.5 part 3 of the Contract is amended and restated to read as follows:

Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP care plan for care coordination level 2 and level 3 care coordination

159) Section 7.16.4.1 of the Contract is amended and restated to read as follows:
7.16.4.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its subcontractors, including its Contract Providers, to provide, the officials and entities identified in this Section with prompt, reasonable and adequate access to any records that are related to the scope of work performed under this Agreement within two (2) to ten (10) business days NMSA § 27-11-4(B).

160) Section 7.6.6.1 of the Contract is amended and restated to read as follows:

7.6.6.1 In the event that CMS does not approve the 1115(a) Waiver by [ ], HSD may terminate the Agreement immediately in writing to the CONTRACTOR without penalty. In the event of a termination under this Section [7.6.6.1] of this Agreement, HSD shall not be liable or required to compensate the CONTRACTOR for any work performed or expenses incurred prior to termination. Reserved.

161) Section 7.16.4.1 of the Contract is amended and restated to read as follows:

7.16.4.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its subcontractors, including its Contract Providers, to provide, the officials and entities identified in this Section with prompt, reasonable and adequate access to any records that are related to the scope of work performed under this Agreement within two (2) to ten (10) business days per NMSA 1978, § 27-11-4(B).

162) Section 7.27 of the Contract is amended to add sections 7.27.11-7.27.13 which read as follows:

7.27.11 Referrals For Credible Allegations Of Fraud

7.27.11.1 The CONTRACTOR shall follow HSD’s direction in identifying and reporting cases of credible allegations of fraud. This includes, but is not limited to:

7.27.11.1.1 The CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD’s notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pended Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until
further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD’s notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider; or

7.27.11.1.4.2 The dismissal of all charges and/or claims against the provider related to the provider’s alleged fraud by a court of competent jurisdiction.

7.27.11.1.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR’s assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

7.27.12 Recovery for Fraud/False Claims

7.27.12.1 Should MFEAD or HSD pursue what it alleges are false and/or fraudulent claims as permitted under law and identified by the CONTRACTOR against a provider, any recovery (either by the
provider making payment, collection on a judgment or restitution) shall be divided as follows:

7.27.12.1 HSD shall recoup and remit to CMS the federal share;

7.27.12.1.2 HSD shall retain the non-federal share and for:

7.27.12.1.2.1 Aggregate Recovery in excess of $25,000.00 but less than $100,000.00 remit to the CONTRACTOR forty percent (40%) of the non-federal share; or

7.27.12.1.2.2 Aggregate recovery in excess of $100,000.00 but less than $250,000.00, remit to the CONTRACTOR thirty percent (30%) of the non-federal share; or

7.27.12.1.2.3 Aggregate recovery in excess of $250,000.00, remit to the CONTRACTOR twenty-five percent (25%) of the non-federal share.

7.27.12.1.3 HSD and the CONTRACTOR shall work together in good faith to come to a mutually agreeable process for any remittance due the CONTRACTOR and how that remittance will be treated for purposes of the medical loss ratio.

7.27.12.1.4 HSD shall provide the CONTRACTOR with quarterly reports regarding any recovery for which the CONTRACTOR may be entitled to a remittance.

7.27.13 The CONTRACTOR is not entitled to any recovery under this subsection when MFEAD and/or HSD independently identifies and pursues false claims and/or fraudulent claims.

163) **Section 7.30.4 of the Contract is deleted.**

7.30.4 The CONTRACTOR agrees to advise all employees of the availability of State publically-financed health coverage programs by providing each employee with, as a minimum, the following web link to additional information: [http://www.insurenewmexico.state.nm.us/](http://www.insurenewmexico.state.nm.us/).

164) **Attachment 2 is amended and restated to read as follows:**

**Attachment 2: Centennial Care Covered Services**
### Non-Community Benefit Services Included Under Centennial Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accredited Residential Treatment Center Services</td>
<td></td>
</tr>
<tr>
<td>Adaptive Skills Building (Autism)</td>
<td></td>
</tr>
<tr>
<td>Adult Day Health</td>
<td></td>
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<tr>
<td>Adult Psychological Rehabilitation Services</td>
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<tr>
<td>Ambulatory Surgical Center Services</td>
<td></td>
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<tr>
<td>Anesthesia Services</td>
<td></td>
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<tr>
<td>Assertive Community Treatment Services</td>
<td></td>
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<tr>
<td>Assisted Living</td>
<td></td>
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<tr>
<td>Behavior Support Consultation</td>
<td></td>
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<tr>
<td>Behavior Management Skills Development Services</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Professional Services: outpatient behavioral health and</td>
<td>substance abuse services</td>
</tr>
<tr>
<td>Care Coordination</td>
<td></td>
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<tr>
<td>Case Management</td>
<td></td>
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<tr>
<td>Community Transition Services</td>
<td></td>
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<tr>
<td>Community Health Workers</td>
<td></td>
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<tr>
<td>Community Interveners for the Deaf and Blind</td>
<td></td>
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<tr>
<td>Comprehensive Community Support Services</td>
<td></td>
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<tr>
<td>Day Treatment Services</td>
<td></td>
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<tr>
<td>Dental Services</td>
<td></td>
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<tr>
<td>Diagnostic Imaging and Therapeutic Radiology Services</td>
<td></td>
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<tr>
<td>Dialysis Services</td>
<td></td>
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<tr>
<td>Durable Medical Equipment and Supplies</td>
<td></td>
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<tr>
<td>Emergency Response</td>
<td></td>
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<tr>
<td>Emergency Services (including emergency room visits and psychiatric ER)</td>
<td></td>
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<tr>
<td>Employment Supports</td>
<td></td>
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<tr>
<td>Environmental Modifications</td>
<td></td>
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<tr>
<td>Experimental or Investigational Procedures, Technology or Non-Drug Therapies¹</td>
<td></td>
</tr>
<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td></td>
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<tr>
<td>EPSDT Personal Care Services</td>
<td></td>
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<tr>
<td>EPSDT Private Duty Nursing</td>
<td></td>
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<tr>
<td>EPSDT Rehabilitation Services</td>
<td></td>
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<tr>
<td>Family Planning</td>
<td></td>
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<tr>
<td>Family Support (Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center Services</td>
<td></td>
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<tr>
<td>Hearing Aids and Related Evaluations</td>
<td></td>
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<tr>
<td>Home Health Aide</td>
<td></td>
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<tr>
<td>Home Health Services</td>
<td></td>
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<tr>
<td>Homemaker</td>
<td></td>
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<tr>
<td>Hospice Services</td>
<td></td>
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<tr>
<td>Hospital Inpatient (including Detoxification services)</td>
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<tr>
<td>Hospital Outpatient</td>
<td></td>
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<tr>
<td>Indian Health Services</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization in Freestanding Psychiatric Hospitals</td>
<td></td>
</tr>
</tbody>
</table>

¹ Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.
<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Outpatient Program Services</td>
</tr>
<tr>
<td>ICF/MR</td>
</tr>
<tr>
<td>IV Outpatient Services</td>
</tr>
<tr>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Medical Services Providers</td>
</tr>
<tr>
<td>Medication Assisted Treatment for Opioid Dependence</td>
</tr>
<tr>
<td>Midwife Services</td>
</tr>
<tr>
<td>Multi-Systemic Therapy Services</td>
</tr>
<tr>
<td>Non-Accredited Residential Treatment Centers and Group Homes</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
</tr>
<tr>
<td>Nutritional Services</td>
</tr>
<tr>
<td>Occupational Services</td>
</tr>
<tr>
<td>Outpatient Hospital based Psychiatric Services and Partial Hospitalization</td>
</tr>
<tr>
<td>Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital</td>
</tr>
<tr>
<td>Outpatient Health Care Professional Services</td>
</tr>
<tr>
<td>Personal Care Services</td>
</tr>
<tr>
<td>Pharmacy Services</td>
</tr>
<tr>
<td>Physical Health Services</td>
</tr>
<tr>
<td>Physical Therapy</td>
</tr>
<tr>
<td>Physician Visits</td>
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<tr>
<td>Podiatry Services</td>
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<tr>
<td>Pregnancy Termination Procedures</td>
</tr>
<tr>
<td>Preventive Services</td>
</tr>
<tr>
<td>Private Duty Nursing for Adults</td>
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<tr>
<td>Prosthetics and Orthotics</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
</tr>
<tr>
<td>Radiology Facilities</td>
</tr>
<tr>
<td>Recovery Services (Behavioral Health)</td>
</tr>
<tr>
<td>Rehabilitation Option Services</td>
</tr>
<tr>
<td>Rehabilitation Services Providers</td>
</tr>
<tr>
<td>Related Goods</td>
</tr>
<tr>
<td>Reproductive Health Services</td>
</tr>
<tr>
<td>Respite (Behavioral Health)</td>
</tr>
<tr>
<td>Rural Health Clinics Services</td>
</tr>
<tr>
<td>School-Based Services</td>
</tr>
<tr>
<td>Skilled Maintenance Therapy Services</td>
</tr>
<tr>
<td>Smoking Cessation Services</td>
</tr>
<tr>
<td>Specialized Therapies</td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>Swing Bed Hospital Services</td>
</tr>
<tr>
<td>Telehealth Services</td>
</tr>
<tr>
<td>Tot-to-Teen Health Checks</td>
</tr>
<tr>
<td>Transplant Services</td>
</tr>
<tr>
<td>Transportation Services (medical)</td>
</tr>
<tr>
<td>Transportation Services (non-medical)</td>
</tr>
<tr>
<td>Treatment Foster Care</td>
</tr>
<tr>
<td>Treatment Foster Care II</td>
</tr>
<tr>
<td>Vision Care Services</td>
</tr>
</tbody>
</table>
### Agency-Based Community Benefit Services Included Under Centennial Care

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Personal Care Services
- Private Duty Nursing for Adults
- Respite
- Skilled Maintenance Therapy Services

### Self-Directed Community Benefit Services Included Under Centennial Care

- Behavior Support Consultation
- Customized Community Support
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Homemaker/Personal Care
- Nutritional Counseling
- Private Duty Nursing for Adults
- Related Goods
- Respite
- Skilled Maintenance Therapy Services
- Specialized Therapies
- Transportation (non-medical)

165) **Attachment 3 is amended and restated to read as follows:**

**Attachment 3: Delivery System Improvement Targets**

Delivery System Improvements for Year One (1) of Implementation of Centennial Care

<table>
<thead>
<tr>
<th>Delivery System Improvement Objective</th>
<th>Delivery System Improvement Target for Release of Withhold</th>
<th>Number of Points out of 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Reform Section [4.10.7] of this Agreement</td>
<td>Health Homes Section [4.13.2] of this Agreement - Telehealth</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Each CONTRACTOR shall submit for HSD approval, a delivery system improvement project that is designed to increase the use of electronic health records by its Contract Providers and to increase the number of its Contract Providers who participate in the exchange of electronic health information using the HIE operated by the NM Health Information Collaborative or its successor. The CONTRACTOR’s submission should include: a brief description of the project; a clearly stated goal that can be validated with data; a discussion of the base line from which the plan seeks to make progress and the data used to determine the base line; and a discussion about measuring progress toward the goal and the data used to measure progress. The CONTRACTOR’s plan shall be submitted to HSD by February 1, 2014 and HSD will provide feedback/approval within two (2) weeks of receipt of the CONTRACTOR’s plan. The goal agreed to by the CONTRACTOR and HSD will become the target for release of the withhold associated with this objective.</td>
<td>A minimum of eight (8) four (4) Health Homes operating in the CONTRACTOR’s network, with a minimum of four (4) Behavioral Health Homes. A minimum of a fifteen percent (15%) increase in telehealth “office” visits with specialists, including Behavioral Health providers, for Members in Rural and Frontier areas. At least five percent (5%) of the increase must be visits with Behavioral Health providers. Telehealth visits conducted at I/T/U/s outside of the Albuquerque area are included. Project ECHO is not considered “telehealth” for this delivery system improvement target nor is routine telemedicine such as interpretations of radiologic exams by a radiologist at a remote site. The Member must be present at the originating site to count as a telehealth visit. Each CONTRACTOR must submit its baseline, and an explanation of the data used to arrive at the baseline, to HSD by February 1, 2014.</td>
<td></td>
</tr>
</tbody>
</table>
Patient-Centered Medical Homes
Section [4.13.1] of this Agreement

- A minimum of five percent (5%) of the CONTRACTOR’s Members being served by Patient-Centered Medical Homes (including both PCMHs that have achieved NCQA accreditation and those that have not).

Emergency Room Diversion

- A minimum of a ten percent (10%) reduction in non-emergent use of the emergency room. The baseline to determine the reduction will be provided to the CONTRACTOR by HSD based on historical data.

The CONTRACTOR shall submit a report no later than [——] by February 1, 2015, describing the results of (i) the payment reform projects, delivery system improvement on (ii) HIT and HIE, (ii) telehealth Health Homes and (iii) Patient-Centered Medical Homes, and the emergency room diversion based on the targets established for Year One set forth in this Attachment [3].

The CONTRACTOR shall submit a report no later than [——], describing the results of the emergency room diversion based on the targets established for Year One set forth in this Attachment [3].

166) Attachment 4 is amended and restated to read as follows:

**Attachment 4: List of Reports**

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Frequency of Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Health Education Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Member Enrollment Materials Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Member Satisfaction Survey Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Native American Members Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Cultural Competency/Sensitivity Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Native American Meeting Report</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>Program Integrity Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Payment Reform Pilot Project Updates</td>
<td>Monthly</td>
</tr>
<tr>
<td>Activities of the Member Advisory Committee</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>Call Center Report</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

During the first 30 days of implementation the MCO must submit all call center response statistics daily.
<table>
<thead>
<tr>
<th>Report</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hiring Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Privacy/Security Incident Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Network Adequacy Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Geographic access</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>PCP Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Telehealth Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Provider Network Development and Management Plan Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Network Development and Management Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Suspensions and Terminations Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Provider Training and Outreach Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Training and Outreach Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Satisfaction Survey Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Medicaid School-Based Health Centers (SBHC) Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Value Added Services Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Self-Directed Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Developmental Disabilities Specialty Dental Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Jackson Class Members Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Facilities Readmission Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Member Incentive Rewards Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Coordination Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Transitions Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Level of Care (LOC) Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Agency-Based Community Benefit Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Caseload and Staffing Ratio Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Unreachable Members Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Patient Centered Medical Homes Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Health Homes Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Electronic Visit Verification Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>UM Program Description and an associated work plan</td>
<td>Annually</td>
</tr>
<tr>
<td>UM Program Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>Over/Under Utilization of Services Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Utilization Management Report</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Prior Authorization Report</td>
<td></td>
</tr>
<tr>
<td>CMS 416 Reports</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Pharmacy Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Institutional Utilization Report</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Grievances and Appeals</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Quarterly</td>
<td></td>
</tr>
<tr>
<td>Disease Management Description</td>
<td>Annually</td>
</tr>
<tr>
<td>Disease Management Annual Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>QM/QI Program Description and associated work plan</td>
<td>Annually</td>
</tr>
<tr>
<td>QM/QI Program Annual Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>Report on Performance Improvement Projects</td>
<td>Annually</td>
</tr>
<tr>
<td>NCQA Accreditation Report</td>
<td>Immediately upon receipt</td>
</tr>
<tr>
<td>Reevaluation of Accreditation Status based on HEDIS</td>
<td>Immediately upon receipt</td>
</tr>
<tr>
<td>Report of Audited CAHPS Results and Audited HEDIS</td>
<td>Annually</td>
</tr>
<tr>
<td>Report</td>
<td>Frequency</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Critical Incidents Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Business Continuity and Disaster Recovery (BC-DR) Plan</td>
<td>At least fifteen (15) Calendar Days prior to their proposed incorporation</td>
</tr>
<tr>
<td>Systems Availability and Performance Report</td>
<td>Monthly, Quarterly</td>
</tr>
<tr>
<td>Encounter Data Files</td>
<td>Weekly</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Claims Payment Accuracy Report</td>
<td>Monthly, Quarterly</td>
</tr>
<tr>
<td>Claims Activity Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>For at least the first one-hundred eighty (180) days, a claims activity report shall be submitted weekly</td>
<td></td>
</tr>
<tr>
<td>Encounter Processing and Submission Report</td>
<td>Monthly, Quarterly</td>
</tr>
<tr>
<td>Member Care Coordination Activities Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Audited Financial Statements</td>
<td>Annually by June 1st - April 1st</td>
</tr>
<tr>
<td>Medicaid Specific Audited Schedule of Revenue and Expenses Recovery and Cost Avoidance Report</td>
<td>Monthly, Quarterly, and Annually</td>
</tr>
<tr>
<td>Medicaid Specific Unaudited Schedule of Revenue and Expenses</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter</td>
<td></td>
</tr>
<tr>
<td>Division Office of the Superintendent of Insurance Reports</td>
<td>Quarterly and Annually</td>
</tr>
<tr>
<td>Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month of the quarter and March 1 for the annual statement</td>
<td></td>
</tr>
<tr>
<td>Quarterly and Annual Medicaid Financial Reporting Package</td>
<td>Quarterly report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month of the quarter.</td>
</tr>
<tr>
<td>Annual supplement is due May 15th or alternative date determined by HSD</td>
<td></td>
</tr>
<tr>
<td>Report Type</td>
<td>Due Date Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patient Liability Information Reports</td>
<td>Quarterly and Annually Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement Included in Quarterly and Annual Medicaid Financial Reporting Package</td>
</tr>
<tr>
<td>Expenditures by Category of Services Report</td>
<td>Quarterly and Annually Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement Included in Quarterly and Annual Medicaid Financial Reporting Package</td>
</tr>
<tr>
<td>Utilization by Category of Services Report</td>
<td>Quarterly and Annually Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement</td>
</tr>
<tr>
<td>FQHC/RHC Payment Reports (Check Register)</td>
<td>Quarterly Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter</td>
</tr>
<tr>
<td>Payments to IHS and Tribal 638 Providers Reports</td>
<td>Quarterly Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter</td>
</tr>
<tr>
<td>Service/Report</td>
<td>Frequency</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Subcapitation Expenditure and Utilization report</td>
<td>Quarterly and Annually Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement Included in Quarterly and Annual Medicaid Financial Reporting Package</td>
</tr>
<tr>
<td>Withholding Bank Statement for Performance Measures</td>
<td>Monthly Report is due forty-five (45) Calendar Days after month end</td>
</tr>
<tr>
<td>Fidelity Bond or Insurance Protection</td>
<td>Annually Initial within sixty (60) Calendar Days or date designated by HSD.</td>
</tr>
<tr>
<td>Reinsurance Policy Report</td>
<td>Annually or at renewal</td>
</tr>
<tr>
<td>Cash Reserve Statement Reports</td>
<td>Quarterly Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter Fifteen (15) Calendar Days after the most recent quarter end or within thirty (30) Calendar Days after increase to the balance of the fund as directed by HSD</td>
</tr>
<tr>
<td>Performance Bond</td>
<td>Initial: Within forty-five (45) calendar days of the first month of capitation. Quarterly</td>
</tr>
<tr>
<td>Business Restructuring</td>
<td>No later than sixty (60) Calendar Days following the change of ownership</td>
</tr>
<tr>
<td>Activities of the Native American Advisory Board</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>CSA Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Comprehensive Care Plan Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Overpayment Report</td>
<td>Within sixty (60) Calendar Days from the date on which the provider identifies an overpayment.</td>
</tr>
</tbody>
</table>

