STATE OF NEW MEXICO
INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
STATEWIDE BEHAVIORAL HEALTH SERVICES CONTRACT

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CONTRACT TERMS AND CONDITIONS
STATE OF NEW MEXICO
INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE
STATEWIDE BEHAVIORAL HEALTH SERVICES CONTRACT

THIS AGREEMENT (Contract) between the State of New Mexico (State) Interagency Behavioral Health Purchasing Collaborative (Collaborative) and ValueOptions of New Mexico, Inc., the Statewide Entity (SE), as Contractor, specifies the terms and conditions under which the SE shall provide statewide behavioral health services for the Collaborative.

The Collaborative is a legal entity with the authority to contract for the services as set forth in this Contract and to make decisions regarding the administration, direction and management of state-funded behavioral health services and care. It is comprised of the following New Mexico State Agencies: the Department of Health (DOH); the Human Services Department (HSD); the Children, Youth and Families Department (CYFD); the Aging and Long Term Services Department (ALTSD); the Department of Finance and Administration (DFA); the Mortgage Finance Authority (MFA); the Public Education Department (PED); the Department of Transportation (DOT); the New Mexico Corrections Department (NMCD); the Division of Vocational Rehabilitation (DVR) of PED; the Department of Labor (DOL); the Health Policy Commission (HPC), the Developmental Disabilities Planning Council (DDPC); the Governor’s Commission on Disabilities (GCC); the Indian Affairs Department (IAD); the Governor’s Senior Health Policy Advisor; and the Administrative Office of the Courts (AOC). Each of these agencies fund or provide behavioral health treatment or prevention services. Many provide critical support services in addition for persons covered by this Contract. In addition, valuable input is provided by ex officio representatives of the NM Public Defender; the Children’s Cabinet Coordinator in the Office of the Lieutenant Governor; and the Office of Workforce Training and Development and the new Higher Education Department, all of whom participate on the Collaborative as non-voting members. All together, 21 statutory and ex-officio members of the Collaborative represent these governmental entities and agencies.

ARTICLE 1 – RECITALS AND TERMS

1.1 The SE possesses the required delegated authority and expertise to meet the terms of this Contract.

1.2 All services provided pursuant to this Contract are subject to the State’s Procurement Code and all other related regulations, unless specifically provided otherwise herein.

1.3 The Collaborative’s values and principles, described below and as set forth in the original Request for Proposals (RFP)*, shall be incorporated into the SE’s administration, direction, and management of the services provided under this Contract. Services shall be delivered in a manner that is individually (consumer) centered and family-focused, based on principles of an individual’s capacity for recovery and resiliency, i.e. they shall

A. Increase consumer and family abilities to successfully manage life challenges, including, but not limited to, housing, employment, and school success;

B. Utilize consumer and family/caregiver abilities and strengths;

* NM General Services Department RFP #50-630-10-00183, Statewide Behavioral Health System of Care, 2004
C. Ensure consultation with the consumer, his or her family or legal guardian, caregivers, and other persons critical to the consumer’s life and well-being, where appropriate;

D. Be based on evidence of effectiveness and the individual consumer’s and family’s preferences;

E. Be consumer and family/caregiver-driven or –operated, as appropriate;

F. Be delivered in a culturally competent, responsive and respectful manner via the most appropriate, least restrictive means, including utilization of home- and community-based services and settings wherever and whenever possible;

G. Be coordinated, accessible (in accordance with the Americans with Disabilities Act [ADA]), accountable, and of high quality;

H. Be evaluated with system performance and consumer- and family-friendly outcomes;

I. Ensure that behavioral health wellness promotion, prevention, early intervention, treatment, community support, supported housing, supported employment, supports for families and children, and other activities further recovery and resiliency;

J. Demonstrate sensitivity to, and respect for, diversity, including race, age, gender, disability, culture, ethnicity, spirituality, sexual identity, literacy level, criminal history, place of residence and primary language;

K. Utilize “person first” and “people who” language;

L. Provide the highest quality of care in a timely manner;

M. Ensure mechanisms for continuous quality improvement;

N. Maintain standards for accessibility;

O. Make available the services of peer specialists, consumers, family members or staff to provide individual assistance for consumers with needs for special assistance related to written or verbal communications; and

P. Ensure meaningful involvement of consumers, family members and peer-run organizations at all levels of the decision-making processes concerning operations and oversight of the behavioral health service system.

1.4 The parties to this Contract acknowledge the need to work cooperatively and in an expeditious and responsive manner to address and resolve problems that may arise in the administration and performance of this Contract. The parties agree to document all agreements in writing prior to implementation for any new contract requirements in accordance with the provisions of Article 39 and Article 40 of this Contract.

1.5 The following terms, as used in this Contract, are defined as follows:

A. ASAM – the American Society of Addiction Medicine.

B. Behavioral Health – mental health and substance abuse.

C. Behavioral Health Planning Council (BHPC) – A body created to meet federal and state advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico.

D. Bobby-approved: Standards for website accessibility in keeping with ADA and other national standardization criteria.

E. Clinical Necessity – A behavioral health care service that a behavioral health professional, exercising prudent clinical judgment, would provide to a consumer intended to promote normal growth and development and prevent, diagnose,
detect, treat, ameliorate, or palliate the effects of a mental or behavioral condition, injury, or disability.

F. Collaborative Cross-Agency Team (CAT): A workgroup consisting of staff from various Collaborative member agencies.

G. Collaborative – The Behavioral Health Purchasing Collaborative, created by NMSA Section 9-7-6.4, and its statutory member agencies collectively, operating under a Memorandum of Understanding dated June 25, 2004. Wherever the term “Collaborative” is used within this Contract, the Collaborative may delegate that role to a subcommittee of the Collaborative, to the Contract Manager, to a Cross Agency Team, or to a designated staff or group of staff from member agencies, except for those matters specifically required to be a decision of the Collaborative itself (e.g., approving and signing this Contract and any amendments thereto).

H. Collaborative members or member agencies – the 17 statutory representatives on the NM Interagency Behavioral Health Purchasing Collaborative.

I. Competence (as it pertains to Cultural Competence) – having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

J. Consumer – a person receiving or eligible to receive behavioral health services through the Collaborative through this Contract.

K. Contract Manager – the individual in charge of overseeing all Contract activities as the agent of the Collaborative.

L. Culture – integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

M. Cultural Competence – a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

N. Enrollee, Enrolled individual – an individual who is enrolled as an active client with the SE through an SE-contracted provider.

O. Individual with Special Health Care Needs (ISHCN) – an individual who has or is at an increased risk for evidencing a chronic mental, developmental, behavioral, neurobiological and/or emotional condition and who also requires behavioral health and related services of a type or amount beyond that required by persons generally. Individuals identified with special health care needs have ongoing health conditions, high or complex service utilization, and low to severe functional limitations.

P. Letter of Direction (LOD) – written instructions, detailed action steps and guidelines to clarify the implementation and interpretation of service and deliverables in the Contract or applicable statutes or regulations.

Q. Local Collaborative (LC) – an advisory body, delineated by either judicial district or tribal grouping and recognized by the Collaborative, that provides input on local and regional behavioral health issues to the Collaborative, to the Statewide Entity, and to the BHPC.

R. Managed Care Organization (MCO) – an organization that contracts to provide a variety of healthcare services to enrolled consumers, usually through a capitation system of payment. In the case of New Mexico, three MCOs provide physical

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health and ancillary services to individuals who are receiving Medicaid through the Salud! program.

S. Management Letter – a document signed by the Co-Chairs of the Collaborative and a representative of the SE authorized to bind the SE, that describes a certain task or activity to be pursued or conducted by the SE, the specific approach, the expected result and the schedule to be followed to implement the task or activity. Such letters are not intended to be amendments to this Agreement, but more specific directions for completing generalized tasks within the scope of work.

T. Native American Program – a program of behavioral health care developed, administered or implemented by a federally recognized Indian Nation, Tribe or Pueblo located wholly or partially in New Mexico and/or any behavioral health program administered by the federal government and/or an Indian entity organized for the benefit of Native Americans in the area of behavioral health that may include, but not limited to, prevention, intervention, mental health, substance abuse, traditional healing, telehealth, education, training and the delivery of other behavioral health services.

U. Performance measures – a system of operational and tracking indicators, including but not limited to, the Governor’s Performance & Accountability Measures and other objectives necessary to quantify the SE’s performance on this Contract.

V. Plan of Care (Care Coordination Plan) – A comprehensive plan that addresses a consumer’s need for coordination of treatment and access to services. Components of the plan include an assessment of the goals, needs, capacities and medical condition of the consumer, addresses the needs and goals of the family (as applicable to the consumer’s care), identifies clear goals that can be regularly evaluated along with the intensity of care coordination to ensure that progress is being made, and identifies linkages with multiple agencies and practitioners as needed.

W. Priority Workplan – A plan that delineates the tasks, timeframes, accountabilities, and resources necessary for the successful implementation of one or more programs or processes.

X. Provider – an agency or individual practitioner under subcontract with the SE or paid by the SE to deliver services for consumers.

Y. Practitioner – an individual licensed NM behavioral health professional who has been credentialed and contracted by the SE to provide behavioral health services funded through the Collaborative.

Z. Psychosocial Necessity – Services or products provided to a consumer with the goal or helping the consumer develop his or her fullest capacities through learning and environmental supports and/or the reduce the risk of the consumer developing a behavioral health disorder or an increase in the severity of behavioral health symptoms. The consumer need not have a behavioral health diagnosis but rather have a need to improve psychosocial functioning.

AA. Region – The Collaborative-designated area of the State for purposes of SE service provision and Local Collaborative organization. The State is made up of six regions: five geographically delineated regions (see Attachment A – Map) and one all-State Native American region.
Steering Group – the working group of the Collaborative, made up of senior management, the chairs of the CATs, and other related workgroups.

Statewide Entity (SE) – the organization designated to execute the requirements of this Contract.

NOW, THEREFORE, in consideration of the mutual promises contained herein, the Collaborative and the SE agree as follows:

**ARTICLE 2 – TERM OF CONTRACT AND SCOPE OF WORK**

2.1 Term of Contract – Phase Two

A. The term of this Contract shall be from July 1, 2006 through June 30, 2008, (Phase Two) and the SE shall perform the work as specified in this Article.

B. During the term of this Contract, the Collaborative and SE may renegotiate contract requirements and reimbursement rates consistent with Articles 39 and 40.

C. The Collaborative and the SE shall, prior to the expiration of this contract, enter into contract negotiations for the performance of Phase Three work. (July 1, 2008 through June 30, 2009)

D. The SE shall perform the work set forth below. Additional Scope of Work requirements shall be incorporated into this Contract by management letter, attached addendum, or by reference.

E. In the event of a dispute in the Scope of Work requirements in this Contract or any previous versions of this Contract, the default shall always be to the Scope of Work as defined in the RFP, then to the specific Scope of Work requirements in this Contract, then to any attached or referenced Scope of Work or the Offeror’s proposal, whichever is more specific, then to the Scope of Work for the existing behavioral health programs.

F. To the extent necessary, any outstanding Phase One activities that were either not completed or have been identified as requiring additional work shall be set forth in an Attachment to this Contract.

G. The SE shall make any necessary revisions to the Phase Two work plan no later than August 1, 2006.

H. The SE shall work with the Collaborative to design a plan for work required under Phase Three and shall provide the Phase Three plan to the Collaborative no later than January 1, 2008.

2.2 Management Letters

A. The parties acknowledge and agree that the precise details of certain implementation and operational activities cannot be determined at this time and further agree that a limited number of Management Letters, as defined in Section 1.5, will serve as the method for defining and approving future implementation and operational activities.
B. Management Letters shall be signed by the Co-Chairs of the Collaborative and by any Collaborative member whose funds or authority are affected by such Management Letter, as determined by the Co-Chairs; and signed by a representative of the SE authorized to bind the SE.

C. Management Letters may not take the place of or replace existing administrative rules or agency policy manuals.

D. The SE may submit a management letter for approval by the Collaborative for those implementation and operational task or activities that the SE believes are necessary to fulfill the obligations of this agreement. The Collaborative Co-Chairs may cause to be prepared or request that the SE prepare a management letter for implementation and operational tasks or activities it believes are necessary to fulfill the obligations of this agreement.

E. The SE’s preparation of a Management Letter at the request of the Collaborative does not constitute the SE’s agreement to such Management Letter unless it is signed by the SE pursuant to Section 2.2 B above.

F. Management Letters employed in prior Contract years are understood as having the scope and impact as contemplated under the prior Contract form governing those Contract years only.

G. Approval of Management Letters shall be conducted as follows:
   1. In the event that the SE, on its own initiative, submits to the Collaborative a Management Letter for approval, the Contract Manager shall review and recommend the Management Letter for approval as outlined in Section 2.2 B above.
   2. In the event that the Collaborative prepares or requests the SE to prepare a Management Letter for approval, the Contract Manager shall revise or recommend that Management Letter for approval as outlined in Section 2.2 B above. If the Contract Manager modifies the Management Letter prior to approval, then the modified Management Letter shall be submitted to the SE for approval or further modification as outlined in Section 2.2 B above.

2.3 General Scope of Work Requirements: Phase Two

A. The SE shall perform the following general work requirements:
   1. It shall work closely with the Collaborative to ensure that quality behavioral health services are provided; contracted and subcontracted providers are compensated for the services they deliver; data are reported and all performance standards met; and service system changes are implemented to promote prevention, recovery, resilience, and efficient use of available resources.
   2. It shall manage all covered behavioral health services statewide for both Medicaid and non-Medicaid individuals.
   3. It shall manage and account for all related funding and other requirements of the agencies and departments that form the Collaborative and are part of this agreement.
4. It shall identify, track and report all allowable and non-allowable expenses and utilization for required state and federal reporting by fund source.

5. It shall implement quality improvement and quality management mechanisms that ensure the delivery of quality services for consumers.

6. It shall implement care coordination mechanisms that ensure the delivery of appropriate, efficient and cost-effective services for consumers, including mechanisms to ensure appropriate eligibility referral processes for non-Medicaid determined consumers.

7. It shall comply with any State or federal regulations or statutes, including but not limited to those pertaining to the 1997 Balanced Budget Act (BBA) affecting Medicaid or Medicaid managed care on the regulations’ or statutes’ effective dates and those required under provisions for the receipt of federal block grant or other federal funding.

8. To the extent that the SE has access to, or can reasonably create or get access to, such data, it shall support the ability of the State to demonstrate fulfillment of all relevant state, federal, foundation and other fund source requirements (including but not limited to the Governor’s Performance & Accountability Measures (related to behavioral health), maintenance of effort; set-asides; Treatment Episode Data Set (TEDS) reporting; performance measurement; National Outcome Measures (NOMS), Uniform Reporting System (URS) Basic and Developmental Tables, required Block Grant applications report information; and U.S. Department of Housing and Urban Development (HUD) requirements under 24 CFR Part 576 related to reporting, funding and monitoring of providers) in the following manner:
   a. Submit reports throughout the year related to financial and payment issues; data elements, service utilization and encounter data; state and federal requirements; quality management; performance measures; incidents of abuse or neglect; complaints and grievances; consumer satisfaction; and, progress in development of the Collaborative service delivery system;
   b. Work with the Collaborative to develop the reports for the previously mentioned purposes, specifically reports necessary to meet the State and federal reporting requirements. Reports shall be developed in order of priority and by the dates as determined by the Collaborative;
   c. Work, in conjunction with the Collaborative, throughout the Contract period in the design of additional/new reports and queries and modification of existing reports and queries necessary to streamline reporting and meet the state and federal reporting requirements.

9. It shall generate reports and track provider performance in terms of report completion/submission, create profiles illustrating each provider’s compliance, and implement corrective action plans with providers to improve accuracy and timeliness and to monitor the impact of the action.

10. It shall provide the State, upon request, with an updated continuity of care and care coordination plan for consumers/families who receive services from multiple agencies or systems.

11. It shall provide the Collaborative with copies of provider or practitioner reviews and/or audit schedules, upon request, so that the Collaborative may participate if it so desires.

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12. It shall improve provider capacity and expertise by working with consumers, families, providers or provider groups, disability organizations, and academic institutions.

13. It shall utilize best practices planning to incorporate the funding and services in Phase Two of the new Behavioral Health System, consulting with Collaborative staff throughout the planning process.

14. It shall operate a comprehensive Service Center and six (6) Regional Offices (five regional and one Native American) in New Mexico, including a clinical call center. The clinical call center shall be staffed twenty-four (24) hours a day, three-hundred sixty-five (365) days a year within or without New Mexico. All utilization review decisions will be decided by a licensed clinician. Approval decisions, after hours, can be authorized by a licensed clinician outside of New Mexico and will be reviewed by a New Mexico licensed clinician on the next business day. All denials will be decided by a New Mexico licensed physician. All denials for consumers age 18 or under will be, to the extent possible, decided by a New Mexico board-certified child and adolescent psychiatrist. All required administrative functions, including claims adjudication, provider contracting and credentialing, shall be done with decision-making authority in New Mexico.

15. It shall employ a Chief Executive Officer (CEO) who will be responsible for all New Mexico-based operations, with authority to reallocate staff and resources to ensure Contract compliance. The CEO of ValueOptions New Mexico will be accountable to the CEO of ValueOptions and will receive support from the administrative staff of the regional and national offices. The corporate resources of ValueOptions, Inc. also will be provided to assist ValueOptions of New Mexico in complying with contractual requirements.

16. It shall employ as Medical Director a single individual who is licensed to practice medicine in New Mexico, with preference given to individuals who are Board Certified in Psychiatry. This individual shall perform integral functions in the development and maintenance of the behavioral health service system. The Medical Director shall have the authority to delegate activities to other psychiatrists, physicians or other appropriate licensed providers, but the Medical Director shall remain responsible for coordination, management, oversight, and reporting of these activities. The Medical Director may provide both indirect and direct services.

17. The SE shall hire a CEO and Medical Director with the approval of the Collaborative CEO and Co-Chairs and seek the approval of the Collaborative CEO and Co-Chairs before any change in these positions.

18. The SE shall notify the Contract Manager and Collaborative Co-chairs within thirty (30) days when changes in key personnel occur or there are significant changes in staffing. Key personnel positions shall be determined between the SE and the Collaborative, however at a minimum shall include all heads of Departments within the organization and critical supervisors within departments such as finance, Information Technology, Quality, Provider Relations, Service Systems, Recovery and Resiliency and Clinical.

19. The SE shall maintain adequate staffing levels in all of its departments and regional offices necessary to fulfill the requirements under this Agreement.
20. It shall coordinate those efforts of the SE on behalf of the Collaborative with other public or private behavioral health initiatives also under way throughout the state.

21. It shall maintain the following standards for accessibility:
   a. All facilities are to be ADA-compliant, including entrances, restrooms, business offices, therapy locations and all service delivery sites.
   b. The long-range planning for housing in NM must include, but not be limited to, universal design that accommodates individuals with disabilities who have mental health and/or substance abuse disorders. Admission to a publicly funded housing facility may not be denied based on criminal history, unless required by law.
   c. All web-based applications and computer interfaces with individuals receiving services must be fully accessible according to national disability guidelines (e.g., Bobby-approved).
   d. All telecommunications systems for intake and throughout the service delivery systems shall have TTY services and/or be accessible through the 711 telecommunication system.
   e. Information that is verbally presented or in written form must be linguistically appropriate and culturally sensitive. This includes, but not limited to:
      i. commonly understood language and avoidance of professional jargon;
      ii. availability of interpreters (both for sign language and when the primary home language is other than English);
      iii. written materials provided in a variety of formats for consumers and families to ensure access to information, and may include reduced reading level, large print, and/or translation into languages other than English; and
      iv. electronic format, including audiotapes and computer disks.

B. The SE shall comply with the following provisions, which are incorporated herein by reference:

1. Title XIX and Title XXI of the Social Security Act and Code of Federal Regulations (CFR) Title 42 Parts 430 to end, as revised from time to time;

2. All applicable statutes, regulations and rules implemented by the Federal Government, the State, and HSD concerning Medicaid services, managed care organizations, health maintenance organizations, fiscal and fiduciary responsibilities applicable under the Insurance Code of New Mexico, NMSA 1978 §§ 59A-1-1 et. seq., and any other applicable laws;

3. All applicable statutes, regulations and rules implemented by the Federal Government, the State, and the Collaborative, including but not limited to the Child and Family Services Review (CFSR), 45 CFR 1355 Federal Regulations, Title IV B and Title IV E of the Social Security Act, and the current New Mexico Children’s Code;

4. The Indian Child Welfare Act, 25 USC § 1901, et seq (ICWA);

5. The Adult Protective Services Act, Chapter 27, Section 7 (27-7-14 through 27-7-31);
6. The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA);

7. For Substance Abuse Services funded by the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the comprehensive Alcohol and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, as amended (42 USC Section 290 dd-1, et seq. and the Public Health Service Act 42 USC Sections 300x, et seq.);

8. For Mental Health Services funded by the Community Mental Health Services Block Grant, the Community Mental Health Centers Act (42 USC Section 2681, et seq., as amended), the Act (42 USC Section 300x, et seq.), and applicable Federal regulations;

9. The applicable provisions of Titles II and III of the Americans with Disabilities Act of 1990, P.L. 101-336 (42 USC Section 12101, et seq.) and Section 504 of the Rehabilitation Act (29 USC Section 794);

10. The requirements of the Pro-Children Act of 1994 (20 USC Sections 6083, et seq.) that prohibits smoking in any portion of any indoor facility used routinely or regularly for the provision of health services to children under the age of 18 funded by federal grants;

11. All applicable statutes, regulations and rules related to any federal grant specified in this contract and any management letters, protocols or procedures relevant to implementation of such grant awards;

12. All procedures related to the exchange of data related to consumers, providers, and encounter information between the SE and the Collaborative members as specified within department-specific regulations, manuals, policies and memoranda;

13. Any and all provider or eligibility manuals or policy statements, including all updates and revisions therefor, or substitutions and replacements thereof, duly adopted in accordance with applicable law for all Agencies included within the Collaborative:
   a. To the extent these manuals are unclear or inconsistent, the SE shall identify those areas in writing, and the Collaborative staff will clarify intent, change the content, or otherwise instruct the SE.
   b. All defined terms used within this Contract shall have the meanings given them in any manual or policy statement;

14. Any and all consent decrees, legally-binding agreements, and contracts related to behavioral health services entered into by the Collaborative, or by any Collaborative Agency.

15. The RFP, all RFP amendments, Bidders’ questions and the Collaborative’s answers, and the Collaborative’s written clarifications;

16. The SE’s Best and Final Offers; and

17. The SE’s Proposal (including any and all written materials presented in the orals portion of the procurement) where not inconsistent with this Contract and subsequent amendments to this Contract

C. The SE shall evaluate administrative costs at the provider level and develop a plan and recommendations for Phase Three to reduce these costs in consultation with the Collaborative, said plan and recommendations to be developed and submitted to the Collaborative no later than February 1, 2008.
2.4 Priority Workplans

For those issues in the contract designated as needing a priority workplan, the Collaborative will convene and facilitate a work group on that issue. The SE shall participate in this work group. The product of the work group will be a workplan for development, funding, and implementation, which delineates tasks, timeframes, accountabilities, and resources. The workplan must be developed and presented to the Collaborative Co-Chairs to comply with the specified provisions of the contract.

ARTICLE 3 –GENERAL PROGRAM REQUIREMENTS: PHASE TWO

3.1 Access Requirements

A. Ensuring Access

1. The SE shall provide access to services for eligible individuals and shall use diagnostic criteria and risk factors to prioritize such access.

2. The SE shall maintain protocols to ensure the accessibility and availability of behavioral health care providers for each medically, clinically, or psychosocially necessary service.

3. The SE shall submit documentation to the Collaborative, as requested, giving assurances that it has the capacity to serve the expected enrollment in its service areas.

4. The SE shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

5. The SE shall maintain and update, as necessary, its Service Access Plan for managing a system of consumer access to services from various points of entry. The plan will be reviewed during regular quarterly meetings between the SE, the Collaborative and the Oversight CAT. Consumers shall be allowed to self-refer to these entry points, where an evaluation of their need for treatment and/or supports can be conducted.

6. The SE shall ensure in each region of the State an array of behavioral health services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.
   a. This array can include providers that may be out-of-state for those consumers who require services not available from in-state providers.
   b. Preference shall be given to existing in-state residential providers; an in-state residential service shall be developed by the SE where incidence of out-of-state placement warrants.

7. The SE shall report to the Collaborative any high-volume providers (as defined by the SE) in the network that are not accepting new consumers.
3.2 Children in Custody or Under State Supervision

A. The SE shall work with the Collaborative to ensure that children in State or Tribal custody receive a behavioral health assessment within twenty-four (24) hours of a referral.

B. The SE shall work with the Collaborative to ensure that behavioral health assessments for every child or adolescent be conducted within twenty-four (24) hours of the individual’s entering the juvenile justice system and housed in a juvenile detention center including, those referred to Juvenile Justice Service for the acts of alleged delinquent and status offenses.

C. The SE shall ensure availability 24 hours a day, 365 days a year, clinical consultation to answer State staff questions and concerns regarding treatment, assessment, and medications for children involved with CYFD.

D. The SE shall, if requested by Indian Tribes, Nations, and Pueblos located partially or wholly in New Mexico, negotiate in good faith to enter into agreements to develop assessment and treatment protocols and procedures to ensure that services are provided to all Native American children who are in need of such services. Should such Tribes, Nations and Pueblos choose not to enter into such agreements, the SE shall not be liable for providing such services.

3.3 Access to Emergency Services

A. The SE shall cover services for behavioral health emergency conditions provided by behavioral health providers, including urgent conditions and post-stabilization care only within the US for individuals eligible for such care.

1. An urgent condition exists when a consumer manifests acute symptoms and signs that, by reasonable judgment, represent a condition of sufficient severity that the absence of treatment within twenty-four (24) hours could reasonably result in a worsening of the consumer’s condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for an individual or serious jeopardy to the behavioral health of the individual are considered urgent conditions.

2. An emergency condition exists when a consumer manifests acute symptoms and signs that, by reasonable judgment of a lay person, represent a condition of sufficient severity that the absence of immediate medical and/or behavioral health attention, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the consumer or others.

3. Post-stabilization care means covered services related to an emergency behavioral health condition that are provided after the consumer is stabilized in order to maintain the stabilized condition and may include improving or resolving the consumer’s condition or circumstances.

   a. Urgent and emergency conditions shall be addressed as soon as possible for the children and adolescents in the custody of the State who are traveling outside the United States with written permission from the legal guardian designee and from the State (CYFD).

B. The SE shall ensure that there is no clinically significant delay for urgent or emergent behavioral health care. Prior authorization shall not be required for emergency behavioral health services in or out of the network and all emergency

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behavioral health services shall be reimbursed at the Medicaid fee-for-service rate.

C. The SE shall not retroactively deny a claim for an emergency behavioral health screening examination because the condition, which appeared to be an emergency behavioral health condition under the prudent layperson standard, turned out to be non-emergency in nature.

D. The SE shall ensure that a consumer eligible for out-of-state emergency behavioral health care has the right to use any hospital or other appropriate licensed emergency setting for emergency behavioral health care, regardless of whether the provider is contracted with the SE.

E. The SE shall complete these obligations in a manner that meets related federal funding requirements from block grants or other sources. The SE and the State shall share all contracts as requested.

3.4 Face-to-Face Appointment Times

A. For non-urgent, non-emergent behavioral health care, the request-to-appointment time shall be no more than fourteen (14) days, unless the consumer requests a later time.

B. For urgent behavioral health care, appointments shall be available within twenty-four (24) hours.

C. For emergency care, face-to-face appointments shall be available within four (4) hours.

3.5 SE Telephone Access

A. The SE shall ensure availability of a twenty-four (24)-hour, three-hundred-sixty-five (365)-days-a-year toll-free communication system for providers, consumers, and other interested parties.

1. This system shall not require a “touch-tone” phone and shall allow for communication with callers whose primary language is not English or who are hearing impaired.

2. This system shall be staffed by behavioral health professionals who are culturally competent, are trained to screen crisis or emergency calls, and are able to assess the consumer’s degree of acuity and need for treatment.

3. This system shall answer ninety (90) percent of calls within thirty (30) seconds with no more than ten (10) percent of abandoned calls.

3.6 Access to Pharmacy Services

A. The SE shall work with the Collaborative to develop strategies for meeting the medication needs of non-Medicaid-eligible enrollees.

B. For Medicaid-eligible individuals, the SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner. The in-person prescription fill time (ready for pickup) shall be no longer than forty (40) minutes. A prescription telephoned in by a practitioner shall be filled within ninety (90) minutes.

C. The SE shall ensure that a sufficient number of pharmacy providers are available for eligible persons. The SE shall ensure that pharmacy services meet geographic access standards based on the consumer’s county of residence. The access standards are as follows:

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1. Ninety (90) percent of urban consumers shall travel no farther than thirty (30) miles;
2. Ninety (90) percent of rural consumers shall travel no farther than forty-five (45) miles; and
3. Ninety (90) percent of frontier consumers shall travel no farther than sixty (60) miles.

D. The SE shall provide all covered pharmacy services and maintain a network of prescriber providers that are appropriately licensed and operating within their scope of practice.

E. For the Medicaid Coordinated (FFS) program, the SE shall pursue allowed drug rebates, perform dispute resolution on drug rebates, refund rebate amounts to HSD, and cooperate with HSD in negotiating supplemental drug rebates with manufacturers.
   1. Upon request, the SE shall disclose all rebate amounts to HSD. The SE shall pursue rebates with similar aggressiveness and thoroughness as rebates are pursued in comparable national SE commercial lines of business.
   2. HSD shall provide the SE with complete, timely and accurate information about Medicaid enrollees’ eligibility for Part D Medicare.
   3. Within thirty (30) days of issuing rebate invoices to the manufacturers, the SE shall remit to HSD the amount equal to the rebate invoices unless the manufacturer is disputing the invoiced amount.
   4. The SE shall require the manufacturer to pay interest that shall begin to accrue thirty-eight (38) days after the date of the invoice if unpaid by the manufacturer. The interest amount will be determined by the SE and reimbursed to HSD. Calculation of the rate of interest shall be based on the average Treasury bill rate as provided by the Centers for Medicare and Medicaid Services (CMS).
   5. At any time, HSD shall have the option of conducting the rebate process and collecting the rebate amounts directly according to CMS drug rebate requirements and principles.

F. HSD and the SE agree that they shall continue to negotiate pharmaceutical rates as necessary to take into account any changes resulting from the effect of Medicare Part D.
   1. The SE shall continue to use information provided by HSD indicating enrollees who are eligible for Medicare Part D. When a consumer is eligible for Medicare Part D, the SE shall not issue reimbursement for any drug item that is included in the coverage of Medicare Part D.
   2. The SE shall continue to cover items that are excluded by Medicare Part D and over-the-counter items to the extent otherwise required by the Medicaid State Plan (SPA).
   3. The SE shall not be required to pay any amount towards a consumer co-payment or a drug item paid by Medicare Part D.

G. The SE shall coordinate with the Medicaid MCOs regarding consumers’ pharmacy services.

### 3.7 Transportation

A. The SE shall assists consumers in accessing existing transportation needed for behavioral health services

*Deleted: coordinate behavioral health transportation with the consumer’s funding sources, by assisting*
B. The SE shall establish written protocols with each Medicaid MCO outlining the
process for coordinating transportation services for the MCO consumers
receiving behavioral health services. At a minimum, the protocols shall address
the following:
1. Contact information and process for arranging services with local, in-state
   long distance, and out-of-state long distance transportation subcontractors;
2. Consumer service coordination in the event that the consumer is unable to
   coordinate transportation services on their own;
3. Coordination of complex transportation needs (care coordination);
4. Travel reimbursement for mileage, meals and lodging for the consumer
   and/or escort(s);
5. Clinical overrides;
6. Utilization reviews for transportation services; and
7. Travel reimbursement for families of children in State (CYFD) custody in
   instances where the families are required to travel to participate in
   treatment/therapy per the child’s treatment and permanency plan.

C. The SE shall, when absolutely necessary, pay up front out of CYFD flex funding
for transportation costs in urgent situations where the family is not able to pay up
front themselves.

D. The SE shall, with the Medicaid MCOs, actively assist individuals with special
   health care needs (ISHCN) in arranging transportation to needed services.

E. The SE shall assist the Collaborative in preventing reduction of access to existing
   transportation benefits or resources and to increase coordination of public
   transportation services through other sources.

F. The SE shall update, coordinate and maintain an alternative transportation plan
   for those individuals who are not Medicaid recipients or who are not Medicaid-
   eligible. The updates shall be completed by October 1 of each Contract year.

3.8 Care Coordination

A. Care coordination is an administrative function of the SE in which designated SE
   staff (Care Coordinators) provide coordination services to assist identified consumers
   who may have difficulty navigating the behavioral health system; may have multiple
   and complex needs; and/or may be transitioning to higher or lower levels of care and
   or who are transitioning from institutional and jail facilities. Care coordination shall
   also be offered to clients transitioning from providers who will no longer provide
   services and who need help finding a new provider.

   The Care Coordinator shall coordinate with providers in ensuring that the consumer’s
   needs are met and treatment plans are developed and implemented.

   The goal of care coordination is to ensure that consumers receive needed behavioral
   health services that are coordinated (as appropriate) and are provided without
   disruptions and there is continuity of care.

   1. Care coordination operates within the SE with dedicated care coordination
      staff functioning independently, but structurally linked to, the other SE
      systems, such as quality assurance, utilization management (UM) and
      grievances.
2. Activities provided through care coordination at the SE level differ from case management services contracted with the provider network as part of the specific case management programs included in the Medicaid and other Collaborative agencies' benefit packages. These case management services may be replaced by Comprehensive Community Support Services in the Collaborative benefit package of services.

B. A consumer or their legal guardian shall have the right to refuse care coordination. If care coordination is refused, the SE shall have no further obligation to that consumer with respect to care coordination until such time that the consumer or legal guardian requests care coordination. If a consumer is referred to the SE for care coordination by a family member, provider, or state agency, the SE shall contact the consumer to offer care coordination.

C. The SE shall develop and implement policies and procedures to ensure that ISHCNs, as defined in NMAC 8.305.15.9, and Collaborative Special Populations, as defined by the Collaborative and SE, have access to care coordination.

D. The SE, with the assistance of the Collaborative, will develop criteria identifying ISHCNs and Special Populations who will then be offered care coordination services. Criteria will include such issues as the need for multiple services and systems, past high use of behavioral health services, and high risk of needing intensive behavioral health services. The criteria will be approved by the Collaborative, published and distributed and utilized as standard criteria throughout the State. The criteria and intensity levels will be included in the SE's policies and procedures. The SE shall use their existing policies and procedures to deliver care coordination until any new criteria can be developed and approved.

E. The SE shall adhere to the following requirements for care coordination, which will also be included in the policies and procedures:
   1. Identify proactively the eligible populations;
   2. Ensure access to care coordination for all Medicaid-eligible ISHCN, as required by federal regulations;
   3. Provide a designated person to be responsible for coordinating the health services furnished to a specific consumer and to serve as the single point of contact for the consumer.

F. The Care Coordinator assigned to a specific consumer shall be responsible for the following activities:
   1. Communicating to the consumer and legal guardian the care coordinator's name and contact information;
   2. Developing a Plan of Care (Care Coordination Plan) in conjunction with the consumer and legal guardian, which is based on an assessment and includes care coordination goals, needs, capacities and medical condition of the consumer and the needs and goals of the family as applicable to the consumer's care;
   3. Coordinate with the designated MCO care coordinators on co-managed cases;
   4. Coordinate care among other applicable agencies in the Collaborative, such as Waiver programs;
   5. Collaborate with appropriate state agency staff and community agencies in order to facilitate appropriate and timely referrals to services.
6. Ensuring access to a qualified provider who is responsible for developing and implementing a treatment plan or when multiple providers are involved, a multi-disciplinary service plan to be followed by all providers delivering services for the individual.
   a. ensure that physical health as well as behavioral health services are identified in the treatment plan developed by the provider (as appropriate).

7. Request and review collateral clinical information from providers in order to determine that the treatment plan is in place and services are appropriate. Assist the provider and consumer in identifying and resolving problems and to prevent duplication of services.

8. Provide resources and information on treatment options and services to the consumer and his/her provider to assist in the development and implementation of the treatment plan.

9. Ensure an evaluation process occurs that measures the consumer’s response to interventions. The plan should be revised as needed.

10. Ensure the consumer and his/her family and/or legal guardian, as appropriate, is involved in the development and implementation of the plan of care with routine reviews.

11. Ensure that all SE care coordination functions include responsibility for sharing the Plan of Care with key providers; this information sharing is required to ensure optimum care and communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems involved with providing services for consumers.

In the event that a local case manager is not available, perform case management functions (as needed) for the consumer.

G. The SE shall work with the Collaborative to develop a core service agency pilot project. The SE shall participate in the development of a core service agency pilot project to other services, populations and geographic regions, if found feasible based on the successful results of the pilot project. Collaborative staff or designee will convene and facilitate the development of the core service agency pilot project to other geographic regions, if found feasible based on the successful results of the pilot project.

The SE shall develop a multi-disciplinary treatment plan for each individual, which will be reviewed and approved by the Collaborative no later than June 30, 2008.

3.9 Coordination of Physical and Behavioral Health Services

A. Primary Care Linkage and Referral

1. The SE shall develop policies and procedures to encourage its providers to make a referral for (a) a physical exam if the consumer has not had a physical exam within 12 months of the date of enrollment and (b) a dental exam if the consumer has not had a dental exam within 6 months of the date of enrollment.

2. The SE shall educate and assist its provider network regarding proper procedures for making appropriate referrals for physical health consultations and treatment.
3. The SE shall coordinate care with primary care providers (PCP) when appropriate.

4. The SE shall educate the appropriate physical health providers regarding its services.

5. Develop and implement written policies and procedures with the MCOs governing how care coordination shall be provided for members with physical health and behavioral health complex needs. These policies shall address mechanisms for exchanging relevant clinical information between the SE and the MCO care coordination and Medical Directors to ensure services are delivered seamlessly.

6. The SE shall require its provider network to forward a written report of the outcome of any referral containing sufficient information to coordinate the consumer’s care to the PCP within seven (7) calendar days after screening and evaluation, and the SE shall monitor this process.

7. The SE shall require through its provider contracts ensure that physical health care providers have access to relevant behavioral health medical records and shall be responsible for monitoring the referrals to physical health providers. In addition, the SE shall require through its provider contracts that behavioral health providers communicate with physical health providers as appropriate.

B. Independent Access

1. The SE shall not require consumers to obtain a referral from the PCP to access behavioral health services.

C. Medicaid-Eligible Consumers

1. The SE shall develop policies and procedures to ensure effective care coordination with the appropriate MCO, and shall assist in coordinating a consumer’s care with the appropriate MCO if needed.

2. The SE shall develop policies and procedures that maximize access to Medicaid and non-Medicaid services that are external to the SE and MCO’s programs and that are consistent with the MCO’s policies and procedures.

3. For individuals who are Medicaid-eligible, the SE or the MCO responsible for the care of that individual’s most acute condition shall take primary lead on care coordination activities, and the SE will coordinate care with the MCO as needed. Where the SE and MCO disagree on “most acute condition,” HSD shall decide and instruct the SE and MCO accordingly.

4. For consumers enrolled in Medicaid but not in managed care, physical and behavioral health services shall be provided through a clinically coordinated system between the SE and the HSD care coordination entity.

D. Non-Medicaid-Eligible Consumers

1. For non-Medicaid-eligible consumers, the SE will implement policies and procedures for coordination of behavioral health services with appropriate physical health care providers.

2. The SE will refer non-Medicaid-eligible consumers to regional and statewide primary care resources, including the Public Health District Offices, indigent care providers or other physical health care providers as appropriate, when it is determined in the course of screening, assessment, or delivery of services.
behavioral health care services that physical health care services are necessary.

3.10 Coordination with HIV Treatment Providers

A. The SE shall participate in meetings and training opportunities with Public Health District Offices, HIV counseling and testing sites, and the Health Management Alliances that provide HIV/AIDS treatment statewide to facilitate the referral of eligible consumers in need of behavioral or physical health screening, assessment or treatment services.

B. The SE shall develop policies and procedures that encourage its provider network to utilize these resources as appropriate.

3.11 Coordination of Adolescents Transitioning into the Adult System

A. The SE shall have policies and procedures in place to define and identify high-risk youth ages sixteen (16) to twenty-one (21) who are transitioning into the adult system (for example, those who qualify as an ISHCN or are in State custody or supervision). These policies and procedures will require coordination with all relevant providers and agencies that are currently involved in the consumer’s care, and with the family and legal custodian, as appropriate.

B. The Collaborative shall convene and facilitate a Priority Work Plan process, as described in Article 2.4, to design and implement transitional services for adolescents moving from the youth delivery system into the adult delivery system. The SE shall actively participate in this Priority Work Plan process. A priority work plan for development, funding, implementation and sustainability with clearly delineated tasks, timeframes, accountabilities and resources will be developed with in a timeframe set by the Collaborative.

C. 

3.12 Interagency Collaboration

A. Coordination with Collaborative Cross-Agency Teams

1. The SE shall communicate, participate in and collaborate with the Collaborative Steering Group, all Cross-Agency Teams (CATs), and other cross-agency workgroups/teams or Collaborative subcommittees as requested.

2. The SE shall participate in a Priority Work Plan process, as described in Article 2.4, with a cross–agency work group consisting of those state agencies dealing with the issues of custody, supervision, protective services and/or court ordered treatment for children and adults. Collaborative staff will convene and facilitate this Priority Work Plan process. A priority work plan for the integration of these populations into the SE service system will be developed and approved by the Collaborative no later than January 1, 2008.

B. Coordination for Children

1. The SE shall work with CYFD Juvenile Justice Services (JJS) and other Collaborative member staff to promote early identification of youth who are engaging in delinquent or high-risk factors including exhibiting signs of serious emotional disturbance.
2. The SE shall be available to consult as requested with CYFD staff and participate with CYFD Team Decision-Making process prior to an adolescent/young adult’s release from a juvenile correctional facility.

3. The SE shall have policies and procedures governing coordination of services with the CYFD Protective Services (PS) and JJS divisions, including discharge planning.

4. The SE shall through provider contracts begin discharge planning with staff within twenty-four (24) hours of the child’s admission to an acute setting or out-of-home setting to identify precipitants to the placement and conditions for the child’s return to the community.

5. The SE shall, through provider contracts and at the request of CYFD, assess the child/adolescent/young adult’s emotional, social and cognitive needs and develop, prior to discharge from a JJS or treatment facility, a comprehensive plan of clinical and supportive services that could be immediately implemented upon their discharge and that could involve multiple providers using the same plan.

6. The SE shall ensure the assigned CYFD worker is actively involved in a child’s life is included in care coordination.

7. The SE shall ensure that providers adopt and implement policies related to including families, foster families and adoptive families and youth in treatment planning.

8. The SE shall establish and/or support the existing Medical/Behavioral Health Committee to improve coordination with an emphasis on behavioral health screens, especially for children ages zero (0) to three (3).

9. The SE shall incorporate in policies and procedures coordination with the DOH Families, Infants, and Toddlers (FIT) Program.

C. Coordination with ALTSD

1. The SE shall have policies and procedures governing coordination of services with ALTSD’s Adult Protective Services (APS), including discharge planning. The SE shall ensure that any APS worker actively involved in an individual’s life is included in care coordination.

2. The SE shall address in policy and procedures coordination of services with other Medicaid and non-Medicaid programs administered by ALTSD which may be concurrently serving persons receiving behavioral health services including, but not limited to, the Brain Injury and Personal Care Option programs.

D. Coordination with NMCD and CYFD

1. The SE shall promote coordination between adult and juvenile detention facilities and its behavioral health providers to establish a process to communicate the behavioral health needs of detainees at intake and discharge to establish a continuity of care between the two entities and shall facilitate that coordination if requested.

2. The SE shall provide cross training, as requested, to promote and facilitate the coordination between adult and juvenile detention facility staff and providers regarding service availability, referrals, and eligibility criteria to promote coordination and access to services upon release.
3. The SE shall ensure assessment and appropriate services for all NMCD-referred adults and CYFD-referred juveniles, to the extent resources are available, and shall work with the Collaborative to implement criteria to prioritize NMCD-referred adults and CYFD-referred juveniles to prevent recidivism to the extent possible.

4. The SE shall work with NMCD for the care coordination of incarcerated individuals identified by the Collaborative with high needs as these individuals transition back into the community from prison to ensure continuum of care.

5. The SE shall also work with CYFD for the care coordination of committed juveniles with high needs as these individuals transition back into the community from juvenile correctional facilities to facilitate continuum of care.

6. The SE shall work closely with NMCD and CYFD to develop a system interface between the three agencies.

E. Coordination with Adult and Juvenile Judicial System Regarding Court-Ordered and/or Parole Board-Ordered Treatment

1. The SE shall establish policy and procedures at the provider network level that address the establishment and maintenance of professional relationships with magistrate, municipal, and district judges and parole board members regarding cases that contain behavioral health elements. These policies and procedures shall encourage the development and implementation of the following elements:

   a. Education of judges and parole board members regarding appropriate referral procedures, consumer eligibility, resource availability and clinically and medically appropriate treatment alternatives;

   b. Review of assessments, court orders and/or conditions of probation or parole that order individuals into behavioral health services to ensure that the level of treatment intervention is medically, clinically, and/or psychosocially appropriate to assessed consumer need and is within the authorized licensed capacity and resource availability of the provider;

   c. A process for reviewing with CYFD cases where care is determined not to be medically, clinically, and/or psychosocially appropriate with the goal of identifying services that are appropriate to the needs of the consumer.

   d. The SE shall work with NMCD, CYFD, providers, the Courts and the Adult and Juvenile Parole Boards to educate the criminal justice system on behavioral health services and to facilitate requests for modification to court orders or conditions of parole when clinically indicated.

F. Coordination with Medicaid Waiver and Non-Medicaid Disability Programs

1. Currently, Medicaid has five home- and community-based waiver programs: developmental disabilities waiver, the disabled and elderly waiver, the medically fragile waiver, the HIV-AIDS waiver, and the Mi Via Self-Directed waiver. Four of these waiver programs are responsible for the case management function for consumers receiving services through waivers. The Mi Via waiver program does not mandate case management. The SE shall establish policies and procedures governing coordination of care and services as needed and appropriate with providers serving behavioral health consumers under these waivers.
2. The SE shall coordinate care as needed with the consumer’s waiver case manager to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. [8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04; A, 7-1-05]

3. The SE shall coordinate care as needed with DOH non-Medicaid Developmental Disability Services.

G. Coordination Related to Medicaid Eligibility
   1. The SE shall require its provider network to identify whether persons seeking behavioral health care may be eligible for Medicaid coverage.
   2. If a person may be eligible, the SE shall assist the provider in helping the consumers make contact with the appropriate agency to begin the eligibility process; i.e., HSD Income Support Division field offices, the Social Security Administration (SSA), or DOH or ALTSD for certain waiver programs.
   3. The SE shall have practices and procedures in place related to Medicaid outreach and enrollment and Medicaid recertification. These practices and procedures shall include, at a minimum, providing consumer Medicaid expiration dates to all residential providers at the time of a consumer’s placement in that residential setting.

3.13 Requirements for Evidence-Based Practices
   A. The Collaborative is committed to purchasing a continuum of services comprised of models that have been demonstrated to be effective.
   B. The SE, in the delivery of services, shall work with the Collaborative to continue and improve the ongoing implementation of evidence-based practices, including promising and best practices for person with developmental disabilities, mental illness, and autism spectrum disorder.

3.14 Behavioral Health Consumer and Family Member Involvement and Activities
   A. The SE shall support and help strengthen existing consumer and family networks and community peer advocacy organizations in expanding behavioral health consumer and family member peer advocacy, self-help programs, support networks, and peer-directed services.
   B. The SE shall support efforts that involve utilizing behavioral health consumers and family members in the implementation and development of peer-directed services. The SE shall work with the Collaborative in the development of peer support specialist and family and child support specialist services.
   C. The SE shall ensure that treatment providers develop mechanisms for behavioral health consumer and family member involvement in quality activities and advocacy development.
   D. The SE shall conduct ongoing training and technical assistance for child, adult and family peers and shall include curricula that help to develop the skills necessary to match goals with services and to advocate for the needs of behavioral health consumers and their families.
   E. The SE shall attend at least two (2) statewide behavioral health consumer and family member-driven or -hosted meetings per year if scheduled, that focus on BH consumer and family member or service system issues and needs, in order to ensure that concerns are heard and addressed. These meetings shall be of the SE’s choosing.
F. The SE shall ensure that all initiatives and activities will have multimedia announcements that would identify opportunities that are available for consumer and family members and how consumers and family members may access those opportunities.

G. The SE, in partnership with the Collaborative, shall ensure outreach, recruitment, orientation and training and development of behavioral health consumer and family member representatives to participate on its Quality Improvement Committee and shall encourage those representatives to attend the Office of Consumer Affairs (OCA) Leadership Academy and the SE Recovery and Resiliency Department’s Community Empowerment Training.

H. The SE shall foster open communication as well as a collaborative relationships with State agency consumer/family liaisons. At a minimum, this shall involve established monthly mechanisms for briefing one another with regard to regional coordination of behavioral health consumer and family member issues and peer advocacy, self-help programs and support networks, and peer-directed services, as well as exploring additional opportunities for coordination of technical assistance and quality improvement.

I. The SE shall ensure its providers educate consumers so that their ability to make informed choices regarding effective treatment is enhanced.

J. The SE shall ensure that behavioral health consumers, and family members where appropriate, are presented with opportunities to proactively engage and participate in treatment planning and the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer’s preferences and wishes.

K. The SE shall ensure that its providers make appropriate accommodations to ensure the participation of consumers and family members with cognitive and/or physical disabilities in all aspects of treatment plan planning, development, and implementation.

3.15 Telehealth Requirements

A. In providing services under this contract, the SE shall employ broad-based utilization of statewide access to HIPAA-compliant telemedicine and telehealth service systems including, but not limited to, access to TTYs and 711 Telecommunication Relay Services.

B. The SE shall

1. follow State guidelines for telehealth equipment or connectivity;
2. attend meetings of the Telehealth Commission as requested;
3. follow accepted HIPAA and 42 CFR Part 2 regulations that affect telehealth transmission, including but not limited to staff and provider training, room setup, security of transmission lines, etc. Have written policies and procedures that follow security and procedure guidelines;
4. identify, develop, and implement training for accepted telehealth practices;
5. provide to the Collaborative any performance measure data related to telehealth encounters;
6. participate in the needs assessment of the organizational, developmental, and programmatic requirements of telehealth programs;
7. pilot telehealth for behavioral health at two rural locations and at two school-based health centers in FY07;
8. Report to the Collaborative on the telehealth outcomes of pilot or other telehealth projects;

9. Ensure that telebehavioral health services meet the following shared values of the New Mexico Telehealth Commission:
   a. Ensuring competent care with regards to culture and language needs;
   b. Networked sites are equally distributed across regions of the state, including Native American sites, for both clinical and educational purposes, with focus on development of regional networks in line with regional breakout of state agencies; and
   c. Ensuring coordination of telehealth and technical functions at either end of network connection.

3.16 Requirements for Services for Native Americans

A. The SE shall acknowledge and honor Native American Tribes, Nations, and Pueblos as inherently sovereign nations on and off their Tribal, Nation, or Pueblo lands.

B. The SE shall design, implement and maintain culturally and linguistically appropriate services and supports for members of the New Mexico-based Indian Tribes, Nations, and Pueblos and other Native Americans.

C. The SE shall work with appropriate Tribal, Nation, and Pueblo communities and their programs on providing behavioral health services, including substance abuse and mental health issues.

D. The SE shall respect and respond appropriately to the inherent sovereignty of Native American Tribes, Nations, and Pueblos in planning or changing service delivery and evaluation.

E. The SE shall be flexible and considerate in meeting the needs of Native Americans throughout the State.

F. The SE shall seek, incorporate and utilize the views of Native American stakeholders (consumers and family members; BHPC Native American Subcommittee; providers; Tribal, Nation, and Pueblo leaders; and advocates) in the design and implementation of the behavioral health service delivery system and in making modifications to the system for improvements.

G. The SE shall promote and utilize culturally and linguistically appropriate traditional healing services for Native Americans while maintaining sensitivity to the unique perspectives of the various Tribes, Nations, and Pueblos that may prefer to limit their participation because of cultural beliefs and to keep religious practices safeguarded.

H. The SE shall provide and strengthen its organizational structures that respect the unique government-to-government relationships of the State and the Native American Tribes, Nations, and Pueblos, which also recognizes the unique system of the Indian Health Service (IHS), for purposes of collaborating, cooperating, and communicating with each other.

I. The SE shall provide for appropriate personnel for purposes of accessing and delivering behavioral health services and as direct liaisons with the 22 Native American Tribes, Nations, and Pueblos, Indian Health Service (IHS), LCs, and other tribal entities.

J. The SE shall hire staff who have experience with Native American behavioral health issues and New Mexico tribal communities to work specifically with Tribal,
Nation, or Pueblo communities and providers who serve Native Americans to create, strengthen, support, and provide assistance to the LC(s) in Region 6 and any Urban Native Americans throughout the State. At least one full-time SE staff person shall be dedicated to working on Native American issues.

K. Subject to available funding, the SE shall preserve the current reimbursement system for Native Americans with the goal of preserving services and specific programming for Native Americans.

L. The SE shall maintain contracts with IHS of Albuquerque and Navajo Area IHS and with 638, Tribal, Nation, Pueblo and Urban Indian behavioral health providers that meet minimal credentialing requirements for service delivery within New Mexico who want to contract with the SE.

M. The SE shall ensure that linkages with Tribal, Nation, and Pueblo Courts; IHS; Bureau of Indian Affairs (BIA); and Tribal, Nation, or Pueblo 638 programs are developed at the SE level and shall ensure that its subcontracted providers have established linkages with the preceding agencies in order to ensure appropriate coordination of care for Native American consumers utilizing those programs.

N. The SE shall provide technical assistance upon request. Further, the SE shall provide training for billing, credentialing standards, benefits and services, and quality of care to IHS, Tribal, Nation, Pueblo and Urban Indian behavioral health providers following any major program changes or at the Collaborative’s request, but no less than two (2) times a year.

O. The SE shall establish professional relationships with Native American programs statewide that provide behavioral health services and shall document the contacts.

P. The SE shall refer Native American consumers to Native American programs to the extent possible, so that consumers’ needs may be assessed and met through culturally relevant Native American treatment services, unless a consumer requests otherwise.

Q. The SE shall provide services through its providers to Native American consumers when appropriate except where a consumer requests otherwise.

R. The SE shall ensure that alternative/ traditional healing services (i.e., traditional healers, sweat lodges, ceremonies, acupuncture, etc.) provided through Native American programs continue and/or are developed as appropriate.

S. The SE shall show good faith effort to work with Tribal, Nation, and Pueblo judges and courts regarding tribal members.

T. The SE shall make good faith efforts to work with schools, whether public, Tribal, Nation, Pueblo, or federal, regarding behavioral health care for Native American consumers and their families.

U. The SE shall provide a quarterly written report to the Collaborative, the co-chairs of the BHPC, and the chair of the BHPC Native American Subcommittee on the progress of the Region 6 office, implementing the activities identified above, or the plans to implement those activities.

3.17 Requirements for Services for People with Cognitive and Physical Disabilities

A. The SE shall work with the Collaborative to evaluate the behavioral health system needs of people with cognitive and physical disabilities, including people with both developmental disabilities and mental illness and people with autism spectrum disorders.

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B. The SE shall work with the Collaborative and providers to develop and provide, to the extent possible, community-based services for adults with serious mental illness who otherwise would be subject to inpatient or outpatient commitment.

3.18 Requirements for Work with the BHPC and Local Collaboratives

A. The BHPC shall serve as the primary statewide advisory body for mental health and substance abuse issues.
   1. The SE shall seek advice and comment from the BHPC during the planning, implementation, and evaluation of services under this Contract.
   2. The SE shall make available to the BHPC information, training, technical assistance and data about SE operations or proposed operations.
   3. The SE shall utilize data and information from the BHPC in its operations under the contract, including making available sufficient public opportunity for input before operations commence or change at the beginning and throughout the contract.

B. The LCs for each of the thirteen (13) geographical areas (see Attachment B – Judicial District Map) and for Native American Tribes or Pueblos, as formally recognized by the Collaborative, shall act as advisors to the SE. The SE shall share information with LCs and consult with and consider their input on service delivery issues in their geographic or cultural area.
   1. The SE shall work closely with the LCs to assist them in recruiting and training providers, consumers, and family members to be fully participating members of the LCs as requested.
   2. The SE shall, in conjunction with the CATs, participate in a needs assessment of the organizational, developmental and programmatic requirements of each of the LCs and identify ways the SE will assist in meeting these needs as requested.
   3. The SE shall disseminate needs and utilization data to the LCs and utilize data provided by the LCs to inform service deliver, program development and quality improvement.
   4. The SE shall provide program evaluation training to LCs to assist in data evaluation as requested.
   5. The SE shall structure SE committees so that there is opportunity for BHPC representation.
   6. Within each SE Regional Office, the SE shall identify a LC liaison to fully partner with the state CATs to achieve the outcomes identified in the Guidelines for Local Collaboratives. The SE staff in the regional areas shall be knowledgeable of the cultural and linguistic diversity issues within the areas in which they serve.
   7. The SE shall provide Regional staff who shall work with LCs to identify available local support groups and provide information on natural community-based informal support mechanisms to consumers and families.
   8. The SE shall provide LCs with regular aggregate and trended service utilization information for their geographic area population.
   9. The SE shall provide LCs with regular aggregate and trended service information about consumer and family complaints and grievances appropriate to the population from that geographic area, compared to the state as a whole.
10. The SE shall meet and consult with the Collaborative regarding the use of LCs where used to shape overall implementation of the Contract and the provision of behavioral health services in New Mexico.

11. The SE shall meet and consult with LCs to develop service area plans for each of the six regions upon request.

12. The SE shall provide culturally competent training, technical assistance, capacity building, planning and logistical resources, for LCs within designated districts and within Native American Tribes and Pueblos.

13. The SE shall meet and consult with the LCs to identify service gaps and needs.

14. The SE shall upon request, work with LCs to develop and provide educational materials to LCs in a culturally competent manner and in prevalent languages other than English.

15. Upon request the SE’s staff shall interact with LCs, including informing and educating LCs regarding relevant aspects of operations affecting local areas.

C. The SE shall attend and participate in BHPC and LC meetings regularly, but at least six (6) times per year.

D. The SE shall provide resources along with the Collaborative and other funding sources for the development of an electronic communication system accessible to the LCs to facilitate communication and information sharing across and within the system.

E. The SE shall establish formal communications and share information at the SE management level related to the LCs.

F. The SE shall utilize information from LCs to improve network capacity at local, regional and statewide levels.

G. The SE shall provide to, and receive information from the BHPC, LCs, and Collaborative members regarding program development and implementation including, but not limited to state and federal initiatives being implemented at the local level.

H. The SE shall consult with the BHPC and the LCs to identify service gaps and needs, including provider training needs, and ensure intersystem coordination at the local level; and shall utilize the BHPC and the LCs in the decision-making process.

I. The SE shall work with the BHPC and the LCs to identify provide, consumer and family concerns, training needs and opportunities. The SE shall report identified concerns and training needs to the Collaborative.

J. The SE shall offer assistance and information to the BHPC and the LCs about the types of system interfaces that work in their communities regarding referrals to and from and collaboration among behavioral health providers, adult corrections, adult and juvenile justice, protective services, schools, regarding individual education plans, child welfare, other health and human services agencies, PCPs, etc.
ARTICLE 4 – PROGRAM-SPECIFIC REQUIREMENTS: PHASE TWO

4.1 General Requirements

A. The SE shall provide behavioral health services described in the benefit packages identified for each eligibility group and funding source, taking into account the need for the following:

1. Development and provision of a continuum of school-based behavioral health services in partnership with the DOH Office of School and Adolescent Health (OSAH) the HSD Medicaid School Health Office, and the Public Education Department (PED) and CYFD;

2. Development and provision of programs interfacing with other systems such as Aging and Long Term Services, Vocational Rehabilitation, Developmental Disabilities, Child Welfare/Protective Services, Adult and Juvenile Justice, primary health care and workforce development;

3. Coordination with public and private inpatient and residential behavioral health care facilities;

4. Coordination with housing, employment and community educational programs necessary for quality community life;

5. Coordination with local Driving While Intoxicated (DWI) councils, upon request, to identify populations and geographic areas in need of prevention services, and also work with the councils to develop plans with measurable goals and objectives, which will guide them in the implementation of evidence-based prevention programming. The SE will also work with the DWI councils to develop a process for evaluating evidence-based prevention programming.

6. Coordination with domestic violence service providers,

7. Development and provision of specialty programs serving persons in corrections, probation and parole and community corrections and adult and juvenile justice and juvenile detention system involvement, including DWI programs, defendants in drug and mental health courts, individuals who are homeless, adult probationers and parolees, and juvenile offenders, and provide care coordination as these populations transition back into the community;

8. Coordination with those involved in the life of a child or adolescent and family involved in the CYFD PS or JJS systems, including the children, adolescents, and families themselves;

9. Coordination with disability agencies and organizations providing services to individuals with disabilities to ensure that a system for accessing appropriate and timely services for individuals with special health care needs or disability-related needs is in place; and

B. The SE shall provide comprehensive behavioral health services, pursuant to the Comprehensive Behavioral Health Statewide Plan, for the following programs:

1. Medicaid (HSD).

   a. All Medicaid-related behavioral health services for all Medicaid-eligible service recipients provided under this Contract shall be subject to the following provisions for administration of the Medicaid program, which are incorporated herein by reference:
i. The program eligibility and provider policy manuals, including all updates, revisions, substitutions and replacements;

ii. Title XIX and Title XXI of the Social Security Act and Code of Federal Regulations Title 42 Parts 430 to end, as revised from time to time;

iii. The New Mexico Medicaid Managed Care benefit package, especially as it relates to the provision of behavioral health services, found in Managed Care Policy 8.305 NMAC.

iv. The New Mexico Medicaid Fee-for-Service (FFS) benefit package, especially as it relates to the provision of behavioral health services, found in the Medical Assistance Division (MAD) Program Policy Manual (excluding 8.305).

v.

b. Hospitalized Consumers: If a consumer is hospitalized at the time of disenrollment from managed care, the SE shall be responsible for payment of all covered inpatient psychiatric hospital or psychiatric unit of an acute care hospital costs including professional services provided from the date of admission to the date of discharge (at the managed care rate). A discharge rate is defined as follows: When a consumer 1) is moved from or to a PPS exempt unit within an acute care hospital, 2) is moved from or to a PPS exempt hospital, or 3) leaves a psychiatric hospital setting to a home/community setting. It is not considered a discharge when a consumer is moved from one acute facility to another acute facility, including out of state acute facilities. The SE shall not be responsible for the payment of any services following the date that a consumer loses eligibility for the Medicaid program (through Medicaid). Should other funding sources be available to pay for the stay, the SE should consider those options.

c. The SE shall be responsible for services provided in a free-standing psychiatric hospital, and in a psychiatric unit of a general hospital. Professional psychiatric services billed by an individual practitioner provided in any facility are also the responsibility of the SE. It will be the responsibility of the Medicaid MCOs to cover Emergency Room facility costs even when the primary diagnosis is a behavioral health diagnosis, with the exception of UNM Psychiatric Emergency Room, which will be the responsibility of the SE. Pharmacy claims prescribed by a behavior health practitioner will be covered by the SE.

d. Laboratory and Radiology Services. The lab and radiology costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute care hospital or UNM Psychiatric ER. In the event that a psychiatrist orders lab work but completes that lab work in their office/facility and bills for it, the SE is responsible for payment. Lab and radiology costs shall be the responsibility of the MCO when a BH provider orders lab and radiology work that is performed by an outside, independent laboratory or radiology, including those lab and radiology services provided for persons within a psychiatric unit, a freestanding psychiatric hospital or the UNM Psychiatric ER.
2. Temporary Assistance for Needy Families (TANF) Substance Abuse Funding (HSD). TANF is a cash assistance block grant program that replaced the Aid to Families with Dependent Children Program (AFDC) in July 1996. All TANF substance abuse funding purchased under this Contract shall be subject to the following provisions, which are incorporated herein by reference:

A. Participant Services - Provide Non-Medical, work focused multi-faceted substance abuse treatment to achieve and sustain recovery. Services paid for with TANF funds must include daytime, evening, and/or weekend programming that will:
   (1) Count as an allowable primary/core Job Readiness work activity for no longer than six weeks in a federal fiscal year, of which no more than 4 weeks may be consecutive. Services may include Intensive Outpatient (IOP) treatment; and other levels of care.
   (2) Provide ongoing supportive substance abuse services that may or may not count as an allowable work activity.

B. Eligible Population to Serve – TANF block grant funding may only be used for the following TANF populations:
   (1) Priority 1 - TANF Cash Recipients Families receiving monthly TANF cash assistance referred by the New Mexico Works (NMW) contractor or Income Support Division (ISD) field office.
   (2) Priority 2 – Not receiving TANF cash assistance. These may be walk-ins to the service provider who include a family caring for at least one related child (or a pregnant woman) with family income at or below 100% of poverty. The eligibility is to be determined by the service provider with a signed statement of income and household size. This priority group may include referrals from other sources including drug court and CYFD.