167) The Attachments 5 to the Contract are amended to add Attachment 5 which reads as follows:

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alta Vista Regional Medical Center</td>
<td>San Miguel</td>
</tr>
<tr>
<td>Artesia General Hospital</td>
<td>Eddy</td>
</tr>
<tr>
<td>Carlsbad Medical Center</td>
<td>Eddy</td>
</tr>
<tr>
<td>Cibola General Hospital</td>
<td>Cibola</td>
</tr>
<tr>
<td>Dan C. Trigg</td>
<td>Quay</td>
</tr>
<tr>
<td>Eastern New Mexico Medical Center</td>
<td>Chaves</td>
</tr>
<tr>
<td>Espanola Hospital</td>
<td>Rio Arriba</td>
</tr>
<tr>
<td>Gerald Champion Medical Center</td>
<td>Otero</td>
</tr>
<tr>
<td>Gila Regional Medical Center</td>
<td>Grant</td>
</tr>
<tr>
<td>Guadalupe Hospital</td>
<td>Guadalupe</td>
</tr>
<tr>
<td>Holy Cross Hospital</td>
<td>Taos</td>
</tr>
<tr>
<td>Lea Regional Hospital</td>
<td>Lea</td>
</tr>
<tr>
<td>Lincoln County Medical Center</td>
<td>Lincoln</td>
</tr>
<tr>
<td>Los Alamos Medical Center</td>
<td>Los Alamos</td>
</tr>
<tr>
<td>Memorial Medical Center</td>
<td>Dona Ana</td>
</tr>
<tr>
<td>Mimbres Memorial Hospital</td>
<td>Luna</td>
</tr>
<tr>
<td>Miners Colfax Medical Center</td>
<td>Colfax</td>
</tr>
<tr>
<td>Mountain View Regional Medical Center</td>
<td>Dona Ana</td>
</tr>
<tr>
<td>Nor-Lea General Hospital</td>
<td>Lea</td>
</tr>
<tr>
<td>Plains Regional Medical Center</td>
<td>Curry</td>
</tr>
<tr>
<td>Rehoboth McKinley Christian Hospital</td>
<td>McKinley</td>
</tr>
<tr>
<td>Roosevelt General Hospital</td>
<td>Roosevelt</td>
</tr>
<tr>
<td>Roswell Regional Hospital</td>
<td>Chaves</td>
</tr>
<tr>
<td>San Juan Regional Medical Center</td>
<td>San Juan</td>
</tr>
<tr>
<td>Sierra Vista Hospital</td>
<td>Sierra</td>
</tr>
<tr>
<td>Socorro General Hospital</td>
<td>Socorro</td>
</tr>
<tr>
<td>CHRISTUS – St. Vincent Regional Medical Ctr</td>
<td>Santa Fe</td>
</tr>
<tr>
<td>Union County General Hospital</td>
<td>Union</td>
</tr>
<tr>
<td>The University of New Mexico Hospital</td>
<td>Bernalillo</td>
</tr>
</tbody>
</table>
168) All brackets in the Contract not otherwise removed by this Amendment are deleted.

All other sections of PSC [xx-xxx-xxxx-xxxx], as amended, remain the same.

The remainder of this page is intentionally left blank.
IN WITNESS WHEREOF, the parties have executed this Agreement as of the date of execution by the State Contracts Officer, below.

**CONTRACTOR**

By: ________________________________        Date: _________________

Title: ________________________________

**STATE OF NEW MEXICO**

By: ________________________________        Date: _________________

Sidonie Squier, Cabinet Secretary
Human Services Department
Co-Chair, The New Mexico Behavioral Health Purchasing Collaborative

By: ________________________________        Date: _________________

Danny Sandoval, CFO
Human Services Department

Approved as to Form and Legal Sufficiency:

By: ________________________________        Date: _________________

Raymond W. Mensack, Chief Legal Counsel
Human Services Department

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

**TAXATION AND REVENUE DEPARTMENT**

ID Number: ________________________________

By: ________________________________        Date: _________________
STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
MEDICAID MANAGED CARE SERVICES AGREEMENT
FOR CENTENNIAL CARE

AMENDMENT NO. 1

This Amendment No. 1 to PSC: [XX-XXX-XXXX-XXXX] is made and entered into by and between the New Mexico Human Services Department (“HSD”), the New Mexico Behavioral Health Purchasing Collaborative (the “Collaborative”) and __________________ (“CONTRACTOR”), and is to be effective as of the date of HSD’s authorized signature.

WHEREAS, the Special Terms and Conditions for New Mexico’s Section 1115 waiver between the Centers for Medicare & Medicaid Services and HSD necessitate certain revisions to the Contract;

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

1) Certain definitions in Article 2 are (i) amended and restated or (ii) added to the Contract and read as follows:

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

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

   Confidential Information means any communication or record – whether oral, written, electronically stored or transmitted, or in any other form – consisting of: (i) confidential Member information, including HIPAA defined protected health information as defined by the Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2; (ii) all non-public budget, expense, payment and other financial information; (iii) all privileged work product; (iv) all information designated by HSD or any other State agency as confidential, and all information designated as confidential under the laws of the State of New Mexico; and (v) information utilized, developed, received, or maintained by HSD, the Collaborative, the CONTRACTOR, or participating State agencies for the purpose of fulfilling a duty or obligation under this Agreement and that has not been disclosed publicly.

   Durable Medical Equipment (DME) means equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to individuals in the absence of an illness or injury or physical disability and is appropriate for use at home.
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 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.

IADL means instrumental activities of daily living.

Member Rewards – The Member rewards program provides incentives to Centennial Care Members for participating in State-defined activities that promote healthy behaviors. A Member who participates in a State-defined activity that promotes healthy behaviors earns credits that are applied to a Member’s account, which will be managed by the MCO. Earned credits may be used for health related expenditures as approved under the Member Rewards program as further explained in section 4.22.

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

Pre-Admission Screening and Resident Review (PASRR) is governed by 42 C.F.R. §§438.100 through 438.138 for all individuals with mental illness or intellectual disability who apply to, or reside in, Medicaid certified Nursing Facilities. PASRR aims to determine if a resident is appropriately placed in the least restrictive environment and whether the individual can be appropriately served in the Nursing Facility, including provision of required mental illness/intellectual disability services.

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

TFC means treatment foster care.

2)  Section 3.3.3.12 of the Contract is amended and restated to read as follows:

3.3.3.12 A full-time staff person dedicated to this Agreement with the education and experience such that the staff person has the skills and/or knowledge necessary to work on Native American health disparity issues and Cultural Competence concerns related to care coordination, services and care delivery.
3) **Section 3 of the Contract is amended to add 3.6 which reads as follows:**

3.6 The CONTRACTOR shall work with the State’s independent consumer supports system as directed by HSD.

4) **Section 4.1.2.2 of the Contract is amended and restated to read as follows:**

4.1.2.2 The CONTRACTOR shall use the tools and processes that have been approved by HSD in conducting the nursing facility level of care evaluation. The CONTRACTOR shall interface with HSD’s eligibility system for level of care in a file format prescribed and approved by HSD.

5) **Section 4.2.2 of the Contract is amended and restated to read as follows:**

4.2.2 Current Medicaid Recipients

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

6) **Section 4.2.8 of the Contract is amended and restated to read as follows:**

4.2.8 Effective Date of Enrollment

4.2.8.1 **Current Medicaid Recipients.** The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.2 of this Agreement shall be Go-Live.

4.2.8.2 **New Medicaid Recipients.** The effective date of enrollment for Recipients who are enrolled in accordance with Section 4.2.3 of this Agreement is the first day of the month in which the Recipient’s eligibility becomes effective.

4.2.8.3 At HSD’s discretion, the effective date of enrollment pursuant to Section 4.2.8.2 of this Agreement may be modified during the term of this Agreement. HSD will notify the CONTRACTOR of any changes to the effective date of enrollment and related processes at least ninety (90) Calendar Days prior notice.
7) **Sections 4.3.2.3.5-4.3.2.3.7 of the Contract are be amended and restated to read as follows:**

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

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

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

8) **Section 4.4.1.2.5 of the Contract is amended and restated to read as follows:**

4.4.1.2.5 Develop and implement a CCP based on the Member’s individual needs and preferences in accordance with Section 4.4.9 of this Agreement;

9) **Section 4.4.1.2.6 of the Contract is amended and restated to read as follows:**

4.4.1.2.6 Deliver on-going care coordination services based on the Member’s assessed need and in accordance with the CCP and contractual obligations for frequency of contact with the Member in accordance with Section 4.4.10; and

10) **Section 4.4.1.4 of the Contract is amended and restated to read as follows:**

4.4.1.4 In coordinating Members’ care, the CONTRACTOR shall ensure that each Member’s privacy is protected consistent with the State and federal confidentiality requirements, including those listed in 45 C.F.R. Parts 160 and 164 and 42 C.F.R. Part 2.
11) **Section 4.4.2.3 of the Contract is amended and restated to read as follows:**

4.4.2.3 During Steady State, the HRA shall be completed with each Member within thirty (30) Calendar Days of the Member’s enrollment in the CONTRACTOR’s MCO.

12) **Section 4.4.2.4 of the Contract is amended and restated to read as follows:**

4.4.2.4 During the Transition Period, the HRA shall be completed as follows:

4.4.2.4.1 For all Members who become eligible for New Mexico Medicaid on January 1, 2014 or later, the CONTRACTOR shall conduct the HRA within thirty (30) Calendar Days of the Member’s enrollment. For all other Members, the CONTRACTOR shall conduct the HRA and, if required, a comprehensive needs assessment and a CCP (further described below) within one-hundred and eighty (180) Calendar Days following the Member’s enrollment.

4.4.2.4.2 The CONTRACTOR shall send the Member written notification within ten (10) Calendar Days of receiving the Member’s enrollment file that explains how the Member can reach the care coordination unit for assistance with concerns or questions pending the HRA and comprehensive needs assessment process.

13) **Section 4.4.2.5.6 of the Contract is amended and restated to read as follows:**

4.4.2.5.6 Request information about the Member’s medications;

14) **Section 4.4.2.6 of the Contract is amended and restated to read as follows:**

4.4.2.6 The CONTRACTOR shall provide the following information to every Member during his or her HRA:

4.4.2.6.1 Information about the services available through care coordination;

4.4.2.6.2 Information about the care coordination levels (CCLs);

4.4.2.6.3 Notification of the Member’s right to request a higher care coordination level;

4.4.2.6.4 Requirement for an in-person comprehensive needs assessment for the purpose of providing services associated with care coordination level 2 or level 3; and

4.4.2.6.5 Information about specific next steps for the Member.
15) **Section 4.4.3.1 of the Contract is amended and restated to read as follows:**

4.4.3.1 The HRA shall determine whether a Member requires care coordination level 1 or requires a comprehensive needs assessment to determine whether the Member should be assigned to care coordination level 2 or level 3.

16) **Section 4.4.3.2 of the Contract is amended and restated to read as follows:**

4.4.3.2 Within seven (7) Calendar Days of completion of the HRA, all Members shall be informed of the care coordination level assigned.

17) **Section 4.4.3.3 of the Contract is amended and restated to read as follows:**

4.4.3.3 A timeframe during which the Member can expect to be contacted by the care coordination unit or individual care coordinator to complete the comprehensive needs assessment (based on the care coordination level assigned).

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

4.4.3.4 *Care Coordination Level 1.* Members who are assigned to care coordination level 1 will not receive a comprehensive needs assessment and are not assigned an individual care coordinator. Members assigned to care coordination level 1 shall be monitored by the care coordination unit according to the provisions in Section 4.4.4 of this Agreement.

19) **Section 4.4.3.5 of the Contract is amended and restated to read as follows:**

4.4.3.5 *Care Coordination Level 2 and Level 3.* For Members meeting one of the indicators below, the CONTRACTOR shall conduct a comprehensive needs assessment (further explained in Section 4.4.5 of this Agreement) to determine whether the Member should be in care coordination level 2 or level 3:

20) **Section 4.4.4 of the Contract is amended and restated to read as follows:**

4.4.4 **Requirements for Care Coordination Level 1**

4.4.4.1 Members in care coordination level 1 shall receive, at a minimum, the following care coordination:
4.4.5.1 HRA annually (according to the standards in Section 4.4.2 of this Agreement) to determine if a higher care coordination level is needed; and

4.4.5.2 Review of Claims and utilization data at least quarterly to determine if the Member is in need of a comprehensive needs assessment and potentially higher level of care coordination.

21) **Section 4.4.5 of the Contract is amended and restated to read as follows:**

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

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

4.4.5.1 The CONTRACTOR shall perform an in-person comprehensive needs assessment on all Members identified for care coordination level 2 or level 3 at the Member’s primary residence. If the Member refuses the care coordinator access to the residence, the visit may occur in another location only with HSD approval.

23) **Section 4.4.5.2 of the Contract is amended and restated to read as follows:**

4.4.5.2 During Steady State for all Members and during the Transition Period for Members who become eligible for New Mexico Medicaid on January 1, 2014 or later, the CONTRACTOR shall:

4.4.5.2.1 Schedule a comprehensive needs assessment within fourteen (14) Calendar Days of the Member receiving a care coordination level 2 or 3 assignment via the HRA; and

4.4.5.2.2 Complete the comprehensive needs assessment within thirty (30) Calendar Days of the HRA.

24) **Section 4.4.5.3.2 of the Contract is amended and restated to read as follows:**

4.4.5.3.2 Continue providing services previously authorized by HSD or its designee in the Member’s approved HCBS care plan or Behavioral Health treatment or service plan without regard to whether such services are being provided by Contract or Non-Contract Providers and shall not reduce these services until the CONTRACTOR has conducted a comprehensive needs assessment and developed a CCP in accordance with Section 4.4.9 of this Agreement;
25) **Section 4.4.5.3 of the Contract is amended and restated to read as follows:**

4.4.5.3 During the Transition Period, the CONTRACTOR shall:

4.4.5.3.1 Accept the Member’s nursing facility level of care determination previously determined by HSD or its designee until redetermination of the Member’s Medicaid eligibility or scheduled level of care assessment, whichever date is earlier.