C. The SE shall:
   (1) On or before July 30, 2007 the SE shall develop and deliver a written service plan that describes in detail how the participant eligible population services will be established and delivered.
   (2) Coordinate the selection of TANF substance abuse sites and providers. Include ISD staff in the decision processes.
   (3) Ensure through Provider contracts on-site services at NMW offices when possible.
   (4) Provide HSD with copies of sub-contracts within 30 days of completion.
   (5) Implement a verification process to determine TANF “Eligibility” for priority 2 participants.
   (6) Assist in the facilitation of referrals from NMW.
   (7) Provide program reports to ISD monthly by the 15th. Information must include:
      a. Service description
      b. Service area and state totals for new, continuing, and completing priority 1 participants separate from priority 2 participants
   (8) Manage the TANF funding by –
3. State General Fund for Non-Medicaid Services for Adults (HSD). The SE shall provide behavioral health services based on regional targets established in consultation with the Collaborative. These targets will include priority populations, co-occurring, sexual assault services and supported employment and be developed by July 31, 2007, and will utilize FY06 and FY07 service data.

   a. At a minimum, fifty (50) percent of the individuals with mental health issues served by the SE with this fund source shall have a Global Assessment Functioning (GAF) score of fifty (50) or lower at registration.

   b. At minimum, fifty (50) percent of the individuals with substance use issues served by the SE shall have an Addiction Severity Index (ASI-MV) Drug/Alcohol Use score of four (4) or higher at the time of enrollment. All individuals with substance abuse and/or co-occurring disorders shall be administered the ASI-MV. The composite scores determined at the following intervals: at admission, at 90 days and then at treatment plan review, but no longer than one hundred-twenty (120) days thereafter and at discharge shall be reported by the providers.

   c. The SE shall ensure that consumers continuing to need clinically necessary services who no longer meet priority financial criteria shall not be terminated from services. Services for these consumers shall be provided based on clinical necessity.

4. Intravenous Drug User (IVDU) Project (HSD). The SE shall ensure that outpatient substance abuse treatment services, care coordination, access to the continuum of care, and access to Opioid Replacement Therapy (ORT), as appropriate, are provided to eligible enrolled consumers. The target population for this project is intravenous drug users, eighteen (18) years of

a. Ensuring expenditures meet federal and state requirements
b. Reconcile actual expenditures with HSD quarterly
c. Reimburse service providers for actual expenditures 15 days after the end of the quarter.
d. Audit provider monthly billing invoices
e. No more than 15% of the contract expenditures may be for administrative expenses include
   i. General administration & coordination of programs including contract & indirect costs
   ii. Salaries, benefits, & other costs of administrative staff performing administration and coordination, Eligibility determinations, Preparation of budgets, program plans and schedules, and monitoring of programs and projects.
   iii. TANF administrative costs exclude sub-contracts with substance abuse service providers.

   (9) Conduct regular program and fiscal reviews by:
   a. Developing and providing a review schedule to HSD by October 1, 2007.
   b. Providing a detailed reports on findings to HSD 30 days after the review.
   c. Include HSD on site-visits
d. Cooperate with HSD reviews and audits

Deleted: <#>TANF Block Grant funds, Federal grant number CFDA 93.558 to provide TANF Substance Abuse Intensive Outpatient Treatment Programs (IOP) shall provide for non-Medicaid substance abuse IOPs statewide for TANF recipients as a first priority as referred by HSD and the New Mexico Works (NMW) contractors. ¶

¶<#> As a second priority population, TANF funds may also be used to serve individuals with a gross family monthly income of less than one hundred (100) percent of the federal poverty guidelines for the size of their family when the individual is either a pregnant woman or the parent or relative caretaker of at least one dependent child living in their home. ¶

¶<#> These IOP services must provide time-limited, multi-faceted-approach treatment services for eligible persons who require structure and support to achieve and sustain recovery. Services may be court-ordered. ¶

¶<#> The IOP program must provide for nine (9) to twenty (20) hours ... [3]
age and older, in Rio Arriba and Santa Fe counties who inject or “skin pop” heroin, cocaine, and/or other drugs.

a. The SE shall ensure the coordination of movement from a lower level of care to a higher level of care and visa versa, of any consumers enrolled in this project.

b. The SE shall ensure that the following services are provided: outpatient substance abuse services, detoxification, and residential treatment to eligible enrolled individuals who meet the ASAM criteria for those levels of care.

c. The SE shall ensure that MAT services are provided in Rio Arriba County to eligible enrolled individuals.

d. The SE shall ensure that outreach services are provided to incarcerated IVDU individuals from Rio Arriba County. Outreach activities shall include but not be limited to drug education, relapse prevention, and referrals to the appropriate SE provider system. Outreach activities shall focus on engaging individuals who are IVDUs and bringing them into the treatment system. The monthly jail outreach target (outreach to eligible incarcerated individuals) is thirty (30). The SE shall ensure that case management services are provided to eligible enrolled individuals, as appropriate. The annual target number for case management is one-hundred-eighteen (118) unduplicated consumers.

e. The SE shall establish linkages with the court system and law enforcement agencies in Santa Fe and Rio Arriba counties and with probation and parole in order to bring individuals eligible for this project into the treatment system.

5. Medication Initiative (NMPI) (HSD). The SE shall assist the Collaborative in identifying former New Mexico Pharmacotherapy Initiative (NMPI) funding among the SE’s contractors. The SE and the Collaborative shall develop a work plan by September 30, 2007, to maximize this funding, and any new funding that has been appropriated, to purchase medications for Non-Medicaid eligible consumers. Priority shall be given to individuals who, without medication, are at risk for becoming institutionalized or incarcerated.

6. Supported Employment (HSD). The SE shall examine and improve performance of ongoing implementation of supported employment initiatives and shall work with the Collaborative to identify and implement strategies that will further and improve model application resulting in improved competitive employment outcomes for consumers.

a. The SE shall work with the Collaborative to identify and implement strategies that will educate and involve employer and employer organizations in the availability of a labor pool in their respective communities resulting in consumers moving from entry-level positions into mid-range employment.

7. Jail Diversion Services (HSD). The SE shall expand jail diversion services in New Mexico for persons with behavioral health needs.

a. The SE shall, in conjunction with the Collaborative, develop a jail diversion services plan for Phase Two.
b. The plan shall incorporate the expertise and knowledge developed through the jail diversion projects funded in FY06 and reflect national best practices.

c. The plan shall be developed by September 30, 2006, and include a plan to provide interim services prior to plan approval.

8. **Comprehensive Women's Services (HSD)**. The SE shall ensure the provision of behavioral health treatment for women, especially those with substance use disorders and their dependent children, families, and significant others. The SE shall work with the Collaborative to develop a plan for gender-specific treatment that will address the requirements of state and federal funding sources, specify roles, resources, and deliverables in a format that shall be agreed upon by the SE and the Collaborative. Services may include, but are not limited to the following:

a. Specialized groups for women to address gender-sensitive issues such as self-esteem, relationships, physical, emotional, or sexual abuse, and cultural issues;

b. Developmental issues of children, including parent education;

c. Daycare for dependent children;

d. Family groups that may include significant others, if the service recipient so wishes;

e. Linkages to primary care that ensure service recipient's health needs are met, including appropriate medical testing and prescription medications;

f. Linkages to pediatric care that ensure that the health needs of dependent children are met, including appropriate medical testing and prescription drugs;

g. Provision of MAT, if the service recipient meets the requirements as set forth by the Center for Substance Abuse Treatment (CSAT) guidelines, and identifies MAT as her treatment of choice;

h. Case management to be provided by a certified case manager as a component of the treatment plan;

i. Linkages to supported employment and housing services;

j. Transportation sufficient to ensure that women in treatment have access to the services provided;

k. Access to peer-led recovery groups; and

l. Aftercare that provides planning and supports for continued recovery.

9. **Co-occurring Disorders – State Incentive Grant (CoSIG) (HSD)**. This program area is designated as needing a Priority Work Plan as described in Article 2.4. The SE shall:

a. Coordinate, with the CoSIG Implementation Team, statewide co-occurring clinical trainings on topics such as principles of co-occurring disorder (COD) treatment, required assessment of substance abuse and mental health for all individuals entering the state system at any level, use of Motivational Interviewing, Stages of Change, and how to perform integrated treatment with mental health and substance abuse professionals;

b. Work with, among others, the COD Implementation Team and its Evaluation team, to ensure that all required data be identified and
collected accurately in a synthesized fashion which is least burdensome
to providers;
c. Work actively with housing and employment stakeholders within and
outside of State government to ensure that funding streams and
community resources are marshaled to improve and increase housing
and employment opportunities;
d. Work with Collaborative member agencies and other relevant government
entities to ensure that consumers in the judicial and corrections systems
receive training in how COD affects individuals and the ways to maximize
treatment and sentencing resources;
e. Work with the Collaborative to identify and implement strategies that will
further and improve model application, resulting in improved outcomes
specific to the reduction of psychiatric and substance use
symptomatology;
f. Take an active role in all processes designed to integrate and streamline
the work and goals of substance abuse and mental health grants in
Collaborative member agencies
g. Work with Collaborative member agency staff to educate, train,
strengthen and support the COD service continuum;
h. Assist CoSIG staff in the education of peer providers, consumer and
family advocates, the BHPC and LCs on the advantages and necessity of
integrated treatment in CODs;
i. Ensure that all providers receive training in gender-based treatment for
individuals with COD;
j. Support and work with the CoSIG team in the implementation of a body of
standardized assessment and screening instruments;
k. Support and work with the CoSIG or other Collaborative member agency
staff to add COD proficiency to clinical credentialing standards and
continuing education training for all mental health and substance abuse
professionals; and
l. Work with the CoSIG team and other Collaborative member agency staff
to identify and offer where possible financial incentives to providers to
engage in any and all aspects of COD treatment.

10. Medication-Assisted Treatment (HSD). The SE shall only contract with
Opioid Treatment Programs (OTP) that meet the requirements of the CSAT,
state laws, regulations, national accreditation bodies, DEA, State, and local
laws governing OTPs. The SE shall encourage ORT providers to use national

a. The providers of MAT services and the specific provider allocation shall be
agreed upon by the SE and the Collaborative. Should the need arise,
the SE shall work with the DOH to substitute any MAT with an appropriate
program replacement.
b. The SE shall ensure that all behavioral health providers receive education
and training in MAT and make referrals, as appropriate, to MAT services.
c. The SE shall abide by the DOH Anti-Discrimination Policy concerning
consumers of services.
11. **SAPT Street Outreach (HSD).** The SE shall assist the Collaborative with the development and implementation of harm reduction initiatives to reduce morbidity and mortality from drug addiction and improve the lives of addicted persons.

   a. The SE shall ensure through provider contracts that outreach and other services to injection drug users continue as required by the SAPT Block Grant and shall meet all Grant requirements, abide by all federal limitations on service provision.

   b. **Street Outreach education** services include, but are not limited to, the following: statewide harm reduction training; development of drop-in centers for drug users; syringe exchange programs; and distribution and monitoring of methods of overdose prevention, such as naloxone (Narcan).

   c. The SE shall assess and report on the need for specific street outreach strategies in each region and present the report to the Collaborative no later than October 1 of the Contract Year.

12. **Federal Mental Health and Substance Abuse Block Grants (HSD).** Services shall be the same as for those funded by the State General Fund, except that these funds shall not be used to provide inpatient services; make cash payments to intended recipients of health services; purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; purchase major medical equipment; satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds; provide financial assistance to any entity other than a public or nonprofit private entity.

13. **Access to Recovery (ATR) Grant (HSD).** The SE shall work with the Collaborative, particularly DOH, in administering the ATR grant, in accordance with Federal regulations and guidelines.

   a. The SE will continue with the current voucher process.

   b. The SE shall work with HSD to secure any required federal approvals or authority associated with the ATR grant.

   c. The SE shall assist HSD in preparing and submitting all reports required by the ATR grant and attend all meetings, conferences or site visits as requested by HSD or the Collaborative.

   d. The SE shall work with the Collaborative to identify ways to continue or transition services under this program should federal funding be discontinued.

14. **Screening, Brief Intervention, Referral and Treatment (SBIRT) Grant (HSD).** The SE shall develop, by July 31, 2006, a SBIRT service plan for the next two years in active partnership with the Collaborative. The plan shall incorporate the expertise and knowledge developed through the SBIRT project, reflect best practices, and include a plan to provide interim services prior to plan approval.

   a. SBIRT services shall be funded at a minimum of $3.075 million and shall continue to employ the Sangre de Cristo Community Health Partnership as the grant’s administrative agency.
b. The SE shall assist the SBIRT administration provider and DOH in preparing and submitting all reports required by the grant.

c. The SE shall ensure that all SBIRT data reporting requirements are met.

d. The SE shall work with the Collaborative to identify ways to continue or transition services under this program should federal funding be discontinued.

15. Sexual Assault Prevention and Intervention Services Statewide (HSD).

These services must comply with the “Sex Crimes Prosecution and Treatment Act” [29-11-1 to 29-11-7 NMSA 1978].

a. Services shall be comprehensive, confidential and sensitive to victims of sexual assault, as mandated by the Sex Crimes Prosecution and Treatment Act.

b. If utilizing Sexual Assault Advocate Volunteers (SAAV), the SE shall ensure that SAAVs complete a Sexual Assault Advocate Training Curriculum approved by HSD or its designee. This curriculum shall cover, at a minimum, the use of rape evidence kits, the legal process, and interventions to and support on behalf of sexual abuse victims at the time of crisis. The SE shall ensure that SAAVs complete a minimum of ten (10) hours of pertinent continuing education annually.

c. The providers of these services and the specific provider allocation shall be agreed upon by the SE and the Collaborative.

d. The SE shall ensure that these essential/specialty providers provide 24-hour, 7 day-a-week telephone services to victims, consumers, families, and significant others who are in crisis, and to callers who represent or seek assistance for persons in a crisis due to sexual assault.

e. The SE shall ensure that the HSD-funded Community Mental Health Centers (CMHC) provide sexual assault intervention services. This includes provision of an emergency response system, intervention to and support on behalf of the victims of sexual assault at the time of crisis, in an appropriate setting such as a hospital, school or church; provision of therapeutic services, and advocacy. The SE shall ensure that the CMHCs demonstrate the capacity to answer crisis calls from individuals seeking assistance for sexual victimization.

f. The SE shall ensure that all contracts with both specialty providers and the CMHCs contain all specific performance and service requirements contained in FY06 HSD contracts with those providers.

g. The SE shall ensure that the Sexual Assault Program Coordinators participate in the orientation training offered by the New Mexico Coalition of Sexual Assault Programs (NMCSAP). The SE shall ensure that the Sexual Assault Program Coordinators attend the twice-a-year Sexual Assault Program Coordinators meeting/training sponsored by the NMCSAP.

h. The SE shall ensure that the Santa Fe Rape Crisis Center and the Rape Crisis Center of Central New Mexico submit to the Collaborative an annual prevention plan that addresses delivery of the required activities no later than August 15 of the Contract Year. The SE shall ensure that these providers submit quarterly reports detailing their prevention activities including the number of crisis line calls received during the
quarter. These quarterly reports are due thirty (30) days after the end of each quarter.


a. The SE shall meet with HSD staff as soon as practicable to provide for a seamless transition to the SE of current programs and contractors. Transition matters to be acted upon by the SE and HSD staff include, but are not limited to: notice of changes to contractors, courts and interested parties; development of model orders, community outreach and education and other matters necessary to fulfill statutory obligations.

b. The SE shall designate a specific staff person to manage this program.

c. The SE shall provide the following services:

i. Adult Forensic Felony Evaluation. A comprehensive, written pre-trial evaluation of an adult defendant’s mental condition in a felony criminal case performed when a state District Court finds it desirable to use State facilities to assist in making the evaluation of a defendant’s competency to stand trial. The issue of amenability to treatment may be included only as it relates to their ability to be treated to competency. Amenability to treatment as a post-trial pre-sentence issue is not included under this service. The adult forensic evaluation shall be accomplished within court ordered and other legal timeframes. The Adult Forensic Evaluation includes a complete history and diagnostic evaluation and is intended to provide sufficient data regarding a defendant’s competency, which may limit the necessity of court testimony. Expert witness testimony, as may be required by the court, is included in this unit.

ii. Adult Forensic Misdemeanor Assessment. A written pre-trial assessment of an adult defendant’s competency to stand trial in a misdemeanor criminal case performed when a state District Court or the Bernalillo County Metropolitan Court finds it desirable to use State facilities to assist in making the assessment. The one reimbursable legal issue is competency to stand trial. The Adult Forensic Assessment shall only be performed on an outpatient basis and pursuant to the order of a State District or Bernalillo Metropolitan Court. The written Adult Forensic Assessment is intended to provide sufficient data on the issue of competency to stand trial.

iii. Forensic Evaluator Peer Review. A formal review process established to fulfill utilization management and quality assurance functions for Adult Forensic Evaluations and Adult Forensic Assessments performed by forensic evaluators, contractors, and their subcontractors. Funding for this review process is included in the overall funding for adult forensics.

iv. Court Feedback. A formal, annual review process established to allow Judges and other appropriate court personnel an opportunity to provide written feedback to the program manager regarding the performance of the contractors and subcontractors. In addition to
the written feedback, a mechanism must be in place which would allow Judges to contact a program manager or designee to report issues that require immediate resolution/attention.

17. General Fund Services for non-Medicaid and Medicaid Children and Families (CYFD). Funding is provided on behalf of children/adolescents, age birth to twenty-one (21), who are diagnosed with (or are at risk of developing) a serious behavioral/ neurobiological/ emotional disturbance, defined as a DSM-IV/ICD-9 diagnosis.

a. Target populations to be served through CYFD community-based children’s behavioral health services are identified and defined by CYFD as follows in priority order:

i. Children (and their families) referred by or involved with CYFD PS and/or JJS and/or Tribal Social Services. “Referred by” means children, youth and families who have been either formally or informally referred by the county PS or the Juvenile Probation/ Parole office or Tribal Social Services.

ii. Children involved with PS, JJS, or Tribal Social Services may receive services up to the age of twenty-one (21). "Involved with" means individuals and families who have an open case with PS, JJS or Tribal Social Services.

iii. Children up to age twenty-one (21) (and their families) at high-risk for services and at high-risk for entry into CYFD’s PS, JJS and/or Tribal Social Services.

b. All children/adolescents receiving CYFD General Fund services (Flexible Funding and Contract Funding) may continue to receive these services when the child/adolescent’s social, physical and environmental well-being has benefited.

c. Evidence-based practices for children receiving these services may include but are not limited to the following:

i. Functional Family Therapy (FFT) and Multi-systemic Therapy (MST)

ii. Psychotropic medication administration protocols for children/adolescents, including a review process for children/adolescents prescribed psychotropic medication to detect non-compliance with the protocol

iii. In those instances where the evidence-based treatments have not been validated or normed for a particular population, the SE shall not require providers to implement these treatments, but instead to incorporate culturally and linguistically responsive care.

d. The SE shall utilize flexible funding for services that support wraparound approaches. Funding allows for delivery of highly individualized treatment of behavioral health services for children and adolescents meeting the eligibility criteria. Services are primarily community-based to prevent out-of-home placement, but out-of-home placements may be funded on a limited basis, including those for undocumented children/adolescents. Non-Medicaid services such as the following may be considered:

- Home-based services
- Alternative therapies (i.e. Native American sweat lodge,)
- Religious/spiritual activities
- Language interpreters (i.e. Spanish, ASL, etc.)
- Multi-Systemic Therapy (MST)
- Intensive outpatient
- Respite
  - Infant Mental Health
  - Shelter Care
  - Transitional Living Services/Semi-Independent Living
  - Treatment Foster Care Room and Board
- Speech/Language, Occupational, and Physical Therapy for individuals diagnosed with Autism Spectrum Disorders.

At least 30 days before the start of each contract year, the Collaborative shall provide the SE specific instructions in the form of a Letter of Direction specifying which services and populations shall be prioritized, limitations on any services or eligible populations, and capitations on any services or eligible populations during the contract year.

e. The SE shall through provider contracts provide Shelter Care, immediate short-term overnight care for children and adolescents up to the age of twenty-one (21) and provides a safe, nurturing and structured environment and the opportunity for individuals to achieve the goals set forth in the individual’s Shelter Care Plan. Services are provided in a twenty-four (24)-hour licensed facility:

i. This service is designed to provide immediate short-term residential overnight care up to ninety (90) days, for children and/or adolescents, or adults up through the age of twenty-one (21), who meet a target population and are homeless or who cannot remain in their current home situation because of safety and other issues.

ii. Admission to shelter care is based not on medical necessity but on safety concerns related to the status of the child or adolescent as runaway, homeless, abused etc. Preauthorization is not required for this service.

iii. Shelter services may be extended up to an additional thirty (30) days with prior approval from the SE.

iv. The Shelter Care Plan may involve up to three-hundred sixty-five (365) days in a shelter to achieve plan goals for pregnant and/or parenting teenaged women

v. To ensure individuals in Shelter Care receive the full spectrum of necessary behavioral health and related services, all appropriate services, including but not limited to Medicaid-funded services or programs and DOH-funded services or programs, should be utilized for each individual as needed and billed to the SE.

f. The SE shall ensure through provider contracts the availability of Children’s/Adolescent Family-Based Shelter Care. This service is designed to provide immediate short-term residential overnight care in a family setting up to ninety (90) days, for children and/or adolescents, or adults up through the age of twenty-one (21), who meet a contracted target population.

i. Shelter services may be extended up to an additional thirty (30) days with prior approval from the SE.
ii. Admission to family-based shelter care is not based on medical necessity, but on safety concerns related to the status of the child as runaway, homeless, abused etc. Pre-authorization is not required for this service.

iii. The agency must be a New Mexico Licensed Child Placement Agency.

iv. To ensure family-based shelter care consumers receive the full spectrum of necessary behavioral health and related services, all appropriate services, including but not limited to Medicaid-funded services or programs and Federal Block Grant or State general Fund services or programs, should be utilized for each consumer as needed and billed to the SE.

g. The SE shall ensure through provider contracts Safehouse Investigative Interview services. An Investigative Interview is an interview performed at the request of Law Enforcement, PS, or Tribal Social Services as part of a child abuse investigation. A trained child interview specialist performs the interview in a neutral, child-friendly setting to optimize the accuracy and comprehensiveness of the child’s account. The goal of the interview is to produce sufficient quality and quantity of information to enhance the investigation for both law enforcement, PS, and Tribal Social Services and to minimize the traumatic effect on the child.

i. An Investigative Interview is one that must be conducted in cases of child sexual abuse, and/or physical abuse, and cases of sexual assault. The intent of the interview is to produce one that is of evidence quality, videotaped, and/or digitally recorded.

ii. The investigative interview must be guided by a multidisciplinary team, which shall consist of at least one of the following but is not limited to: Law enforcement (i.e. local/County Police, FBI, BIA, etc.); District Attorney’s Office; a PS worker from CYFD or Tribal Social Services. Additional team members may include: physicians, therapists, the guardian ad litem, etc. The interview should generate information that is forensically defensible.

h. The SE shall ensure through provider contracts Safehouse Investigative Interview with Advocacy services. Services to be provided by Family Advocate include, but are not limited to

i. Crisis services for the family;

ii. Education of the family about the investigative process in order to enhance cooperation with the investigation;

iii. Referrals made for the family for needed services, and assistance with the referrals;

iv. Support to the family throughout the investigation and subsequent legal proceedings.

i. The SE shall ensure, through provider contracts, Home Visiting services in Doña Ana, Santa Fe, and other counties. This service provides voluntary home visiting services to first time parents during pregnancy and continues to the third year of the child’s life to improve the health and well being of children and families. Home visits are conducted weekly for
the first year of the child’s life and as often as requested the second and third year but no more than weekly.

i. The SE shall ensure that all Home Visiting program service delivery elements, Home Visiting program requirements, and Home Visiting fee/payment rates are implemented in FY07 and thereafter.

j. The SE shall ensure through provider contracts residential treatment services for adolescent females. These services shall be provided at a treatment unit with gender-specific programming for adolescent girls who have a history of high-acuity mental/behavioral health issues, including but not limited to histories of violent and psychotic behaviors.

k. To the degree that funding is available, the SE shall ensure through provider contracts Early Childhood Mental Health Services (Infant Mental Health) throughout the State available for all families, as funds allow. The SE shall promote the use of the Infant Mental Health Training Institute to ensure that its providers are trained in the specific delivery model.

18. Community Services (CYFD). The SE shall work with the Collaborative to establish targets for increasing the number of children who travel less than sixty (60) miles from their home community to receive services. The targets and action plans will be developed within the first sixty (60) days of the contract period.

a. Develop an array of services that enable children and their families to be served within the least restrictive settings and whenever possible within their communities.

b. Create an individualized set of community services and natural supports for an effective wraparound approach to serve children/young adults and their families so that they can achieve positive outcomes and include the child/young adult and their family in every step of the process.

19. Adolescent Transitional Services (CYFD). In collaboration with CYFD and other Collaborative member agencies, the SE shall ensure the design and implementation of effective transitional services for adolescents moving from the youth delivery system into the adult system by developing a formal structure or structures, within the SE. In the design and implementation of these services, the SE shall, at a minimum, work with the Adolescent Transition Group and the CYFD Adolescent and Adoption Review Team.

a. The SE shall develop and maintain semi-independent and independent living services for youth transitioning from adolescence to adulthood.

b. The above transitional services shall not be limited to children and adolescents involved with, or in custody of, CYFD.

c. The SE shall have staff with expertise in the area of transitional living issues and who can function in the role of transitional living policy and program development liaison.

20. School-Based Behavioral Health Services (DOH, HSD, CYFD, PED). The SE shall participate in a Priority Work Plan process, as described in Article 2.4, with a cross-agency work group consisting of those state agencies concerned with behavioral health issues in schools and School-Based Health Centers (SBHC). Staff of the designated lead agency will convene and facilitate this Priority Work Plan process. A priority work plan for the coordination and provision of a continuum of school-based mental health
programs and services by the SE, including how these programs and services will be integrated with existing behavioral health services, will be developed no later than January 1, 2008.

1) The priority work plan will address priority areas needed to enhance and increase behavioral health services for children served in schools and SBHCs. Activities, at a minimum, will address the following:
   i) Development and expansion of school-based suicide prevention and response program activities;
   ii) Creation of transition programs to ensure successful transition for students moving between in-patient, residential treatment and community-based settings;
   iii) Identification and development of public policy reform needed to improve delivery and funding mechanisms for school-based behavioral health services;
   iv) Development and implementation of state standards for behavioral health services provided in schools;
   v) Identification and development of workforce development strategies to enhance skills and knowledge of child and adolescent behavioral health issues;
   vi) Identification and development of a regional mentorship model for schools using effective school-based behavioral health services;
   vii) Development and implementation of recruitment activities necessary to improve the network of providers available to provide behavioral health care delivered in school and SBHC settings;

2) The SE shall reimburse HSD-approved SBHCs for all allowable service codes, including enhanced services, as applicable, used in the delivery of school-based behavioral health care to Medicaid recipients.

3) The SE shall assist SBHCs in increasing their capacity to access Medicaid reimbursement by providing training and technical assistance to SBHCs as needed.

4) The SE shall provide meaningful representation on the SBHC/Medicaid Program Advisory Board quarterly, and on ad-hoc Board committees as requested.

5) The SE shall provide Medicaid encounter data on SBHC claims to HSD monthly or upon request.

6) The SE shall participate in school crisis response teams, in conjunction with Safe Schools Plans, for critical incident debriefing and counseling.

7) The SE shall use prevention funds for evidence-based prevention programs in schools that align with the New Mexico Health Education Content Standards with Benchmarks and Performance Standards, and shall use safe and drug-free school funds appropriately as allowable by the U.S. Department of Education guidance policies and/or regulations concerning Title IV for behavioral health programs, crisis response planning and implementation and training around behavioral health issues.

8) The SE shall collaborate with Title IV, health educators, prevention/intervention/post-intervention strategies on identified programs and communicate those interactions to the Collaborative.

The SE shall work in partnership with OSAH and PED to provide information and technical assistance to student assistance teams, local community health...
care systems, and local collaboratives to ensure access to the behavioral health services provided in and outside of schools and SBHCs, as requested. 9) The SE shall ensure that the following eligibility criteria are used for students served:

i) State general funds target high-risk students that are not currently eligible for Special Education Services in accordance with Individuals with Disabilities Education Act (IDEA).

ii) Funds may not be used to pay for services that Special Education departments are legally required to provide.

iii) The number of service hours per site is determined by contract.

21. State-Funded Peer Supports for Seniors (ALTSD). The SE shall, in collaboration with the Area Agencies on Aging, contract with licensed professional(s) to recruit, train and supervise volunteers to provide individual and group peer counseling services to persons age 55 and older. Such services shall be provided in home and community-based settings, including senior centers.

22. State General Fund and Federal Funds for Services for High-Risk Persons with Behavioral Health Needs, Discharged from Prisons of Jails to Probation or Parole Supervision in the Community (NMCD- CYFD)

a. The SE shall work directly with NMCD to assist in the resource management of the behavioral health needs of those individuals under their supervision in the community, both probationers and parolees as delineated in both the RFP and proposal to include, but not limited to, discharge planning, maintaining and enhancing the current provider network, linking individuals with services offered through other funding sources, provision for clinical consultation and case management, enhancement of linkages pertaining to pharmacy and telemedicine, and data collection and tracking of services provided across Collaborative agencies.

b. The SE shall ensure that providers, contracted directly to serve the behavioral health needs of adults under the supervision of the NMCD, work closely and proactively with the assigned Probation and Parole Officer and, at a minimum, provide clinical documentation as required, staff cases at least monthly, report program non-compliance, and develop a discharge plan with linkages to other community resources at the time of program completion.

c. In addition to working directly with NMCD, the SE shall work with the criminal justice system, both adult and juvenile, and shall at a minimum:

i) Promote behavioral health treatment as a viable alternative to incarceration by providing training on evidence-based practices, funding eligibility and benefits, provision for clinical consultation, resource, referral and assistance in the development of a network of local community providers to meet the needs of individuals diverted from the criminal justice system; and

ii) Support any emerging discharge planning initiatives for state sentenced individuals serving time in county jails generated within the jail or prison systems, juvenile correction facilities or detention system, and promote such initiatives by providing training on team staffing, discharge planning, funding eligibility and benefits, provision for

Deleted: For sites where new SBHC expansion funds are designated, the hours of service will follow the applicable level of service found in the OSAH Guidelines for Models of School-Based Health Centers.

Deleted: The SE shall implement a plan to ensure that behavioral health providers work in cooperation with public schools and school-based health centers (SBHC) throughout New Mexico to guarantee the provision of needed services and coordination of care. ¶

The SE shall work with the Collaborative to increase access to behavioral health services for children served in schools and SBHCs and their families. ¶

The SE shall maintain funding for school-based behavioral health services currently funded by Collaborative agencies. The SE shall further develop the continuum of school-based behavioral health programs and services by implementing screening, assessment, and early intervention and treatment services. ¶

The SE shall expand, in collaboration with the DOH Office of School and Adolescent Health (OSAH), HSD, PED, and CYFD, the continuum of school-based mental health programs and services by developing and implementing prevention, screening, assessment, early intervention, and treatment services, including those provided by community mental health providers working in schools, those working as part of SBHCs, and those provided by schools and school behavioral health professionals. ¶

Funding provided by DOH shall be for the sole purpose of providing access to behavioral health services for students who have no other...[5]

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clinical consultation and case management, and assistance in the
development of a network of local community providers to meet the
needs of releasing individuals.

d. The SE shall work with the Collaborative to identify and develop
intervention strategies with at risk youth entering juvenile detention
centers. The SE and the Collaborative shall develop strategies to avert
detention when possible with the utilization of community based providers
as an alternative to detention.

e. The SE shall work with county detention centers as requested and NMCD
to identify Medicaid-eligible consumers and to assist these individuals in
applying and/or reinstating those benefits upon release back to the
community.

f. The SE shall ensure that the NMCD provider network is maintained and
will discuss with NMCD if changes in providers or programming changes
are recommended (i.e. “best practices”) and get NMCD’s concurrence
prior to changes being made.

g. The SE shall work closely with NMCD in regards to replacement of
services/subcontracts when needed to meet the needs of individuals
involved with NMCD.

h. The SE shall work with NMCD in the development of provider Scopes of
Work to ensure criminal justice needs are addressed and that individual
service component allocations are created, to the extent possible, to
ensure Parole Board/Court-ordered treatment is prioritized.

i. Provider site visits/audits will include a review of compliance with
specific deliverables to NMCD.

ii. Provider site visits/audits will include a review of expenditure
balance and services delivered for compliance with Scope of Work.

23. Behavioral Health Prevention Programming (DOH). The SE shall work
closely with the Office of Substance Abuse Prevention (OSAP) in developing
a Management Letter pursuant to Article 2, Section 2.2 of this Contract to
describe the details of prevention programming to be funded by the SE.

a. The SE shall work with New Mexico’s Prevention Services System,
including PED, DOH, CYFD, HSD, DFA, Center for Substance Abuse
Prevention (CSAP), Southwest Center for the Application of Prevention
Technology (SWCAPT), and others, to develop a state-of-the-art
prevention service system which aligns with New Mexico Health
Education Content Standards with Benchmarks and Performance
Measures. Standards in schools and addresses the entire web of influence
including alcohol, tobacco, illicit drugs, suicide, violence, gangs, teen,
pregnancy, and youth development.

b. The SE shall utilize the evidence-based prevention definition provided by
the Center for Substance Abuse Prevention (CSAP) and any related
program criteria approved by OSAP.

c. The SE shall work with OSAP to implement the five steps of the Strategic
Prevention Framework (SPF) in New Mexico. These steps are required,
and all targeted communities must implement all five steps whether
funded though the SPF-SIG grant or through other sources.
d. The SE shall work with OSAP and the Prevention Advocates to establish priorities and make funding decisions based on those priorities and evidence of successful use of the strategic prevention framework.

e. The SE shall work with OSAP and the Prevention Advocates group to plan for the continued and sustained implementation of evidence-based prevention programming in New Mexico.

f. The SE shall work with the Prevention Advocates to plan for the continued and sustained implementation of evidence-based prevention programming in New Mexico.

g. The SE shall support a prevention continuum of services that is made up of the following items:

i. Evidence-based programs focused on youth 0 to 6 years of age and their families;

ii. Evidence-based programs focused on youth 0 to 6 years of age and their families;

iii. Evidence-based programs focused on youth from kindergarten through grade 6 and their families;

iv. Evidence-based programs focused on 12 to 17 year old youth;

v. For the SPF-SIG grant evidence-based environmental strategies focused on impacting alcohol use patterns of 15-24 year old youth at risk of drinking and driving, especially binge drinking and underage drinking; and

vi. Strong and sustained coalition development activities designed to impact community level indicators.

24. State-Operated Facility Services (DOH). Behavioral health services offered by State-operated (DOH and CYFD) facilities are critical to the success of a single behavioral health care delivery system for the State of New Mexico. The purpose of the transfer of these state-operated program funds to the SE during FY07 with concomitant payment by the SE to the state operated programs is a process designed to allow DOH as a provider, and individual facilities operated by DOH and providing behavioral health services, to learn how to operate successfully as a part of the single statewide behavioral health system, including maximizing billing; providing high-quality inpatient and residential treatment services; and expanding or shifting to provide an array of non-facility, community-based services to meet the needs of consumers receiving care through this Contract. Accordingly, the SE will work with the Collaborative and its member agencies DOH and CYFD during the three (3) years of this Contract to implement this transfer of resources.

a. In FY07, the SE shall do the following:

i. Work with the Collaborative and especially DOH to develop a Management Letter pursuant to Article 2, Section 2.2 of this Contract to guide the transfer of these resources and the development of additional services operated by DOH;

ii. Determine what portion of funding for the Behavioral Health Institute at Las Vegas (BHI/LV), Turquoise Lodge, Yucca Lodge and
Sequoyah Adolescent Treatment Center will be subject to this Contract in FY07; and what other resources, if any, utilized by these state operated programs and by Ft. Bayard or other DOH or CYFD facilities or programs will be added to this process for FY08 and FY09;

iii. Ensure that DOH-operated programs in FY07 receive back from the SE at least as much revenue as the SE receives from DOH and the Collaborative from these resources;

iv. Provide technical assistance to DOH-operated programs with third-party billing (including but not limited to Medicaid, Medicare and private insurance resources) so that overall revenue from third-party sources increases for FY07;

v. Assist DOH-operated programs in identifying service approaches for which they are particularly well-suited and positioned, and develop plans (including programmatic and fiscal elements) to begin the delivery of such services for FY08 and beyond;

vi. Conduct pre-admission screening and/or post-admission assessments or utilization reviews and/or providing DOH-operated programs with training and technical assistance to conduct such assessments to identify individuals admitted to these facilities who could be served in less intensive or less restrictive settings, especially when such approaches would result in additional resources for DOH, the Collaborative and/or consumers served;

vii. Assist DOH-operated programs to provide the SE with encounter or service utilization data as if they were billing for each service rendered;

viii. Provide DOH with monthly reports by program regarding what revenue the facility would have collected had it been dependent on billings for its revenue, and assisting the Collaborative, DOH, and the DOH Facilities to understand the implications of these reports; and

ix. Develop a plan with DOH and CYFD for the Collaborative for FY08 and FY09 regarding how state-operated program resources can best be used to maximize service delivery, quality and revenue, based on the experiences during FY07.

b. The SE shall be allowed to retain up to ten (10) percent of the resources provided by the Collaborative from state-operated program funds if, and only, if these DOH programs are able to increase their third-party revenues by twice the amount retained; for example, the SE may retain one (1) percent of the General Fund (GF) amount provided by the Collaborative if the amount of increased revenues for the affected programs as a whole is equal to or exceeds two (2) percent of the GF amount provided; likewise the SE may retain ten (10) percent if the amount of increased revenues is equal to or exceeds twenty (20) percent of the amount provided, and so forth.

25. Juvenile Detention Centers (CYFD). The SE shall work with CYFD and county juvenile detention centers to develop services, including screening, assessment and treatment, for Medicaid-eligible consumers in detention centers.

a. The SE shall, upon request, provide consultation to CYFD staff for the appropriate level of care/type of service needed for youth leaving juvenile
detention centers. This request for consultation should not be considered a request for authorization for care or services.

b. Temporary lack of Medicaid eligibility shall not prohibit screening, assessment, placement, and follow-up care planning while a youth is being held in detention or other CYFD JJS facilities

c. The SE shall consult with CYFD for appropriate intervention services for youth in detention, when requested.

26. Emergency Shelter Grants (HSD, MFA). The SE shall develop a secure data interface to collect data from the Homeless Management Information System (HMIS). Deleted: DOH

a. MFA shall issue an RFP for Homeless Services and select the contractors to provide the services in FY07 in accordance with MFA’s standard procurement procedures. MFA will enter into contracts with selected contractors and will assign the contracts to SE prior to the beginning of FY07.

b. For FY08, the SE shall determine appropriate providers of these services in accordance with the SE Provider Network development process.

27. Supported Housing (HSD, MFA). The SE shall commence implementation of Supported Housing tasks and initiatives as identified in the Collaborative Statewide Housing Plan and communicated through a transmittal letter to the SE following completion of the Statewide Housing Plan but no later than September 1, 2007.

1. The SE shall arrange for housing support services to be provided to priority consumers who are identified as eligible for housing support services as defined in the Statewide Housing Plan. Priority consumers will be identified by DOH, HSD or CYFD or their designated agencies.

2. The SE will provide or arrange for technical support on the organization and provision of housing support services.

3. The SE will assure clarity in provider contracts for move in assistance, support services, referrals, tenant/landlord relations and other tasks associated with a consumer sustaining housing for people moving into supportive housing arrangements as defined in the Statewide Housing Plan.

4. The SE shall maintain a move-in assistance/eviction prevention loan fund for priority consumers as defined as eligible for supportive housing. (see a. above). The SE shall update and submit local move-in assistance and eviction prevention loan fund management plans for approval by the Collaborative Housing Coordinator that include eligibility criteria, loan agreements, and loan repayment schedules.

5. The SE shall assign a regional housing specialist for each of the six (6) service regions.

6. Housing specialists shall be available for a two day training to be scheduled by the Collaborative Housing Coordinator in the first quarter of the contract year. The Coordinators shall meet

Disaster Behavioral Health Planning and Response. The SE shall participate in disaster behavioral health planning and response in collaboration with the Behavioral Health Services Division and the DOH/Bureau of Emergency Health Management. The participation of the SE in these activities is intended to ensure that the disaster-related emotional needs of individuals with chronic behavioral health disorders, other special populations, the general public and emergency responders will be addressed in a systemic and systematic fashion, and services will be responsive and appropriate to the specific needs of the disaster event and recipients of the services:

a. The SE shall participate in planning activities for statewide disaster behavioral health preparedness and response.

b. The SE shall participate in disaster behavioral health training activities to develop a cadre of providers and individuals prepared to respond to behavioral health needs in a disaster event.

c. The SE shall coordinate with the State Mental Health Authority, to implement behavioral health response activities in the event of a local, state or federally declared disaster. In the event of such as declared disaster, activities shall include participation in identifying individuals to provide psychosocial support services in collaboration with the NM Serves Volunteer Registry initiative coordinated by the DOH/Bureau of Health Emergency Management.

d. In the event of a federally declared disaster, the SE shall coordinate with the Collaborative to locate providers to participate the FEMA and SAMHSA funded Immediate and Regular Service Program Crisis Counseling Services grants. The SE shall also serve as a flow-through of funding for these grants. Management of these grants will be performed by HSD.

e. The SE, through specific subcontract language, shall encourage that its network of providers participate in disaster behavioral health planning efforts at their local area level. The focus of this activity is to ensure that
the needs of their priority populations are addressed in the local emergency plans maintained by Local Emergency Managers (LEMs). In addition, each provider shall develop and maintain an emergency response protocol that evidences collaboration with emergency management, law enforcement, and other first responder personnel in their counties and local communities.

f. The SE, through specific subcontract language, shall encourage that the provider plans be consistent with the protocol for statewide disaster behavioral health response described in the New Mexico Department of Health Emergency Operations Plan, Psychosocial Annex.

29. Supported Employment (HSD). The SE shall provide support for the existing Supported Employment Initiative that includes best practice models and related fidelity scales to measure progress on a quarterly and yearly basis.

a. The SE shall ensure the presence for each of the six (6) service regions of a regional supported employment specialist who shall

i. provide/arrange for training of basic job assessment, job development and coaching, placement with the business community and the development and support of long-term supports.

ii. hold quarterly meetings with employment services personnel within the region to identify problem areas, training needs, development of employment strategies to advance employment services effectively and efficiently in the region; and conduct an annual evaluation of the IPS program; and

iii. submit reports on employment services within each region.

30. State Coverage Insurance (SCI). In FY08, the SE shall ensure, through its provider network, the full array of covered Behavioral Health services for the SCI program. The SE and HSD, or its designated SCI contractors, shall come to agreement on the rates, rate structures, policies, and procedures necessary for covering services under this program. The SE and HSD, or its designated SCI contractors, shall have policies and procedures in place for administering services, coordinating care and benefits, submitting encounter information and reports, and receiving enrollment data and reimbursement for the SCI program.

A. 4.2 Requirements for Individuals with Special Health Care Needs. The SE shall work with the Collaborative to develop new ways of identifying and serving ISHCN.

B. With regards to ISHCNs, the SE shall

1. Have written policies and procedures in place that govern how ISHCNs shall be identified. These policies/procedures shall be approved by the Collaborative prior to implementation.

2. Have written policies and procedures in place to allow direct access to necessary care, consistent with access appointment standards for clinical urgency.

3. Have written policies and procedures in place to ensure that the appropriate level of transportation is arranged, based on the individual’s clinical condition.
4. Have written policies and procedures on the provision of care coordination for ISHCNs, including an internal operations process for applying criteria for determining who will receive such services.

5. Have written policies and procedures for educating ISHCNs and their parent and/or legal guardians regarding the availability of care coordination and when it may be appropriate to their needs.

6. Have written policies and procedures for educating ISHCNs, their family members and/or caregivers on how to access emergency room care and what clinical history to provide when emergency care or inpatient admissions is needed; how to coordinate with the PCP or primary BH specialist when an ISHCN is hospitalized; how to ensure that the emergency room physician has access to the ISHCN’s medical and/or behavioral health clinical history; and obtaining any necessary referrals for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

7. Have written clinical practice guidelines, practice parameters and other criteria that consider the needs of the ISHCN and provide guidance in the provision of acute and chronic behavioral health care services to this population.

8. Have written policies and procedures to ensure that care for those with chronic health care needs shall not be unnecessarily delayed or hindered by the prior authorization process. There shall be a process for review and periodic update for the course of treatment, as indicated.

9. Develop and distribute to ISHCNs, their caregivers, parents and/or legal guardians, as appropriate, information and materials specific to the needs of this population. This includes information such as items and services that are provided or not provided by the SE, information about how to arrange transportation and which services require a referral from a PCP. The ISHCN, family, caregiver or legal guardian shall be informed on how to present the individual for care in an emergency room that maybe unfamiliar with his or her special health or behavioral health care needs. This information may be included either in a special consumer handbook or in an ISHCN insert to the SE consumer handbook.

10. Provide behavioral health education information to assist an ISHCN and/or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including behavioral health conditions.

11. Provide ISHCNs and/or caregivers a list of key SE resource people and their telephone numbers. The SE shall designate a single point of contact that the ISCHN and/or their caregivers or provider may call for information.

12. Ensure that each identified ISCHN is assessed by an appropriate behavioral health care professional regarding the need for care coordination, and that the process is coordinated with the MCO or other physical health provider, should the individual have both physical and behavioral health special needs.

13. The SE shall work with the Collaborative to develop and track performance indicators specific to ISHCNs.

ARTICLE 5 –ADMINISTRATION REQUIREMENTS: PHASE TWO
5.1 Administration

A. The SE, in providing the services under this Contract, shall manage all covered behavioral health services, including mental health and substance abuse services for both Medicaid and non-Medicaid individuals; account for funding and other requirements of State agencies within the Collaborative; and identify, track and report all allowable and non-allowable expenses and utilization for required State and federal reporting, by fund source and by individual consumer. The SE shall ensure the delivery of cost-effective quality services for consumers receiving behavioral health services through the Collaborative.

B. The SE shall not make any significant changes to the behavioral health system or programs during the State’s Legislative session or for sixty (60) days preceding or following the Legislative session. The SE shall provide notice to the Collaborative Co-Chairs sixty (60) days prior to making any such changes before the State’s Legislative Session or shall provide notice of any such changes sixty (60) days after the end of the Legislative Session.

C. The SE shall ensure that services to consumers are minimally disrupted when changes are made to the package of available services.

5.2 General Program Requirements

A. General Program administration requirements shall include all the following:

1. Establishment and management of a process for eligibility and priority determination for all persons served for all funding sources. Eligibility and priority determination criteria are set forth in the relevant rules and policy manuals of the Collaborative member agencies.

2. Utilization of consistent written and electronic forms for universal credentialing, daily operations, clinical assessments, utilization review, service authorization, and billing purposes in order to reduce costs and administrative burdens on providers.

3. Use of a financial reporting system that tracks and is able to report all financial information for each of the fund sources under this Contract.

4. Use of a Data/Information Management System that allows for the collection and reporting of all information necessary for specific reporting requirements for each program and fund source.

5. Continued maintenance of a statewide provider network sufficient to meet the behavioral health service needs of eligible and priority populations.

6. Use of a system that provides for accurate and timely payments to providers in full compliance with all state and federal laws and regulations.

7. Continue to develop and implement a plan, approved by the Collaborative, for moving toward a uniform system of service rates and payment mechanisms across Collaborative funding streams, specifically utilizing the Collaborative common service definitions.

   a. The plan shall be presented to the Collaborative for approval no later than August 1, 2007.

   b. The SE shall work with Collaborative staff, as appropriate, in the implementation of its plan.
c. The SE shall present any substantive changes to its plan to the Collaborative for review and approval prior to making those changes.

d. The SE shall include in its plan:
   i. the changes it will need to make to its fiscal and claims payment systems to implement its plan;
   ii. how it will give providers the support and training that may be necessary in making the transition to the system;
   iii. how it will minimize impact on providers where more uniformity will result in a lower reimbursement rate for a particular provider, provider type, or geographic area; specifically, how it will phase in rate changes that will likely lower a high-volume or specialty provider’s overall revenue by more than ten (10 percent in any six (6)-month period;
   iv. how all providers will transition to a fee-for-service payment system, with a timeline for implementation, and
   v. how its uniform rate structure will assist access in rural and frontier areas.

e. The SE shall further progress toward the goals of more uniform rate and payment processes through the implementation of this plan.

f. The SE will be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty so long as a justifiable reason (i.e., access, volume) for doing so exists;

8. Development and implementation of a system for provider training on billing practices, rate structures, and service issues, to include requirements for credentialing, certification, and professional licensure

5.3 Provider Network Requirements

A. The SE shall maintain a comprehensive network of providers willing and capable of serving consumers enrolled in behavioral health services programs as follows:

B. The SE is solely responsible for the provision of covered services and must ensure that its network includes providers and specialists in sufficient numbers to ensure that all services included in the package are available in accordance with access standards.

C. The SE shall contract with the full array of providers necessary to deliver the services set forth in this Contract and shall take into consideration the characteristics and health care needs of its eligible populations. In establishing and maintaining the network of appropriate providers, the SE shall consider the following:

   1. The geographic location of providers compared with eligible consumers, considering distance and travel time;
   2. The numbers of network providers who are not accepting new consumers;
   3. Whether the location provides physical access, information technology, and written material accessibility for eligible consumers, including consumers with disabilities; and
   4. Whether there are a specific number of providers capable of delivering the services as required under this Contract.
5. The SE shall work with and support the Collaborative to ensure the availability of basic behavioral health services within each Region, including case management/community support, outpatient counseling/therapy, and pharmacotherapy services.

A. The SE shall notify the Collaborative within five (5) business days of unexpected changes to the composition of its provider network that would have a significantly negative affect on consumers or on the SE’s ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in the SE provider network shall be reported to the Contract Manager in writing within thirty (30) days prior to the change, or as soon as the SE knows of the anticipated change. A notice of significant change must contain:
   1. the nature of the change;
   2. how the change affects delivery of or access to covered services; and
   3. the SE’s plan for maintaining access and the quality of consumer care.

B. Notwithstanding the SE’s right to negotiate rates with individual providers as it manages its provider network, the SE shall give the Collaborative at least sixty (60) days notice prior to any proposed changes that would broadly affect provider rates or the provider network. No proposed changes shall go into effect without giving the Collaborative the right to hold public meetings and otherwise obtain public input related to these proposed changes. Thereafter, the SE shall give the Collaborative notice of the effective date of any proposed changes.

C. The SE shall maintain policies and procedures on SE provider recruitment, termination, or appeal thereof. The recruitment policies and procedures shall describe how the SE responds to a change in the network that affects access and its ability to deliver services in a timely manner. The SE shall not:
   1. discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
   2. discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider’s license or certification under applicable state law solely on the basis of the provider’s license or certification;
   3. decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;
   4. be required to subcontract with providers beyond the number necessary to meet the needs of its consumers;
   5. employ or subcontract with providers excluded from participation in federal health care programs because of misconduct or other eligibility requirements; and
   6. be required to contract with providers who are ineligible to receive reimbursement under Medicaid fee-for-service.

7. discriminate and/or retaliate against providers who file grievances.

8. The SE shall not limit or interfere with providers’ efforts to lobby and/or air opinions and concerns regarding their interactions with the SE or their business interests.
D. The SE shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to consumers.

E. The SE shall have written policies and procedures regarding any referral processes. The SE referral process shall be effective and efficient and not impede timely access to and receipt of services.

F. The SE shall have a system to refer consumers to providers who are not affiliated with the SE network if providers with the necessary qualifications or certifications to provide the required care do not participate in the SE’s network.

G. The SE or a provider may initiate a change of provider when the consumer’s or guardian’s behavior toward the provider is such that the provider has made all reasonable efforts to accommodate the consumer or guardian and address the consumer or guardian problems, but those efforts have been unsuccessful. If the SE initiates such change in provider, the consumer or guardian has the right to file a grievance or appeal as outlined in the terms of this contract.

H. The SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials to its network providers.

1. The SE shall provide information to providers that will
   a. inform providers of the conditions of participation with the SE;
   b. inform providers of their responsibilities to the SE and to enrolled consumers;
   c. inform providers of fund-specific policies and procedures (including but not limited to Medicaid), including information on primary and specialized medical care and related information and services specific to the needs of ISHCN and other special populations;
   d. inform providers regarding cultural competency and how to access educational opportunities for providers and their staff on cultural competency;
   e. provide information on credentialing and recredentialing, prior authorization and referral processes and how to request and obtain a second opinion;
   f. inform providers on how to access care coordination services for individuals with physical, behavioral and social support needs, including benefits and services outside the benefit package for those consumers covered by Medicaid;
   g. inform providers regarding the delivery of the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; provide information and training to families and guardians who are eligible for EPSDT services about accessing those services; involve families and guardians as active participants together with PCPs and behavioral health clinicians for the services to be provided;
   h. furnish providers with information on the SE’s internal provider grievance process by which providers can dispute a SE action and file a complaint;
   i. inform providers about their responsibility to report critical incident information and the mechanism to report such information; and
j. Inform providers regarding the delivery of services to children in the custody of the State, including but not limited to issues related to consent, progress reporting, and potential for court testimony.

I. The SE shall conduct an annual provider satisfaction survey, the results of which shall be incorporated into the SE’s quality management and quality improvement (QM/QI) program. Survey results shall be reported to the Collaborative.

J. The SE shall actively solicit input from its network providers in an effort to improve and resolve problem areas related to its programs and incorporate this information into the SE’s QM/QI program.

K. The SE shall work with the Collaborative to identify, develop and implement training and systems change strategies that will result in the development, recruitment and retention of the behavioral health workforce.

1. The SE shall work with all advisory groups and agencies identified by the Collaborative to develop and implement a Treatment Training Plan that shall identify and prioritize training needs of providers and practitioners under contract with the SE. The plan shall specify the type, content, and frequency of training and/or technical assistance (TA) that shall be made available to all providers and practitioners once approved by the Collaborative.

2. The SE shall incorporate this plan, its implementation, and the training and TA outcome evaluation into its QI process.

3. In prioritizing the providers’ training needs, the SE shall identify and implement training that upgrades and maintains the clinical strength of providers and practitioners and their capacity to support recovery and resiliency for consumers.

4. The SE shall ensure that training is made available to providers and practitioners on a repetitive basis.

5. The SE shall maintain and continue these activities with its network providers throughout the term of the provider contractual relationship.

6. The SE shall maintain a record of these activities, which shall be made available to Collaborative member agencies upon request.

O. The SE may, as necessary to meet its requirements under this section, include in its contracts with providers any provisions necessary to ensure that services are provided consistent with the terms and conditions of this Contract.

5.4 Provider Credentialing Requirements

A. The SE shall document the mechanism for credentialing and recredentialing practitioners and providers with whom it contracts or employs to treat consumers who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of providers covered, the credentialing criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or recredentialing arrangements.

B. The SE’s credentialing and recredentialing policies and procedures shall adhere to all applicable Collaborative standards and requirements. The written polices and procedures for the credentialing process that may not be discriminatory under applicable state or federal law, which include the SE’s initial credentialing of practitioners, as well as its subsequent re-credentialing, recertifying and/or
reappointment of practitioners. The credentialing process shall be completed within sixty (60) days from receipt of completed application for all required documentation unless there are extenuating circumstances.

C. Credentialing requirements and processes shall be streamlined and enable practitioners to move across agencies and settings without unnecessary restrictions, once credentialing has been granted. The requirements shall be developed in ways that recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.

D. The SE shall ensure that all contracted providers meet the credentialing and recredentialing requirements of all applicable Collaborative standards and policies. Requirements and procedures shall apply to both existing as well as new providers.

E. The SE shall have a process for receiving input from providers regarding the credentialing and recredentialing process.

F. The SE shall ensure that all providers maintain the professional credentialing and training necessary to provide the services they offer. The SE shall utilize quality management data in conducting provider re-credentialing, re-contracting and/or performance evaluations.

G. The SE shall maintain records, information systems, or credentialing contracts that verify its credentialing activities, including primary source verification, and compliance with credentialing requirements.

H. The SE shall maintain and, upon request, submit to the Collaborative a roster of all providers by type, expertise, geographical location, disability population access, and language abilities.

I. The SE shall credential CYFD and DOH facilities, as allowed by regulations, and as requested by the those agencies, to provide behavioral health services. The SE shall utilize assessments and evaluations of consumers conducted by Collaborative-credentialed professional staff in the CYFD PS and JJS programs and in DOH facilities in its determination of medical necessity and appropriate level of care.

J. At the time of provider credentialing, the SE shall verify or ensure verification of the following information from primary sources:

1. A current valid license to practice; as applicable;
2. The status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;
3. Valid DEA or controlled substance registration (CSR) certificate, if applicable;
4. Education and training, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;
5. Board certification if the provider states on the application that the provider is board certified in a specialty;
6. Current, adequate malpractice insurance, according to the SE’s policy, and history of professional liability claims that resulted in settlement, or judgment paid by or on behalf of the provider; and
7. Complete history of consumer complaints.
K. The SE shall use a Collaborative-approved credentialing form. The provider shall complete a credentialing application that includes a statement by the applicant regarding
   1. ability to perform the essential functions of the positions, with or without accommodation;
   2. lack of present illegal drug use;
   3. history of loss of license and felony convictions;
   4. history of loss or limitation of privileges or disciplinary activity;
   5. any history of sanctions, suspensions or terminations imposed by Medicare, Medicaid and/or other authorities;
   6. history of consumer complaints and their resolution;
   7. the correctness and completeness of the application; and
   8. any other information required by the SE in order to make a credentialing decision.

L. Before a provider is credentialed, the SE shall receive and consider information on the provider from the following organizations and shall include the information in the credentialing files:
   1. National practitioner data bank, if applicable to the provider type;
   2. Information about sanctions, complaints or limitations on licensure from the following agencies, as applicable:
      a. State Board of Medical Examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;
      b. State board of nursing;
      c. The appropriate state licensing board for other provider types for behavioral health;
      d. Other recognized monitoring organizations appropriate to the provider’s discipline;
      e. Medicare, Medicaid, and/or other authorities as applicable.

M. At the time of credentialing, the SE shall perform an initial visit to the offices of potential high-volume behavioral health care providers, prior to acceptance and inclusion as participating providers.
   1. The SE shall determine its method for identifying high-volume behavioral health providers.
   2. The SE shall document a structured review to evaluate the site relative to the SE’s organizational standards and standards identified by the Collaborative.
   3. The SE shall document an evaluation of the medical record keeping practices at each site for conformity with the SE’s organizational standards.

N. The SE shall have formalized recredentialing procedures and shall formally recredential its providers at least every three years. During the recredentialing process, the SE shall verify the following information from primary sources:
   1. A current valid license to practice; as applicable;
   2. The status of clinical privileges at the hospital designated by the provider as the primary admitting facility;
   3. Valid DEA or CSR certificate, if applicable;

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4. Board certification, if the provider was due to be recertified or became board certified since last credentialed or re-credentialed;

5. A history of relevant professional liability claims that resulted in settlement or judgment paid by or on behalf of the provider; and

6. A current, signed attestation statement by the applicant regarding:
   a. ability to perform the essential functions of the positions, with or without accommodation;
   b. lack of present illegal drug use;
   c. history of loss of license and felony convictions;
   d. history of loss or limitation of privileges or disciplinary activity;
   e. any history of sanctions, suspensions or terminations imposed by Medicare, Medicaid and/or other authorities;
   f. history of consumer complaints and their resolution;
   g. the correctness and completeness of the application; and
   h. any other information required by the SE in order to make a credentialing decision.

O. The SE shall provide evidence that, before making a recredentialing decision, it has received and considered information about sanctions, consumer complaints or limitations on licensure from the following agencies, if applicable:
   1. The national practitioner data bank;
   2. Medicare, Medicaid, and/or other authorities;
   3. The appropriate state licensing board; and
   4. Other recognized monitoring organizations appropriate to the provider’s discipline.

P. The SE shall incorporate data from the following sources in its recredentialing decision-making process for providers:
   1. Consumer grievances and appeals;
   2. Information from quality management and improvement activities; and
   3. Medical record reviews conducted under Subsection E of 8.305.8.14 NMAC.

Q. The SE shall have policies and procedures for altering the conditions of the provider’s participation with the SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the SE may take to improve the provider’s performance prior to termination.
   1. The SE shall have procedures for reporting to appropriate authorities, including the Collaborative, serious quality deficiencies that could result in a provider’s suspension or termination.
   2. The SE shall have an appeal process by which the SE may consider provider concerns regarding a proposed change in the conditions of a provider’s participation based on issues of quality of care and service. The SE shall inform providers of the appeal process in writing.

R. The SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with which it intends to contract or with which it is contracted. Organizational providers are those that offer services related to behavioral health, including both mental health and/or substance use disorders, and include but are not limited to residential treatment centers, clinics

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including community mental health centers, twenty-four-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals.

1. At least every three (3) years, the SE shall confirm that the provider is in good standing with state and federal regulatory bodies, including Collaborative agencies as appropriate, and is accredited or certified by the appropriate accrediting body and state certification agency or meets standards of participation required by the SE.

2. The SE shall confirm that the provider has been certified by the appropriate state certification agency, when applicable. Behavioral health organizational providers and services are certified by the following:
   a. DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and
   b. CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification.

3. The SE shall confirm that the appropriate accrediting body has accredited the provider or that the provider has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time, if accreditation is required.

5.5 Utilization Management Requirements

A. The SE shall provide appropriate utilization management (UM) activities for the provision of services under this Contract. The Collaborative requires the implementation of UM standards and activities to ensure the provision of appropriate services in a coordinated fashion with neither over- nor under-utilization.

1. The SE’s UM program shall be based on standard external national criteria, where available, and established clinical criteria that are consistent with applicable Collaborative requirements. Such criteria shall be available to providers, consumers, and the public upon request.

2. The SE’s UM program shall assign responsibility to appropriately qualified, trained, and experienced individuals in order to manage the use of limited resources; maximize the effectiveness of care by evaluating clinical appropriateness; authorize the type and volume of services through fair, consistent and culturally competent decision making; and ensure equitable access to the best available care for the individual’s needs.

B. The SE shall establish, maintain and monitor a UM system that includes an efficient decision-making process and the application of clear and consistent criteria for admission, continued stay and discharge into each service with criteria appropriate to each population and funding source.

1. The SE shall establish and implement a UM system that follows national standards, promotes quality of care, adherence to standards of care, the efficient use of resources, consumer choice, and the identification of service gaps within the service system.

2. The SE’s UM system shall
   a. ensure that consumers receive services based on their current condition and effectiveness of previous treatment;
b. ensure that services are based on the history of the problem/illness, its context, and desired outcomes;
c. assist consumers and/or their families or consumer-identified surrogate decision makers in choosing among providers, practitioners, and available treatments and services; and,
d. be structured to emphasize relapse and crisis prevention, not just crisis intervention.

3. The SE shall educate its UM staff and providers in the application of its UM system, clearly articulating the criteria to be used in making UM decisions and describing specific care management and care coordination functions.

4. The SE shall develop protocols, procedures and criteria for assessing medical, clinical or psychosocial necessity as appropriate to the individual and the funding source, making level-of-care determinations, and authorizing services. Such protocols shall incorporate the definition of medically/clinically/psychosocially necessary services as outlined in 8.305.1 NMAC, the ASAM patient placement criteria, Collaborative member agency service manuals, and other guiding documents. Level-of-care criteria shall be disseminated to providers, consumers, their families, and the public upon request.

5. The determination of medical necessity for Medicaid shall be based on the Collaborative’s medical necessity definition and its application. The SE shall ensure that all medically necessary referrals are arranged and coordinated by either the referring provider or by the SE’s care coordination unit.

C. The SE shall maintain records and/or information systems that will verify its utilization management activities and compliance with UM requirements.

D. The SE shall specify which services will and will not require prior authorization and how the SE will conduct initial, concurrent and retrospective reviews. In all circumstances in which services are authorized at a more or less intensive level of care than requested, the SE shall establish protocols or policies that specify how it will ensure that the level and duration of such services are appropriate.

E. The SE shall establish procedures for honoring advance directives within its UM protocols.

F. The SE shall establish a policy and protocol that protects against conflict of interest in the assignment of referrals and protects the UM system from excessive or inappropriate self-referral or other potential conflicts of interest that might be created in conducting UM functions.

G. Consumers will have an optimal choice of provider agencies and practitioners consistent with their treatment needs and available providers.

H. For each level of care, the SE shall describe the amount and type of choice consumers or their families or consumer-identified surrogate decision makers will be offered in provider organizations and practitioners, in services, and in time and location of the same. The SE shall also describe the options available when their initial selection of provider(s) of services proves unsatisfactory to the consumer, family or consumer-identified surrogate decision maker.

I. In the provision of services to children, the SE shall not require prior authorizations for the following:

1. Evaluations performed for children, adolescents or young adults up to age twenty-one (21) preparing to transition out of a twenty-four (24)-hour facility, including juvenile correctional facilities
2. School-based services except to prevent duplicate services or payment for the same service for the same child

J. The SE shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The SE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the beneficiary’s diagnosis, type of illness, or condition.

K. An updated written description of the SE’s UM program shall outline the program structure and include a clear definition of authority and accountability for all UM activities conducted by the SE or by entities to which the SE delegates UM activities. If any of the SE’s UM functions are delegated to subcontractors(s), the SE shall do so only after approval by the Collaborative, and the SE shall remain fully responsible for all decisions and quality of care.

1. The program description shall reflect the entire scope of the program including: the processes and information sources used to determine medically, clinically or psychosocially necessity, appropriate level(s) of care, and service effectiveness; processes for initial, concurrent, and retrospective reviews; processes for the approval, denial, or adjustment in levels of care; policies and procedures relative to care coordination, triage decisions and cultural competence of service delivery; and processes to evaluate service outcomes and improve outcomes, as needed.

2. A board certified psychiatrist, preferably, in both child/adolescent and adult services, shall have substantial involvement in the design and implementation of the UM program.

3. The UM program shall be evaluated and approved annually by the SE’s senior management, the SE’s Medical Director or QI Committee, and by the Collaborative.

4. The UM program shall include policies and procedures for regularly monitoring inter-rater reliability of all individuals performing UM functions. The procedures shall include a monitoring and education process for all UM staff identified as not meeting 90 percent agreement on test cases, until adequately resolved.

L. In making UM decisions, the SE shall use written utilization review decision criteria that are based on reasonable medical, clinical or psychosocial evidence, consistent with the definition of medical, clinically or psychosocial necessity. These criteria shall be applied in a fair, impartial and consistent manner to serve the best interests of all consumers.

1. UM decisions shall be based on reasonable and scientifically valid utilization review criteria that are objective and measurable.