4.4.5.3.2 Continue providing services previously authorized by HSD or its designee in the Member’s approved HCBS care plan or Behavioral Health treatment or service plan without regard to whether such services are being provided by Contract or Non-Contract Providers and shall not reduce these services until the CONTRACTOR has conducted a comprehensive needs assessment and developed a CCP in accordance with Section 4.4.9 of this Agreement;

4.4.5.3.3 Schedule a comprehensive needs assessment for Members assigned to care coordination levels 2 or 3 within the timeframes identified in Section 4.4.2.4.1;

4.4.5.3.4 Immediately conduct a comprehensive needs assessment and update the Member’s CCP if at any time before conducting a comprehensive needs assessment the CONTRACTOR becomes aware of an increase in the Member’s needs, and the CONTRACTOR shall initiate the change in services within ten (10) Calendar Days of becoming aware of the change in the Member’s needs;

4.4.5.3.6 Remind Members using the most effective means of communication regarding the scheduled date for the comprehensive needs assessment at least two (2) weeks prior to the scheduled date.

26) **Section 4.4.5.5.1 of the Contract is amended and restated to read as follows:**

4.4.5.5.1 Assess physical and Behavioral Health needs including but not limited to: current diagnosis; history of significant physical and Behavioral Health events including hospitalizations; medications; allergies; providers; Durable Medical Equipment (DME); substance abuse screen (CAGE); family history; cognitive ability; health-related lifestyle (smoking, food intake, sleep patterns, continence);
27) **Section 4.4.5.5.2 of the Contract is amended and restated to read as follows:**

   4.4.5.2 Assess Long-Term Care needs including but not limited to: environmental safety including items such as smoke detectors, pests/infestation, and trip and fall dangers and adaptive needs such as ramps or other mobility assistance;

28) **Section 4.4.5.7 of the Contract is amended and restated to read as follows:**

   4.4.5.7 Nursing Facility Level of Care

     4.4.5.7.1 For Members who have indicators that may warrant a nursing facility level of care, the CONTRACTOR shall conduct a nursing facility level of care evaluation. The CONTRACTOR shall use the New Mexico Medicaid Nursing Facility Level of Care Criteria and Instructions to determine nursing facility level of care eligibility for all Members.

29) **Section 4.4.6 of the Contract is amended and restated to read as follows:**

   4.4.6 Requirements for Care Coordination Level 2

30) **Section 4.4.6.1 of the Contract is amended and restated to read as follows:**

   4.4.6.1 Based on the comprehensive needs assessment, the CONTRACTOR shall assign care coordination level 2, at a minimum, to Members with one of the following:

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

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

32) **Section 4.4.6.3 of the Contract is amended and restated to read as follows:**

   4.4.6.3 Care coordinators for Members in care coordination level 2 shall provide and/or arrange for the following care coordination services:

     4.4.6.3.1 Development and implementation of a CCP;

     4.4.6.3.2 Monitoring of the CCP to determine if the CCP is meeting the Member’s identified needs;
4.4.6.3.3 Assessment of need for assignment to a health home;

4.4.6.3.4 Targeted Health Education, including disease management, based on the Member’s individual diagnosis (as determined by the comprehensive needs assessment);

4.4.6.3.5 Annual comprehensive needs assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and if a higher or lower level of care coordination is needed;

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

4.4.6.3.7 Quarterly telephonic contact with the Member.

33) **Section 4.4.7 of the Contract is amended and restated to read as follows:**

4.4.7 Requirements for Care Coordination Level 3

34) **Section 4.4.7.1 of the Contract is amended and restated to read as follows:**

4.4.7.1 Based on the comprehensive needs assessment, the CONTRACTOR shall assign to care coordination level 3, at a minimum, to Members with one the following:

35) **Section 4.4.7.2 of the Contract is amended and restated to read as follows:**

4.4.7.2 The CONTRACTOR shall assign a specific care coordinator to each Member in care coordination level 3.

36) **Section 4.4.7.3 of the Contract is amended and restated to read as follows:**

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

37) **Section 4.4.7.3.2 of the Contract is amended and restated to read as follows:**

4.4.7.3.2 Semi-annual comprehensive needs assessment (according to the standards in Section 4.4.5 of this Agreement) to determine if the CCP is appropriate and determine if a lower level of care coordination is needed;
38) **Section 4.4.8.2 of the Contract is amended and restated to read as follows:**

4.4.8.2 The CONTRACTOR shall use the following criteria, at a minimum, to identify Members for a comprehensive needs assessment either to assess or reassess the Member’s need for a higher level of care coordination:

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

4.4.8.2.6 Information from a periodic review (at least quarterly) beginning no more than one hundred eighty (180) Calendar Days following Go-Live of the following: (i) Claims or Encounter Data; (ii) hospital admission or discharge data; (iii) pharmacy data; and (iv) data collected through UM processes.

40) **Section 4.4.8.6 of the Contract is amended and restated to read as follows:**

4.4.8.6 The CONTRACTOR’s agreement(s) with hospitals shall require the facility to notify the CONTRACTOR within one (1) Business Day of the date a Member is admitted.

41) **Sections 4.4.9.1-4.4.9.6 of the Contract are amended and restated to read as follows:**

4.4.9.1 The CONTRACTOR shall develop and implement CCPs for Members in care coordination levels 2 and 3. The CONTRACTOR is not required to develop and implement CCPs for Members in care coordination level 1.

4.4.9.2 During both the Transition Period and Steady State, the CONTRACTOR shall develop and authorize the CCP within fourteen (14) Business Days of completion of the comprehensive needs assessment.

4.4.9.3 For Members in care coordination levels 2 and 3, the care coordinator shall ensure at a minimum that the Member and Representative participate in developing the CCP.

4.4.9.4 The CONTRACTOR shall ensure that care coordinators consult with the Member’s PCP, specialists, Behavioral Health providers, other providers, and interdisciplinary team experts, as needed when developing the CCP.

4.4.9.5 The care coordinator shall verify that all decisions made regarding the Member’s needs and services, including the Member’s choice to receive institutional care versus HCBS, are documented in a written CCP.

4.4.9.6 The developed CCP shall at a minimum include:
42) **Section 4.4.9.6.16 of the Contract is amended and restated to read as follows:**

4.4.9.6.16 Additional information for Members who elect the Self-Directed Community Benefit, including but not limited to the Member’s self-assessment, (whether the member requires an employer of record (“EOR”)), the back-up plan and the approved Self-Directed Community Benefits as identified in the Comprehensive Needs Assessment;

43) **Section 4.4.9.6.19 of the Contract is amended and restated to read as follows:**

4.4.9.6.19 The Member’s eligibility begin and end date.

44) **Sections 4.4.9.7-4.4.9.10 of the Contract are amended and restated to read as follows:**

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

4.4.9.8 The care coordinator shall provide a copy of the Member’s completed CCP, including any updates, to the Member and the Member’s Representative, as applicable. The care coordination team shall provide copies to other providers authorized to deliver care to the Member, as appropriate, and shall ensure that such providers who do not receive a copy of the CCP are informed in writing of all relevant information needed (including all relevant HSD prescribed forms) to ensure the provision of quality care for the Member and to help ensure the Member’s health, safety, and welfare, including but not limited to the tasks and functions to be performed.

4.4.9.9 For Members in an institutional facility, the care coordination team shall develop the CCP but may use the CCP developed by the institution to supplement the CCP.

4.4.9.10 Within five (5) Business Days of completing a reassessment of a Member’s needs, the care coordination team shall update the Member’s CCP as appropriate, and the CONTRACTOR shall authorize and initiate services in the updated CCP.

45) **Section 4.4.10.1.1 of the Contract is amended and restated to read as follows:**

4.4.10.1.1 Develop and/or update the CCP as needed;
46) **Section 4.4.10.1.5 of the Contract is amended and restated to read as follows:**

4.4.10.1.5 Upon the scheduled initiation of services identified in the Member’s CCP, the care coordination team (as further addressed in Section 4.4.12) shall begin monitoring to ensure that services have been initiated and continue to be provided as authorized and that services continue to meet the Member’s needs;

47) **Section 4.4.10.1.17 of the Contract is amended and restated to read as follows:**

4.4.10.1.7 Identify, address and evaluate service gaps to determine their cause and to minimize gaps going forward to ensure that back-up plans are implemented and effectively working. The CONTRACTOR shall describe in policies and procedures the process for identifying, responding to, and resolving service gaps in a timely manner;

48) **Section 4.4.10.1.18 of the Contract is amended and restated to read as follows:**

4.4.10.1.18 As appropriate, ensure that all PASRR requirements are met prior to the Member’s admission to a Nursing Facility, including, but not limited to, 42 CFR 483.100-138;

49) **Section 4.4.10.3 of the Contract is amended and restated to read as follows:**

4.4.10.3 The CONTRACTOR shall monitor and evaluate a Member’s emergency room and Behavioral Health crisis service utilization to determine the reason for these visits. In monitoring the Member’s emergency room and Behavioral Health crisis service use, the CONTRACTOR shall evaluate whether or not lesser acute care treatment options were available to the Member at the time and place when he/she needed such services. The care coordinator shall take appropriate action to facilitate appropriate utilization of these services, e.g., communicating with the Member’s providers, educating the Member, conducting a comprehensive needs reassessment, and/or updating the Member’s CCP to better manage the Member’s physical health or Behavioral Health condition(s).

50) **Section 4.4.10.5 of the Contract is amended and restated to read as follows:**

4.4.10.5 The CONTRACTOR shall develop policies and procedures to ensure that care coordinators are actively involved in discharge planning when a Member is hospitalized or placed in an institutional facility. The
CONTRACTOR shall define circumstances that require that hospitalized Members receive an in-person visit to complete a needs reassessment and an update to the Member’s CCP as needed.

51) **Section 4.4.11.2.2 of the Contract is amended and restated to read as follows:**

4.4.11.2.2 The most current CCP, including the detailed plan for back-up providers in situations when regularly scheduled providers are unavailable or do not arrive as scheduled;

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

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

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

4.4.12.2 The CONTRACTOR shall use local resources, such as I/T/Us, PCMHs, Health Homes, CSAs, and Tribal services to assist in performing the care coordination functions specified throughout Section 4.4 of this Agreement.

54) **Section 4.4.12.5 of the Contract is amended and restated to read as follows:**

4.4.12.5 The CONTRACTOR shall not exceed the maximum caseload per care coordinator by designated care coordination level as described in this Section 4.4.12.5 of this Agreement. To the extent the CONTRACTOR uses I/T/Us, PCMHs, Health Homes, CSAs and Community Health Workers to perform care coordination functions, such entities may be included in the ratios included in this Section 4.4.12.5.

4.4.12.5.1 Care coordination level 1, 1:750;

4.4.12.5.2 Care coordination level 2, Members not residing in a nursing facility 1:75, and care coordination level 2 Members residing in a nursing facility 1:125;

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

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

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

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

55) **Section 4.4.12.9 of the Contract is amended and restated to read as follows:**

4.4.12.9 The CONTRACTOR shall ensure that Members have a telephone number to call to directly contact (without having to disconnect or place a second call) their care coordinator or a member of their care coordination team during normal business hours (8 a.m. – 5 p.m. Mountain Time). If the Member’s care coordinator or a member of the Member’s care coordination team is not available, the call shall be answered by another qualified staff person in the care coordination unit. If the call requires immediate attention from a care coordinator, the staff member answering the call shall immediately transfer the call to the Member’s care coordinator (or another care coordinator if the Member’s care coordinator is not available) as a Warm Transfer. After normal business hours, calls that require immediate attention by a care coordinator shall be handled by the Member services/nurse advice line in accordance with Section 4.15.1.11 of this Agreement.

56) **Section 4.4.12.16.2 of the Contract is amended and restated to read as follows:**

4.4.12.16.2 Care coordination levels, HRAs, comprehensive needs assessment and reassessment, development of a CCP, and updating the CCP including training on the tools and protocols;

57) **Sections 4.4.13.1.4-4.4.13.1.7 are amended and restated to read as follows:**

4.4.13.1.4 CCPs are developed and updated on schedule and in compliance with this Agreement;

4.4.13.1.5 CCPs reflect needs identified in the comprehensive needs assessment and reassessment process;

4.4.13.1.6 CCPs are appropriate and adequate to address the Member’s needs;
4.4.13.1.7 Services are delivered as described in the CCP and authorized by the CONTRACTOR;

58) Section 4.4.13.3.1 of the Contract is amended and restated to read as follows:

4.4.13.3.1 The ability to capture and track key dates and timeframes specified in this Agreement, including, but not limited to, as applicable, enrollment, date of development of the CCP, date of authorization of the CCP, date of initial service delivery for each service in the CCP, date of each level of care and needs reassessment, date of each update to the CCP, and dates regarding transition from an institutional facility to the community;

59) Section 4.4.13.3.3 of the Contract is amended and restated to read as follows:

4.4.13.3.3 The ability to notify the care coordinator about key dates, e.g., eligibility end date, date for annual level of care reassessment, date of comprehensive needs reassessment, and date to update the CCP;

60) Section 4.13.3.5 of the Contract is amended and restated to read as follows:

4.13.3.5 The ability to capture and monitor the CCP;

61) Section 4.4.14.1.4 of the Contract is amended and restated to read as follows:

4.4.14.1.4 Match services provided to a Member with services authorized in the Member’s CCP;

62) Section 4.4.14.2 of the Contract is amended and restated to read as follows:

4.4.14.2 The CONTRACTOR shall monitor and use information from the electronic visit verification system to verify that services are provided as specified in the CCP, and in accordance with the established schedule, including the amount, frequency, duration, and scope of each service, and that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The CONTRACTOR shall monitor services anytime a Member is receiving services, including after the CONTRACTOR’s regular business hours.
63) **Section 4.4.15.1.4 of the Contract is amended and restated to read as follows:**

4.4.15.1.4 Identification of wrap-around services available in the community where the Member will reside;

64) **Section 4.4.15.2 of the Contract is amended and restated to read as follows:**

4.4.15.2 For those Members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of sixty (60) Calendar Days from the decision to pursue transition or until the transition has occurred and a new CCP is in place. The transition plan shall address the Member’s transition needs including but not limited to:

65) **Section 4.4.16.1.3 of the Contract is amended and restated to read as follows:**

4.4.16.1.3 The CONTRACTOR shall facilitate a seamless transition to new services and/or providers, as applicable, in the CCP developed by the CONTRACTOR without any disruption in services.

66) **Section 4.4.16.1.8 of the Contract is amended and restated to read as follows:**

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

67) **Section 4.4.16.1.10 is deleted from the Contact.**
68) **Section 4.5.6.5.2 of the Contract is amended and restated to read as follows:**

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

69) **Section 4.5.7.2.1 of the Contract is amended and restated to read as follows:**

4.5.7.2.1 Members selecting the Agency-Based Community Benefit will have a choice of the consumer delegated model or consumer directed model for personal care services.

70) **Section 4.5.7 of the Contract is amended to add 4.5.7.5 which reads as follows:**

4.5.7.5 The maximum allowable cost of care for the Community Benefit will be tied to the State’s cost of care for persons served in a private nursing facility, except as described in section 4.6.1.8. However, the maximum allowable cost of care is not an entitlement. A Member’s actual cost of care for the Community Benefit will be determined by the comprehensive needs assessment.

4.5.7.5.1 The annual cost limitation will be determined by HSD prior to the beginning of each annual period for this Agreement based on the projected cost of placement in a Medicaid custodial nursing facility, excluding State Owned Nursing Facilities for low level of care.

4.5.7.5.2 The actual amount that can be spent by a Member in his/her CCP per year is subject to the Member’s comprehensive needs assessment.

4.5.7.5.3 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HSD for expenditures exceeding the cost limitation developed by HSD in Section 4.5.7.5.1 and 4.6.1.8.1 of this Agreement.

71) **Section 4.5.11.1 of the Contract is amended and restated to read as follows:**

4.5.11.1 The CONTRACTOR shall impose the maximal nominal copayments established by HSD for non-emergency use of the emergency room in accordance with federal regulations.

72) **Section 4.5.12 of the Contract is amended and restated to read as follows:**

4.5.12 Copayment for Brand Name Drugs When a Generic Drug Is Available
4.5.12.1 The CONTRACTOR shall impose the maximal nominal copayment established by HSD in accordance with federal regulations on any prescription filled for a Member with a brand name drug when a therapeutically equivalent generic drug is available. This copayment shall not apply to brand name drugs that are classified as psychotropic drugs for the treatment of Behavioral Health conditions. The CONTRACTOR shall develop a copayment exception process to be prior approved by HSD for other brand name drugs where such drugs are not tolerated by the Member.