2. The criteria for determining medically, clinically or psychosocially necessity shall be academically defensible; based on national standards of practice when such standards are available; and acceptable to the SE’s Medical Director, peer consultants and relevant local providers.

3. The SE shall specify what constitutes medically, clinically or psychosocially necessary services in a manner that is no more restrictive than that used by Collaborative agencies, as indicated in State statutes and regulations. The SE must be responsible for the provision of Medicaid services related to the
prevention, diagnosis, and treatment of behavioral health impairments; and the ability to attain, maintain, or regain functional capacity.

4. The SE shall maintain evidence that it has reviewed the criteria for determination of medically, clinically or psychosocially necessity at specified intervals and that the criteria have been updated, as necessary.

5. The SE shall provide such criteria to all practitioners who perform UM functions, all providers, and all consumers, their families, and the public upon request.

M. For the processing of requests for initial and continuing authorization of services, the SE shall

1. ensure the consistent use of written policies and procedures regarding authorization of services by all SE staff performing authorization functions;

2. have in effect a mechanism to ensure consistent application of review criteria for authorization decisions; and

3. consult with requesting providers when appropriate.

N. The SE shall involve physicians and professionally trained and appropriately licensed practitioners in the authorization and review process.

1. Practitioners who make service authorization decisions must be Master's prepared clinicians or Registered Nurses with a minimum of five (5) years of clinical experience in the mental health and/or substance abuse fields. This group would include Master's equivalent Certified Nurse Practitioners and Clinical Nurse Specialists, in addition to other licensed Master's level clinicians, such as LISWs, LPCCs, or psychologists. The SE may use Licensed Alcohol and Drug Abuse Counselors (LACs, LDACs, or LADACs) in its UM decision-making process.

2. The SE shall demonstrate that all UM staff have been trained and are competent in working with individuals with co-occurring psychiatric and addictive disorders.

3. UM staff shall be supervised by appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews.

4. Denials based on lack of medical necessity shall be made by a designated New Mexico licensed physician for the UM program. Denials of care for children and adolescents, to the extent possible, shall be made by a board certified child/adolescent psychiatrist. The reason for the denial shall be cited.

   a. When a request for a service is denied, the SE shall assist the consumer and provider in finding the appropriate level of care.

5. The reason(s) for review decisions (approval/denial) shall be clearly documented and communicated to the requesting practitioner/provider and to the consumer or family or surrogate decision maker.

O. The SE shall make utilization decisions in a timely manner that accommodates the clinical urgency of the situation and shall minimize disruption in the provision and continuity of behavioral health care services. The following time frames are required.

1. For initial authorization of non-urgent (routine) care, the SE shall make a decision within fourteen (14) calendar days from receipt of request for service with a possible extension of up to fourteen (14) additional calendar days if the
consumer or the provider requests the extension. For children and youth in the custody or supervision of CYFD and court-ordered into treatment, notice of action for previously authorized and newly requested services shall be MADE within five (5) business days of the request.

a. For authorization of non-urgent care, the SE shall notify a provider of the decision within one (1) business day of making the decision.

b. For authorization of non-urgent care that results in a denial, the SE shall give the consumer or family or surrogate decision maker and provider written or electronic confirmation of the decision within two (2) business days of making the decision.

2. For initial authorization of urgent care, the SE shall make a decision and notify the provider of the decision within seventy-two (72) hours of receipt of the authorization request.

a. For authorization of urgent care that results in a denial, the SE shall notify both the consumer and provider that an expedited appeal has already occurred.

b. For authorization of urgent care that results in a denial, the SE shall give the consumer or family or surrogate decision maker and provider written or electronic confirmation of the decision within two (2) business days of making the decision.

3. For concurrent review of services, the SE shall make decisions for inpatient care within one business day of obtaining the required information, and ongoing ambulatory care within ten (10) business days of obtaining the required information.

a. For concurrent review, the SE shall notify providers of decisions within one (1) business day of making the decision.

b. For concurrent review decisions that result in a denial, the SE shall give the consumer or family or surrogate decision maker and provider written or electronic confirmation within one (1) business day of the original notification.

c. For concurrent review decisions that result in a denial, the SE shall notify the consumer and provider how to initiate an expedited appeal at the time of notification of the denial.

4. For authorization of both urgent and non-urgent care, the consumer or provider may request a fourteen (14)-calendar-day extension. A fourteen (14)-day extension may also be requested by the SE who must justify in the UM file the need for additional information and that the fourteen (14)-day extension is in the consumer’s interest.

5. The SE shall provide written confirmation of its decisions within two (2) business days of providing notification of a decision, if the initial decision was not in writing.

P. A “denial” of services is non-authorization of a request for care or services. The SE shall clearly document in the UM file a reference to the provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

1. The SE shall make available to a requesting provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.
2. The SE shall send written notification to the enrolled individual, or the legal guardian(s) of the enrolled individual, of the reason for each denial and to the provider, as appropriate.

3. The SE shall recognize that a decision made by a designated official resulting from a Medicaid fair hearing is final and shall be honored by the SE, unless the SE successfully appeals the decision through judicial hearing or arbitration.

Q. The SE shall make every effort to obtain all relevant information needed to make an authorization determination based on medical, clinical or psychosocial necessity, depending on the individual, service type, and fund source.
1. The SE shall have a written description identifying the information required to support UM decision-making.

2. There shall be documentation that relevant information is gathered consistently to support UM decision-making. The SE’s UM policies and procedures will clearly define in writing for providers what constitutes relevant and required information for each type of decision.

3. The information requirements for UM decision-making shall be made known in advance to treating providers and shall be made available to consumers and their families upon request.

R. The SE must ensure that, consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically, clinically or psychosocially necessary services to any consumer, appropriate to the funding source paying for the consumer’s care.

S. The SE shall evaluate the inclusion of new behavioral health treatment technology and the new applications of existing technology in its benefit package. This includes the evaluation of clinical procedures, interventions and drugs.
1. The SE shall have a written description of the process used to determine whether new treatment technology and new uses of existing technologies shall be included in the benefit package.

2. The written description shall include the decision variables used by the SE to evaluate whether new treatment technology and new applications of existing technology shall be included in the benefit package.

3. The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

4. Appropriate practitioners, providers, consumers, family members, advocates, and members of the BHPC and LCs shall participate in the process to decide whether to include new treatment technology and new uses of existing technology in the benefit package.

5. The SE shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of “experimental, investigational or unproven” contained in 8.325.6 NMAC.

6. The SE shall evaluate consumer and provider satisfaction with the UM process as a part of its consumer and provider satisfaction surveys. The SE shall forward the evaluation results to the Collaborative.
T. As part of its UM process, the SE shall establish and implement policies and procedures relative to the closure of case files.
  1. The SE shall ensure that its contracted practitioners and providers adhere to the SE’s policies and procedures for closure of client files, in conformance with Collaborative member agency requirements.

U. The Collaborative shall have access to the SE’S UM review documentation upon request.

5.6 Quality Management/Quality Improvement (QM/QI) Requirements

A. The administration of behavioral health services by the SE under this Contract shall include a comprehensive Quality Management/Quality Improvement (QM/QI) Program that provides continuous monitoring and regular evaluation of clinical services provided and the adequacy of the delivery system, the service network, and the administrative operations of the SE.

B. The SE shall submit annually its comprehensive QM/QI plan for the coming fiscal year as well as a comprehensive QM/QI evaluation of the previous year’s achievement and performance of its goals and initiatives.

C. The QM/QI Program shall ensure the exchange of information as allowable by law and coordination with consumers, family members, advocates, the BHPC, LCs, MCOs, Collaborative staff, and other stakeholders. The ultimate responsibility for the QM/QI Program is with the SE and shall not be delegated.

D. The SE QM/QI Program structure shall be based on a continuous quality improvement (CQI) model through which the SE can identify any quality problems quickly and deal with them in a prompt and effective manner.
  1. The SE shall demonstrate the commitment to the delivery of quality behavioral health care in all of its activities to maximize the benefits of services and minimize the risk to consumers.
  2. The SE QM/QI Program structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements. The SE’s QM/QI Program activities shall demonstrate the linkage of QI projects to findings from multiple quality evaluations sources and an opportunity for improvement but not limited to: the external quality review; annual evaluation; the annual NM Consumer/Family Satisfaction Project; consumer and provider surveys; complaint, grievance and appeals data and trends; and data from required reports and performance measures.
  3. The SE’s QM/QI Program shall include leadership by executive clinical staff of the SE, including the Medical Director, Vice President of Clinical Operations, and Vice-President of Quality Management. The QI program personnel and information resources shall be adequate to meet program needs and devoted to and available for QM/QI activities.
  4. The SE QM/QI Program shall be accountable to the SE governing body that reviews and approves the quality program and to the Collaborative.
  5. The SE shall conduct QM/QI activities in accordance with each of the agencies and pursuant to the funding source requirements and/or interim policies issued by the Collaborative, and shall maintain records and/or
information systems that will verify QM/QI activities and compliance with QM/QI requirements.

6. The SE’s QM/QI functions shall include conducting data-driven evaluations of clinical practices to improve quality of care. The QM/QI activities shall demonstrate how that system has influenced/changed provider practice patterns and produced corresponding improvements in consumer functioning and well-being.

7. The SE shall ensure that its high-volume providers, as defined by the SE and approved by the Collaborative, have a current QM/QI plan for tracking and improving quality in access, appropriateness of care, consumer satisfaction, quality of care, and outcomes. The providers’ plans must describe the roles of provider agency staff, consumers, and family members in development and implementation.

8. The SE shall ensure that high-volume providers submit their annual QM/QI plan no later than August 1 each Contract Year and submit their QM/QI annual report.

   a. Additionally, the SE shall include the provision for its monitoring of a sample of provider’s QM/QI plan performance as a task shared by SE’s QM/QI and Provider Relations departments. The sample will be determined in collaboration with the Collaborative.

E. The SE’s updated QM/QI Program Description/Work Plan (QMPD/WP) shall include specific targeted goals, objectives and structure that cover the SE’s immediate objectives for each Contract Year or Calendar Year, and long-term objectives for the entire Contract period.

   1. The QMPD/WP shall include the specific interventions to be utilized to improve the quality targets as well as the timeframes for evaluation and shall be submitted to the Collaborative each Contract Year no later than July 30.

   2. The QMPD/WP shall specify the roles, authority and responsibilities of a designated physician in the QM/QI Program.

   3. The QMPD/WP shall specify the role of the QI Committee and subcommittees, including any committees dealing with oversight of delegated activities.

   4. The QMPD/WP shall describe QI Committee composition, Committee member selection policies, roles and responsibilities.

   5. The QMPD/WP shall include the QI Committee functions, including policy recommendations; review/evaluation of QM/QI activities; institution of needed actions; follow-up of instituted actions; and contemporaneous documentation of Committee decisions and actions.

   6. The QMPD/WP shall address QM/QI for all major demographic groups served by the SE, such as infants, children, adolescents, adults, seniors and special population groups, including, but not limited to, specific racial and ethnic groups, pregnant women, children in State custody, persons discharged from jail, a detention center or prison, consumers with cognitive or physical disabilities, and persons with co-occurring disorders or other chronic diseases.

   7. The QMPD/WP shall address consumer satisfaction, identifying opportunities for improvement, implementing and measuring effectiveness of interventions and informing consumers and providers of results. The program description
or work plan shall document specific activities related to provider and consumer (adults and children) survey findings that require targeted QI interventions and monitoring.

8. In addition, the QMPD/WP shall address access, appropriateness of care, consumer satisfaction, and provider relations, and shall evaluate complaints, grievances and appeals, with corrective action implemented as indicated. The plan must outline the relationship between the UM system and QI findings. The plan must describe the roles of providers, consumers and family members in development and implementation.

9. The QMPD/WP shall address the process by which the SE adopts, reviews at least every two (2) years, appropriately updates, and disseminates evidence-based clinical practice guidelines for provision of services for acute and chronic or severe conditions. The SE shall involve its providers, consumers, and family members in this process.

10. The QMPD/WP shall address activities aimed at addressing culturally specific behavioral health beliefs and behaviors as well as risk conditions and shall respond to consumer and provider requests for culturally appropriate services. Culturally appropriate services may include language and translation services, dietary practices, individual and family interaction norms, and the role of the family in recovery and resilience. The SE shall incorporate cultural competence into UM, QM/QI, and the planning for the course of treatment.

11. The QMPD/WP shall address activities to improve the behavioral health status of consumers with chronic conditions, including identification of such consumers; implementation of services and programs to assist such consumers in managing their conditions and informing providers about the programs and services for consumers assigned to them.

12. The QMPD/WP shall address activities that ensure care continuity and coordination, including physical and behavioral health services, data collection and analysis, and appropriate interventions to improve coordination and continuity of care.

13. The QMPD/WP shall include specific activities that evaluate continuity and coordination of physical and behavioral health care. The responsibility for these activities shall not be delegated.

14. The QMPD/WP shall address mechanisms for monitoring, addressing, and correcting any evidence of cost-shifting practices by the health provider network, such as pharmacological cost shifting of psychotropic medications prescribed by PCPs over to behavioral health physicians.

15. The QMPD/WP shall include objectives for the year; activities regarding quality of clinical care and service; timelines, responsible person, planned monitoring for both newly identified and previously identified issues; and planned, annual evaluation of the QM/QI Program.

16. The QMPD/WP shall include means by which the SE shall, upon request, communicate non-privileged QI results to LCs, its providers, consumers, families and others at the Collaborative’s direction.

17. The QMPD/WP shall address the ongoing monitoring of provider performance with training and corrective actions implemented as indicated.
18. Subcommittees of the QM/QI Committee may be formed to address any problem identified by the SE or the Collaborative.

F. The Clinical Quality Committee shall oversee and be involved in QM/QI activities. The Clinical Quality committee shall
1. recommend QM/QI policy review and evaluate the results of quality improvement activities, institute needed action and ensure follow-up, as appropriate;
2. have contemporaneous dated and signed minutes that reflect all QM/QI Committee decisions and actions;
3. ensure that the SE’s providers and practitioners have an opportunity to participate actively in the QM/QI Program;
4. ensure that the SE shall coordinate the QM/QI Program with performance monitoring activities throughout the organization, including but not limited to, UM, fraud and abuse detection, credentialing, monitoring and resolution of consumer grievances and appeals, assessment of consumer satisfaction and medical records review;
5. ensure linkages between the QM/QI Program and other management activities, such as network changes, benefits redesign, practice feedback to providers, consumer behavioral health education and consumer services, which will be documented in quarterly progress reports;
6. ensure that the results of QM/QI activities, performance improvement projects and reviews are used to improve the quality of care or service;
7. ensure that the SE communicates the results of QM/QI activities, performance improvement projects and reviews with appropriate individual and institutional providers and uses the information to improve the performance of the providers;
8. ensure that the SE shall also coordinate the QM/QI Program with performance monitoring activities throughout the organization, including but not limited to, its compliance with all quality standards and other specifications in the Contract for services, such as compliance with State and federal requirements;
9. ensure that the SE applies the QM/QI Program to the entire range of behavioral health services provided by the SE and ensure that all major population groups, care settings and types of service are included in the scope of the review (a major population or prevalent group is one that represents at least five [5] percent of the SE’s enrollment);
10. ensure that stakeholders, especially consumers, have an opportunity to provide input and are part of the QM/QI Program; and
11. include, at a minimum, representation from provider agencies, consumers, family members, the BHPC, Collaborative staff and other stakeholders in the QM/QI Program; data from the QM/QI program shall be shared regularly with all committee members.

G. The SE shall evaluate the overall effectiveness of its QM/QI Program and demonstrate improvements in the quality of clinical care and the quality of service for its enrolled individuals and shall report to the Collaborative on these improvements.
1. The SE shall perform an annual written evaluation of the QM/QI Program as well as provide an annual update on its performance in the performance measurement projects and provide a copy to the Collaborative for review. An additional written report shall be provided whenever a finding indicates a significant system problem or warrants serious corrective action. This evaluation shall include at least the following:
   a. A description of completed and ongoing QM/QI activities;
   b. Trending of performance measures data to assess performance in quality of clinical care and quality of service;
   c. An analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service; and
   d. An evaluation of the overall effectiveness of the QM/QI Program.
2. There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of services, including preventive services, provided to consumers and communities.
3. Findings of the QM/QI Program, including data and analysis of performance measures, shall be shared regularly with all stakeholders, including SE executives, the BHPC and LCs, and Collaborative member agencies.

H. The SE shall include provisions for continuous quality improvement related to all internal Contract functions such as the grievance process, consumer and provider relations, UM, claims processing, recovery and resiliency, telephone access, linkage to clinical services, service quality, authorization and denial decisions, and implementation of the complaints and grievances and incident management systems.
   1. The SE shall ensure that ongoing monitoring of various system indicators takes place, with corrective action implemented as indicated to ensure continuous quality improvement in services and operations.
   2. The SE shall also monitor QM/QI processes at the provider level. Monitoring shall include, but not be limited to, annual on-site clinical audits of high-volume providers and ad hoc on-site audits for good cause at the request of the Collaborative.
   3. The QM/QI approach shall include all of the following:
      a. Recognition that opportunities for improvement are unlimited;
      b. A data-driven process;
      c. Consumer and provider input; and
      d. Ongoing measurement of clinical and non-clinical effectiveness and programmatic improvements.

I. The Collaborative shall retain the services of an External Quality Review Organization (EQRO) in accordance with the Social Security Act, Section 1902 (a) (30) [C]. The SE shall cooperate fully with the EQRO and prove to that organization the SE’s adherence to the HSD quality standards as set forth in HSD Policy Section 8.305.8. NMAC. The Collaborative shall contract with an EQRO to audit a statistically valid sample of the SE’s behavioral health UM decisions based on a frequency defined by the Collaborative, including authorizations, reductions, terminations and denials. This audit is intended to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. To the extent possible, the EQRO will also perform
audit and review activities related to non-Medicaid programs. The SE shall cooperate fully with that organization.

1. The SE shall participate in various other tasks identified by the Collaborative that will enable the Collaborative to gauge performance in a variety of areas, i.e., care coordination, treatment of special populations, and encounter data validation. Areas identified by the EQRO that require corrective action will be shared with the SE in written documentation with the expectation that an applicable corrective action plan will be devised and implemented by the SE in a timely manner.

2. The SE shall utilize technical assistance and guidelines offered by the EQRO, unless otherwise agreed upon by the State and the SE.

3. The EQRO retained by the Collaborative or one of the participating agencies shall not be a competitor of the SE.

4. The SE shall provide the Collaborative or any of the participating agencies with encounter data on a routine basis. The EQRO may use encounter data as a mechanism for monitoring quality of care and provider compliance with billing standards. Serious levels of inaccuracy and/or incompleteness of data submission can result in sanctions by the Collaborative impacting the SE and/or provider pursuant to Article 10, Enforcement.

J. The SE shall actively work to attain, improve, maintain or regain the functional status of its consumers with chronic behavioral health conditions, utilizing best practices throughout the SE’s provider networks.

1. The SE shall implement targeted disease management protocols and procedures for chronic diseases and/or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied Collaborative member agency populations.

2. The SE shall identify the number of adults with severe and disabling mental illness and children with severe emotional, behavioral and neurobiological disturbances as well as adults with chronic substance abuse.

3. The SE through provider network shall have a defined process to promote a high level of enrolled individual participation in follow-up appointments, consultations/referrals and diagnostic laboratory, diagnostic imaging and other testing.

4. The SE, through its provider network, shall have a defined process to ensure prompt consumer or family notification by its providers of abnormal results of testing, and this notification will be documented in the medical record.

5. The SE shall ensure that the processes for follow-up visits, consultations and referrals are consistent with high-quality care and service and do not create a clinically significant impediment to timely delivery of service funded under this Contract.

K. The SE shall track performance measures through the applicable data source, report at intervals defined by the Collaborative, and use for QM/QI.

1. Performance measures are tools that the Collaborative chooses to gauge the SE’s ability to improve performance and enrolled individual outcomes in targeted areas within its operations and take actions as needed to improve specifics of the performance measures.
2. The Collaborative expects that the SE will improve its performance in other identified focus areas to meet the goals set by the Collaborative annually. The SE shall
   a. be required to have access to, and the ability to collect and manage data necessary to support the performance measurement aspects of QM/QI activities, including establishment of the baseline and tracking of change in performance over time;
   b. be required to have the ability to design sound quality studies, apply statistical analyses to data, and determine the significance of the data collected;
   c. adhere to the timely and accurate collection of project data, which will show the SE’s performance rate for those performance measures identified for improvement by the Collaborative;
   d. identify specific interventions that the SE intends to use to improve performance measures in a given area;
   e. achieve demonstrable improvement in each performance measure during the course of the Contract;
   f. perform subsequent measurement and assessment of the ongoing effectiveness of named interventions and measures; and
   g. be responsible for demonstrating to the Collaborative that the results of QM/QI projects and reviews are used to improve the quality of service coverage and delivery with appropriate individual practitioners and institutional providers. When the SE determines that there are provider performance problems, the SE is responsible to take and document appropriate action.

L. The SE shall, along with State staff, coordinate the annual collection and submission of a statistically valid adult and child/family consumer satisfaction survey based on the national Mental Health Statistics Improvement Project (MHSIP), hereafter known as the NM Consumer/Family Satisfaction Project (C/FSP), including coordination, training, technical assistance, data entry and publication/report writing tasks.
   1. The annual C/FSP shall also include non-survey performance measures as part of this reporting requirement for each Contract calendar year.
   2. The SE shall report the C/FSP data set and any additional requested data each Contract calendar year.

M. The SE shall use information such as the C/FSP, provider surveys, and the annual results of the EQRO’s activities and performance measures as a means to evaluate the quality of care and service provided and to identify opportunities for improvement.
   1. The SE must be able to demonstrate processes for assessing access to care and quality of care performance, identifying opportunities for improvement, initiating targeted quality interventions, and monitoring the intervention’s effectiveness.
   2. Focused QI studies shall be done; and stakeholders shall be involved in the design of the studies, interpretation of the finding, and development of corrective actions as indicated.

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3. The SE shall, as directed by the Collaborative, conduct selected studies jointly with the Medicaid MCOs with other key entities that impact services for consumers and consumers’ lives. No more than two (2) studies per year will be required.

N. The SE shall provide services utilizing a system of Collaborative-approved performance measures that shall emphasize the delivery of quality and appropriate services, timely and accurate payment of providers, and development of data and accurate reporting for multiple systems.

1. These performance measures shall be designed to favorably affect consumer outcomes and satisfaction over time.

2. To the extent possible, performance measure demographics should include breakout by disability group, specifically Autism Spectrum Disorders (ASD), cognitive disabilities, brain injury, deaf or hard of hearing, blind and visually impaired, and physical disabilities.

3. The SE shall work with the BHPC and the Medicaid MCOs to identify individuals within the Collaborative member agencies to work as a subcommittee to identify and make recommendations regarding services for these populations and performance measures to evaluate the quality of these services.

4. To the extent that the SE has access to the data, the SE shall utilize performance measures, including those that allow the Collaborative to meet the requirements of the Governor’s Performance & Accountability Measures. These shall include but not be limited to the following:
   a. Percent of individuals committing suicide or reporting suicidal attempts, specifically suicide rates for youth ages 15-19 and 20-24; persons aged 20 years and older; Native Americans, adults over the age of 65; and percent of youth reporting they have considered or attempted suicide.
   b. Percent of adults with serious mental illness in competitive employment of their choice;
   c. Percent of children/adolescents with severe emotional disturbances receiving services who are successful in school;
   d. Percent of individuals with mental illness and/or substance abuse disorders receiving services with decent, safe, affordable housing;
   e. Percent of people receiving substance abuse treatment who demonstrate improvement on three (3) or more domains on the Addiction Severity Index (ASI);
   f. Percent of adults presenting with psychiatric issues who are screened for substance abuse; and percentage of adults presenting with substance abuse issues who are screened for psychiatric issues;
   g. Percent of adults and youth served who have contact or repeat contact with the adult or juvenile justice system or adult corrections;
   h. Percent of persons receiving substance abuse services who are arrested for DWI or use of illicit substances;
   i. Percent of individuals discharged from inpatient facilities who receive follow-up services at seven (7) days and thirty (30) days;
   j. Percent of consumers and families reporting satisfaction with services;
k. Number of individuals served annually in substance abuse and mental health programs, by ethnicity, region, age and risk level (high risk);
l. Percent and number of ISHCN served by major disability group (ASD, DD, brain injury, deaf and hard of hearing, blind, and physical disabilities)
m. Number of individuals served in evidence-based practice programs;

n. Percent of children with improved functional assessments between admission and discharge in CYFD-funded community-based programs;
o. Percent of JJS consumers in facilities assessed as having behavioral health needs on intake who receive behavioral health services;
p. Percent of all payments made to providers within the required timeframes;
q. Percentage of individuals with COD receiving services, the percentage of individuals diagnosed with COD who have treatment goals in both the mental health and substance abuse realms, and appropriate discharge planning that considers an individual's future COD service needs;
r. Percent of expenditures for community-based services operated by consumers/families as a share of total community-based services expenditures;
s. Percent of individuals in rural and frontier locations with access to an appropriate behavioral health provider within sixty (60), and ninety (90) miles, respectively; and
t. Number of programs/agencies using promotoras, peer specialists and practitioners designed specifically for persons who are Native American or Spanish speaking.
u. Prevention performance measures developed by the SE with the approval of the Collaborative.

5. Working with the SE, the Collaborative shall establish baselines and targets for the SE for each of these performance measures on the following timeframe:
   a. Baselines shall be established no later than January 1, 2007;
   b. Targets for FY 2008 shall be established no later than January 1, 2007;
   c. Targets for FY 2009 shall be established no later than January 1, 2008.
   d. Quarterly reports of the SE’s progress relating to these performance measures shall begin as soon as possible, but no later than April 2007.

6. The SE shall participate in the ongoing development and use of performance measures. Over the course of the Contract period, individual performance measures may be deleted, added, or modified based on the data collected by the SE and its subcontractors and their meaningfulness as analyzed by Collaborative staff.

7. The SE shall be accountable for the achievement of the performance measure targets as identified by the Collaborative. Failure to report on or achieve performance targets may result in sanctions pursuant to Article 10. The Collaborative will identify the performance targets for which sanctions are applicable.

O. The SE shall implement a required number of targeted disease management programs as defined by the Collaborative, pursuant to federal regulations and the requirements of HSD’s 1915b waiver.
The SE’s plan for program integrity shall be composed of several initiatives, some targeting program management areas and others targeting specific benefit categories.

1. Program integrity is a priority. Achieving program integrity requires the active involvement of every component of the behavioral health system and effective coordination with the SE and the Collaborative’s partners, including contractors, providers, beneficiaries, and law enforcement.

2. Any indication of suspicious activity must be reported to the Collaborative’s Oversight Team Leader or designee.

3. The SE shall promptly conduct a preliminary investigation and report the results of the investigation to the Collaborative CEO or designee. The Collaborative may ask the SE to conduct a formal investigation and/or to cooperate during the Collaborative’s investigation. Provider profile reports that inform the SE as to a deviation (set at a predefined threshold) from normal practice patterns shall be shared with the Collaborative for purposes of investigating over- and under-utilization, or other SE or provider performance or quality concerns.

4. The SE shall have policies and procedures to address prevention, detection, preliminary investigation and reporting of potential and actual fraud and abuse.

5. The SE shall have specific controls for prevention and detection such as claims edits, post-processing review of claims, provider profiling and credentialing; utilization and quality management and relevant provisions in the SE’s contract with its providers and subcontractors.

6. The SE shall have a comprehensive internal program to prevent, detect and investigate program violations to help recover funds misspent due to fraudulent actions.

7. The SE shall cooperate with any Collaborative member agency’s investigation unit and with the Medicaid Fraud Control Unit of the NM Attorney General’s office and other investigatory agencies as directed by the Collaborative.

8. The SE shall have systems that can monitor service utilization and encounters for fraud and abuse.

9. The SE shall report all suspected fraud and abuse to the Oversight Team Leader, including the results of all internal investigations of suspected fraud and abuse.

5.7 Incident Management Requirements

A. The SE shall establish and maintain a statewide morbidity and mortality review process that identifies and tracks morbidity and mortality, corrects case-specific issues, addresses identified systems’ issues that place consumers at risk, and promotes the development of a more effective behavioral health delivery system. The SE shall follow guidelines for this process as established through consensus and policy with the Collaborative.

B. The SE shall develop and implement an incident management system in accordance with Collaborative agency guidelines and incident management protocols as developed by the Collaborative or its agencies.
1. The SE shall report the following adverse events involving all eligible consumers to the Collaborative: suicides; other deaths; attempted suicides; involuntary hospitalizations; detentions for protective custody; detentions for alleged criminal activity; elopements; and any incident resulting in significant physical harm to a consumer or to others allegedly caused by a consumer.

2. The report shall separately identify adverse events involving individuals with serious mental illness, serious emotional disturbances, chronic substance abuse, and co-occurring mental health and substance abuse issues. The SE shall utilize the Collaborative’s definitions for identifying these categories of behavioral health consumers for standardization purposes.

3. Any event that could be associated with placing consumers at immediate risk shall be reported immediately.

5.8 Consumer Rights and Responsibilities

A. The SE shall be required to comply with the HSD regulation 8.305.8.15, Member [Consumer] Bill of Rights, and any other Collaborative agency rights’ statements.

B. The SE shall provide each enrolled individual with the written information, in English or the prevalent language, as appropriate, found in the HSD Member [Consumer] Bill of Rights pursuant to HSD 8.305.8.15.

C. The SE’S written information on consumer rights and responsibilities shall include the following:

1. Consumers, their families or legal guardians, and designated surrogate decision-makers have a right to obtain equitable treatment, respecting and recognizing of the enrolled individual’s dignity and need for privacy.

2. Consumers have a right to make and have honored an advance directive as allowed by State and Federal laws; the SE shall ensure that consumers are offered that opportunity and upon request provided assistance in the process.

3. Consumers have a right to receive behavioral health care services in a non-discriminatory fashion.

4. Consumers and, as appropriate, their families or legal guardians, and designated surrogate decision-makers have a right to participate with practitioners in decision making regarding all aspects of their behavioral health care, including development of the course of treatment.

5. The SE’s policy shall contain procedures for obtaining informed consent.

6. Legally determined surrogate decision makers have a right to be involved, as appropriate, to facilitate care decisions.

7. Consumers, their families or legal guardians, and surrogate decision makers have a right and the means to voice complaints or file grievances and appeals about the care provided by the SE.

8. Consumers, their families or legal guardians, and surrogate decision makers and/or legal guardians have a right and the means to be able to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements.

9. Consumers have a right to have access to their medical records in accordance with the applicable Federal and State laws and regulations.
10. Consumers, their families or legal guardians, and surrogate decision makers, to the extent possible, have a responsibility to provide information that the SE, its practitioners, and providers need in order to care for the consumer.

11. Consumers, their families or legal guardians, and surrogate decision makers, to the degree possible, have a right and responsibility to participate in understanding their behavioral health problems and developing mutually agreed-upon treatment goals.

12. Consumers, their families or legal guardians, and surrogate decision makers have a responsibility to follow the plans and instructions for care that they have agreed upon with their practitioners;

13. Consumers, their families or legal guardians, and surrogate decision makers have a responsibility to keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.

14. Consumers have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

5.9 Statewide Entity (SE) Grievance System Requirements

A. The SE shall have a consumer grievance system in place that includes a grievance process related to dissatisfaction.

1. A grievance is a consumer’s or family’s expression of dissatisfaction about any matter or aspect of the SE or its operation.

2. The consumer, legal guardian of the consumer for a minor or an incapacitated adult, or a representative of the consumer as designated in writing to the SE or in an advance directive, has the right to file a grievance on behalf of the consumer with the SE or with a Collaborative agency. A practitioner or provider acting on behalf of the consumer, with the consumer’s written consent, may file a grievance with the SE and/or with a Collaborative agency.

B. The SE shall implement written policies and procedures describing how the consumer may file a grievance with the SE and/or with a Collaborative agency. The policy shall include a description of the grievance resolution process.

1. The SE shall provide to all service providers in the SE’s network a written description of the SE’s grievance process and how the provider can submit a grievance on behalf of the consumer.

2. The SE shall have available to the consumer reasonable assistance or accommodation in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

3. The SE shall name a specific individual(s) designated as the SE’s consumer grievance coordinator with the authority to administer the policies and procedures for resolution of a grievance, to review patterns and trends in grievances, and to initiate corrective action.

4. The SE shall ensure that the individuals who make decisions regarding grievances have not been involved in any previous activities related to the grievance. The SE shall also ensure that behavioral health care professionals with appropriate clinical expertise shall make decisions regarding a grievance that involves clinical issues.
5. Upon enrollment, the SE shall provide consumers, at no cost, with a consumer information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance, and the resolution process.

6. The SE shall ensure that punitive or retaliatory action is not taken against a consumer, a provider that files a grievance on behalf of the consumer, or a provider that supports a consumer’s grievance.

7. The SE shall provide information about the grievance system to all providers and subcontractors at the time they enter into a contract.

8. All grievance files shall be maintained by the SE in a secure and designated area and shall be accessible to Collaborative agencies, upon request, for review. Grievance files shall be retained for six years following the resolution by the SE, or closure of a file, whichever occurs later.