4.5.12.2 The CONTRACTOR may not deny services for a Member’s failure to pay the copayment amounts.

4.5.12.3 The CONTRACTOR shall not impose any copayments on Native Americans.

73) **Section 4.6.1 of the Contract is amended and restated to read as follows:**

4.6.1 General

4.6.1.1 The CONTRACTOR shall offer the Self-Directed Community Benefit (SDCB) to Members who meet nursing facility level of care and are determined through a comprehensive needs assessment/reassessment to need the Community Benefit. Self-direction in Centennial Care affords Members the opportunity to have choice and control over how SDCB services are provided, who provides the services and how much providers are paid for providing care in accordance with a range of rates per service established by HSD. A list of SDCB services is included in Attachment 2.

4.6.1.2 The CONTRACTOR shall enter into a contract with the FMA specified by HSD to provide assistance to members who choose the SDCB.

4.6.1.3 Members who participate in the SDCB choose either to serve as the EOR of their providers or to designate an individual to serve as the EOR on his or her behalf. A Member who is an un-emancipated minor or under guardianship cannot serve as the EOR and must designate an individual to assume the functions on his or her behalf.

4.6.1.4 Reserved.

4.6.1.5 The EOR and Authorized Agent, if any, must be documented in the Member’s file. The care coordinator shall also include a copy of any EOR/ and authorized agent forms in the Member’s file and provide copies to the Member, the Member’s Representative and the FMA.
4.6.1.6 The CONTRACTOR shall have a contract effective with the FMA for each of the periods covered by this Agreement and shall not terminate their agreement with the FMA during the term of this Agreement.

4.6.1.7 HSD shall include the cost of the FMA contract in the capitated payments made by HSD to the CONTRACTOR in accordance with Section 6 of this agreement.

4.6.1.8 Existing Self-Directed Community Benefit Members

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

4.6.1.8.2 Grandfathered clients while not subject to the annual Community Benefit cost limitations imposed by Section 4.5.7.5 of this Agreement will be subject to the comprehensive needs assessment and CCP development process.

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

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

4.6.1.9 New Self-Directed Community Benefit Members

4.6.1.9.1 Members who were not enrolled as self-directed or did not have an approved self-directed budget that exceeds the cost limitation described in section 4.5.7.5 prior to January 1, 2014 are subject to annual cost limitations defined by HSD in Section 4.5.7.5.1 of this Agreement.

4.6.1.9.2 The CONTRACTOR may choose to spend additional amounts but will not be compensated by HSD for expenditures exceeding the cost limitation developed by HSD in Section 4.5.7.5.1 of this Agreement.

74) Section 4.6.2 of the Contract is amended and restated to read as follows:

4.6.2 CONTRACTOR Responsibilities

4.6.2.1 The CONTRACTOR shall ensure that the Member and/or the Member’s Representative fully participate in developing and administering the SDCB and that sufficient supports are made available to assist Members who require assistance. This includes but is not limited to the development of the
annual budget amount based on the Member’s needs as identified in the annual comprehensive needs assessment. In this capacity, the CONTRACTOR shall fulfill, at a minimum, the following tasks:

4.6.2.1.1 Understand Member and employer of records roles and responsibilities;

4.6.2.1.2 Identify resources outside the Centennial Care program, including natural and informal supports that may assist in meeting the Member’s needs;

4.6.2.1.3 Understand the array of the SDCB;

4.6.2.1.4 Determine the annual budget for the SDCB, based on the comprehensive needs assessment to address the needs of the Member in accordance with the requirements stated in this Section 4.6 and the Member’s Community Benefit;

4.6.2.1.5 Monitor utilization of SDCB services and goods on a regular basis;

4.6.2.1.6 Conduct employer-related activities such as assisting a Member in identifying a designated EOR (as appropriate);

4.6.2.1.7 Identify and resolve issues related to the implementation of the CCP;

4.6.2.1.8 Assist the Member with quality assurance activities to ensure implementation of the Member’s SDCB care plan and utilization of the authorized budget;

4.6.2.1.9 Recognize and report Critical Incidents, including Abuse, neglect, exploitation, Emergency Services, law enforcement involvement, and environmental hazards; and

4.6.2.1.10 Monitor quality, including but not limited to, (i) the adequacy of Member-to-support broker ratios, (ii) the relationship between support brokers and care coordinators and (iii) the services provided by support brokers.

75) **Section 4.6.3 of the Contract is amended and restated to read as follows:**

4.6.3 Support Broker Functions

4.6.3.1 The CONTRACTOR shall perform, or contract with a qualified vendor to perform, the supports broker functions for Members electing the SDCB. If the functions are subcontracted, the CONTRACTOR shall be responsible for ensuring that all applicable requirements are met. At a minimum, the CONTRACTOR (either directly or through a subcontractor) shall perform the following supports broker functions:
4.6.3.1.1 Educate Members on how to use self-directed supports and services and provide information on program changes or updates;

4.6.3.1.2 Review, monitor and document progress of the Member’s SDCB services and budget;

4.6.3.1.3 Assist in managing budget expenditures and complete and submit budget revision requests;

4.6.3.1.4 Assist with employer functions such as recruiting, hiring and supervising providers;

4.6.3.1.5 Assist with approving/processing job descriptions for direct supports;

4.6.3.1.6 Assist with completing forms related to employees;

4.6.3.1.7 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; and

4.6.3.1.8 Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;

4.6.3.1.9 Facilitate resolution of any disputes regarding payment to providers for services rendered;

4.6.3.1.10 Develop the care plan for SDCB services, based on the budget amount, and ensure that it is included in the CCP; and

4.6.3.1.11 Assist in completing all documentation required by the FMA.

4.6.3.2 The CONTRACTOR shall have policies and procedures in place to ensure that supports brokers and care coordinators work in a collaborative manner and do not duplicate activities or functions.

76) Section 4.6.4.2 of the Contract is amended and restated to read as follows:

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:
77) **Sections 4.6.4.2.1-4.6.4.2.2 of the Contract are amended and restated to read as follows:**

4.6.4.2.1 The role and responsibilities of the care coordinator, including, but not limited to, comprehensive needs assessment and CCP development, CCP implementation and monitoring processes, including the development and activation of a back-up plan for Members participating in the SDCB;

4.6.4.2.2 The FMA’s responsibilities for communicating with the CONTRACTOR, Members, EORs, authorized agents, providers and HSD, and the process by which to do this;

78) **Section 4.6.5 of the Contract is amended and restated to read as follows:**

4.6.5 **Self-Assessment**

4.6.5.1 The care coordinator shall provide the Member with a self-assessment instrument developed by HSD. The self-assessment instrument shall be completed by the Member with assistance from the Member’s care coordinator as appropriate. The care coordinator shall file the completed self-assessment in the Member’s file.

4.6.5.2 If, based on the results of the self-assessment, the care coordinator determines that a Member requires assistance to direct his or her services, the care coordinator shall inform the Member that he or she will need to designate an EOR to assume the self-direction functions on his or her behalf.

79) **Section 4.6.6 of the Contract is amended and restated to read as follows:**

4.6.6 **Back-up Plan**

4.6.6.1 The supports broker shall assist the Member/EOR in developing a back-up plan for the SDCB that adequately identifies how the Member/EOR will address situations when a scheduled provider is not available or fails to show up as scheduled.

4.6.6.2 The CONTRACTOR shall file a copy of the back-up plan in the Member’s file.

4.6.6.3 The Member’s supports broker shall assess the adequacy of the Member’s back-up plan on at least an annual basis and any time there are changes in the type, amount, duration, scope of the SDCB or the schedule at which such services are needed, changes in providers (when such providers also serve as a back-up to other providers) or changes in the availability of paid or unpaid back-up providers to deliver needed care.
Section 4.6.7 of the Contract is amended and restated to read as follows:

4.6.7 Budget

4.6.7.1 The care coordinator shall develop a budget for the SDCB services the Member is identified to need as a result of the comprehensive needs assessment.

4.6.7.2 The supports broker and the Member shall work together to develop a plan for the SDCB services that are part of the overall CCP within the SDCB budget. The supports broker and Member shall refer to the range of rates specified by HSD in selecting payment rates for providers and vendors.

4.6.7.3 The budget for the SDCB services shall be based upon the Member’s assessed needs. The Member shall have the flexibility to negotiate provider rates within the rate range and allocated budget. A Member shall have the flexibility to choose from the range of HSD specified rates for all SDCB services.

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

4.6.7.5 The supports broker shall closely monitor the adequacy and appropriateness of the services and rates to determine the extent to which adjustments to the SDCB care plan will necessitate adjustments to the budget and that the Member does not exceed his or her budget.

Section 4.6.9.1 of the Contract is amended and restated to read as follows:

4.6.9.1 The CONTRACTOR shall require all Members electing to enroll in the SDCB and their EORs to receive relevant training. The supports broker shall be responsible for arranging for initial and ongoing training of Members and/or EORs.

Section 4.6.9.2 of the Contract is amended and restated to read as follows:

4.6.9.2 At a minimum, self-direction training for Members and/or EORs shall address the following issues:

Section 4.6.9.2.1 of the Contract is amended and restated to read as follows:

4.6.9.2.1 Understanding the role of Members and EORs with the SDCB;
84) **Section 4.6.9.3 of the Contract is amended and restated to read as follows:**

4.6.9.3 The CONTRACTOR shall arrange for ongoing training for Members and/or EORs upon request and/or if a supports broker, through monitoring, determines that additional training is warranted.

85) **Section 4.6.9.4.1 of the Contract is amended and restated to read as follows:**

4.6.9.4.1 Overview of the Centennial Care program and the SDCB;

86) **Section 4.6.9.7 of the Contract is amended and restated to read as follows:**

4.6.9.7 Additional training and refresher components may be provided to a provider to address issues identified by the supports broker, Member and/or the EOR or at the request of the provider.

87) **Section 4.6.10.1 of the Contract is amended and restated to read as follows:**

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.

88) **Section 4.6.10.3 of the Contract is amended and restated to read as follows:**

4.6.10.3 The care coordinator shall monitor a Member’s participation in the SDCB to determine, at a minimum, the success and the viability of the service delivery model for the Member. The care coordinator shall note any patterns, such as frequent turnover of EORs and providers that may warrant intervention by the care coordinator. If problems are identified, a care coordinator should also ask a Member to complete a self-assessment to determine what additional supports, if any (such as designating an EOR or authorized agent), could be made available to assist the Member.

89) **Section 4.6.11 of the Contract is amended and restated to read as follows:**

4.6.11 Termination from the Self-Directed Community Benefit

4.6.11.1 The CONTRACTOR may involuntarily terminate a Member from the SDCB under any of the following circumstances:

4.6.11.1.1 The Member refuses to follow HSD rules and regulations after receiving focused technical assistance on multiple occasions, support from the care coordinator or FMA, which is supported by documentation of the efforts to assist the Member;
4.6.11.2 There is an immediate risk to the Member’s health or safety by
continued self-direction of services, i.e., the Member is in
imminent risk of death or serious bodily injury. Examples
include but are not limited to the following: the Member (i)
refuses to include and maintain services in his or her CCP that
would address health and safety issues identified in his or her
comprehensive needs assessment or challenges the assessment
after repeated and focused technical assistance and support from
program staff, care coordination or FMA, (ii) is experiencing
significant health or safety needs and, refuses to incorporate the
care coordinator’s recommendations into his or her CCP, or (iii)
exhibits behaviors that endanger him/her or others;

4.6.11.3 The Member misuses his or her SDCB budget following
repeated and focused technical assistance and support from the
care coordinator and/or FMA, which is supported by
documentation;

4.6.11.4 The Member expends his/her entire SDCB budget prior to the
end of the CCP year; or

4.6.11.5 The Member commits Medicaid Fraud.

4.6.11.2 The CONTRACTOR shall submit to HSD any requests to terminate a
Member from the SDCB with sufficient documentation regarding the
rationale for termination.

4.6.11.3 Upon HSD approval, the CONTRACTOR shall notify the Member
regarding termination in accordance with HSD rules and regulations.
The Member shall have the right to Appeal the determination by
requesting a Fair Hearing.

4.6.11.4 The CONTRACTOR shall facilitate a seamless transition from the
SDCB to ensure there are no interruptions or gaps in services.

4.6.11.5 Involuntary termination of a Member from the SDCB shall not affect a
Member’s eligibility for Covered Services or enrollment in Centennial
Care.

4.6.11.6 The CONTRACTOR shall notify the FMA within one (1) Business
Day of processing the outbound enrollment file when a Member is
involuntarily terminated from the SDCB and when a Member is
disenrolled from Centennial Care. The notification should include the
effective date of termination and/or disenrollment, as applicable.

4.6.11.7 Members who have been involuntarily terminated may request to be
reinstated in the SDCB. Such request may not be made more than once
in a twelve (12) month period. The care coordinator shall work with the
FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to reinstatement. All Members shall be required to participate in SDCB training programs prior to re-instatement in the SDCB.

90) **Section 4.6.12.2 of the Contract is amended and restated to read as follows:**

4.6.12.2 No SDCB provider shall exceed forty (40) hours paid work in a consecutive seven (7) Calendar Day period.

91) **Section 4.6.12.5 of the Contract is amended and restated to read as follows:**

4.6.12.5 The CONTRACTOR shall reimburse the FMA for authorized SDCB services provided by providers at the appropriate rate for the self-directed HCBS, which includes applicable payroll taxes.

92) **Sections 4.8.1.6-4.8.1.8 of the Contract are amended and restated to read as follows:**

4.8.1.6 Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to Members;

4.8.1.7 Not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or SCHIP sanctions, except for Emergency Services; and

4.8.1.8 Provide Members with special health care needs direct access to a specialist, as appropriate for the member’s health care condition, as specified in 42 CFR § 438.208(c)(4).

93) **Section 4.8.13.3 of the Contract is amended and restated to read as follows:**

4.8.13.3 Support brokers to assist with administering the SDCB.

94) **Section 4.8.16.2 of the Contract is amended and restated to read as follows:**

4.8.16.2 The CONTRACTOR shall participate in Project ECHO, in accordance with State prescribed requirements and standards including but not limited to paying its fair share of administrative costs to support Project ECHO, and shall:
95) **Section 4.9.2.45 of the Contract is amended and restated to read as follows:**

4.9.2.45 Specify that reimbursement of a Community Benefit provider shall be contingent upon the provision of services to an eligible Member in accordance with applicable federal and State requirements and the Member’s CCP as authorized by the CONTRACTOR;

96) **Section 4.10.2.2 of the Contract is amended and restated to read as follows:**

4.10.2.2 I/T/Us

The CONTRACTOR shall reimburse both Contract and Non-Contract Provider I/T/Us at a minimum of one hundred percent (100%) of the rate currently established for the IHS facilities or federally leased facilities by the Office of Management and Budget (OMB). If a rate is not established by OMB for any particular service, then reimbursement shall be at an amount not less than the Medicaid fee schedule. Services provided within I/T/Us are not subject to prior authorization requirements.

97) **Section 4.10 of the Contract is amended to add section 4.10.8 which reads as follows:**

4.10.8 Safety-Net Care Pool Hospitals

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

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

98) **Section 4.11.2.7 of the Contract is amended and restated to read as follows:**

4.11.2.7 The CONTRACTOR shall adequately staff the provider service line to ensure that the line, including the Utilization Management line/queue, meets the following performance standards on a monthly basis:

99) **Section 4.12.3.1 of the Contract is amended and restated to read as follows:**

4.12.3.1 HSD shall retain the services of an EQRO in accordance with section 1902(c)(30)(C) of the Social Security Act. The EQRO shall conduct all necessary audits as well as any additional optional audits that further the management of the Centennial Care program. The CONTRACTOR shall cooperate fully with the EQRO and demonstrate to the EQRO the CONTRACTOR’s compliance with HSD’s managed care regulations and
quality standards as set forth in federal regulation and HSD policy. The CONTRACTOR shall provide data and other requested information to the EQRO in a format prescribed by the EQRO.

100) **Sections 4.12.4.9 and 4.12.4.10 of the Contract are amended and restated to read as follows:**

4.12.4.9 Have an annual QM/QI work plan to be submitted in accordance with Attachment 1 and thereafter at the beginning of each year of the Agreement, approved by HSD that includes, at a minimum, immediate objectives for each Agreement year and long-term objectives for the entire term of this Agreement. The QM/QI work plan shall contain the scope, objectives, planned activities, timeframes and data indicators for tracking performance and other relevant QM/QI information, including adult quality improvement projects identified by HSD;

4.12.4.10 Implement Performance Improvement Projects (PIPs) identified internally by the CONTRACTOR in discussion with HSD or implement PIPs as directed by HSD. At a minimum, the CONTRACTOR shall implement PIPs in the following areas: one (1) on Behavioral Health, one (1) on services to children, one (1) on Long-Term Care, and one (1) on women’s health; three (3) of the PIPs shall focus specifically on the prevention and management of diabetes, the screening/management of clinical depression as required by the Adult Medicaid Quality Grant and Early and Periodic Screening, Diagnostic and Treatment (EPSDT). PIPs work plan and activities must be consistent with federal/State statutes, regulations and Quality Assessment and Performance Improvement Program requirements for pursuant to 42 C.F.R. § 438.240. For more detailed information refer to the “EQR Managed Care Organization Protocol” available at http://www.medicaid.gov/Medicaid-CSP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html;

101) **Section 4.12.5.1 of the Contract is amended and restated to read as follows:**

4.12.5.1 As part of the QI program for Centennial Care, the CONTRACTOR shall conduct an annual survey that shall assess Member satisfaction with the quality, availability, and accessibility of care. The CONTRACTOR shall implement the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for all Centennial Care Members. The CAHPS survey shall provide a statistically valid sample of CONTRACTOR’s Members who must have at least six (6) months of continuous enrollment, including Members who have requested to change their PCPs. The Member surveys shall address Member receipt of educational materials, Member satisfaction with care coordination and involvement in care coordination processes, including development of the CCP. The CONTRACTOR shall
follow all federal and State confidentiality statutes and regulations in conducting this Member Satisfaction Survey.

102) **Section 4.12.8.1 of the Contract is amended and restated to read as follows:**

4.12.8.1 All performance measures (PMs) and targets shall be based on HEDIS. PMs and targets shall be reasonable and based on industry standards that are applicable to substantially similar populations. The CONTRACTOR shall meet performance targets specified by HSD. HSD considers calendar year 2014 and calendar year 2015 to be a noncompetitive baseline years for performance measure thresholds and for setting future targets. The first full HEDIS audit will be expected in SFY 2016. To the extent the CONTRACTOR has yet to achieve NCQA accreditation in the State of New Mexico, the CONTRACTOR shall report on the performance measures using NCQA HEDIS methods and technical specifications as specified by HSD or its designee. The CONTRACTOR may be required to collect, track, trend and report performance measures or other measures as directed by HSD or its designee. The CONTRACTOR shall provide quality data and other relevant information as requested to HSD and/or its designee.

103) **Sections 4.12.10.1.6 and 4.12.10.1.7 of the Contract are amended and restated to read as follows:**

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

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

104) **Section 4.12 of the Contract is amended to add section 4.12.17 which reads as follows:**

4.12.17 Tracking Measures

4.12.17.1 The CONTRACTOR shall report on the tracking measures included in this Section 4.12.17 in a format prescribed by HSD.

4.12.17.2 The tracking measures included in this Section 4.12.17 are not subject to sanctions in section 7.3.6.1. of this Agreement.

4.12.17.3 TM#1- Fall Risk Management

The Percentage of Medicaid Members 65 years of age and older who had a fall or had problems with balance or walking in the past 12 months, who
were seen by a practitioner in the past 12 months and who received fall risk intervention from their current practitioner.

4.12.17.4 TM#2- Diabetes, Short-Term Complications Admission Rate

The number of inpatient discharges for diabetes short-term complications per 100,000 Medicaid enrollees age 18 and older.

4.12.17.5 TM#3- Screening for Clinical Depression and Follow-Up Plan

The percentage of Medicaid enrollees age 18 and older screened for clinical depression using a standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen.

105) Section 4.13.1.3.7 of the Contract is amended and restated to read as follows:

4.13.1.3.7 Promoting adoption of the use of Health Information Technology (“HIT”) and supporting the exchange of electronic health information; and

106) Section 4.13 of the Contract is amended to add 4.13.3 which reads as follows:

4.13.3 New Mexico’s Health Information Exchange (HIE)

4.13.3.1 The CONTRACTOR shall make its Centennial Care health plan’s health information available to the HIE and use the HIE to exchange electronic health information with other providers and health plans in accordance with applicable State and Federal law.

4.13.3.2 The CONTRACTOR shall issue monthly payments to the New Mexico Health Information Collaborative (NMHIC), or its successor, as operator of the HIE.

4.13.3.2.1 The payment shall be an amount based on the CONTRACTOR’s Centennial Care membership for that month using a PMPM set by HSD.

4.13.3.2.2 The payment shall be made no later than ten (10) Calendar Days, or at HSD’s discretion, following the CONTRACTOR’s receipt of the monthly capitation payment for its membership from HSD.

107) Section 4.14.8.3.6 of the Contract is amended and restated to read as follows:

4.14.8.3.6 Reserved;
108) **Section 4.14.8.3.10 of the Contract is amended and restated to read as follows:**

4.14.8.3.10 Reserved;

109) **Sections 4.15.1.9-4.15.1.11 of the Contract are amended and restated to read as follows:**

4.15.1.9 The Member services information line shall be staffed twenty-four (24) hours-a-day, seven (7) days-a-week with qualified nurses to triage urgent care and emergency calls from Members and to facilitate transfer of calls to a care coordinator. The CONTRACTOR may meet this requirement by having a separate nurse triage/nurse advice line that otherwise meets all of the requirements of this Section 4.15.1.

4.15.1.10 Staff providing triage/nurse advice services must be registered nurses (R.N.), physician assistants, nurse practitioners, or medical doctors. At all times there must be staff on hand equipped to handle Behavioral Health crises. The primary intent of this triage is to decrease inappropriate utilization of emergency rooms and improve coordination and continuity of care with a Member’s PCP. However, having the phone line staffed by someone who is also able to provide treatment as appropriate is encouraged.

4.15.1.11 The CONTRACTOR shall ensure that all calls from Members to the nurse triage/nurse advice line that require immediate attention are immediately addressed by qualified nurses or transferred to a care coordinator, whichever is most appropriate. During normal business hours, the transfer to the care coordination unit shall be a Warm Transfer. After normal business hours, if the CONTRACTOR cannot transfer the call to the care coordination unit as a Warm Transfer, the CONTRACTOR shall ensure that a care coordinator is notified about the call and returns the Member’s call within thirty (30) minutes. When returning the call the care coordinator must have access to the necessary information (e.g., the Member’s CCP) to resolve Member issues. The CONTRACTOR shall implement protocols, with prior approval from HSD, that describe how calls to the nurse triage/nurse advice line from Members will be handled.

110) **Section 4.15.2.1 of the Contract is amended and restated to read as follows:**

4.15.2.1 The CONTRACTOR shall adequately staff the Member services information line to ensure that the line, including the nurse triage/nurse advice line or queue, meets the following performance standards on a monthly basis: less than five percent (5%) call abandonment rate; eighty-five percent (85%) of calls are answered by a live voice within thirty (30) seconds (or the prevailing benchmark
established by NCQA); and average wait time for assistance does not exceed two (2) minutes.

111) Section 4.16.8 of the Contract is amended and restated to read as follows:

4.16.8 Provider Grievances and Appeals

The CONTRACTOR shall establish and maintain written policies and procedures for the filing of provider Grievances and Appeals. A provider shall have the right to file a Grievance or an Appeal with the CONTRACTOR. Provider Grievances or Appeals shall be resolved within thirty (30) Calendar Days. If the provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, the CONTRACTOR shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by the CONTRACTOR. A provider shall have the right to file an Appeal with the CONTRACTOR regarding provider payment issues and/or Utilization Management decisions.

112) Section 4.17.2.4 of the Contract is amended and restated to read as follows:

4.17.2.4 The CONTRACTOR shall promptly (within five (5) Business Days) perform a preliminary investigation of all incidents of suspected and/or confirmed Fraud and Abuse. Unless prior written approval is obtained from the agency to whom the incident was reported or its designee, after reporting Fraud or suspected Fraud and/or suspected Abuse and/or confirmed Abuse, the CONTRACTOR shall not take any of the following actions as they specifically relate to Centennial Care:

113) Section 4.17 of the Contract is amended to add section 4.17.4 which reads as follows:

4.17.4 Recoveries of Overpayments and/or Fraud

4.17.4.1 Identification Process For Overpayments

4.17.4.1.1 Providers are required to report overpayments to the CONTRACTOR by the later of: (i) the date which is sixty (60) Calendar Days after the date on which the overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A provider has identified an overpayment if the provider has actual knowledge of the existence of an overpayment or acts in reckless disregard or with deliberate indifference of the overpayment.

4.17.4.1.2 An overpayment shall be deemed to have been “identified” by a provider when:
4.17.4.1.2.1 The provider reviews billing or payment records and learns that it incorrectly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursement;

4.17.4.1.2.2 The provider learns that a patient death occurred prior to the service date on which a claim that has been submitted for payment;

4.17.4.1.2.3 The provider learns that services were provided by unlicensed or excluded individual on its behalf;

4.17.4.1.2.4 The provider performs an internal audit and discovers that an overpayment exists;

4.17.4.1.2.5 The provider is informed by a government agency of an audit that discovered a potential overpayment;

4.17.4.1.2.6 The provider is informed by the CONTRACTOR, HSD, or the RAC of an audit that discovered a potential overpayment;

4.17.4.1.2.7 The provider experiences a significant increase in Medicaid revenue and there is no apparent reason – such as a new partner added to a group practice or new focus on a particular area of medicine – for the increase;

4.17.4.1.2.8 The provider has been notified that the CONTRACTOR or a government agency has received a hotline call for email; and/or

4.17.4.1.2.9 The provider has been notified that the CONTRACTOR or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the provider submitted a claim for payment.

4.17.4.2 Self-Reporting

4.17.4.2.1 Within the timeframes specified in 4.17.4.1.1, the provider shall send an “Overpayment Report” to the CONTRACTOR and HSD which shall include, at a minimum, (i) provider’s name; (ii) provider’s tax identification number and National Provider Number; (iii) how the overpayment was discovered; (iv) the reason for the overpayment; (v) the health insurance claim number, as appropriate; (vi) date(s) of service; (vii) Medicaid claim control number, as appropriate; (viii) description of a
corrective action plan to ensure the overpayment does not occur again; (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 the OIG Self-Disclosure Protocol; (x) the specific dates (or time-span) within which the problem existed that caused the overpayments; (xi) if a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment; and (xii) the refund amount.

4.17.4.3 Refunds

4.17.4.3.1 All self-reported refunds for overpayments shall be made by the provider to the CONTRACTOR as an Intermediary and are property of the CONTRACTOR unless:

4.17.4.3.1.1 HSD, the RAC or MFEAD independently notified the provider that an overpayment existed; or

4.17.4.3.1.2 The CONTRACTOR fails to initiate recovery within twelve (12) months from the date the CONTRACTOR first paid the claim; or

4.17.4.3.1.3 The CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first paid the claim.

4.17.4.3.2 The provider may request that the CONTRACTOR permit installment payments of the refund, such request shall be agreed to by the CONTRACTOR and the provider; or

4.17.4.3.3 In cases where HSD, the RAC, or MFEAD identifies the overpayment, HSD shall seek recovery of the overpayment in accordance with NMAC §8.351.2.13.

4.17.4.4 Failure To Self-Report And/Or Refund Overpayments

4.17.4.4.1 Overpayments that have been identified by a provider and not self-reported within the sixty (60) Calendar Day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud.
Sections 4.18.2.1 and 4.18.2.2 of the Contract are amended and restated to read as follows:

4.18.2.1 The CONTRACTOR must be licensed or certified by the State as a risk-bearing entity. The CONTRACTOR shall establish and maintain a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in State of New Mexico in accordance with section 1903(m)(1) of the Social Security Act (amended by section 4706 of the Balanced Budget Act of 1997), and State Insurance Code, NMSA 1978, § 59A-46-13. The CONTRACTOR shall deposit, in the form of cash or liquid assets, an amount equal to ninety percent (90%) of the total capitation payment paid to the contractor in the first month of the Contract Year as determined by HSD. This provision shall remain in effect as long as the CONTRACTOR continues to contract with HSD.

4.18.2.1.1 The insolvency protection account must be restricted to the CONTRACTOR’s Centennial Care program.

4.18.2.1.2 The CONTRACTOR must satisfy this requirement no later than thirty (30) Calendar Days after notification by HSD of the deposit amount required.

4.18.2.1.3 Thereafter, the CONTRACTOR shall maintain this account such that the balance is equal to no less than ninety (90%) percent of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD.

4.18.2.1.4 The CONTRACTOR shall provide a statement of the account balance to HSD within fifteen (15) Calendar Days after the most recent quarter end.

4.18.2.1.5 If the account balance falls below the required amounts as determined by HSD the CONTRACTOR has thirty (30) Calendar Days, after notification from HSD to increase the account balance to an amount no less than the required amount specified by HSD and Section 4.18.2.1.3 of this Agreement.

4.18.2.1.6 The CONTRACTOR is permitted to withdraw interest or amounts in excess of the required account balance as determined by HSD from this account so long as the account balance after the withdrawal is not less than required amount as specified by HSD.

4.18.2.1.6.1 The CONTRACTOR shall notify HSD prior to withdrawal of funds from this account as outlined in Section 4.18.2.1.6.
4.18.2.1.7 The CONTRACTOR is prohibited from leveraging the insolvency account for another loan or creating other creditors from using this account as security.

4.18.2.1.8 The CONTRACTOR shall deposit the cash or liquid assets with the Superintendent of Insurance or, at the discretion of the Superintendent of Insurance, with any organization or trustee acceptable through which a custodial or controlled account is utilized as per NMSA 1978, § 59A-46-13.

4.18.2.2 In the event that a determination is made by HSD that the CONTRACTOR is insolvent or insolvent per NMSA 1978, § 59A-46, HSD may draw upon the amount. Funds may be disbursed to meet financial obligations incurred by the CONTRACTOR under this Agreement. A statement of account balance shall be provided by the CONTRACTOR within fifteen (15) Calendar Days of request of HSD.

4.18.2.3 If the Agreement is terminated, expired, or not continued, the account balance shall be released by HSD to the CONTRACTOR upon receipt of proof of satisfaction of all outstanding obligations incurred under this Agreement.

4.18.2.4 In the event the Agreement is terminated or not renewed and the CONTRACTOR is insolvent, HSD may draw upon the insolvency protection account to pay any outstanding debts the CONTRACTOR owes HSD including, but not limited to, overpayments made to the CONTRACTOR, and fines imposed under the Agreement or State requirements for which a final order has been issued. In addition, if the Agreement is terminated or not renewed and the CONTRACTOR is unable to pay all of its outstanding debts to health care providers, HSD and the CONTRACTOR agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds contained in the insolvency protection account. An appointed receiver shall give outstanding debts owed to HSD priority over other claims.

4.18.2.5 HSD shall adjust this reserve requirement quarterly, as needed. The reserve account may be accessed solely for payment for Covered Services to the CONTRACTOR’s Members in the event that the CONTRACTOR becomes insolvent. Money in the cash reserve account remains the property of the CONTRACTOR, including any interest earned provided the requirement under Section 4.18.2.1 of this Agreement is satisfied. The CONTRACTOR shall be permitted to invest its cash reserves consistent with the Office of the Superintendent of Insurance regulations and guidelines.
4.18.2.6 Failure to maintain the reserve as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

115) **Section 4.18.3 of the Contract is amended and restated to read as follows:**

4.18.3 Surplus Start-Up Account

The CONTRACTOR, at the agreement execution, shall submit to HSD proof of working capital in the form of cash or liquid assets excluding revenues from Medicaid capitation equal to at least the first three (3) months of operating expenses. This provision shall not apply if the CONTRACTOR has been providing services to Medicaid Members for a period exceeding three (3) months.

116) **Section 4.18.4 of the Contract is amended and restated to read as follows:**

4.18.4 Surplus Requirement

The CONTRACTOR shall maintain at all times in the form of cash, investments that mature in less than one hundred eighty (180) Calendar Days and allowable as admitted assets by the New Mexico Office of the Superintendent of Insurance, and restricted funds of deposits controlled by HSD (including the CONTRACTOR’s insolvency protection account), a surplus amount equal to the greater of one million five hundred thousand dollars ($1,500,000), ten percent (10%) of total liabilities, or two percent (2%) of the annualized amount of the CONTRACTOR’s prepaid revenues. In the event that the CONTRACTOR’s surplus falls below the amount specified in this paragraph, HSD shall prohibit the CONTRACTOR from engaging in community Outreach activities, shall cease to process new enrollments until the required balance is achieved, or may terminate the Agreement.

117) **Section 4.18.7 of the Contract is amended and restated to read as follows:**

4.18.7 Fidelity Bond

4.18.7.1 The CONTRACTOR shall maintain in force a fidelity bond as specified in the Insurance Code, NMSA 1978, 59A-46-6 et seq. however HSD requires the CONTRACTOR to maintain in force a fidelity bond amount of at least one million dollars ($1,000,000).