9. The SE shall have procedures for ensuring that files contain sufficient information to identify the grievance, including the date it was received, the nature of the grievance, notice to the consumer of receipt of the grievance, all correspondence between the SE and the consumer, the date the grievance was resolved, the resolution letter to the consumer, and all other pertinent information.

10. Documentation regarding the grievance shall be made available to the consumer, if requested.

C. A consumer may file a grievance either orally or in writing with the SE and/or a Collaborative agency within ninety (90) calendar days of the date of the event causing the dissatisfaction.

1. For purposes of this Article, a “consumer” is defined as the consumer, legal guardian of the consumer for a minor or incapacitated adult, a representative of the consumer as designated in writing to the SE or in an advance directive, or a practitioner or provider acting on behalf of the consumer with the consumer’s written consent.

D. Within five business days of receipt of the grievance, the SE shall provide the consumer with written notice that the grievance has been received and the expected date of its resolution.

E. The investigation and final SE resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the SE and shall include a resolution letter to the consumer.

F. The SE may request an extension from the Collaborative agency of up to fourteen (14) calendar days if the consumer requests the extension, or the SE demonstrates to the Collaborative that there is need for additional information, and the extension is in the consumer’s interest. For any extension not requested by the consumer, the SE shall give the consumer written notice of the reason for the extension within two business days of the decision to extend the timeframe.

G. Upon resolution of the grievance, the SE shall mail a resolution letter to the consumer. The resolution letter shall include, but not be limited to, the following:
   1. All information considered in investigating the grievance;
   2. Findings and conclusions based on the investigation; and
   3. The disposition of the grievance.
H. The SE grievance system shall include an appeals process related to an SE action, including the opportunity to request a fair hearing if the individual is a Medicaid-eligible enrollee.

1. An appeal is a request for review by the SE of an SE action. An action is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

2. The consumer, legal guardian of the consumer for a minor or an incapacitated adult, or a representative of the consumer as designated in writing to the SE or in an advance directive, has the right to file an appeal of an SE action on behalf of the consumer within ninety (90) days of receiving the SE’s notice of action. A provider acting on behalf of the consumer, with the consumer’s written consent, may file an appeal of an SE action.

3. In addition to the SE appeals process described above, a consumer, legal guardian of the consumer for a minor or an incapacitated adult, or the representative of the consumer has the right to request a fair hearing on behalf of the consumer directly as described in 8.352.2. NMAC, Fair Hearings, if an SE decision results in termination, modification, suspension, reduction, or denial of services to a Medicaid consumer or if a Medicaid consumer believes the SE has taken an action erroneously. A Medicaid fair hearing may be requested prior to, concurrent with, subsequent to, or in lieu of a grievance or appeal to the SE.

4. The SE shall implement written policies and procedures describing how the consumer may submit a request for an appeal with the SE or submit a request for a fair hearing. The policy shall include a description of the appeal resolution process.

5. The SE shall provide to all service providers in the SE’s network a written description of the SE’s appeal process and how the provider can submit an appeal.

6. The SE shall have available reasonable assistance and accommodations in completing appeals-related procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

7. The SE shall name a specific individual(s) designated as the SE’s appeals coordinator with the authority to administer the policies and procedures for resolution of an appeal, to review patterns and trends in appeals, and to initiate corrective action.

8. The SE shall ensure that the individuals who make decisions regarding appeals have not been involved in any previous level of review or decision-making. The SE shall also ensure that behavioral health care professionals with appropriate clinical expertise shall make decisions regarding the following:

   a. An appeal of an SE denial that is based on lack of medical, clinical or psychosocial necessity as appropriate to the individual and the funding source;

   b. An SE denial that is upheld in an expedited resolution;
c. A grievance or appeal that involves clinical issues.

9. Upon enrollment, the SE shall provide consumers, at no cost, with an information sheet or handbook that provides information on how they and/or their representative(s) can file an appeal, and the resolution process. The consumer information shall also advise Medicaid-eligible consumers and their representatives of their right to file a request for a fair hearing upon notification of an SE action, or concurrent with, following, or in lieu of filing an appeal with the SE. The information shall meet the standards specified in Paragraph (15) of Subsection C of 8.305.8.15 NMAC.

10. The SE shall ensure that punitive or retaliatory action is not taken against a consumer or a provider that files an appeal, or a provider that supports a consumer's appeal.

11. The SE shall mail a notice of action to the consumer and/or legal guardian, of the decision within ten (10) days of an action for previously authorized and, within fourteen (14) days of the action for newly requested services (42 CFR 431.213 and 431.214). For children and youth in the custody or supervision of CYFD and court-ordered into treatment, notice of action for previously authorized and newly requested services shall be MAILED within two (2) business days of the request. Denials of claims that may result in consumer financial liability requires immediate notification. The notice shall contain, but not be limited to, the following:
   a. The action the SE has taken or intends to take;
   b. The reasons for the action;
   c. The consumer's or the provider's right to file an appeal of the SE action through the SE;
   d. The consumer's right to request a fair hearing if the consumer is a Medicaid-eligible person and the action involves a Medicaid-funded service and what the process would be;
   e. The procedures for exercising the rights specified;
   f. The circumstances under which expedited resolution of an appeal is available and how to request it; and
   g. A Medicaid recipient's right to have Medicaid benefits continue pending resolution of an appeal, how to request the continuation of benefits, and the circumstances under which the consumer may be required to pay the costs of continuing these benefits.

12. The SE has thirty (30) calendar days from the date it receives the initial oral or written appeal to resolve the appeal.

13. The SE shall have a process in place that ensures that an oral or written inquiry from a consumer seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal).

14. An oral appeal shall be followed by a written appeal, signed by the consumer, within ten (10) calendar days. The SE shall use its best efforts to assist and accommodate the consumer as needed with the written appeal.

15. Within five (5) business days of receipt of the appeal, the SE shall provide the consumer and/or the consumer's representative with written notice that the appeal has been received and the expected date of its resolution. The SE
shall confirm in writing receipt of oral appeals, unless the consumer or the provider requests an expedited resolution.

16. The SE may extend the thirty (30)-day timeframe by fourteen (14) calendar days if the consumer requests the extension, or the SE demonstrates that there is need for additional information, and the extension is in the consumer’s interest. For any extension not requested by the appellant, the SE shall give the appellant written notice of the extension and the reason for the extension within two (2) business days of the decision to extend the timeframe.

17. The SE shall provide the consumer and/or the consumer’s representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

18. The SE shall provide the consumer and/or the consumer’s representative the opportunity, before and during the appeals process, to examine the consumer’s case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The SE shall include as parties to the appeal the consumer and his or her representative, or the legal representative of a deceased consumer’s estate.

19. For all appeals, the SE shall provide written notice within the thirty (30)-calendar-day timeframe for resolutions to the consumer or the provider, if the provider filed the appeal.

20. The written notice of the appeal resolution shall include, but not be limited to, the results of the appeal resolution and the date it was completed.

21. If the consumer is Medicaid-eligible, the written notice of the appeal resolution for appeals not resolved wholly in favor of the consumer shall include, but not be limited to, the following information:
   a. the right to request a fair hearing and how to do so;
   b. the right to request receipt of benefits while the hearing is pending, and how to make the request; and
   c. that the consumer may be held liable for the cost of continuing benefits if the hearing decision upholds the SE’s action.

22. The SE shall continue the consumer’s benefits if all of the following are met:
   i. The consumer is a Medicaid recipient.
   ii. The consumer or the provider files a timely appeal of the SE action (within 10 days of the date on the notice of action from the SE).
   iii. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment funded by Medicaid
   iv. An authorized provider ordered the services.
   v. The time period covered by the original authorization has not expired.
   vi. The consumer requests extension of the benefits.

23. The SE shall provide Medicaid benefits until one of the following occurs:
   i. The consumer withdraws the appeal.
   ii. Ten days have passed since the date of the resolution letter, provided the resolution of the appeal was against the consumer and the consumer has taken no further action.
iii. HSD issues a hearing decision adverse to the consumer.

iv. The time period or service limits of a previously authorized service has expired.

24. If the final resolution of the appeal is adverse to the consumer, that is, the SE’s action is upheld, the SE may recover the cost of the services furnished to the consumer while the appeal was pending, to the extent that Medicaid services were furnished solely because of the requirements of this section and in accordance with the policy in 42 CFR 431.230(b).

25. If the SE or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the SE shall authorize or provide the disputed services promptly and as expeditiously as the consumer’s health condition requires.

26. If the SE or HSD reverses a decision to deny, limit or delay services and the consumer received the disputed services while the appeal was pending, the SE shall pay for these services.

27. The SE may continue non-Medicaid services pending a Medicaid eligible consumer’s appeal at the SE’s discretion or as directed by the Collaborative.

I. An expedited resolution of an appeal is an expedited review by the SE of an SE action.

1. The SE shall establish and maintain an expedited review process for appeals when the SE determines that allowing the time for a standard resolution could seriously jeopardize the consumer’s life or health or ability to attain, maintain, or regain maximum function, or the child or youth is in the custody or supervision of CYFD and the SE had denied authorization for court-ordered out-of-home treatment. Such determination shall be based on:
   a. a request from the appellant;
   b. a provider’s support of the appellant’s request;
   c. a provider’s request on behalf of the appellant; or
   d. the SE’s independent determination.

2. The SE shall ensure that the expedited review process is convenient and efficient for the appellant.

3. The SE shall resolve the appeal within three (3) business days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in Subsection A of 8.305.12.13 NMAC.

4. The SE may extend the timeframe by up to fourteen (14) calendar days if the appellant requests the extension, or the SE demonstrates a need for additional information and the extension is in the appellant’s interest. For any extension not requested by the appellant, the SE shall give the appellant and the consumer written notice of the reason for the delay.

5. The SE shall ensure that punitive action is not taken against a consumer or a provider who requests an expedited resolution or supports a consumer’s expedited appeal.

6. The SE shall provide an expedited resolution, if the request meets the definition of an expedited appeal, in response to an oral or written request from the appellant.
7. The SE shall inform the Medicaid consumer of the limited time available to present evidence and allegations in fact or law at a Medicaid fair hearing.

8. If the SE denies a request for an expedited resolution of an appeal, it shall
   a. transfer the appeal to the thirty (30)-day timeframe for standard resolution, in which the thirty (30)-day period begins on the date the SE received the original request for appeal;
   b. make reasonable efforts to give the appellant prompt oral notice of the denial, and follow up with a written notice within two (2) calendar days; and
   c. inform Medicaid consumers in the written notice of the right to file an appeal and/or request an HSD fair hearing if the consumer is dissatisfied with the SE’s decision to deny an expedited resolution.

9. The SE shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

10. In the case of expedited service authorization decisions that deny or limit services, the SE shall, within seventy-two (72) hours of receipt of the service request, automatically file an appeal on behalf of the consumer, use its best effort to give the consumer oral notice of the decision on the automatic appeal and to resolve the appeal.

J. Other processes related to grievances and appeals include the following:

1. The SE shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system and appeals process to all providers and subcontractors at the time they enter into a contract.

2. All appeal files shall be maintained in a secure and designated area and be accessible to the Collaborative, upon request, for review. Appeal files shall be retained for six (6) years following the final decision by the SE, the Collaborative, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.
   a. The SE shall have procedures for ensuring that files contain sufficient information to identify the appeal, including the date it was received, the nature of the appeal, notice to the consumer of receipt of the appeal, all correspondence between the SE and the appellant, the date the appeal was resolved, the resolution, and all other pertinent information.
   b. Documentation regarding the appeal shall be made available to the appellant and the consumer, if requested.

3. The SE shall establish and maintain written policies and procedures for the filing of provider appeals. A provider shall have the right to file an appeal with the SE regarding provider payment issues. Appeals shall be resolved within thirty (30) calendar days.

5.10 Demonstrated Commitment to Cultural Competency

A. The SE shall update, implement, maintain and evaluate for effectiveness a Cultural Competency Plan for itself and for all contracted providers to ensure that consumers and their families receive behavioral health care that is culturally and linguistically appropriate to meet their needs. This Cultural Competency Plan shall include consideration of disability issues.
B. The SE shall incorporate nationally accepted Cultural Competence standards in its Cultural Competency Plan. Examples include the National Standards for Culturally and Linguistically Appropriate Services in Health Care or Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.

C. The SE shall select a staff member with appropriate training and experience to serve as the Director of Diversity Initiatives in addition to other job responsibilities. The Director will implement cultural community support system activities as well as evaluation and treatment performance measures. The Director also will work with the SE QM/QI Department to monitor, evaluate and address diversity issues within the SE and the delivery system.

D. The SE shall work with the Collaborative to appoint individuals within each Collaborative member agency to form a workgroup with the SE to identify and make recommendations regarding systems-wide issues, indicators, goals, and objectives related to the development of a culturally competent behavioral health system.

E. The SE shall submit a quarterly progress report to the Collaborative for review and recommendations outlining progress in implementing activities outlined in the Cultural Competency Plan.

5.11 Medical Records

A. The SE shall have written policies and procedures for medical records documentation. The SE will assess these requirements during audits of provider client files. When deficiencies are identified in provider files, corrective action should be implemented with a follow up audit performed to ensure adequate correction of those deficiencies. Clinical record audits, retrospective record reviews, and on-site reviews may be jointly performed with Collaborative agencies’ staff with corrective actions implemented as indicated.

B. Accreditation reviews, reports, and requests for corrective action may substitute for SE action regarding a particular provider’s records, except that the SE shall determine whether these reviews and reports signify a reason for additional SE review or technical assistance and shall act accordingly.

5.12 Confidentiality

A. The SE shall have written policies and procedures on confidentiality consistent with federal and state law, including a provision that all materials concerning the care and treatment of consumers/families shall be made available to the Collaborative.

B. The SE shall periodically check high-volume and specialty providers and providers for whom complaints are received to determine whether they are following policies and procedures regarding confidentiality.

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5.13 Clinical Practice Guidelines

A. The SE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic behavioral health care conditions.

B. The SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of the eligible populations.

C. The clinical practice guidelines shall be based on reasonable medical or scientific evidence.

D. The SE shall involve providers from its network who are appropriate to the clinical issue, as well as consumers and family members affected by the guidelines, in the development and adoption of clinical practice guidelines.

E. The SE shall develop a mechanism for reviewing and updating the guidelines when clinically appropriate, but at least every two (2) years.

F. The SE shall distribute the guidelines to the appropriate providers and to the Collaborative upon request and shall make them available to consumers, families, and the public upon request.

G. The SE shall periodically assess practitioner performance against at least three guidelines and determine consistency of decision-making based on the clinical practice guidelines.

H. Decision-making in UM, consumer education, interpretation of covered benefits and other areas shall be consistent with these guidelines.

5.14 Reporting Requirements

A. The SE shall provide to the Collaborative a variety of reports to support the Collaborative’s management, policymaking, and decision-making functions. The Collaborative, working with the SE, will provide to the SE in writing a grid of all required reports to include: report name, report specifications, frequency, priority, level of analysis, and submission dates. Such reports shall include information related to QM, UM, financial management, program evaluation, and other state and/or federally mandated areas of responsibility. The content, format and schedule for the submission of such reports shall be determined by the Collaborative. Forty-five (45) days following the approval of the Guidance Memorandum, the SE shall develop and submit any new routine reports required by the Collaborative not appearing in the grid attachment. The Collaborative may require the SE to prepare and submit ad hoc reports.

B. Reports submitted by the SE to the Collaborative shall meet certain standards:

1. The SE shall verify the accuracy and completeness of data and other information on reports submitted.

2. Reports or other required data shall be received on or before scheduled due dates.

3. Reports or other required data shall conform to the Collaborative’s defined written standards.

4. All required information shall be fully disclosed in a manner that is responsive and with no material omission.

5. Reports shall be accompanied by a brief narrative that describes the content of the reports and highlights salient findings of the reports.
6. As appropriate, the SE shall analyze the reports for any early patterns of change, identified trend, or outlier (catastrophic case) and shall submit a written summary with the report including such analysis and interpretation of findings. At a minimum, analysis will include the identification of change(s), the potential reasons for change(s), and the proposed action(s). Pursuant to Article 5.14A, the report grid shall indicate the reports needing this level of analysis.

7. The SE shall notify the Collaborative regarding any significant changes in its ability to collect information relative to required reports.

C. The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by the Collaborative or its designee on the SE for failure to submit accurate and timely reports.

D. Collaborative requirements regarding reports, report content and frequency of submission may change during the term of the Contract. The SE shall have at least forty-five (45) days to comply with changes specified in writing by the Collaborative.

E. Required reports fall into three categories: managerial, utilization and quality management, and financial.

1. Managerial reports demonstrate compliance with operational requirements of the Contract.
   a. The reports shall include, but not be limited to, information on such topics as:
      i. The composition of the current provider network and capacity to take new Collaborative members, and any changes in the composition and/or capacity of the current provider network;
      ii. Access standards;
      iii. Timeliness of claims payment as specified by the Collaborative;
      iv. Encounter data as specified by the Collaborative;
      v. Identification of third-party liability;
      vi. Fraud and abuse detection activities;
      vii. Delegation oversight activities;
      viii. Required legal timelines for services involving children in State custody. CYFD shall provide the SE with all relevant legal timelines at least 30 days before the start of the contract year and periodically updated on a timely basis during the contract year in response to changes to the legal timeframes; and
      ix. Other topics as mutually agreed upon between the SE and Collaborative, and specified in writing by the Collaborative.

2. UM and QM reports shall demonstrate compliance with the Collaborative’s service delivery and quality standards.
   a. The SE’s reports shall include, but not be limited to
      i. Critical incidents as specified by the Collaborative;
      ii. Performance measures as specified by the Collaborative.
      iii. Grievance resolution activity;
      iv. Consumer satisfaction;
      v. Regular reporting of UM and QM/QI activity as specified by the Collaborative;
vi. Other reporting as mutually agreed upon between the SE and the Collaborative, and specified in writing by the Collaborative.

b. The SE’s MIS shall have the capability to report on the achievement of performance measures and in accordance with the frequency specified.

c. Regular reporting on SE participation in state and/or federally required surveys, studies, reviews, e.g., HEDIS, C/FSP, Child and Family Services Review.

d. The SE shall report the MHSIP data set and any additional requested data as mutually agreed upon by the SE and the Collaborative each Contract calendar year. In addition, the SE shall submit to the Collaborative a written report of the completed calculation of performance measures, including an analysis of the data and a comparison to the baseline, if available.

3. Financial reports demonstrate the SE’s ability to meet its commitments under the terms of the contract. The format, content and frequency of submission for financial reports shall be determined by the Collaborative. The SE shall meet the following general requirements:

a. The SE shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of revenues and expenses. The result of the SE’s annual audit and related management letters shall be submitted to the Collaborative no later than 150 days following the close of the SE’s fiscal year. The audit shall be performed by an independent certified public accountant. The SE shall submit for examination any financial reports related to the performance of the Contract, requested by the Collaborative.

b. The SE and its subcontractors shall maintain their accounting systems in accordance with generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between the SE and its subcontractors and the SE and the Collaborative. Such transactions shall include, but not be limited to, claim payments, refunds, and adjustment of payments.

c. The SE and its subcontractors shall make available to the Collaborative and other authorized state and/or federal agencies, all financial records required to examine compliance by the SE, in so far as the records are related to SE performance under the Contract. The SE and its subcontractors shall provide the Collaborative access to its facilities for the purpose of examining, reviewing and inspecting the SE’s records.

d. The SE shall make available and insure that its subcontractors make available all data required by federal grants, in compliance with federal guidelines.

e. The SE and its subcontractors shall retain all records and reports relating to agreements with the Collaborative for a minimum of ten years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the
minimum ten-year retention period shall begin on the date such actions are resolved.

f. The SE is mandated to notify the Collaborative as soon as practicable, when any change in ownership results in a change of control. Change of control is considered to have occurred if VOI would no longer own 51% of ValueOptions New Mexico or if the ownership changes by more than 10%. The SE shall submit a detailed work plan to the Insurance Division of the Public Regulation Commission during the transition period no later than the date of the sale that identifies areas of the Contract that may be affected by the change in ownership, including management and staff.

g. The SE shall submit records involving any business restructuring when changes in ownership interest in the SE of five percent or more have occurred. The SE’s records shall include, but shall not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the SE of five percent or more. The SE’s records shall be provided no later than 60 days following the change in ownership.

h. The Collaborative reserves the right to comment on the impact of any sale or change of ownership and may terminate this Contract if in its sole discretion such sale or change of ownership may have an adverse impact on the SE’s ability to perform this Contract. Any such termination shall be subject to the provisions of Articles 11, 12, and 13.

5.15 Management Information System (MIS) Requirements

A. Ownership of Data – It is recognized that the Collaborative is the owner of all nonproprietary data associated with this contract. Data include, but are not limited to individual client-specific data such as enrollment, claims, encounters, eligibility, financial data such as rates/fee schedules, provider payments, distribution of funds, contractor/provider-specific information, and any other data necessary to measure program effectiveness, and ensure compliance with state and federal requirements. Notwithstanding the above, the SE shall be permitted to maintain a copy of all such data for a period of ten (10) years from the termination or expiration of the Contract so long as confidentiality of the data is maintained and data are not used for any marketing or product development purposes.

B. The Collaborative will develop a data collection or management information system to meet the needs of the Collaborative. The SE’s participation is integral to the project plan associated with the implementation of this system. To that end, the Collaborative will convene a workgroup to begin the planning phase of this project. The SE will be required to participate in the planning and assigned reasonable types and amounts of work tasks and as such the SE must identify a point person to represent the SE.

C. A Priority Work Plan, as described in Article 2.4, for the development, funding and implementation of this system will delineate tasks, timeframes, accountabilities and resources and will address decision support resources, retention of data, report generation, and quality improvement. The deadline to develop the Priority Work Plan is to be determined and must be approved by the Collaborative co-Chairs or CEO.
D. In addition, at a minimum, the Priority Work Plan will identify a requirement whereby the SE must transmit regularly scheduled feeds of data to the Collaborative system. The SE must participate in discussion on how, what and when the data will be transmitted. The work plan associated with this part of the project must be completed no later than October 1, 2007.

E. Notwithstanding anything above to the contrary, any new Collaborative system must be structured in such a fashion that it permits a smooth and seamless integration with the SE management information system (MIS) such that any transmissions from, or interaction between, the SE MIS and the Collaborative system will not require the SE to modify its MIS in order to work with the Collaborative system.

F. In the event this AGREEMENT is terminated for any reason, or upon expiration, the SE shall assist and cooperate with the Collaborative in an orderly and timely transfer of files, computer software, documentation, and other materials owned by the Collaborative as defined under Article 16. The SE will also transfer all data referred to under Ownership of Data, in a timely fashion to assure a smooth transition and subsequently will transfer any and all enrollment, claims, and encounter data that are received up to 90 days after termination.

G. The SE shall develop and operate a HIPAA-compliant, statewide management information system (MIS) and decision support system designed to meet the multiple-fund tracking and reporting requirements of the Collaborative. This system must be able to report by funding source by agency and by consumer across funding sources and agencies.

H. The SE's MIS shall address operational issues about the data to be supplied, who will supply it, how the data will be exchanged, and how the data will be kept secure.

I. The SE's MIS shall support daily operations and monitor the integrity of the service system and the performance of service providers.

J. The SE's MIS shall have the capability of adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements, including data collection, records and reporting based upon a single consumer identifier to track services and expenditures across funding streams. The SE and the Collaborative will work together to develop a change management process for MIS development or enhancements.

K. The SE's MIS must have the capability of producing a wide variety of reports to support the Collaborative’s management, policymaking, quality improvement, program evaluation, funding decisions and federal and state mandates. The Collaborative reserves the right to modify and/or expand data required as needed. The SE and the Collaborative shall agree upon these modifications and expansions and the Collaborative shall put such modifications and expansions in writing to the SE.

L. The SE's MIS shall have the capacity to meet all requirements, including HIPAA, pertaining to security and confidentiality for all client data exchanged manually or electronically.

M. The SE shall have a secure interface and collect data for MFA through the HMIS as required by HUD.
N. The SE shall have the capacity to submit electronic files (encounter data) to HSD that can be processed by the Medicaid Management Information System.

O. The SE shall ensure data submission timeliness, accuracy and completeness.

P. The SE shall identify its MIS staffing and staffing duties and responsibilities through a MIS staffing organizational chart. Each SE staff member shall be identified as a dedicated New Mexico staff or a shared staff member.

Q. The SE will provide the appropriate MIS staff to meet the MIS and data reporting needs of the Collaborative. A mutually identified process between the SE and the Collaborative will be instituted to identify the appropriate SE MIS staff required to meet the needs of the Collaborative.

R. The SE shall notify the Collaborative of any significant changes in its MIS system.

S. The SE shall provide instructions and training to subcontractors on collection of Collaborative required information, monitor providers’ difficulty in successfully collecting these data, and take action promptly to eliminate collection and submission problems. MIS-related training and evaluation shall be ongoing for both providers and the SE's staff.

T. The SE shall provide a mutually agreed upon mechanism for the Collaborative to access data, including program and fiscal information regarding clients served, services rendered, etc. This mechanism will provide exported data on a mutually agreed upon schedule and in a mutually agreed upon format to a single information system or a variety of information systems owned and operated by the Collaborative agencies.

U. The SE shall provide designated Collaborative staff with access to a designated data warehouse for designated staff and provide training in the use of the data warehouse reporting tool and, as requested, grant ability to Collaborative agency staff to develop and retrieve reports directly from the SE’s data warehouse.

V. The SE shall train designated Collaborative staff to have the ability to export data to other systems, securely, for further analysis, reporting, and oversight purposes.

W. The SE’s MIS shall have the capability of adjudicating requests for payment and process payments to subcontractors.

X. The MIS shall have the capacity to process provider payments including, accepting electronic service information, maintaining provider specific fee schedules, supporting automated payment adjudication, producing Explanation of Benefits (EOB), interfacing with financial systems, etc.

Y. The SE must also maintain a mechanism to collect non-electronic service data.

Z. The SE must have the capability to receive service information in the Collaborative’s approved service/procedure code set using CPT, HCPCS, Revenue Codes, etc. in accordance with the HIPAA Transactions and Code Sets regulations. If the service provider is unable to submit service information to the SE in the required format, it is the SE’s responsibility to assist the provider in its compliance preparation activities related to HIPAA.
The SE shall participate in the further development of performance measures and outcomes, including establishing thresholds and gathering data. The SE shall notify the Collaborative of any significant changes in its ability to collect information on achieving its performance measures. The SE shall submit progress on performance measures as directed by the Collaborative. The SE shall support the need of the Collaborative to report performance measures (outside of the SE-contracted performance measures) to outside agencies and/or legislators.

5.16 Training Requirements

A. The SE shall provide or arrange for regular and ongoing comprehensive training and orientation for SE staff, Collaborative agency staff, and service providers. The training shall be provided regionally whenever possible in order to accommodate Collaborative agency staff and service providers.

B. The SE shall confer with the specific Collaborative agencies included in the Collaborative and coordinate specific training requirements with each Collaborative agency.

C. The SE shall develop and implement a process to determine the effectiveness of the training provided, and report the results of the training to the Collaborative as requested.

D. The SE shall identify and provide timely, targeted training to SE staff, Collaborative agency staff and service providers as issues are identified, in addition to any other training that is provided.

E. The SE shall update a comprehensive Training Plan that includes training and orientation for SE staff, Collaborative agency staff and service providers. The Training Plan shall include a proposed training schedule that identifies training topics; target audience, proposed training dates, locations for the Contract year, and proposed method of determining the effectiveness of the training provided. The Training Plan shall clearly identify those training topics that will be provided by SE staff and those that will be coordinated by the SE but provided by another entity. The proposed Training Plan shall be submitted to the Collaborative by September 1, 2006, for review and approval.

F. The Training Plan shall include, but not be limited to the following:

1. Training/orientation for SE staff regarding
   a. The role and function of the Collaborative;
   b. The relationship between the SE and the Collaborative;
   c. The role of the BHPC and LCs and the SE’s relationship with these entities;
   d. The mission of the state agencies included in the Collaborative and the populations served by each;
   e. Performance and reporting expectations as identified in the SE’s Contract with the Collaborative; and
   f. Development of evidence-based practices.

2. Training/orientation for Collaborative agency staff included in the Collaborative regarding the following:
a. The relationship between the SE and the Collaborative;
b. The role and function of the SE in providing and overseeing behavioral health services for consumers associated with the state agencies;
c. Relationship between the SE and the Local Collaboratives;
d. Services available for consumers associated with the State agencies and how State staff access and coordinate services for consumers with the SE;
e. SE contact information;
f. Service provider network information;
g. Development and implementation of evidence-based practices;
h. Performance and reporting expectations as identified in the SE’s Contract with the Collaborative; and
i. Specific topics related to SE system data, interpretation of data and how the data supports future Collaborative agency and SE planning.

3. Training/orientation for service providers regarding
a. Administrative supports;
b. Operational systems;
c. Role and relationships between the SE, the BHPC, the LCs, and the Collaborative.
d. Development and implementation of evidence-based and promising practices which may include
   • Intensive Outpatient Programs;
   • Team-based services;
   • Culturally specific services;
   • Co-occurring disorders;
   • Comprehensive Community Support Services;
   • Juvenile/Criminal Justice Reintegration services;
   • Adult/adolescent transitional services;
   • Early childhood services;
   • The Taos DD/MI Pilot Project;
   • Multisystemic Therapy (MST); and
   • Functional Family Therapy (FFT);

   e. Services and practices related to specific Collaborative agency initiatives and block grants including but not limited to
      • Addiction Severity Index (ASI);
      • Assertive Community Treatment (ACT);
      • Boston Recovery Model (BU Center for Psychiatric Rehabilitation);
      • Brief Intervention & Motivational Interviewing;
      • Cognitive Behavioral Therapy;
      • Client-centered approaches to services;
      • Cultural competency;
      • Supported Employment;
      • Supported Housing and Housing First models; and
      • Wraparound approaches;
f. Consumer, family and provider education and training and program evaluation to determine effectiveness of training activities. Training is to include, but not be limited to

- Behavioral health service providers to understand the impact of disabilities on the delivery of behavioral health services;
- Consumers and family members regarding behavioral health diagnoses and implications, availability of and access to resources for information and services, and coordination with other disability services providers;
- Methods for referral sources to make appropriate referrals for services.

g. Consumers and family members may attend provider training.

G. The SE shall submit a quarterly training activity report to the Contract Manager in accordance with the requirements set forth in Article 5.14. This report shall provide a summary of each training event by title, location(s), number of registrations, number of participants completing the event, number and type of CEUs offered, and a summation of the participants’ satisfaction surveys. The report shall also include any cancelled event with an explanation of the cancellation.

H. The SE shall report biannually on the effectiveness of the training provided and recommendations for additional training.

ARTICLE 6 –FINANCE REQUIREMENTS: PHASE TWO

6.1 Direct Services

A. During Phase Two, the SE shall ensure that the amounts set forth in Table 6A are spent on direct services. For each program, administrative costs may not exceed the maximum indicated or allowed for each funding source.

B. The SE shall pay ninety (90) percent of all clean claims from practitioners who are in individual or group practice or who practice in shared health facilities within 30 days of date of receipt, and shall pay ninety-nine (99) percent of all such clean claims within ninety (90) days of receipt.

1. A “clean claim” means a manually or electronically submitted claim from a participating provider that: contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the SE’s system. A clean claim is any claim in which a decision has been made to pay or deny.

2. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity, or one that is not materially deficient or improper, including lacking substantiating documentation currently required by the SE; or one that has no particular or unusual circumstances requiring special treatment that prevent payment from being made by the SE within thirty (30) days of the date of receipt if submitted electronically or forty-five (45) days if submitted manually.

C. The SE shall pay providers or subcontractors within 30 (thirty) days of approval by the SE of a submitted deliverable, in which case the SE shall notify the
provider or subcontractor of approval within ten (10) days of receipt of the deliverable or evidence of such.

D. The Contractor is required to date stamp all claims on the date of receipt.

E. The SE shall be required to report the number and allowed amount of claims that were not processed within the 45 day Collaborative requirement, including the amount of interest paid to providers. Such reports will be submitted in a time frame determined by the Collaborative.

6.2 Phase Two Services

A. During Phase Two, the SE shall deliver services under this Contract, taking into consideration the funding and populations served for the programs as set forth in Table 6A.

6.3 Community Reinvestment and Enhanced Services

A. The SE shall offer Medicaid Managed Care consumers enhanced services in accordance with Medicaid regulations. The cost of these services cannot be included when the Collaborative determines the payment rates. Enhanced services are not included in the Medicaid benefit package.

B. The SE shall apply \(X\) percent of the total amount of the HSD Managed Care revenue toward Community Reinvestment and Enhanced Services. The community reinvestment portion can be used for service-related expenditures and/or for administrative activities. Use of reinvestment dollars for administrative activities must be identified and included within the total administrative allocation. Before expending these funds, the SE will consult with and obtain approval from the Collaborative on the process and criteria for determining use of these funds. The Collaborative shall require that the SE submit a quarterly report that shows the total amount of the community reinvestment amounts withheld and report the amount expended and obligated from each funding source.

C. The SE may use Community Reinvestment dollars to pay for enhanced services. The combined obligation of Community Reinvestment and Enhanced Services shall be in accordance with the amount stipulated in 6.3B above. The Collaborative shall provide direction on the types and quantities of those Enhanced Services to be funded.