4.18.7.2 The CONTRACTOR shall secure and maintain during the life of this Agreement a blanket fidelity bond from a company doing business in the State of New Mexico on all personnel in its employment. The bond shall be issued in the amount of at least one million dollars ($1,000,000) per occurrence. Said bond shall protect HSD from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of the CONTRACTOR and subcontractors.
4.18.7.3 The CONTRACTOR shall submit proof of coverage to HSD within sixty (60) Calendar Days after the execution of this Agreement or date designated by HSD.

118) Section 4.18.8.3 of the Contract is deleted.

119) Section 4.18.9 of the Contract is amended and restated to read as follows:

4.18.9 Working Capital Requirements

120) Section 4.18.10.3.2 of the Contract is amended and restated to read as follows:

4.18.10.3.2 Defensive Interval: Must be greater than or equal to thirty (30) Calendar Days.

\[
\text{Defensive Interval} = \frac{\text{(Cash + Current Investments)}}{\text{((Operating Expense - Non-Cash Expense) / (Period Being Measured in Days))}}
\]

Non-Cash expense is any expense not paid for in cash such as depreciation

121) Section 4.18.10.3.3 of the Contract is deleted.

122) Section 4.18.11 of the Contract is amended and restated to read as follows:

4.18.11 Performance Bond

4.18.11.1 The CONTRACTOR shall maintain in force a performance bond in the initial amount of one hundred percent (100%) of the first month of capitation payment as determined by HSD and thereafter in the amount set forth in Section 4.18.11.3 of this Agreement.

4.18.11.1.1 The performance bond requirement is restricted to one of the methods outlined in 4.18.11.1.1 through 4.18.11.1.4 unless the CONTRACTOR submits and receives written approval by HSD of an alternative:

4.18.11.1.1 Cash Deposits;

4.18.11.1.2 Irrevocable letter of credit issued by a bank insured by the Federal Deposit Insurance Corporation (FDIC) or equivalent federally insured deposit;
4.18.11.1.3 Surety Bond issued by a surety or insurance company licensed to do business in New Mexico;

4.18.11.1.4 Certificate of Deposit

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

4.18.11.3 If the performance bond falls below ninety percent (90%) of the average monthly capitation paid to the CONTRACTOR in the most recent quarter determined by HSD the CONTRACTOR has thirty (30) Calendar Days to comply with the requirements of this Section and provide proof of the increased bond amount.

4.18.11.4 HSD shall have access to, and if necessary, draw upon the performance bond in the event HSD determines the CONTRACTOR to be in default of or failing to perform the activities outlined in this Agreement or if HSD determines the CONTRACTOR insolvent or insolvent per NMSA 1978, § 59A-46.

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

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

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

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

4.18.11.9 Failure to maintain the performance bond as directed above will result in financial penalties equal to twenty-five percent (25%) of the shortfall in the account each month.

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

123) **Section 4.18.12 of the Contract is amended and restated to read as follows:**

4.18.12 Reinsurance
4.18.12.1 The CONTRACTOR shall have and maintain a minimum of one million dollars ($1,000,000) per occurrence in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CONTRACTOR shall submit to HSD such documentation as is necessary to prove the existence of this protection, which may include policies and procedures of reinsurance.

4.18.12.2 HSD reserves the right to revisit reinsurance annually and modify the reinsurance threshold amount, to be determined by HSD, if, upon review of financial and Encounter Data, or other information, fiscal concerns arise that such a change in reinsurance threshold is deemed warranted by HSD.

4.18.12.3 If the CONTRACTOR purchases reinsurance from an affiliate to satisfy the requirements of 4.18.12 of this Agreement, the CONTRACTOR must submit a copy of its annual Insurance Holding Company Statement D filing, showing that it submitted its reinsurance agreements to the Office of the Superintendent of Insurance for approval. The CONTRACTOR must submit the pricing details of the reinsurance agreement including the covered period to HSD as well as a copy to the Office of the Superintendent of Insurance for approval.

4.18.12.4 The CONTRACTOR shall ensure that the reinsurance agreement meets a medical loss ratio of at least 85% annually.

124) **Section 4.18.13.1 of the Contract is amended and restated to read as follows:**

4.18.13.1 The CONTRACTOR shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and notify the agency’s third-party liability vendor of any third-party creditable coverage discovered. Specifically, the CONTRACTOR:

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

- **4.18.13.1.2** Shall inform HSD within twenty (20) Calendar Days of receiving information regarding any member who has other health coverage;

- **4.18.13.1.3** Shall provide documentation within twenty (20) Calendar Days to HSD, Third-Party Liability Unit enabling HSD to pursue its right under federal and State law, regulations and rules; documentation shall include payment information, collection and/or recoveries for
services provided to enrolled members as required by HSD; and

4.18.13.1.4 Has the sole right of collection to recover from a third-party resource or from a provider who has been overpaid due to a third-party resource for twelve (12) months from the date the CONTRACTOR first pays the claim to initiate recovery and attempt to recover any third-party resources available to Medicaid Members, for all services provided by the CONTRACTOR pursuant to this Agreement or any other Agreement for Medicaid services between the CONTRACTOR and HSD. Without mitigating any rights the CONTRACTOR’s provider has pursuant to federal and state law and regulations, the CONTRACTOR:

4.18.13.1.4.1 Agrees HSD has the sole right of collection from a third-party resource which the CONTRACTOR has failed to identify within twelve (12) months from the date the CONTRACTOR first pays the claim;

4.18.13.1.4.2 Agrees HSD has the sole right of recovery from the CONTRACTOR or a CONTRACTOR’s provider who has been overpaid due to the combined payments of the CONTRACTOR and a third-party resource when the CONTRACTOR has not made a recovery within twelve (12) months from the date the CONTRACTOR first pays the claim;

4.18.13.1.4.3 Agrees HSD has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR’s provider if the CONTRACTOR has identified a third-party resource but failed to initiate recovery within the twelve (12) month period;

4.18.13.1.4.4 Agrees has the sole right of recovery from a third party resource, the CONTRACTOR or a CONTRACTOR’s provider if the CONTRACTOR has accepted the denial of payment or recovery from a third-party resource or when the CONTRACTOR fails to complete the recovery within fifteen (15) months from the date the CONTRACTOR first pays the claim; and may permit payments to be made in accordance with state regulations
The exception to this twelve (12) month period is for cases in which a capitation has been recouped from the CONTRACTOR pursuant to Article 6.2.4, whereupon the CONTRACTOR shall retain the sole right of recovery for all paid claims related to members and months that were recouped.

125) **Section 4.18.14 of the Contract** is amended to add 4.18.14.5 which reads as follows:

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

126) **Section 4.18.16.1 of the Contract** is amended and restated to read as follows:

4.18.16.1 The CONTRACTOR shall submit quarterly and annual insurance filings and financial statements that are specific to the operations of the CONTRACTOR’s New Mexico operations rather than a parent or umbrella organization in accordance with Section 4.21.12.1 of this Agreement.

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

4.19.2.2.13 Meet Encounter accuracy requirements by submitting CONTRACTOR paid Encounters with no more than a three percent (3%) error rate per invoice type (837I adjudicated at the header level, 837P and 837I adjudicated at the line level, 837D, NCPDP), calculated for a month’s worth of submissions. HSD will monitor the CONTRACTOR corrections to denied Encounters for services covered under this Agreement by random sampling performed quarterly and over the term of the Agreement. The methodology for the error rates will be determined by HSD. Seventy-five percent (75%) of the denied Encounters for services covered under this Agreement included in the random sample must have been corrected and resubmitted by the CONTRACTOR within thirty (30) Calendar Days of denial;

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

4.19.2.2.14 The CONTRACTOR shall submit a report of the number of denied Claims by invoice type (professional, institutional, pharmacy, dental) by date of payment and date of service in accordance with Section 4.21.11.1 of this Agreement. This report will be compared to Encounter Data to evaluate the completeness of data submitted. A variance between the CONTRACTOR’s report and the record of Encounters received cannot
exceed five percent (5%) for months of payment greater than ninety (90) Calendar Days. The methodology for the variances will be determined by HSD;

129) **Section 4.19.2.2 of the Contract is amended to add section 4.19.2.2.17 which reads as follows:**

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

130) **Section 4.21.1.8 of the Contract is amended and restated to read as follows:**

4.21.1.8 Each report must include an analysis, which shall include, at a minimum: (i) identification of any changes compared to previous reporting periods as well as trending over time; (ii) an explanation of said changes (positive or negative); (iii) an action plan or performance improvement activities addressing any negative changes; and (iv) any other additional information pertinent to the reporting period. HSD may assess liquidated damages for failure to address any of these requirements. The above data requirements may be represented in charts, graphs, tables and any other data illustrations to demonstrate findings.

131) **Section 4.21.2.1.2 of the Contract is amended and restated to read as follows:**

4.21.2.1.2 The CONTRACTOR shall, upon request, provide information regarding Member education, training and Outreach initiatives including, but not limited to, the following: (i) target audiences; (ii) location of training/event; (iii) date of training/event; (iv) topics; (v) funds expended; (vi) number and types of attendees and (vii) sign-in sheets.

132) **Section 4.21.4.4 of the Contract is amended and restated to read as follows:**

4.21.4.4 The CONTRACTOR shall submit a monthly *Call Center Report* that provides information about the Member services, provider services, and nurse advice lines. During the first 30 days of implementation the MCO must submit all call center response statistics daily. If deficiencies are found, the state and the MCO must determine how the MCO will remedy the deficiency as soon as possible. After the first 30 days, if the MCO is consistently meeting requirements, the MCO may submit weekly reports for the first 180 days of implementation. The report shall, at a minimum, include by language queue: (i) number of calls received; (ii) number of calls
answered; (iii) abandonment rate; (iv) number of calls answered within thirty (30) seconds; and (v) call topics.

133) **Section 4.21.4 of the Contract is amended to add section 4.21.4.7 which reads as follows:**

4.21.4.7 The CONTRACTOR shall submit an *Activities of the Native American Advisory Board Report* ten (10) Calendar Days following each meeting pursuant to Section 4.12.1 of this Agreement. The report shall, at a minimum, include: (i) how notice of such meeting was delivered to Native American representatives that were asked to attend the meeting; (ii) meeting agenda; (iii) a list of meeting attendees; (iv) meeting minutes; (v) action items and/or recommendations to the CONTRACTOR and/or HSD and (vi) the date, time and location of the next meeting.

134) **Section 4.21.5.1.1 of the Contract is amended and restated to read as follows:**

4.21.5.1.1 The CONTRACTOR shall submit a quarterly *Network Adequacy Report* that provides the information on activities from the previous quarter broken out by month. At a minimum, the report shall include: (i) number of providers by provider type; (ii) geographic access standards by county; and (iii) the time between a Member’s initial request for an appointment and the date of the appointment. The data may be collected using statistical sampling methods (including periodic Member or provider surveys).

135) **Section 4.21.5.1.3 of the Contract is amended and restated to read as follows:**

4.21.5.1.3 The CONTRACTOR shall submit a monthly *PCP Report* that provides the information on activities from the previous month. At a minimum, the report shall include: (i) the PCP to Member ratio per 2,000 Members; (ii) the percent of PCP panel slots open; (iii) the number of providers serving as PCPs stratified by type (nurse practitioners, internists, pediatricians, etc); (iv) the number of PCP visits per 2,000 Members; (v) the percent of new Members who did not select a PCP and were assigned to one; and (vi) the number of PCP change requests received and processed.

136) **Section 4.21.5.1.6 of the Contract is amended and restated to read as follows:**

4.21.5.1.6 The CONTRACTOR shall submit a quarterly *Provider Suspensions and Terminations Report* that lists by name all Contract Provider suspensions or terminations. This report shall include information on all Contract Providers. At a minimum, the report shall include: (i) each Contract Provider’s name; (ii) the
Contract Provider’s specialty; (iii) the Contract Provider’s NPI; (iv) the Contract Provider’s primary city; (v) reason(s) for the action taken; and (vi) the effective date of the suspension or termination. If the CONTRACTOR has taken no action against providers during the quarter this should be documented in the Provider Suspensions and Terminations Report.

137) Section 4.21.6 of the Contract is amended and restated to read as follows:

4.21.6.1 The CONTRACTOR shall submit a quarterly Medicaid School-Based Health Centers (SBHC) Report that provides information on all of the procedure codes being billed by each approved SBHC, by sponsoring entity. The report shall include the number of submitted, paid, denied, resubmitted, adjudicated, open and reversed SBHC Claims. At a minimum, the report will include (i) delivery site; (ii) Medicaid SBHC provider name; (iii) provider’s NPI, (iv) total Claims submitted, paid, denied, resubmitted, adjudicated, open and reversed; (v) funding source; (vi) YTD services by service code; (vii) YTD Claims total; (viii) YTD Claims status; and (xi) Claims denied and resubmitted.

4.21.6.2 To the extent the CONTRACTOR provides Value Added Services in accordance with Section 4.7 of this Agreement, the CONTRACTOR shall submit a quarterly Value Added Services Report that, at a minimum, lists: (i) the service; (ii) procedure code for each service; (iii) the number of unduplicated Members for each service; (iv) the numbers of Encounters for each service; (v) the total dollar amount expended in the quarter; (vi) the total dollar amount expended YTD; and (vii) provider name and county. Additionally, the CONTRACTOR shall provide: (i) a description of each benefit; (ii) definition; (iii) availability of the service and any service limitations; (iv) geographic locations where the service is offered; and (v) payment code.

4.21.6.3 The CONTRACTOR shall submit a quarterly Self-Directed Report that, at a minimum, provides (i) information on the utilization of Self-Directed Community Benefit services and (ii) information on the Member’s utilization of the SDCB budget.

4.21.6.4 The CONTRACTOR shall submit a quarterly Developmental Disabilities Specialty Dental Report that, at a minimum, lists the following information: (i) Member name; (ii) provider name; (iii) date of service; and (iv) amount paid for service.

4.21.6.5 The CONTRACTOR shall submit a quarterly Jackson Class Members Report that provides, at a minimum, information regarding new requests for new adaptive equipment and for modifications and repairs.
4.21.6.6 The CONTRACTOR shall submit a quarterly *Facilities Readmission Report* that provides information by county regarding the number of Members who are readmitted to a facility such as, an RTC, TFC, hospital, within thirty (30) Calendar Days of a previous discharge. The report shall provide data by procedure codes and populations as specified by HSD.

4.21.6.7 The CONTRACTOR shall submit a quarterly *Member Rewards Report* that at a minimum includes: (i) the total credits available to each Medicaid household and Member; (ii) the total volume purchased with Member incentive credits for each covered item on the HSD-approved schedule; (iii) the total value of the benefits purchased with those credits by each Medicaid household and Member; and (iv) the ratio of credits earned to items purchased for all households and Members that participate in the Member incentive program as described in Section 4.22.1 of this Agreement.

138) Sections 4.21.7.3 and 4.21.7.4 of the Contract are amended and restated to read as follows:

4.21.7.3 The CONTRACTOR shall submit a monthly *Level of Care (LOC) Report* that provides information regarding initial and annual nursing facility level of care determinations. The report shall, at a minimum, include information regarding number of Members who meet nursing facility level of care and compliance with timeframes associated with level of care determinations as well as their care setting.

4.21.7.4 The CONTRACTOR shall submit a quarterly *Agency-Based Community Benefit Report* that provides information regarding the amount of the Community Benefit used by Members stratified by level of need as directed by HSD. The report shall also provide information regarding the number of Members that have exhausted their Community Benefit.

139) Section 4.21.7 of the Contract is amended to add sections 4.21.7.10 and 4.21.7.11 which read as follows:

4.21.7.10 The CONTRACTOR shall submit a quarterly *CSA Report* that provides information regarding the number of CSAs assisting the MCOs’ members and the following information at a minimum for each CSA: (i) name of CSA, (ii) number of Members in CSA that are identified as CSA Members, (iii) number of Members that were admitted to an out of home placement, (iv) number of Members that were admitted to a psychiatric hospital, (v) number of Members who had a crisis incident, (vi) number of SED and SMI members served by the CSA, and (vii) the types of services provided by the CSA.
4.21.7.11 The CONTRACTOR shall submit a monthly *Comprehensive Care Plan Report* that provides information regarding, at a minimum (i) reductions, (ii) suspensions, (iii) denials and/or (iv) terminations of previously authorized services.

140) **Section 4.21.8.4 of the Contract is amended and restated to read as follows:**

4.21.8.4 *Prior Authorization Report* that includes prior authorization information by service. The report shall, at a minimum, include the following data: (i) the service for which a prior authorization is being requested; (ii) the number of initial and continued requests for each service; (iii) the number of requests approved, denied (administrative and clinical), pended for each service (initial and continued); and (iv) the number of terminations and reductions in service for each service.

141) **Section 4.21.9.1 of the Contract is amended and restated to read as follows:**

4.21.9.1 The CONTRACTOR shall submit a monthly *Grievances and Appeals Report*. The CONTRACTOR shall submit reports of all provider and Member Grievances (informal and formal), Appeals, and Fair Hearings utilizing the State-provided reporting templates and codes.

142) **Section 4.21.10.2 of the Contract is amended and restated to read as follows:**

4.21.10.2 The CONTRACTOR shall submit a quarterly *Systems Availability and Performance Report* that provides information on availability and unavailability by major system as well as response times for the CONTRACTOR’s confirmation of CONTRACTOR’s enrollment and electronic Claims management functions, as measured within the CONTRACTOR’s span of control. The report shall meet the requirements of Section 4.20.4 of this Agreement.

143) **Sections 4.21.11.1 and 4.21.11.2 of the Contract are amended and restated to read as follows:**

4.21.11.1 The CONTRACTOR shall submit a quarterly *Claims Payment Accuracy Report*. The report shall include the results of the internal audit of the random sample of all “processed or paid” Claims and shall report on the number and percent of Claims that are paid accurately. If the CONTRACTOR subcontracts for the provision of any Covered Services, and the subcontractor is responsible for processing Claims, then the CONTRACTOR shall submit a Claims payment accuracy percentage report for the Claims processed by the subcontractor. The report for each subcontractor shall include the results of the internal audit conducted and shall report on the number and percent of Claims that are paid accurately.
4.21.11.2 The CONTRACTOR shall submit a monthly Claims Activity Report. At a minimum, this report shall identify the number of Claims received, number of Claims denied (by reason), number of Claims paid, total amount paid by the categories of service specified by HSD in accordance with Section 4.19 of this Agreement. During the first 180 Calendar Days of implementation the CONTRACTOR must submit a weekly claims activity report. After the first 180 Calendar Days, at the discretion of HSD, the CONTRACTOR may submit monthly reports.

144) Section 4.21.11 of the Contract is amended to add 4.21.11.5 which reads as follows:

4.21.11.5 The CONTRACTOR shall submit a quarterly Encounter Processing and Submission Report that tracks encounters paid in a reporting period and provides a cross tabulation of service delivery cost by month of service and month of payment for managed care encounters; including all inpatient, outpatient, dental and pharmacy encounters.

145) Section 4.21.12 of the Contract is amended and restated to read as follows:

4.21.12 Financial Management

4.21.12.1 By June 1 of each Agreement year, the CONTRACTOR shall submit annual Independently Audited Financial Statements, including, but not limited to, its income statement, statement of changes in financial condition or cash flow, and balance sheet that allow HSD to determine solvency and CMS compliance. Such financial statements shall be specific to the operations of the CONTRACTOR rather than a parent or umbrella organization.

4.21.12.2 By June 1 of each Agreement year, the CONTRACTOR shall submit a New Mexico Medicaid Specific Audited Schedule of Revenue and Expenses report that allow HSD to determine solvency and CMS compliance.

4.21.12.3 Reserved.

4.21.12.4 Reserved.

4.21.12.5 The CONTRACTOR shall submit quarterly and annual Office of the Superintendent of Insurance Reports that allow HSD to determine solvency and CMS compliance. The report is due forty-five (45) Calendar Days from
the end of the quarter or the fifteenth (15th) Calendar Day of the second month the quarter and March 1 for the annual statement.

4.21.12.6 Reserved.

4.21.12.7 The CONTRACTOR shall submit the quarterly Medicaid Financial Reporting Package. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter.

4.21.12.7.1 The CONTRACTOR shall submit the annual Medicaid Financial Reporting Package Supplement to HSD by May 15th or an alternative date established by HSD.

4.21.12.8 Reserved.

4.21.12.9 Reserved.

4.21.12.10 The CONTRACTOR shall submit a quarterly Payments to IHS and Tribal 638 Providers Reports that facilitate HSD’s reimbursement to the CONTRACTOR after comparison to Encounters and acceptance of the report. The report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month following the end of the quarter.

4.21.12.11 Reserved.

4.21.12.12 The CONTRACTOR shall submit a monthly Withholding Bank Statement for Delivery System Improvements to allow HSD to verify compliance with delivery system improvement requirements in accordance with Section 6.10 and Attachment 3 of this Agreement. The report is due forty-five (45) Calendar Days after month end.

4.21.12.13 Initially and upon renewal, the CONTRACTOR shall submit an annual report that identifies the fidelity bond or insurance protection by amount of coverage in relation to annual payments, and allows HSD to examine and confirm solvency and CMS compliance.

4.21.12.14 Initially and upon renewal, the CONTRACTOR shall submit an annual Reinsurance Policy Report that allows HSD to assess solvency and CMS compliance.
4.21.12.15 The CONTRACTOR shall submit a quarterly *Cash Reserve Statement Reports* that allow HSD to examine and confirm solvency and CMS compliance. The report is due thirty (30) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter.

4.21.12.16 The CONTRACTOR shall submit records involving any business restructuring when changes in ownership interest of five percent (5%) or more have occurred. These records shall include, but are not limited to, an updated list of names and addresses of all persons or entities having ownership interest of five percent (5%) or more. These records shall be provided no later than sixty (60) Calendar Days following the change of ownership.

4.21.12.17 By April 1 of each Agreement year, the CONTRACTOR shall submit an annual *Risk Withholding Report* that allows HSD to analyze risk sharing.

4.21.12.18 Reserved.


4.21.12.20 The CONTRACTOR shall submit an annual *Payment Reform Report*, see Section 4.10.7.1.2 of the Agreement that allows HSD to assess the CONTRACTOR’s incentive programs that have been approved by HSD.

4.21.12.21 The CONTRACTOR shall submit a quarterly report that identifies the performance bond, insurance protection or deposit by amount of coverage in relation to HSD requirements, and allows HSD to examine and confirm the value of the performance bond in accordance with 4.18.11.

146) **Section 4.22.1.1.3 of the Contract is amended and restated to read as follows:**

4.22.1.1.3 Amounts expended to administer the Member rewards program shall be deemed as administrative expenses and amounts expended on the value of the rewards themselves shall be deemed as direct services for purposes of the medical expense ratio (see Section 7.2 of this Agreement).
147) Section 4.22.1.2 of the Contract is amended and restated to read as follows:

4.22.1.2 Specific Requirements

4.22.1.2.1 The activities and behaviors proposed to be rewarded with incentives should promote good health, Health Literacy, and continuity of care for all Members and shall be prior approved by HSD. Behaviors to be rewarded will be agreed to by the CONTRACTOR, the other Centennial Care MCOs and HSD.

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

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

148) Section 4.22.1.3 of the Contract is amended and restated to read as follows:

4.22.1.3 Data Sharing and Reporting

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

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

4.22.1.3.3 The credits for Member rewards may be tracked and accumulated based on an alternative process, subject to agreement by all the MCOs and prior approval by HSD. In no instance shall the methodology proposed fail to provide the credits to the Members in less than forty-five (45) Calendar Days from payment of the associated claim or receipt by the MCO or a written request for a non-claim based reward.

4.22.1.3.4 The CONTRACTOR shall design and operate an automated system to communicate information on the credits available for each Member to the vendor retained by the Centennial Care MCOs to administer the provider catalog fulfillment process.

149) Section 6.3 is amended and restated to read as follows:

6.3 Reimbursement to CONTRACTOR for I/T/U Services
6.6 Changes in the Capitation Payment Rates

151) Section 6.7.1 of the Contract is amended to add section 6.7.1.4 which reads as follows:

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

152) Section 6.8.1 of the Contract is amended and restated to read as follows:

6.8.1 HSD monthly capitation payments will be “net” of patient liability. The capitation payments are based on “gross” cost and reduced by the amount of patient responsibility.

153) Section 6.8 of the Contract is amended to add section 6.8.4 of the Contract which reads as follows:

6.8.4 HSD shall perform a reconciliation of the patient liability amounts every six months during the term of this Agreement to recoup or adjust payment based on actual enrolled member patient liability and the net capitation payment.

154) Section 6 of the Contract is amended to add section 6.11 which reads as follows:

6.11 Community Benefit Reconciliation

6.11.1 HSD shall review Members determined by the CONTRACTOR to need access to the Community Benefit. If a Member does not utilize Community Benefit services within ninety (90) Calendar Days of approval of the CCP, HSD will recoup the capitation payment for the Community Benefit from the CONTRACTOR.

155) Section 7.2 of the Contract is amended and restated to read as follows:
7.2 Limitation on Underwriting Gain

156) Sections 7.2.1-7.2.6 of the Contract are amended and restated to read as follows:

7.2.1 The CONTRACTOR is permitted to retain one hundred percent (100%) of any underwriting gain generated under this Agreement up to three percent (3.0%) of net capitation revenue as defined in Section 7.2.2 of this Agreement generated annually under this Agreement. The CONTRACTOR shall share fifty percent (50%) of any underwriting gain generated in excess of three percent (3.0%) with HSD. HSD shall measure the annual underwriting gain based on the Medicaid Financial Reporting Package. The measurement will be performed as outlined in Section 7.2.2 of this Agreement.

7.2.2 For purposes of this Section, “underwriting gain” is defined as the net income before State and federal taxes for the Medicaid line of business on an annual basis. The Delivery System Improvement Fund and Liquidated Damages will not be considered reductions to revenue and/or countable expenses in the calculation of the limitation on underwriting gain.

Medicaid line of business Net Capitation Revenue:
Prospective capitation premium, excluding IHS supplemental revenue, less Premium Tax, less NMMIP Assessments during the annual period.

Medicaid line of business Total Medical Expense:
Medical Expense (net of reinsurance and TPL post payment recoveries) incurred during the annual period less IHS expenditures and less expenses for care coordination services deemed to be administrative per Section 7.2.9 of this Agreement.

Medicaid Administration:
Administrative expense (outlined in 7.2.8 of this Agreement) incurred during the annual period including expenses for care coordination services deemed to be administrative per Section 7.2.9 of this Agreement less Premium Tax less NMMIP Assessment during the annual period.

Underwriting Gain:
Net Capitation Revenue less Medicaid line of business Total Medical Expense less Administrative expenses equals underwriting gain.

7.2.3 HSD has established the underwriting gain limit and sharing outlined in 7.2.1 of this Agreement; however, HSD makes no guarantee of any
level of underwriting gain to the CONTRACTOR under this Agreement.

7.2.4 HSD will utilize the annual Medicaid Financial Reporting Package following the close of the calendar year to calculate the underwriting gain. If underwriting gain in excess of three percent (3.0%) is realized, HSD will recoup the amount for the excess underwriting gain share outlined in Section 7.2.1 of this Agreement.

7.2.5 HSD reserves the right to examine the allocation methodologies utilized for any non-direct expenditure by the CONTRACTOR as it relates to any expenditure including but not limited to administrative expense.

7.2.6 HSD reserves the right to modify the measurement of underwriting gain based on review of allocation methodologies.

157) **Section 7.2.9.2.6 of the Contract is amended and restated to read as follows:**

7.2.9.2.6 CCP development and updates;

158) **Section 7.3.5 part 3 of the Contract is amended and restated to read as follows:**

Failure to comply with the timeframes for a comprehensive care assessment and developing and approving a CCP for care coordination level 2 and level 3

159) **Section 7.16.4.1 of the Contract is amended and restated to read as follows:**

7.16.4.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its subcontractors, including its Contract Providers, to provide, the officials and entities identified in this Section with reasonable and adequate access to any records that are related to the scope of work performed under this Agreement within two (2) to ten (10) business days, NMSA § 27-11-4(B).

160) **Section 7.6.6.1 of the Contract is amended and restated to read as follows:**

7.6.6.1 Reserved.

161) **Section 7.16.4.1 of the Contract is amended and restated to read as follows:**

7.16.4.1 Upon reasonable notice, the CONTRACTOR must provide, and cause its subcontractors, including its Contract Providers, to provide, the officials and entities identified in this Section with reasonable and adequate access to any
records that are related to the scope of work performed under this Agreement within two (2) to ten (10) business days per NMSA 1978, § 27-11-4(B).

162) **Section 7.27 of the Contract is amended to add sections 7.27.11-7.27.13 which read as follows:**

7.27.11 Referrals For Credible Allegations Of Fraud

7.27.11.1 The CONTRACTOR shall follow HSD’s direction in identifying and reporting cases of credible allegations of fraud. This includes, but is not limited to:

7.27.11.1.1 The CONTRACTOR shall suspend all Medicaid payments, in whole or in part as directed by HSD, to a provider after HSD has verified that there is a credible allegation of fraud and the referral has been accepted by MFEAD. HSD may, at its sole discretion, determine that good cause exists to release the payment suspension, in whole or in part. Should HSD suspend payments in whole, upon receipt of HSD’s notice, the CONTRACTOR (i) shall immediately suspend payments, including all payments for prior adjudicated Claims, pended Claims, or non-adjudicated Claims; and (ii) is prohibited from making any payment to the provider until further notified by HSD. Should the CONTRACTOR fail to comply with this provision, HSD may seek recovery from the CONTRACTOR for all money released by the CONTRACTOR to the Provider from the date the CONTRACTOR received HSD’s notice.

7.27.11.1.2 The CONTRACTOR acknowledges that if MFEAD accepts the referral of a credible allegation of fraud, MFEAD has the right to conduct an investigation and to pursue any recovery against the provider as authorized by law.

7.27.11.1.3 If MFEAD, after investigation, decides to conclude its investigation, HSD, at its sole discretion, may seek recovery against the provider for any overpayments and any refund shall be the property of HSD.

7.27.11.1.4 Any suspension of provider payments imposed pursuant to this subsection shall terminate upon:

7.27.11.1.4.1 A determination by HSD, MFEAD or its authorized agent or designee that there is insufficient evidence of fraud by the provider; or
7.27.11.4.2 The dismissal of all charges and/or claims against the provider related to the provider’s alleged fraud by a court of competent jurisdiction.

7.27.11.5 HSD shall document in writing the termination of a payment suspension and shall provide such documentation to the CONTRACTOR.

7.27.11.2 Should HSD require the CONTRACTOR’s assistance, beyond what is required by the terms of this Agreement, in investigating credible allegations of fraud in matters, including but not limited to, performing audits, medical records review, IT business and billing system review, licensing, credentialing and contract services review, and/or staff interviews, HSD and the CONTRACTOR shall, in good faith, negotiate an amendment to this Agreement.

7.27.12 Recovery for Fraud/False Claims

7.27.12.1 Should MFEAD or HSD pursue what it alleges are false and/or fraudulent claims as permitted under law and identified by the CONTRACTOR against a provider, any recovery (either by the provider making payment, collection on a judgment or restitution) shall be divided as follows:

7.27.12.1.1 HSD shall recoup and remit to CMS the federal share;

7.27.12.1.2 HSD shall retain the non-federal share and for:

   7.27.12.1.2.1 Aggregate Recovery in excess of $25,000.00 but less than $100,000.00 remit to the CONTRACTOR forty percent (40%) of the non-federal share; or

   7.27.12.1.2.2 Aggregate recovery in excess of $100,000.00 but less than $250,000.00, remit to the CONTRACTOR thirty percent (30%) of the non-federal share; or

   7.27.12.1.2.3 Aggregate recovery in excess of $250,000.00, remit to the CONTRACTOR twenty-five percent (25%) of the non-federal share.

7.27.12.1.3 HSD and the CONTRACTOR shall work together in good faith to come to a mutually agreeable process for any remittance due the CONTRACTOR and how that
remittance will be treated for purposes of the medical loss ratio.

7.27.12.1.4 HSD shall provide the CONTRACTOR with quarterly reports regarding any recovery for which the CONTRACTOR may be entitled to a remittance.

7.27.13 The CONTRACTOR is not entitled to any recovery under this subsection when MFEAD and/or HSD independently identifies and pursues false claims and/or fraudulent claims.