D. The SE shall also make available $250,000 for community reinvestment in addition to the three (3) percent required by the Contract in Article 6.3A. These funds may be used to purchase any licenses associated with the Addiction Severity Index – Multimedia Version (ASI-MV) referenced under Article 4.1B(3).

E. To ensure that community reinvestment funds are appropriately budgeted and expended to support the vision and goals of the Collaborative for the new behavioral health delivery system, the SE shall work with the Collaborative to develop and implement a Community Reinvestment Plan for annual community reinvestment Initiatives for each Contract year.

1. The SE shall work with Collaborative staff in the development of the Plan.
2. The Plan shall be due by the end of the first quarter following any new fiscal/contract year.
3. The Plan shall be presented to the Collaborative following the end of the first quarter at a meeting identified by the Collaborative Co-Chairs.
4. The Plan shall include the priorities for reinvestment as established by the Collaborative and the SE.
5. The Plan shall include how the SE will solicit ideas for reinvestment and how the SE will establish the criteria by which reinvestment projects are selected. These criteria shall include, but need not be limited to: project sustainability; coordination with Local Collaboratives and other resources; cost; and how closely the projects would help meet the priorities set forth by the Collaborative and in the Community Reinvestment Plan, specifically moving services toward evidence-based practices; meeting performance targets; or moving toward support of consumer recovery and resiliency.
6. The Plan shall set forth a timeline indicating how much money shall be obligated and spent by what dates.

F. In addition to, or concurrently with, the development of the Plan, the Community Reinvestment process shall include
1. Identifying the overall annual target expenditure level for community reinvestment, which shall be three (3) percent of each fund designated in this contract for community reinvestment;
2. Mutually determining those planned services and projects that will be Community Reinvestment Initiatives for that Contract year, as well as the projected level of expenditure in each Initiative in each quarter of the Contract year;
3. Consideration of input from the BHPC and its subcommittees, LCs and other stakeholders as the planned services and projects are selected by the Collaborative and the SE;
4. Quarterly accounting by the SE to the Collaborative or its designee of expenditures and accruals in Community Reinvestment Initiatives indicating dollar amounts withheld and total obligations and expenditures from each funding source; and
5. Adjustment of the community reinvestment if expenditures and accruals vary materially from original projections. The Contract Manager and the SE will mutually agree upon such adjustments, based on criteria set forth in the Community Reinvestment Plan.

G. The SE shall submit a plan for proposed community reinvestment initiatives under this Contract that shall be subject to Collaborative approval.

6.4 Agency-Specific Finance Requirements

A. **Jail Diversion.** The providers of these services and the specific provider allocation (as determined to meet state or federal requirements) shall be agreed upon by the SE and the Collaborative.

B. **School-Based Services.** The SE shall track and report the subcontract funding source as follows: HSD State General Funds, $286,000.

1. **Comprehensive Women’s Services.** The providers of these services and the specific provider allocation (as determined to meet state or federal requirements) shall be agreed upon by the SE and the Collaborative.

C. **CoSIG.** The providers of these services and the specific provider allocation (as determined to meet state or federal requirements) shall be agreed upon by the SE and the Collaborative.
SAPT Street Outreach Initiatives. The providers of these services and the specific provider allocation (as determined to meet state or federal requirements) shall be agreed upon by the SE and the Collaborative.

D. DOH State-Operated Programs.

1. For FY07, the SE shall work with the Collaborative to develop a Management Letter pursuant to Article 2, Section 2.2 of this Contract to describe the details of funding the DOH State-Operated Facilities; i.e., the Behavioral Health Institute at Las Vegas, Turquoise Lodge, Yucca Lodge, and the Sequoyah Adolescent Treatment Center.

2. The SE shall reimburse DOH State-Operated programs during FY08 an amount to be determined, based on state appropriations and negotiations during FY07, commensurate with these facilities’ performance and services offered.

E. Behavioral Health Planning Council. The SE shall provide an annual payment of $5,000 to support the BHPC by no later than August 1, 2006 for FY 2007 and no later than August 1, 2007 for FY 2008.

F. Local Collaboratives. The SE shall provide administrative and logistical support for the development and ongoing maintenance of the LCs as identified by Letters of Interest per the Guidelines for Local Collaboratives, including an annual payment of $3,000 per Local Collaborative by no later than August 1, 2006 for FY 2007 and no later than August 1, 2007 for FY 2008, or within thirty (30) days of the identification of additional LCs up to a maximum of eighteen (18).

G. As part of the effort to ensure behavioral health system capacity to implement key system changes (including Core Service Agencies, balanced residential and community-based care), the Collaborative is providing $300,000 to be used by the Contractor to strengthen management information systems within identified provider agencies. Disbursement of these one-time-only infrastructure development funds will be made in accordance with the following guidance:

1. The Contractor shall utilize Technical Assistance Plans that are developed from the Provider Readiness Tool completed with providers and VO Regional Directors. These plans will be utilized to identify those providers in each Region with the greatest need for infrastructure support and the greatest potential to benefit from these funds.

2. The Contractor shall establish a process for prioritizing the distribution of funds in collaboration with the Collaborative CEO.

3. Recommendations for disbursement of funds shall be submitted to the Collaborative CEO for review prior to funds disbursement.

4. Funds may be used for hardware, software, MIS system development, connectivity and related staff training.

5. Funds must be expended by September 30, 2007. Any extensions to this date must be approved by the Collaborative CEO.


H. Any amounts required by this contract to be provided to specific providers shall apply for FY07 only and are subject to adequate provider performance.
1. At any time the SE determines that a specifically named provider is not adequately performing, the SE shall inform the Contract Manager and the Collaborative member agency involved, and shall propose a manner in which to improve that provider's performance or switch the funding to another provider. The Contract Manager and the funding Collaborative member agency must approve any change during FY07.

2. During FY07, the SE shall determine which agencies it proposes to receive these funds for FY08 and why, and provide the Contract Manager and the funding Collaborative member agency an opportunity for input and consultation about this determination, prior to March 1, 2007.

I. The SE shall work with the Collaborative and LCs, and in coordination with any related capital outlay projects, to develop projects and/or provider contracts to implement any FY08 special appropriations.

J. Mid-year Funds

During the contract year, funds may become available to the Collaborative or one of its member Agencies through federal grants, state appropriations, or other sources. The Collaborative reserves the right to add new funding to this contract for services and activities that broadly fit within the scope of work described in Articles 2, 3, 4, or 6.

[Deleted: $250,000 to establish mobile crisis teams in Las Cruces; $250,000 for residential and non-residential transitional treatment or temporary beds for court-ordered jail diversion; $859,000 to expand STOP (sex offender treatment program) at NMBH; $50,000 for adult suicide prevention efforts; $50,000 for rape crisis services in Albuquerque; $19,500 for a suicide prevention project in Northern New Mexico; $200,000 for an alcohol recovery program in Santa Fe; $100,000 for detoxification and behavioral healthcare services in San Juan County; $350,000 for operations expenses of DWI, alcohol and drug treatment and rehabilitation programs in San Juan County; $30,000 for a substance abuse treatment program in San Juan County; $25,000 for alcoholism treatment programs in Santa Fe County; $19,500 for alcoholism and substance abuse treatment services in Taos in Taos County; $650,000 for prevention and treatment services to methamphetamine addicts; $121,000 for methamphetamine treatment and prevention statewide; and $50,000 for expansion of the Chimayo Youth Conservation Corps to provide drug abuse prevention and harm reduction services to youth 12-21 years of age in the Chimayo area.]

Deleted: System Evaluation. The SE shall provide $120,000 for the evaluation of the behavioral health system with input and approval from the Collaborative. The amount shall be payable in equal quarterly installments payable on the first day of each quarter of the contract period. Any funds unexpended of the Year One $120,000 for the evaluation of the behavioral health system shall be expended in FY07 or FY08 at the direction of the ...
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<th>Department</th>
<th>Collaborative Agency Funding</th>
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| Community Corrections Grant Fund | 3,176,583 |

| MFA | 2,718,849 |

| ALTSD | 2,718,849 |

| HSD | 2,718,849 |

| Medicaid: Managed Care, State | 2,718,849 |

| Medicaid: Coordinated FFS, Federal | 2,718,849 |

| Medicaid: Coordinated FFS, State | 2,718,849 |

| TANF (Federal) | 2,718,849 |

| CYFD | 2,718,849 |

<p>| General Fund | 2,718,849 |</p>
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<td>Access to Recovery (ATR) – Federal</td>
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<td>Co-SIG – Federal</td>
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ARTICLE 7 - COMPENSATION AND PAYMENT

7.1 General
A. The Collaborative shall make payments to the SE for the behavioral health service programs as described in this Contract and the RFP.

7.2 Taxation
A. To the extent, if any, it is determined by the appropriate taxing authority, that the performance of this Contract by the SE is subject to taxation, the amounts paid by the Collaborative to the SE under this Contract, shall include such applicable tax(es) and shall be paid out of non-direct service amounts.
B. The SE shall account for any performance under this Contract subject to a premium tax for Medicaid-managed care services and shall specifically account for Medicaid managed care services, so that any applicable premium tax shall be attributed only to those Medicaid services. The SE is responsible for reporting and remitting all applicable taxes to the appropriate taxing agency.

7.3 Compensation and Reimbursement
A. The Parties to this Contract understand and agree that the compensation and payment reimbursement for statewide behavioral health services is dependent upon Federal and State funding and regulatory approvals and such funding and all rates of compensation and payment are to be determined and agreed to on annual basis. Neither the SE nor the Collaborative can or will guarantee funding or rates of payment or compensation for any year beyond the current year for which the SE and Collaborative have received funding and reached agreement upon rates of compensation and payment. The Parties further understand that program changes affecting compensation for the statewide behavioral health programs are likely to occur during the term of this Contract and further agree to the following if such program changes are implemented by the Collaborative during the term of this Contract:

1. In the event that the Collaborative initiates a programmatic change affecting compensation and/or payment reimbursement for any behavioral health service program during the term of this Contract, prior to initiating any such change the Collaborative shall provide the SE with as much notice as is possible, generally at least sixty (60) days, given the circumstance of the contemplated change and the effect it will have on compensation and payment reimbursement for any behavioral health service program.

2. Upon notice of a proposed program modification or change, the SE may request negotiations for a modification of the Contract concerning changes in compensation and payment reimbursement for any behavioral health service program changes, as provided in the notice from the Collaborative. Such programmatic changes and any resulting negotiations and modifications shall be limited to the change in compensation and payment reimbursement for any behavioral health
service program changes, and shall not subject the entire Contract to being reopened.

3. If the SE does not request negotiations for a modification of the Contract concerning the change in compensation and payment reimbursement for any behavioral health service program changes within thirty (30) business days of the notice from the Collaborative, then the change shall be implemented and become effective under Article 40 of this Contract.

4. The SE will provide notice to the Collaborative of any service or programmatic changes anticipated by the SE that will have a budgetary impact on any of the Collaborative Agencies. This notice shall be provide on a timeline that will allow Collaborative Agencies to adjust their budget requests. The SE must submit notice of anticipated changes for FY09 to the Collaborative by August 1, 2007. The SE must submit notice of anticipated changes for FY10 to the Collaborative by July 1, 2008.

5. Any renegotiation of rates, amounts, or service system pursuant to this section shall be memorialized in writing and signed by the SE, the Co-Chairs of the Collaborative, and the funding Collaborative agency.
7.4 Payment for Services – Non-Medicaid

A. Each Collaborative member agency providing funds for services under this Contract shall pay the SE one-twelfth (1/12th) of the amount indicated in Table 6A, each month, no later than the thirtieth (30th) day of each month.

B. The SE shall keep these monthly payments in a separate account with any interest accruing to that account to be used for behavioral health services.

C. By the thirtieth day following the end of each quarter, the SE shall provide the Collaborative with amounts paid by the SE for direct services appropriate to each fund source, including encounter-based data where required. To the extent the amount spent in that quarter does not equal the amount required to be spent for direct services for any fund source, or the data have not been provided by the SE by the thirtieth day following the end of a quarter, the SE shall provide a plan for meeting that level of expenditure by the end of the following quarter. This plan shall be approved by the Contract Manager and the funding Collaborative agency.

D. If the amount expended by the following quarter does not meet the required amount to be expended for direct services, the Contract Manager and funding Collaborative agency shall agree on and instruct the SE how to expend the necessary amount for direct services. The SE shall comply with that instruction.

E. No later than May 31 of the contract year, the SE shall notify all providers delivering non-Medicaid funded services that all billing for those services delivered during the contract year must be submitted within thirty (30) days of the end of the contract year.

F. Within ninety (90) days of the end of each contract year, the SE shall ensure that all funds appropriated by the Legislature for the delivery of behavioral health services through the SE are paid and/or encumbered for services delivered during the contract year.

G. The SE shall refund any and all unexpended or unencumbered funds for Direct Services and Administrative fees to the appropriate Collaborative Agency by the end of November 2007 for the contract year ending June 30, 2007 and by the end of November 2008 for the contract year ending June 30, 2008.

H. To the extent that the SE fails to comply with the instructions set forth above in this Article, the Collaborative may invoke sanctions in accordance with Article 10.

7.5 Payment for Services – Temporary Assistance for Needy Families (TANF)

A. The SE shall provide a billing invoice due to HSD monthly on the 15th day of the month. The final invoice shall be due no later than 07/10/08.

B. The SE shall bill 1/12th of the full budget each month as a reimbursement.
7.6 Payment for Services – Medicaid

A. HSD shall pay a capitated amount to the SE for the provision of the managed care benefit package at specified rates. The monthly rate for each managed care consumer is based on actuarially sound capitation rate cells. The SE shall accept the capitation rate paid each month by HSD/MAD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. HSD/MAD will calculate the SE’s income at the end of the State Fiscal Year to determine if the percent was expended on the services required under the contract utilization reported information and the Department of Insurance reports. Quarterly reviews will be conducted and an annual reconciliation, 90 days after the end of the fiscal year, will be conducted. Administrative costs, to be no higher than the allowable percent, including all SE-delegated entities (if applicable) and other financial information will be monitored. The SE does not have the option of deleting benefits from the Medicaid defined benefit package. Should the SE not meet the required administrative or direct services costs, sanctions, as detailed in Article 10, may be imposed.

B. HSD shall also pay an administrative fee for each non-managed care-eligible Medicaid recipient. In addition, HSD will reimburse the SE for all claims paid on behalf of these recipients.

C. Medicaid and SCHIP consumers shall be held harmless against any liability for debts of the SE that were incurred within the Contract in providing behavioral health care to the Medicaid or SCHIP consumers excluding any eligible’s liability for co-payments or eligible’s liability for an overpayment resulting from benefits paid pending the results of a fair hearing.

D. Federal regulation 42 CFR Section 438.6(c), which regulates participation in the Medicaid managed care program, requires that rates be actuarially sound and approved as such by CMS prior to implementation. To meet the requirement for actuarial soundness, managed care rates must be certified by an actuary meeting the qualification standards of the American Academy of Actuaries following generally accepted actuarial principles, as set forth in the standards of practice established by the Actuarial Standards Board. Accordingly, the State’s offer of managed care rates referred to in the attached Schedule of this Contract (Attachment C, D) is contingent both on certification by the State’s actuary and final approval by CMS, prior to becoming effective for payment purposes. In the event such certification or approval is not obtained for any or all capitation rates subject to this regulation, the State reserves the right to renegotiate these rates. The State’s decision to renegotiate rates under the circumstances described above is binding on the SE.

E. Payment on Risk Basis

1. For Medicaid Managed Care consumers, HSD shall not provide a retroactive payment adjustment to the SE to reflect the cost of services actually furnished by the SE.
2. The SE may retain any unused amounts if service provision, community reinvestment, and access requirements are met.

F. Changes in the Capitation Rates

1. The Collaborative reserves the right to renegotiate the Medicaid rate for FY07, FY08 and/or FY09 of this Contract if necessary. The capitation rates may be adjusted based on factors such as changes in the scope of work, CMS requires a modification of the State’s waiver or new or amended federal or state laws or regulations are implemented, inflation, significant changes in the demographic characteristics of the population served, or the disproportionate enrollment selection of the SE by consumers in certain rate cohorts.

2. In the event of an approved Medicaid State Plan Amendment that adds additional services to the Medicaid benefit package in the middle of a fiscal year, HSD will develop new, actuarially sound, rates to reflect those new services.

3. In the event HSD obtains additional funding identified for increased reimbursement to specific service providers, the SE agrees that it will pass on all such additional funding following its receipt from HSD. SE shall make such payments only to those types of service providers identified by HSD in writing and who are contracted directly, or through a delegated arrangement, with the SE.
   a. The SE and HSD agree that the SE’s obligation under this section to pass through any additional funding will require at least thirty (30) business days’ prior written notice.
   b. HSD and the SE agree that no payments will be required to be made pursuant to this section until HSD has provided written approval of the payment process to be utilized by the SE to ensure that the process will meet HSD audit requirements.
   c. HSD reserves the right to direct payments to providers if it is determined that the SE has failed to comply with the pass-through requirements. These additional funds shall be entirely for provider rate increases; no portion shall be used for any other purpose. These additional funds shall not be part of the total Medicaid Managed Care revenue used to calculate the Reinvestment amount.

4. Any changes to the managed care rates shall be actuarially sound and negotiated and implemented pursuant to Articles 40 (Contract Modification) and 39 (Amendments) of this Contract.

5. Any changes to the fee-for-service rates shall be negotiated and implemented pursuant to Articles 40 (Contract Modification) and 39 (Amendments) of this Contract.

6. HSD shall compensate the SE for work performed under this Contract for FY07 at the rates shown on Attachment C and D.

7. The SE shall obtain reinsurance for coverage of consumers as required by this Contract. However, the SE remains ultimately liable to HSD for the services rendered under the terms of this Contract. The SE shall provide a copy of its proposed reinsurance agreement prior to July 1, 2006.
G. Payment Procedures for Medicaid Managed Care

1. HSD shall distribute an aggregate amount to the SE for all consumers enrolled with the SE on or before the second Friday of each month.

2. HSD shall make a full monthly payment to the SE for the month in which the consumer’s enrollment is terminated. The SE shall be responsible for covered medical services provided to the consumer in any month for which HSD paid the SE for the consumer’s care under the terms of this Contract.

3. HSD shall have the discretion to recoup payments made for consumers who die prior to the enrollment month for which payment was made; and/or payments for consumers whom are later determined to be ineligible for Medicaid during the enrollment month for which payment was made. HSD will recoup any duplicate payments made to the SE upon identification of either the HSD the SE or any other source.
   a. To allow for claim submission lags, HSD will not request a payment recoupment until one-hundred-twenty (120) days has elapsed from the date of which the enrollment and claims payment error was made.
   b. In the event of an error, which causes payments(s) to the SE to be issued by HSD, HSD shall recoup the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the 30th day following the notice.
   c. Any process that automates the recoupment procedures will be mutually agreed upon in advance by HSD and the SE and documented in writing, prior to implementation of a new automated recoupment process. The SE has the right to dispute any recoupment requests in accordance with Article 31 of this Contract.

4. On a periodic basis, HSD shall provide the SE with coordination of benefits information for enrolled members. The SE shall
   a. Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under other behavioral health care contracts;
   b. Notify HSD as set forth below when the SE learns (not identified in enrollment roster) that a consumer has third-party liability for medical or behavioral health care:
      i. Within fifteen (15) business days when a consumer is verified as having dual coverage under its MCO; or
      ii. Within sixty (60) calendar days when a consumer is verified as having coverage with any other MCO or behavioral health carrier;
   c. Communicate and ensure compliance with the requirements of this section by subcontractors that provide services under the terms of this Contract.

5. Consumers shall not be charged for services covered under the terms of this Contract, except as provided in the MAD Provider Policy.
Manual Section MAD- 701.7, Acceptance of Recipient or Third Party Payments.

6. Payments provided for under this Contract shall be denied for new consumers when, and for so long as, payment for those consumers is denied under 42 CFR Section 434.67(e).

7. In those instances where a duplicate payment is identified either by the SE or HSD, HSD retains the ability to recoup these payments within time periods allowed by law.

H. Payment Procedures for Medicaid Fee-For-Service

1. For the Medicaid Coordinated Fee-for-Service (CFFS) program, HSD shall make payment to the SE of an administrative fee for each fee-for-service consumer, plus reimbursement for claims by the SE to behavioral health providers. The negotiated administrative fee appears in Attachment D.

2. The administrative fee shall include payment for activities associated with the CFFS program. This includes care coordination, utilization management, provider enrollment, and network maintenance, grievance and appeals, and claims processing. The administrative fee will also include the costs of administering the CFFS drug rebate program on behalf of the Collaborative.

The SE is responsible for the payment of all CFFS claims at the established Medicaid Fee-for-Service fee schedule. HSD will make a state general fund payment on July 30 of the contract year (July 30, 2007 for State Fiscal Year 2008) in an amount equal to the estimated one (1) month expenditure by the SE for CFFS claims. HSD will then reimburse the SE weekly for any claim from a submitted encounter data file that is approved and validated by the Medicaid Management Information System (Omnicaid) in the prior week. No later than two (2) months following any contract year, HSD will reconcile payments, recouping any funds that are above and beyond the amounts approved and validated in Omnicaid.

7.7 Special Payment Requirements - Medicaid

A. The Medicaid behavioral health costs of Native Americans provided at IHS and Tribal 638 facilities is established by HSD and will be fully reimbursed to the SE.

B. The SE shall reimburse IHS and tribal 638 facilities for services rendered to Native American members. HSD/MAD will reimburse the SE for payments made to the IHS or tribal 638 facilities for those services. Reimbursement for these services are not included in the determination of capitation rates.

C. If an Indian Health Service (HIS) or Tribal 638 provider delivers services to a Medicaid consumer who is a Native American, the SE shall reimburse the provider at the all inclusive rate (OMB rate) for both Managed Care and FFS or at the fee schedule rate established by HSD/MAD for FFS. The SE may use the fee schedule rate or may negotiate different rates for Managed Care on those services indentified in the fee schedule. OMB rates are published annually in the federal register.
D. IHS pharmacy benefits are not part of the SE’s responsibility.

7.8 Reimbursement of Federally Qualified Health Centers (FQHCs)
A. FQHCs are reimbursed at one hundred (100) percent of reasonable cost for Medicaid consumers and Medicaid services under a Medicaid fee-for-service or managed care program.
B. The FQHC can waive its right to reasonable cost and elect to receive the rate negotiated with the SE.
C. During the course of the Contract negotiations with the SE, the FQHC shall state explicitly that it elects to receive one hundred (100) percent of reasonable costs or waive this requirement.
D. Reasonable costs shall be the Medicaid fee-for-service rates established by HSD.

7.9 Sufficiency of Rates and Compensation
A. In the event that either the SE or the Collaborative determine that the existing negotiated rates are not sufficient to effectively fund all services required under this Contract or the underwriting data and/or the assumptions supporting such data supplied by the Collaborative, on which such rates are based, proves to be in error or inadequate to provide sound actuarial analysis, the SE or the Collaborative shall have the right to request modification of this Contract in accordance with Articles 39 and 40.

ARTICLE 8 - COLLABORATIVE RESPONSIBILITIES

8.1 Overall Role
A. The Collaborative’s overall role is to provide leadership, planning, policy direction and oversight for all behavioral health services within the scope of the member agencies. This role includes selecting, contracting and ongoing communication to ensure effective working relationships with the SE. In this capacity the Collaborative shall do the following:
1. Establish and maintain all Medicaid eligibility information and transfer eligibility information to ensure appropriate enrollment in and assignment to the SE. On the SE’s request, this information shall be transferred electronically. The SE shall have the right to rely on eligibility and enrollment information transmitted to the SE by the Collaborative. The Collaborative will work with the SE to develop protocols for determining the appropriate payer when a Medicaid-covered individual has multiple payer resources for a Medicaid-covered service;
2. Provide the SE with eligibility and priority determination criteria related to the non-Medicaid adult, child and adolescent populations;
3. Provide the SE with information concerning each potential consumer (both Medicaid and non-Medicaid) receiving services from the SE, including the potential consumer’s name and social security number,
address, date of birth and gender, and, to the extent possible, available information concerning third-party coverage; for Medicaid, information will include the consumer’s rate category;

4. Compensate the SE as specified in Article 7;

5. Clarify or change any unclear or inconsistent State policies or rules identified by the SE so that the Collaborative and the SE approaches will be consistent and support development of the single statewide behavioral health delivery system contemplated by State law;

6. For Medicaid consumers, provide a mechanism for fair/administrative hearings to review denials and Utilization Management decisions made by the SE;

7. Conduct review and monitoring activities as needed to meet CMS, SAMHSA or other funder requirements for State oversight responsibilities.

8. Establish requirements for review and make decisions concerning the SE’s requests for disenrollment of consumers covered by Medicaid Managed Care;

9. Determine the period of time within which a consumer covered by Medicaid Managed Care cannot be reenrolled with the SE, when it has successfully requested his/her disenrollment;

10. Provide mandatory Medicaid enrollees with specific information about services and benefits;

11. Have the right to receive solvency and reinsurance information from the SE, and to inspect the SE’S financial records as frequently as necessary, but at least annually;

12. Have the right to receive all information regarding third-party liability from the SE so that it may pursue its rights under State and Federal law.

13. Provide the content, format and schedule for the SE’s reports and deliverables submission;

14. Work with the SE to consolidate the number and kinds of reports to provide the information and data needed for fund source reporting and for performance accountability while minimizing unnecessary or duplicate reporting;

15. Inspect, examine, and review the SE’s financial records as necessary to ensure compliance with all applicable State and Federal laws and regulations;

16. Provide federally required or other essential data elements and specifications related to data reporting requirements for the SE to use in reporting;

17. Monitor encounter and other data submitted by the SE;

18. Ensure that no requirement or specification established or provided by the Collaborative under this section conflicts with requirements or specifications established pursuant to HIPAA and the regulations promulgated thereunder;

19. Cooperate with the SE in SE’s efforts to achieve compliance with HIPAA requirements;
20. Work with the SE on operational matters through the use of the Collaborative senior management Steering Group, which shall meet on a regularly scheduled basis, and shall include participation by appropriate SE staff as needed but on at least a monthly basis;

B. Through the use of the Steering Group, five (5) cross-agency teams (CAT), and any ad hoc cross-agency group, the Collaborative shall provide ongoing liaison, support and interaction with the SE to promote the effectiveness of the partnership. This shall include supplying guidance and technical information at the required level of specificity in a timely fashion.

1. The five CATs will focus on the following key areas of potential interaction with the SE:
   a. The Oversight CAT will establish and implement guidelines for multi-agency Contract monitoring and Contract management of the SE to ensure Contract compliance, quality performance, and quality of care of SE, its contractors and delegates. It will ensure the Collaborative’s goals and requirements are met.
   b. The Local Collaboratives CAT will support and coordinate the work of the Collaborative-recognized LCs, ensuring their input and participation in planning, coordination and review of the service system in their areas.
      i. Interagency Staff Teams, as a subset of the LC CAT, will be responsible for translating state policy to local areas and Native American Tribes and Pueblos within their designated area. They will work with regional SE staff and the LCs to identify needs and develop programmatic recommendations and to resolve problems or issues that may arise regarding services, service delivery, consumer and family or provider concerns, and issues affecting service quality. The staff teams will advise the SE.
   c. The Policy and Planning CAT will provide policy recommendations to the BH Collaborative as well as the development of a comprehensive and integrated statewide behavioral health planning process.
   d. The Capacity, Program Development and Research/Evaluation CAT will develop improved workforce and program capacity for effective practices and coordinate and support an effective program of research/evaluation to ensure continued improvement.
   e. The Administrative Systems and Supports CAT will develop and implement more efficient state administrative systems as needed to support success of the Collaborative.

2. The Oversight CAT shall be responsible for Contract oversight of the SE. The Oversight Team will address quality issues and other program development issues that may arise, and will advise and direct the SE. The Team Leader shall be primary point of contact for Contract matters.

3. These teams, as well as other staff work activities, will be coordinated through the Steering Group and will encourage participation and
communication with the SE as needed to ensure effective partnership.

C. The Collaborative shall establish a single point of contact and coordination for work with all state staff through the Contract Manager, whose role shall include primary liaison with the SE, pursuant to Article 37.

8.2. Advisory Groups; Relationship between State and SE Staff

A. The Collaborative shall, in the administration of this Contract, seek input on behavioral health care-related issues from the BHPC and the LCs. The Collaborative may seek the input of the SE on issues that may affect the SE raised by the BHPC or LCs.

B. Performance by the SE shall not be contingent upon time availability of the Collaborative personnel or resources with the exception of specific responsibilities stated in the RFP and the normal cooperation that can be expected in such a Contractual Agreement. The SE’s access to the Collaborative personnel shall be granted as freely as possible. However, the competency/sufficiency of the Collaborative staff shall not be reason for relieving the SE of any responsibility for failing to meet required deadlines or producing unacceptable deliverables.

C. To the extent the SE is unable to perform any obligation or meet any deadline under this Contract because of the failure of the Collaborative to perform its specific responsibilities under the Contract, the SE’s performance shall be excused or delayed, as appropriate. The SE shall provide the Collaborative, through the Contract Manager, with written notice as soon as possible, but in no event later than the expiration of any deadline or date for performance, that identifies the specific responsibility that the Collaborative has failed to meet, as well as the reason the Collaborative’s failure impacts the SE’s ability to meet its performance obligations under the Contract.

D. The SE shall be held harmless for implementation delays when the SE is not responsible for the cause of the delay.

ARTICLE 9 – TERM AND LIMITATION OF COSTS

9.1 The effective date of the Contract shall be July 1, 2006 (Effective Date – Phase Two Activities) and will end no later than June 30, 2008 (Expiration Date – Phase Two Activities) and from July 1, 2008 (Effective Date – Phase Three Activities) to June 30, 2009 (Expiration Date – Phase Three Activities). During the first Contract year, assuming satisfactory performance, Contract terms for the next years will be negotiated, with all compensation rates and payment amounts to be negotiated annually. Assuming continued satisfactory performance, a fourth year will be negotiated at the mutual agreement of the parties. Approval of the Contract by CMS and DFA must be obtained before the Effective Dates of the Contract.

9.2 The term “day(s)” refers to calendar days, unless otherwise specified. Timelines or due dates falling on a weekend or state or federal holiday shall be extended to the first business day after the weekend or holiday.
9.3 In no event shall fees or other payments provided for in the Contract exceed the payment limits set forth in any relevant state or federal statute, regulation or rule. In no event shall the Collaborative pay twice for the provision of services.

ARTICLE 10 – ENFORCEMENT

10.1 Overview

A. The State’s SE Oversight Team will serve as the penalty review team to identify potential and actual problems with the SE’s performance. When the Oversight Team verifies the presence of Contract deficiencies, it will provide the Contract Manager with details of the identified deficiencies as well as recommendations for sanction interventions based on the nature of the deficiencies. The Contract Manager will then have an array of options to choose from if sanction is necessary.

B. The Contract Manager will notify the Collaborative Co-Chairs and the Collaborative member representatives who are liaisons with the Oversight Team and seek their input before imposing any sanctions on the SE.

C. The federal requirements related to managed care waiver circumstances and provision of sanctions are outlined in 42 CFR. These provisions for the imposition of sanctions are required by CMS for compliance with the following federal requirements: 42 CFR 438.700; 42 CFR 92.36(j)(1); 42 CFR 438.702; 42 CFR 422.208; and 42 CFR 422.210. The Oversight Team acknowledges the need to be in compliance with the most stringent State agency’s sanction regulations, which are the federal regulations as found in the CFR.

10.2 Process

A. The Oversight Team will have the authority and capacity to perform joint department investigations for evaluation of Contract compliance. In the course of these investigations, if SE is determined to be substantially non-compliant with Contract requirements, the Oversight Team will discuss the issues and determine what action is recommended.

B. The Oversight Team or a Collaborative Agency will provide the Contract Manager with specific documentation of the findings that substantiate the need for sanction and will recommend the type of sanction they feel is necessary based on the nature of the deficiency.

C. The Contract Manager will review the information and consult with any appropriate Collaborative agencies or staff if needed in order to determine if sanctions are appropriate.

D. If the Contract Manager determines that sanctions are necessary, then she or he shall inform the SE’s CEO or designee via phone regarding the presence of State non-compliance concerns. The Contract Manager will also consult with Collaborative member agencies as indicated in 10.1, above. The Contract Manager will follow this verbal communication with a written notice to the CEO outlining in detail the nature and extent of the sanction deficiencies. The Collaborative Co-Chairs shall sign any written
sanction notice to the SE. The written notice of sanction will include but not be limited to the basis and nature of the sanction, as well as any other due process protections the State elects to provide.

E. The SE will have the right to dispute the sanction according to the procedures outlined in the Sanction Dispute Procedures section.

10.3 Array of Sanction Options

A. The following options represent current actions utilized in multiple state agency sanction language. The Collaborative (“State”) may use a combination of these actions dependent upon the nature of the sanction deficiency.