163) **Section 7.30.4 of the Contract is deleted.**

164) **Attachment 2 is amended and restated to read as follows:**

**Attachment 2: Centennial Care Covered Services**

<table>
<thead>
<tr>
<th>Non-Community Benefit Services Included Under Centennial Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accredited Residential Treatment Center Services</strong></td>
</tr>
<tr>
<td><strong>Adaptive Skills Building (Autism)</strong></td>
</tr>
<tr>
<td><strong>Adult Psychological Rehabilitation Services</strong></td>
</tr>
<tr>
<td><strong>Ambulatory Surgical Center Services</strong></td>
</tr>
<tr>
<td><strong>Anesthesia Services</strong></td>
</tr>
<tr>
<td><strong>Assertive Community Treatment Services</strong></td>
</tr>
<tr>
<td><strong>Behavior Management Skills Development Services</strong></td>
</tr>
<tr>
<td><strong>Behavioral Health Professional Services: outpatient behavioral health and substance abuse services</strong></td>
</tr>
<tr>
<td><strong>Case Management</strong></td>
</tr>
<tr>
<td><strong>Community Interveners for the Deaf and Blind</strong></td>
</tr>
<tr>
<td><strong>Comprehensive Community Support Services</strong></td>
</tr>
<tr>
<td><strong>Day Treatment Services</strong></td>
</tr>
<tr>
<td><strong>Dental Services</strong></td>
</tr>
<tr>
<td><strong>Diagnostic Imaging and Therapeutic Radiology Services</strong></td>
</tr>
<tr>
<td><strong>Dialysis Services</strong></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Supplies</strong></td>
</tr>
<tr>
<td><strong>Emergency Services (including emergency room visits and psychiatric ER)</strong></td>
</tr>
<tr>
<td><strong>Experimental or Investigational Procedures, Technology or Non-Drug Therapies</strong></td>
</tr>
<tr>
<td><strong>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</strong></td>
</tr>
<tr>
<td><strong>EPSDT Personal Care Services</strong></td>
</tr>
<tr>
<td><strong>EPSDT Private Duty Nursing</strong></td>
</tr>
<tr>
<td><strong>EPSDT Rehabilitation Services</strong></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
</tr>
</tbody>
</table>

---

1 Experimental and investigational procedures, technologies or therapies are only available to the extent specified in MAD 8.325.6.9 or its successor regulation.
<table>
<thead>
<tr>
<th>Service Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support (Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>Federally Qualified Health Center Services</td>
<td></td>
</tr>
<tr>
<td>Hearing Aids and Related Evaluations</td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td></td>
</tr>
<tr>
<td>Hospice Services</td>
<td></td>
</tr>
<tr>
<td>Hospital Inpatient (including Detoxification services)</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospitalization in Freestanding Psychiatric Hospitals</td>
<td></td>
</tr>
<tr>
<td>Intensive Outpatient Program Services</td>
<td></td>
</tr>
<tr>
<td>IV Outpatient Services</td>
<td></td>
</tr>
<tr>
<td>Laboratory Services</td>
<td></td>
</tr>
<tr>
<td>Medication Assisted Treatment for Opioid Dependence</td>
<td></td>
</tr>
<tr>
<td>Midwife Services</td>
<td></td>
</tr>
<tr>
<td>Multi-Systemic Therapy Services</td>
<td></td>
</tr>
<tr>
<td>Non-Accredited Residential Treatment Centers and Group Homes</td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td></td>
</tr>
<tr>
<td>Nutritional Services</td>
<td></td>
</tr>
<tr>
<td>Occupational Services</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital Based Psychiatric Services and Partial Hospitalization</td>
<td></td>
</tr>
<tr>
<td>Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital</td>
<td></td>
</tr>
<tr>
<td>Outpatient Health Care Professional Services</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
</tr>
<tr>
<td>Physical Health Services</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
</tr>
<tr>
<td>Physician Visits</td>
<td></td>
</tr>
<tr>
<td>Podiatry Services</td>
<td></td>
</tr>
<tr>
<td>Pregnancy Termination Procedures</td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Prosthetics and Orthotics</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td></td>
</tr>
<tr>
<td>Radiology Facilities</td>
<td></td>
</tr>
<tr>
<td>Recovery Services (Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Option Services</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Services Providers</td>
<td></td>
</tr>
<tr>
<td>Reproductive Health Services</td>
<td></td>
</tr>
<tr>
<td>Respite (Behavioral Health)</td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinics Services</td>
<td></td>
</tr>
<tr>
<td>School-Based Services</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation Services</td>
<td></td>
</tr>
<tr>
<td>Speech and Language Therapy</td>
<td></td>
</tr>
<tr>
<td>Swing Bed Hospital Services</td>
<td></td>
</tr>
<tr>
<td>Telehealth Services</td>
<td></td>
</tr>
<tr>
<td>Tot-to-Teen Health Checks</td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td></td>
</tr>
<tr>
<td>Transportation Services (medical)</td>
<td></td>
</tr>
<tr>
<td>Treatment Foster Care</td>
<td></td>
</tr>
<tr>
<td>Treatment Foster Care II</td>
<td></td>
</tr>
<tr>
<td>Vision Care Services</td>
<td></td>
</tr>
</tbody>
</table>
Attachment 3 is amended and restated to read as follows:

**Attachment 3: Delivery System Improvement Targets**

Delivery System Improvements for Year One (1) of Implementation of Centennial Care

<table>
<thead>
<tr>
<th>Delivery System Improvement Objective</th>
<th>Delivery System Improvement Target for Release of Withhold</th>
<th>Number of Points out of 100</th>
</tr>
</thead>
</table>
Each CONTRACTOR shall submit for HSD approval, a delivery system improvement project that is designed to increase the use of electronic health records by its Contract Providers and to increase the number of its Contract Providers who participate in the exchange of electronic health information using the HIE operated by the NM Health Information Collaborative or its successor. The CONTRACTOR’s submission should include: a brief description of the project; a clearly stated goal that can be validated with data; a discussion of the base line from which the plan seeks to make progress and the data used to determine the base line; and a discussion about measuring progress toward the goal and the data used to measure progress. The CONTRACTOR’s plan shall be submitted to HSD by February 1, 2014 and HSD will provide feedback/approval within two (2) weeks of receipt of the CONTRACTOR’s plan. The goal agreed to by the CONTRACTOR and HSD will become the target for release of the withhold associated with this objective.

A minimum of a fifteen percent (15%) increase in telehealth “office” visits with specialists, including Behavioral Health providers, for Members in Rural and Frontier areas. At least five percent (5%) of the increase must be visits with Behavioral Health providers. Telehealth visits conducted at I/T/Us outside of the Albuquerque area are included. Project ECHO is not considered “telehealth” for this delivery system improvement target nor is routine telemedicine such as interpretations of radiologic exams by a radiologist at a remote site. The Member must be present at the originating site to count as a telehealth visit. Each CONTRACTOR must submit its baseline, and an explanation of the data used to arrive at the baseline, to HSD by February 1, 2014.
Patient-Centered Medical Homes
Section 4.13.1 of this Agreement

- A minimum of five percent (5%) of the CONTRACTOR’s Members being served by Patient-Centered Medical Homes (including both PCMHs that have achieved NCQA accreditation and those that have not).

Emergency Room Diversion

- A minimum of a ten percent (10%) reduction in non-emergent use of the emergency room. The baseline to determine the reduction will be provided to the CONTRACTOR by HSD based on historical data.

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

166) **Attachment 4 is amended and restated to read as follows:**

**Attachment 4: List of Reports**

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Frequency of Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Health Education Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Member Enrollment Materials Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Member Satisfaction Survey Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Native American Members Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Cultural Competency/Sensitivity Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Native American Meeting Report</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>Program Integrity Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Payment Reform Pilot Project Updates</td>
<td>Monthly</td>
</tr>
<tr>
<td>Activities of the Member Advisory Committee</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>Call Center Report</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>During the first 30 days of implementation the MCO must submit all call center response statistics daily.</td>
</tr>
<tr>
<td>Hiring Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Privacy/Security Incident Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Report</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Network Adequacy Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Geographic access</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>PCP Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Telehealth Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Provider Network Development and Management Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Network Development and Management Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Suspensions and Terminations Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Provider Training and Outreach Plan</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Training and Outreach Evaluation Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Provider Satisfaction Survey Report</td>
<td>Annually</td>
</tr>
<tr>
<td>Medicaid School-Based Health Centers (SBHC) Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Value Added Services Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Self-Directed Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Developmental Disabilities Specialty Dental Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Jackson Class Members Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Facilities Readmission Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Member Rewards Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Coordination Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Care Transitions Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Level of Care (LOC) Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Agency-Based Community Benefit Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Caseload and Staffing Ratio Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Unreachable Members Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Patient Centered Medical Homes Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Health Homes Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Electronic Visit Verification Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>UM Program Description and an associated work plan</td>
<td>Annually</td>
</tr>
<tr>
<td>UM Program Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>Over/Under Utilization of Services Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Utilization Management Report</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Prior Authorization Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>CMS 416 Reports</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Pharmacy Report</td>
<td>Monthly</td>
</tr>
<tr>
<td>Institutional Utilization Report</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Grievances and Appeals</td>
<td>Monthly</td>
</tr>
<tr>
<td>Disease Management Description</td>
<td>Annually</td>
</tr>
<tr>
<td>Disease Management Annual Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>QM/QI Program Description and associated work plan</td>
<td>Annually</td>
</tr>
<tr>
<td>QM/QI Program Annual Evaluation</td>
<td>Annually</td>
</tr>
<tr>
<td>Report on Performance Improvement Projects</td>
<td>Annually</td>
</tr>
<tr>
<td>NCQA Accreditation Report</td>
<td>Immediately upon receipt</td>
</tr>
<tr>
<td>Reevaluation of Accreditation Status based on HEDIS</td>
<td>Immediately upon receipt</td>
</tr>
<tr>
<td>Report of Audited CAHPS Results and Audited HEDIS</td>
<td>Annually</td>
</tr>
<tr>
<td>Critical Incidents Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Report Type</td>
<td>Frequency/Period</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Business Continuity and Disaster Recovery (BC-DR) Plan</td>
<td>At least fifteen (15) Calendar Days prior to their proposed incorporation</td>
</tr>
<tr>
<td>Systems Availability and Performance Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Encounter Data Files</td>
<td>Weekly</td>
</tr>
<tr>
<td>Encounter Data</td>
<td>As specified by HSD</td>
</tr>
<tr>
<td>Claims Payment Accuracy Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Claims Activity Report</td>
<td>Monthly</td>
</tr>
<tr>
<td></td>
<td>For at least the first one-hundred eighty (180) days, a claims activity report shall be submitted weekly</td>
</tr>
<tr>
<td>Encounter Processing and Submission Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Member Care Coordination Activities Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Audited Financial Statements</td>
<td>Annually by June 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Medicaid Specific Audited Schedule of Revenue and Expenses</td>
<td>Annually by June 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Recovery and Cost Avoidance Report</td>
<td>Monthly, Quarterly, and Annually</td>
</tr>
<tr>
<td>Medicaid Specific Unaudited Schedule of Revenue and Expenses</td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) day of the second month following the end of the quarter</td>
</tr>
<tr>
<td>Office of the Superintendent of Insurance Reports</td>
<td>Quarterly and Annually</td>
</tr>
<tr>
<td></td>
<td>Report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month of the quarter and March 1 for the annual statement</td>
</tr>
<tr>
<td>Quarterly and Annual Medicaid Financial Reporting Package</td>
<td>Quarterly report is due forty-five (45) Calendar Days from the end of the quarter or the fifteenth (15th) Calendar Day of the second month of the quarter.</td>
</tr>
<tr>
<td></td>
<td>Annual supplement is due May 15&lt;sup&gt;th&lt;/sup&gt; or alternative date determined by HSD</td>
</tr>
<tr>
<td>Report Description</td>
<td>Frequency</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Payments to IHS and Tribal 638 Providers Reports</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Report is due forty-five (45) Calendar Days from the end of the quarter or the</td>
<td></td>
</tr>
<tr>
<td>fifteenth (15th) day of the second month following the end of the quarter</td>
<td></td>
</tr>
<tr>
<td>Withholding Bank Statement for Performance Measures</td>
<td>Monthly</td>
</tr>
<tr>
<td>Report is due forty-five (45) Calendar Days after month end</td>
<td></td>
</tr>
<tr>
<td>Fidelity Bond or Insurance Protection</td>
<td>Annually</td>
</tr>
<tr>
<td>Initial within sixty (60) Calendar Days or date designated by HSD.</td>
<td></td>
</tr>
<tr>
<td>Reinsurance Policy Report</td>
<td>Annually or at renewal</td>
</tr>
<tr>
<td>Cash Reserve Statement Reports</td>
<td>Annually or at renewal</td>
</tr>
<tr>
<td>Fifteen (15) Calendar Days after the most recent quarter end or within thirty</td>
<td></td>
</tr>
<tr>
<td>(30) Calendar Days after increase to the balance of the fund as directed by HSD.</td>
<td></td>
</tr>
<tr>
<td>Performance Bond</td>
<td>Initial: Within forty-five (45) calendar days of the first month of capitation.</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td>Business Restructuring</td>
<td>No later than sixty (60) Calendar Days following the change of ownership</td>
</tr>
<tr>
<td>Risk Withholding Report</td>
<td>Annually by April 1st</td>
</tr>
<tr>
<td>Activities of the Native American Advisory Board</td>
<td>(10) Calendar Days following each meeting</td>
</tr>
<tr>
<td>CSA Report</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Comprehensive Care Plan Report</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
### Overpayment Report

<table>
<thead>
<tr>
<th>HOSPITAL NAME</th>
<th>COUNTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alta Vista Regional Medical Center</td>
<td>San Miguel</td>
</tr>
<tr>
<td>Artesia General Hospital</td>
<td>Eddy</td>
</tr>
<tr>
<td>Carlsbad Medical Center</td>
<td>Eddy</td>
</tr>
<tr>
<td>Cibola General Hospital</td>
<td>Cibola</td>
</tr>
<tr>
<td>Dan C. Trigg</td>
<td>Quay</td>
</tr>
<tr>
<td>Eastern New Mexico Medical Center</td>
<td>Chaves</td>
</tr>
<tr>
<td>Espanola Hospital</td>
<td>Rio Arriba</td>
</tr>
<tr>
<td>Gerald Champion Medical Center</td>
<td>Otero</td>
</tr>
<tr>
<td>Gila Regional Medical Center</td>
<td>Grant</td>
</tr>
<tr>
<td>Guadalupe Hospital</td>
<td>Guadalupe</td>
</tr>
<tr>
<td>Holy Cross Hospital</td>
<td>Taos</td>
</tr>
<tr>
<td>Lea Regional Hospital</td>
<td>Lea</td>
</tr>
<tr>
<td>Lincoln County Medical Center</td>
<td>Lincoln</td>
</tr>
<tr>
<td>Los Alamos Medical Center</td>
<td>Los Alamos</td>
</tr>
<tr>
<td>Memorial Medical Center</td>
<td>Dona Ana</td>
</tr>
<tr>
<td>Mimbres Memorial Hospital</td>
<td>Luna</td>
</tr>
<tr>
<td>Miners Colfax Medical Center</td>
<td>Colfax</td>
</tr>
<tr>
<td>Mountain View Regional Medical Center</td>
<td>Dona Ana</td>
</tr>
<tr>
<td>Nor-Lea General Hospital</td>
<td>Lea</td>
</tr>
<tr>
<td>Plains Regional Medical Center</td>
<td>Curry</td>
</tr>
<tr>
<td>Rehoboth McKinley Christian Hospital</td>
<td>McKinley</td>
</tr>
<tr>
<td>Roosevelt General Hospital</td>
<td>Roosevelt</td>
</tr>
<tr>
<td>Roswell Regional Hospital</td>
<td>Chaves</td>
</tr>
<tr>
<td>San Juan Regional Medical Center</td>
<td>San Juan</td>
</tr>
<tr>
<td>Sierra Vista Hospital</td>
<td>Sierra</td>
</tr>
<tr>
<td>Socorro General Hospital</td>
<td>Socorro</td>
</tr>
<tr>
<td>CHRISTUS – St. Vincent Regional Medical Ctr</td>
<td>Santa Fe</td>
</tr>
<tr>
<td>Union County General Hospital</td>
<td>Union</td>
</tr>
<tr>
<td>The University of New Mexico Hospital</td>
<td>Bernalillo</td>
</tr>
</tbody>
</table>

167) The Attachments to the Contract are amended to add Attachment 5 which reads as follows:

168) All brackets in the Contract not otherwise removed by this Amendment are deleted.
All other sections of PSC [xx-xxx-xxxx-xxxx], as amended, remain the same.

The remainder of this page is intentionally left blank.
IN WITNESS WHEREOF, the parties have executed this first amendment to the PSC as of the date of signature by DFA’s Contracts Review Bureau.

CONTRACTOR

By: ________________________________ Date: ________________
Title: ______________________________

STATE OF NEW MEXICO

By: ________________________________ Date: ________________
   Sidonie Squier, Cabinet Secretary
   Human Services Department
   Co-Chair, The New Mexico Behavioral Health Purchasing Collaborative

By: ________________________________ Date: ________________
   Danny Sandoval, CFO
   Human Services Department

Approved as to Form and Legal Sufficiency:

By: ________________________________ Date: ________________
   Raymond W. Mensack, Chief Legal Counsel
   Human Services Department

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

TAXATION AND REVENUE DEPARTMENT

ID Number: ______________________________

By: ________________________________ Date: ________________