1. Corrective Action Plan (CAP). The use and implementation of a CAP represents the most often commonly used sanction intervention. The implementation of a CAP is utilized when deficiencies are identified and mutual anticipation of a timely remedy is expected. Timelines for CAPs are based on the nature of the deficiency(s). The submission by the SE of its proposed CAP interventions shall follow the following timelines:
   a. One-week turnaround time for health & safety violations
   b. Two-week turnaround time for non-health & safety violations
   c. Other timelines as allowed by the Notice of Sanction letter

2. Directed Corrective Action Plan (DCAP). The Oversight Team develops a directed and very specific DCAP, which outlines all of the identified deficiencies. Each identified deficiency is linked to specifically directed actions and interventions as well as specified timeframes for completion. Each deficiency has a defined and required outcome that the contractor must achieve within the specified timeframe for completion. If the DCAP implementation is not effectively implemented, this is a basis for further sanction considerations.

3. Civil Monetary Penalties (CMP). Any of the following monetary penalties may be imposed alone or in combination:
   a. Imposition of a daily fee leveraged against the SE until the deficiency is corrected;
   b. Withhold of payment, as indicated in the Notice of Sanction letter; and/or
   c. Calculated Lump Sum per consumer impacted by the deficiency. Examples, $25,000 per consumer up to a maximum amount or suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the State is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
   d. Suspension of monthly payments described under Article 7.4.

4. Temporary Management
   a. The State may impose temporary management only if it finds (through onsite survey, consumer complaints, financial audits, or any other means) that
i. There is continued egregious behavior by the SE, including but not limited to behavior that is described in Social Security Act, as enacted in 42 CFR section §438.700;

ii. There is substantial risk to consumers’ health and safety; or

iii. The sanction is necessary to ensure the health of consumers while improvements are made to remedy violations under 42 CFR section 438.700 or until there is an orderly termination or reorganization of the SE.

b. The imposition of Temporary Management is at the expense of the SE and is instituted at the SE’s level. The State may delay imposition of Temporary Management to provide a hearing before imposing this sanction, at the Collaborative’s sole discretion. The State may not terminate Temporary Management until it determines that the SE can ensure that the sanctioned behavior will not recur.

5. Termination of Contract
   The Collaborative has the authority to terminate this Contract and enroll that entity’s consumers with another contractor(s), or provide consumers services (including their Medicaid benefits) through other options included in the State plan, if the State determines that the contractor has failed to do either of the following:
   a. Carry out the substantive terms of its contract;
   b. Meet all applicable federal requirements listed in Title 19, Social Security Act sections 1932, 1903(m), and 1905(t); or
   c. Meet all applicable State laws or regulations or requirements under this Contract.

10.4 Sanction Dispute Procedures
   A. Any dispute concerning sanctions imposed under the Contract shall be reported in writing to the Contract Manager within 15 days of the date the SE received notice of the sanction. The decision of the Collaborative shall be delivered to the SE in writing within 30 days and shall be final and conclusive unless, within 15 days from the date of the decision, the SE requests a written appeal of the decision to the Co-Chairs of the Collaborative.

   B. Failure to file a timely appeal shall be deemed acceptance of the Collaborative’s decision and waiver of any further claim.

   C. In any appeal under this Article, the SE shall be afforded an opportunity to be heard by the Collaborative and to offer evidence and argument in support of its position to the Collaborative. The appeal is an informal hearing that shall not be recorded or transcribed and is not subject to formal rules of evidence or procedure. The appeal shall be open to the public unless State law allows such hearings in executive session.

   D. The Collaborative Co-Chairs or a designee shall review the issues and evidence presented and issue a determination in writing, which shall conclude the administrative process available to the SE. The Collaborative Co-Chairs shall notify the SE of the decision within 30 days.
of the notice of the appeal, unless otherwise agreed to by the SE in writing or extended by the Collaborative Co-Chair for good cause.

E. Pending decision by the Collaborative Co-Chairs, both parties shall proceed diligently with performance of the Contract, in accordance with the Contract.

F. Failure to initiate or participate in any part of this process shall be deemed waiver of any claim.

10.5 Federal Requirement of Sanction Notification

A. The State must give the CMS Regional Office written notice whenever it imposes or lifts a sanction for one of the violations listed in the 42 CFR 438.700. The notice must be given no later than 30 days after the State imposes or lifts a sanction and specify the affected contractor, the kind of sanction, and the reason for the State's decision to impose or lift a sanction.

ARTICLE 11 – TERMINATION

11.1 All terminations shall be effective at the end of a month, unless otherwise specified in this Article.

11.2 This Contract may be terminated under the following circumstances:

A. By mutual written agreement of the Collaborative and the SE upon such terms and conditions as they may agree;

B. By the Collaborative for convenience, upon not less than 180 days’ written notice to the SE;

C. By the Collaborative as a sanction pursuant to Article 10, not less than 60 days after completion of any Notice of Sanction and subsequent appeals.

D. The Termination Date of this Contract has been reached. The SE shall be paid solely for covered services provided prior to the Expiration Date or termination date, if the Contract is earlier terminated pursuant to this Article.

1. The SE is obligated to pay all claims for all dates of covered service prior to the termination date, if such claims are filed within one year after the termination date.

2. In the event of the Contract Expiration Date or if either party terminates this Contract prior to the Contract Expiration Date pursuant to this Article, and, if a recipient is in any facility at the time of the Effective Date or Expiration Date or termination, the SE shall be responsible for payment of all covered inpatient facility, non-State-operated residential facility and the associated professional services for such inpatient or residential facility from the date of admission to the date of discharge.

3. In the case of residential facility coverage, the SE shall not be responsible for payment for services for any period in excess of 30 days post-termination.
E. By the Collaborative for cause upon failure of the SE to materially comply with the terms and conditions of this Contract. The Collaborative shall give the SE written notice specifying the SE’s failure to comply in accordance with the provisions of Article 10, Enforcement, and Article 27, Disputes, and shall provide the SE a period of 30 days to cure such breach. If the SE fails to comply, the Collaborative may serve written notice stating the date of termination and work stoppage arrangements, not otherwise specified in this Contract. Such date of termination shall be no less than 30 days following the date on which notice is provided to the SE.

F. By the Collaborative, if required by modification, change, or interpretation in State or Federal law or CMS waiver terms, because of court order, or because of insufficient funding from the Federal or State government(s), if Federal or State appropriations for Medicaid managed care are not obtained, or are withdrawn, reduced, or limited, or if Medicaid managed care expenditures are greater than anticipated such that funds are insufficient to allow for the purchase of services as required by this Contract. The Collaborative’s decision as to whether sufficient funds are available shall be accepted by the SE and shall be final.

G. By the Collaborative, in the event of the SE’s default, which is defined as the inability of the SE to provide services, where such inability is not otherwise excused pursuant to this Contract, described in this Contract or the SE’s insolvency. With the exception of termination due to insolvency, the SE shall be given 30 days to cure any such default, unless such opportunity would result in immediate harm to recipients, or the improper diversion of Medicaid or other public funds covered by this Contract.

H. By the Collaborative, in the event of notification by the Insurance Division of the Public Regulation Commission or other applicable regulatory body that the certificate of authority under which the SE operates has been revoked, or that it has expired and shall not be renewed.

I. By the Collaborative, in the event of notification that the owners or managers of the SE, or other entities with substantial contractual relationship with the SE, have been convicted of Medicare or Medicaid fraud or abuse or received certain sanctions as specified in Section 1128 of the Social Security Act.

J. By the Collaborative, in the event it determines that the health or welfare of consumers is in jeopardy should the Contract continue. For purposes of this paragraph, termination of the Contract requires a written finding by the Collaborative that a substantial number of recipients face the threat of immediate and serious harm.

K. By the Collaborative, in the event the SE’s failure to comply with composition of enrollment requirements and the Scope of Work. The SE shall be given 14 days to cure any such enrollment composition requirement, unless such opportunity would violate any federal law or regulation.

L. By the Collaborative, in the event a petition for bankruptcy is filed by or against the SE.
M. By the Collaborative, if the SE fails substantially to provide items and services that are required under this Contract.

N. By the Collaborative, if the SE discriminates among consumers on the basis of their behavioral health or disability status or requirements for behavioral health services, including expulsion or refusal to reenroll a consumer, except as permitted by this Contract and Federal or State law, or the SE’s engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible consumers or by consumers whose condition or history indicates a need for substantial future behavioral health services.

O. By the Collaborative, if the SE intentionally misrepresents or falsifies information that is furnished to the US Secretary of Health and Human Services, the Collaborative or consumers, potential enrolled individuals or providers under the Social Security Act or pursuant to this Contract.

P. By the Collaborative, if the SE fails to comply with applicable physician incentive prohibitions of Section 1903(m)(2)(A)(x) of the Social Security Act.

Q. By the SE, on at least 30 days’ prior written notice in the event the Collaborative fails to pay any amount due the SE hereunder within 30 days of the date such payments are due.

R. By the SE, on 60 days’ written notice with cause, or 180 days’ written notice without cause.

11.2 If the Collaborative terminates this Contract pursuant to this Article and unless otherwise specified in this Article, the Collaborative shall provide the SE written notice of such termination at least 60 days prior to the effective date of the termination, unless the Collaborative itself receives less than 60 days’ notice, in which case the Collaborative shall provide the SE with as much notice as possible, but in no event less than 30 days’ notice. If the Collaborative determines a reduction in the scope of work is necessary, it shall notify the SE and the parties shall proceed to amend this Contract pursuant to its provisions.

11.3 By termination pursuant to this Article, neither party may nullify obligations already incurred for performance of services prior to the date of notice or, unless specifically stated in the notice, required to be performed through the effective date of termination. Any agreement or notice of termination shall incorporate necessary transition arrangements if such arrangements are not otherwise specified in this Contract.

11.4 In the event that either party seeks early termination of this Contract, the SE and the Collaborative shall negotiate an early termination agreement that may include transition activities, the status of the SE during the termination or transition period, cost recovery, payment terms, and any other matter that is necessary for the orderly termination and transfer of activities to a new contractor or the Collaborative. Such agreement shall be concluded within 30 days of the notice of termination. If agreement is not reached regarding the termination agreement within the specified 30-day period, the Contract shall terminate 30 days thereafter.
11.5 The SE shall reimburse the Collaborative for costs associated with termination or transition if no transition agreement is reached if such costs are the result of the negligence or misconduct on the part of the SE.

ARTICLE 12 – TERMINATION MANAGEMENT

12.1 When the Collaborative has reduced to writing and delivered to the SE notice of termination, the effective date, and reasons therefore, if any, the Collaborative, in addition to other rights provided in this Contract, may require the SE to transfer, deliver, and/or make readily available to the Collaborative, any property in which the Collaborative has a financial interest. Subject to the Collaborative’s recoupment rights herein, property acquired with Medicaid capitation or other payments made for Medicaid consumers properly enrolled shall not be considered property in which the Collaborative has a financial interest.

12.2 In the event this Contract is terminated by the Collaborative, immediately as of the notice date, the SE shall

A. Incur no further financial obligations for materials, services, or facilities under this Contract, except as the Collaborative may direct for orderly completion and transition;

B. Terminate all purchase orders or procurements and subcontracts and stop all work to the extent specified in the notice of termination, except as the Collaborative may direct for orderly completion and transition;

C. Agree that the Collaborative is not liable for any costs of the SE arising out of termination, except as otherwise provided in this Contract, unless the SE establishes that the Contract was terminated due to the Collaborative’s negligence, wrongful act, or breach of the Contract;

D. Take such action as the Collaborative may reasonably direct, for protection and preservation of all property and all records related to and required by this Contract;

E. Cooperate fully in the closeout or transition of any activities so as to permit continuity in the administration of the Collaborative programs;

F. Allow the Collaborative, its agents and representatives full access to the SE’s facilities and records to the extent necessary to arrange the orderly transfer of the contracted activities. These records include the information necessary for the reimbursement of any outstanding Medicaid or other fund source claims and any consumer records necessary to effectuate the orderly transition of consumers’ care.

ARTICLE 13 – RIGHTS UPON TERMINATION OR EXPIRATION

13.1 Upon termination or expiration of this Contract, the SE shall, upon request of the Collaborative, make available to the Collaborative, or to a person authorized by the Collaborative, all records and equipment that are the property of the Collaborative.
13.2 Upon termination or expiration, the Collaborative shall pay the SE all amounts due for service through the effective date of such termination. The Collaborative may deduct from amounts otherwise payable to the SE monies determined to be due the Collaborative from the SE. Any amounts in dispute at the time of termination shall be placed by the Collaborative in an interest-bearing escrow account with an escrow agent mutually agreed to by the Collaborative and the SE.

13.3 In the event that the Collaborative terminates the Contract for cause in full or in part, the Collaborative may procure services similar to those terminated and the SE shall be liable to the Collaborative for any reasonable excess costs for such similar services for any calendar month for which the SE has been paid for providing services for consumers. In addition, the SE shall be liable to the Collaborative for administrative costs incurred by the Collaborative in procuring such similar services. The rights and remedies of the Collaborative provided in this paragraph shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

13.4 The SE is responsible for any claims from subcontractors or other providers, including emergency service providers, for services provided prior to the termination date for services authorized by the SE for consumers who qualify for the Medicaid Managed Care benefit package. The SE shall promptly notify the Collaborative of any outstanding claims for which the Collaborative may owe, or be liable for fee-for-service payment, which are known to the SE at the time of termination or when such new claims incurred prior to termination are received.

13.5 Any payments advanced to the SE for coverage of consumers for periods after the date of termination shall be promptly returned to the Collaborative. If the Contract is terminated mid-month, the Medicaid capitation payments for that month shall be apportioned on a daily basis. The SE shall be entitled to Medicaid capitation payments for the period of time prior to the date of termination, and the Collaborative shall be entitled to a refund for the balance of the month. All terminations shall include a final accounting of capitation payments received and number of Medicaid consumers during the month in which termination is effective.

13.6 The SE shall ensure the orderly and reasonable transfer of consumer care in progress, whether or not those consumers are hospitalized or in long-term treatment.

13.7 The SE shall be responsible to the Collaborative for liquidated damages arising out of the SE’s breach of this Contract.

13.8 In the event the Collaborative proves that the SE’s course of performance has resulted in reductions in the Collaborative’s receipt of federal program funds, as a Federal sanction, the SE shall remit to the Collaborative, as liquidated damages, such funds as are necessary to make the Collaborative whole but only to the extent such damages are caused by the actions of the SE. This provision is subject to Article 27.

**ARTICLE 14 – APPROPRIATIONS**
14.1 The performance of this Contract is subject to the condition precedent that sufficient funds are appropriated, authorized, and allocated by the Legislature of the State of New Mexico and/or by the federal government. If sufficient appropriations, authorizations, and allocations are not made by the Legislature of the State of New Mexico and/or by the federal government, necessitating a decrease in the amount of Contract funds available for expenditure by the Collaborative, this Contract may be terminated or amended to a lower amount of funds upon written notice given by the Collaborative to the SE. If the Collaborative proposes a Contract amendment to unilaterally reduce Contract funding, the SE shall have the option to terminate the Contract upon 30 days' written notice to the Collaborative and its payments shall not be reduced during the period of the pending termination.

14.2 The decision of the Collaborative as to the amount of Contract funds available for expenditure from the appropriation, authorization and/or allocation shall be final and binding on the SE.

ARTICLE 15 – STATUS OF SE

15.1 The SE shall be responsible for contracting with providers, paying provider claims, ensuring care coordination, conducting utilization review and utilization management activities, ensuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the Collaborative.

15.2 The SE is the agent of the Collaborative and shall “coordinate,” “braid” or “blend” the funding, human resources and service capacity available from the various Collaborative member agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

A. "Coordinated" funding and resources occurs where multiple agencies and funding streams are used to achieve related consumer or system outcomes and there is cross-system collaboration to avoid duplicative services or processes. The resources themselves are not mixed, but activities and goals are collaboratively agreed.

B. "Braided" funding is the pooling and coordination of resources from various agencies to provide needed services, while maintaining the integrity of each agency's funding stream. Funds in a braided approach are used for their original intent and are tracked separately, particularly where there is categorical funding for a particular program and usually for the purpose of accounting to federal program administrators. An agreed set of services may be provided by multiple agencies to shared consumers through the braiding approach, with tracking of specific eligibility for services.

C. "Blended" resources are created when separate agencies contribute to a common pool or co-mingle funds into a single source from which agreed service goals are met, offering both significant flexibility for state and local
agencies and reduced amounts of work on reporting and accountability. Often blended funds are used to pay for activities that cannot be billed to a specific funding source.

15.3 Whether resources are "coordinated," "braided," or "blended," the SE will serve the Collaborative's intention to create services that are easier to administer, constitute a more person-centered approach, and further recovery and resiliency-oriented outcomes.

15.4 The SE is an agent of the Collaborative performing professional services for the Collaborative and is not an employee of the State. The SE shall not accrue leave, retirement, insurance, bonding, have use of State vehicles, or receive any other benefits afforded to employees of the State as a result of this Contract.

15.5 The SE shall be solely responsible for all applicable taxes, insurance, licensing and other costs of doing business unless otherwise agreed to by the parties and specified in writing. Should the SE default in these or other responsibilities, jeopardizing the SE'S ability to perform services, this Contract may be terminated immediately upon written notice, pursuant to Sections 11, 12, and 9.

15.6 The SE shall not purport to bind the Collaborative, its officers or employees, the State of New Mexico, nor any member agencies of the Collaborative or the governmental entities or offices they represent to any obligation not expressly authorized herein unless the Collaborative has expressly given the SE the authority to do so in writing.

ARTICLE 16 – PROPERTY

16.1 Title to all property furnished by the Collaborative shall remain in the Collaborative. Title to all property acquired by the SE, including acquisition through lease-purchase contract, for the cost of which the SE is to be reimbursed as a direct item of cost under this Contract shall immediately vest in the Collaborative upon delivery of such property to the SE. Title to other property, the costs of which is to be reimbursed to the SE under this Contract, shall immediately vest in the Collaborative upon (1) issuance for use of such property in the performance of this Contract; (2) use of such property in the performance of this Contract; (3) SE reimbursement of the cost thereof by the Collaborative, whichever first occurs. The Collaborative shall have no property rights in any property acquired by the SE through any funds not specifically provided for direct items of cost or reimbursed specifically by the Collaborative.

16.2 Title to the Collaborative property shall not be affected or lose its identity by reason of affixation to any realty or attachment at law.

16.3 The SE shall maintain a property inventory and administer a program of maintenance, repair and protection of the Collaborative property, acquired under the terms of Article 16.1 above, so as to ensure its full availability and usefulness for performance under this contract. In the event the SE is indemnified, reimbursed, or otherwise compensated for any loss or destruction of, or damage to the Collaborative property during the period of this Contract, it shall use the proceeds to repair or replace the Collaborative property.
ARTICLE 17 – INTELLECTUAL PROPERTY

17.1 In the event the SE shall elect to use or incorporate in the materials to be produced any components of a system already existing, the SE shall first notify the Collaborative, who after investigation may direct the SE not to incorporate such components. If the Collaborative shall not object, and after the SE obtains written consent of the party owning the same, and furnishing a copy to the Collaborative, the SE may incorporate such components.

17.2 The SE warrants that all materials produced hereunder shall not infringe upon or violate any patent, copyright, trade secret or other property right of any third party, and the SE shall indemnify and hold the Collaborative and its member agencies harmless from and against any loss, cost, liability, or expense arising out of breach or claimed breach of this warranty. The intellectual property rights for any materials, processes, criteria, protocols or other materials developed by SE in course of providing services under this Contract shall be solely the property of the SE.

ARTICLE 18 – ASSIGNMENT

18.1 With the exception of provider subcontracts or other subcontracts expressly permitted under this Contract, the SE shall not assign, transfer or delegate any rights, obligations, duties or other interest in this Contract or assign any claim for money due or to become due under this Contract without the express written permission of the Collaborative.

ARTICLE 19 – SUBCONTRACTS

19.1 The SE is solely responsible for fulfillment of the Contract with the Collaborative. The Collaborative shall make Contract payments only to the SE.

19.2 The SE shall remain solely responsible for performance by any subcontractor under such subcontract(s) and shall, in the event that any subcontractor is incapable of performing the service contracted for by the SE, the SE shall, upon the Collaborative’s request, assume responsibility for providing the services that the subcontractor is incapable of performing. Upon the Collaborative’s request, the SE shall provide any required services directly until the SE identifies and contracts with a provider to provide such services.

19.3 The Collaborative may undertake or award other agreements for work related to the tasks described in this document or any portion therein if the SE’s available time and/or priorities do not allow for such work to be provided by the SE. The SE shall fully cooperate with such other Contractors and the Collaborative in all such cases.

19.4 The SE shall conduct any subcontracting under the following conditions:

A. Except as otherwise provided in this Contract, the SE may subcontract to a qualified individual or organization for the provision of any service or required program function. The SE remains legally responsible to the Collaborative for all work performed by any subcontractor. The SE shall submit to the Collaborative boilerplate subcontract language and/or sample subcontracts for various types of subcontracts during the
procurement process. Changes to boilerplates or samples that may materially affect consumers shall be approved by the Collaborative prior to execution by any subcontractor;

B. The Collaborative reserves the right to review and disapprove all subcontracts and/or any significant modifications to previously approved subcontracts to ensure compliance with requirements set forth in 42 CFR 434.6 or this Contract. The SE is required to give the Collaborative prior notice with regard to its intent to subcontract certain significant Contract requirements as specified herein or in writing by the Collaborative including, but not limited to, credentialing, utilization review, and claims processing. The Collaborative reserves the right to disallow a proposed subcontracting arrangement if the proposed subcontractor has been formally restricted from participating in a federal entitlement program (e.g., Medicare, Medicaid) for other good cause;

C. The SE shall not subcontract with an individual provider, an entity, or an entity with an individual who is an officer, director, agent or manager or person with more than five percent of beneficial ownership of the entity’s equity, that has been convicted of crimes specified in the Section 1128 of the Social Security Act, or who has a contractual relationship with an entity convicted of a crime specified in Section 1128;

D. Pursuant to 42 CFR 417.479(a), no specific payment may be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual recipient. The SE shall disclose to the Collaborative the information on provider incentive plans set forth in 42 CFR 471.479(h)(1)(i)-(iv) at the times required by 42 CFR 434.70(a)(3) to allow the Collaborative to determine whether the incentive plans meet the requirements of 42 CFR 471.479(d) through (g). The SE shall provide capitation data required by 42 CFR 471.479(h)(1)(iv) for the previous calendar year to the Collaborative by application/SE renewal of each year. The SE shall provide the information on its physician incentive plans allowed by 42 CFR 471.479(h)(3) to any Medicaid recipient upon request.

E. In its subcontracts, the SE shall ensure that subcontractors, whether administrative or provider agree to hold harmless the Collaborative, the Collaborative’s member agencies, and the SE’s consumers in the event that the SE cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the subcontract between the SE and the subcontractor or provider for services rendered prior to the termination of the subcontract, regardless of the cause that gives rise to termination and shall be construed to be for the benefit of the consumers.

F. The SE shall have a written document, signed by both parties, that describes the responsibilities of the SE and the subcontractor or provider, including any applicable delegation requirements and language if applicable; the subcontracted activities; the frequency of reporting (if applicable) to the SE; the process by which the SE evaluates and monitors the subcontractor or provider; and the remedies, including the
revocation of any delegation, available to the SE if the subcontractor or provider does not fulfill its obligations under the subcontract.

G. The SE shall have policies and procedures to ensure that the subcontractor or provider is obligated to meet all standards of performance mandated by the Collaborative for Medicaid or any other applicable program. These include, but are not limited to, use of appropriately qualified staff, application of clinical practice guidelines and utilization of management, reporting capability, and ensuring consumers’ access to care.

H. The SE shall have policies and procedures for the oversight of any functions that are delegated to subcontractors or providers.

I. The SE shall have policies and procedures to ensure consistent statewide application of all utilization management criteria when utilization management is delegated to any subcontractor or provider.

J. The SE shall maintain policies and procedures for verifying that the credentials of all its providers and subcontractors meet applicable standards as stated in the Article 2, Scope of Work.

K. The SE shall maintain a fully executed original of all subcontracts or provider contracts, which are accessible to the Collaborative upon request.

L. Subcontracts, including those with providers, shall contain at least the following provisions:

1. Subcontracts shall be executed in accordance with all applicable Federal and State laws, regulations, policies and procedures and rules.

2. Subcontracts shall identify the parties of the subcontract and their legal basis of operation in the State of New Mexico.

3. Subcontracts shall include the procedures and specific criteria for terminating the subcontract.

4. Subcontracts shall identify the services to be performed by the subcontractor and those services performed under any other subcontract(s). Subcontracts shall include provisions(s) describing how consumers access services provided under the terms of the subcontract;

5. Subcontracts shall include the reimbursement rates and risk assumption, if applicable.

6. Subcontractors shall maintain all records relating to services provided to recipients for a 10-year period and shall make all consumer medical records available for the purpose of quality review conducted by the Collaborative or its designated agents both during and after the subcontract period;

7. Subcontracts shall require that recipient information be kept confidential, as defined by Federal and State law.

8. Subcontracts shall include a provision that authorized representatives of the Collaborative have reasonable access to facilities and records.
for financial and medical audit purposes both during and after the subcontract period;

9. Subcontracts shall include a provision for the subcontractor to release to the SE any information necessary to perform any of its obligations.

10. Subcontractors shall accept payment from the SE as payment for any services included in the benefit package, and cannot request payment from the Collaborative for services performed under the subcontract.

11. If the subcontract includes primary care, provisions for compliance with PCP requirements delineated in the primary MCO contract and Medicaid fee-for-service rules apply.

12. Subcontractors shall comply with all applicable State and Federal statutes, laws, rules, and regulations.

13. Subcontracts shall include provision for termination for any violation of applicable the Collaborative, State or Federal requirements.

14. Subcontracts with service providers shall contain a provision requiring at least thirty (30) days notice of any intent to diminish, materially change, or substantially reduce services provided pursuant to the subcontract and shall require continuation of services as is during that 30 days and shall require negotiations with the SE and, to the extent the Collaborative desires, with the Collaborative regarding continuation or transition of said services.

15. Subcontracts shall not prohibit a provider or other subcontractor (with the exception of third party administrators) from entering into a contractual relationship.

16. Subcontracts shall not include any incentive or disincentive that encourages a provider or other subcontractor not to enter into another contractual relationship.

17. The subcontract cannot contain any gag order provisions that prohibit or otherwise restrict covered health professionals from advising patients about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act or in contravention of Section 59A-57-1 to 57-11 NMSA 1978, the Patient Protection Act;

18. The subcontract for pharmacy providers shall include a payment provision consistent with Section 27-2-16B NMSA 1978 unless the subcontractor provides a voluntary waiver to any rights under § 27-2-16B NMSA 1978 or the SE is notified by the Collaborative that the provisions of § 27-2-16B NMSA 1978 do not apply to the SE’s subcontract with the pharmacies.

19. The SE shall identify the OMB Circular A-133 requirements in their subcontracts with subcontractors. This includes identifying the Catalog of Federal Domestic Assistance (CFDA number 93.958 for the CMHS Block Grant and CFDA number 93.959 for the SAPT Block Grant), stating that subcontractors shall conduct an A-133 audit if they meet the $500,000 of Federal funds threshold, and including the language regarding allowable and unallowable cost/activities as specified by this Contract or regulation.
ARTICLE 20 – INSURANCE & BONDING

20.1 The SE and its officers, directors and each person employed by the SE who handles funds under this Contract, including personnel authorizing payment of such funds, shall be covered by the terms of a policy of insurance or fidelity bond providing for indemnification of losses occasioned by any fraudulent or dishonest act or acts committed by the SE, its officers, directors or any of the SE’s employees either alone or in collusion with others; or failure of the SE, its officers, directors or any of its employees to perform fiduciary duties or to account properly for all monies and property received by virtue of their position or employment. If using crime coverage under a policy of insurance, such coverage shall be not less than $1,000,000 per claim.

20.2 If using a fidelity bond, the fidelity bond shall be in an amount equal to twenty-five (25) percent of the total Contract amount.

20.3 The SE shall submit a copy of the bond or proof of insurance to the Collaborative within 30 days of the effective date of this contract. The bond or insurance policy shall include third-party coverage for property of consumers. If the SE is a sole proprietorship or partnership, the proprietor or the partners must be considered employees under the terms of the bond. Loss payment by the bonding company shall be made to the State of New Mexico, the Collaborative. (i.e., the Collaborative shall be named as Loss Payee). The SE shall provide the Collaborative with a Certificate of Insurance evidencing this coverage. The certificate shall provide the Collaborative with thirty (30) days written notice of bond cancellation. The bond shall remain in effect for the term of the Contract plus thirty (30) days.

20.4 If using a policy of insurance, the SE shall maintain professional liability insurance coverage to ensure it against any claim for damages arising out of any acts or omissions in connection with the SE’s actions or omissions in performance of the SE’s services specified under this Contract. Such coverage shall not be less than five million dollars ($5,000,000) per occurrence and ten million dollars ($10,000,000) aggregate.

A. The SE shall maintain Comprehensive General Liability Insurance, Directors’, Trustees’ and Officers’ Liability Insurance Policy and Automobile Liability Insurance that shall provide a minimum of one million dollars ($1,000,000) aggregate liability coverage for each policy year. The SE shall also maintain Workers’ Compensation Insurance at limits as may be required under the laws and regulations of the State of New Mexico.

B. The Collaborative and each of the statutory members shall be named as an additional ensured on the Commercial General Liability insurance policy with which the SE shall furnish the Collaborative as evidence that foregoing insurance policies are in force and that the Collaborative is endorsed as an additional ensured on the Commercial General Liability Insurance policy.

20.5 The SE shall maintain throughout the term of this Contract a license to conduct the business of this Contract in New Mexico.
ARTICLE 21 - EQUAL EMPLOYMENT OPPORTUNITY


21.2 This Article is binding on the SE, its successor, transfers, assignees and subcontractors as long as they receive funding or other assistance originating from the Collaborative. If the Collaborative finds that the SE is not in compliance with this requirement at any time during the term of this Contract, the Collaborative reserves the right to terminate this Contract pursuant to Article 11 Termination, or take such other steps it deems appropriate to correct said deficiency.

ARTICLE 22 – RECORDS & AUDIT

22.1 Compensation Records

   A. After final payment under the Contract or 10 years after a pending audit is completed and resolved, whichever is later, the Collaborative or its designee shall have the right to audit billings both before and after payment. The SE shall maintain all necessary records to substantiate the services it rendered under this Contract. These records shall be subject to inspection by the Collaborative, the Department of Finance and Administration, the State Auditor and/or any authorized State or Federal entity and shall be retained for 10 years. Payment under this Contract shall not foreclose the right of the Collaborative to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.

22.2 Other Records

   A. In addition, the SE shall retain all recipient medical records, collected data, and other information subject to the Collaborative, State and Federal reporting or monitoring requirements for ten (10) years after the Contract is terminated under any provisions of Article 11 of this Contract or ten (10) years after any pending audit is completed and resolved, whichever is later. These records shall be subject to inspection by the Collaborative, DFA, and/or any authorized State or Federal entity. Payment under this Contract shall not foreclose the right of the Collaborative to recover excessive or illegal payments as well as interest, attorney fees and costs incurred in such recovery.
22.3 Standards for Clinical Records and Provider Medical Records

A. The SE shall require clinical and medical records to be maintained in a manner, either on paper and/or in electronic format, that is timely, legible, current, set forth, and organized, and permits effective and confidential consumer care and quality review.

B. The SE shall have written clinical and medical record confidentiality policies and procedures that implement the requirements of State and Federal law and policy and any additional requirements of this Contract.

C. The SE shall establish, and shall require its practitioners to have, an organized clinical and medical record keeping system and standards for the availability of clinical and medical records appropriate to the practice site.

D. The SE shall include provisions in its subcontracts with providers requiring appropriate access to the medical records of the behavioral health services consumers for purposes of quality reviews to be conducted by the Collaborative or agents thereof, and that the medical records be available to behavioral health care practitioners for each clinical encounter.

22.4 Requests for Records

A. The SE shall comply with the Collaborative’s reasonable requests for records and documents as necessary to verify that the SE is meeting its obligations under this Contract, or for data reporting legally required of the Collaborative.

B. Nothing in this Contract shall require the SE to provide the Collaborative with information, records, and/or documents which are protected from disclosure by any law, including, but not limited to, laws protecting proprietary information as a trade secret, confidentiality laws, and any applicable legal privileges (including but not limited to, attorney/client, physician/patient, quality assurance and peer review), except as may otherwise be required by law or pursuant to a legally adequate release from the affected consumer(s).

22.5 Inspection Requirements

A. The SE shall provide the State of New Mexico, the Collaborative, and any other legally authorized governmental entity, or their authorized representatives, the right to enter at all reasonable times the SE’s premises or other places where work under this Contract is performed to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this contract. The SE shall provide reasonable facilities and assistance for the safety and convenience of the persons performing those duties (e.g. assistance from the SE staff to retrieve and/or copy materials). The Collaborative and its authorized agents shall schedule access with the SE in advance within a reasonable period of time except in case of suspected fraud and abuse. All inspection, monitoring and evaluation shall be performed in such a manner as not to unduly interfere with the work being performed under this contract.
B. In the event right of access is requested under this section, the SE or subcontractor shall upon request provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal representatives conducting the audit or inspection effort.

C. All inspections or audits shall be conducted in a manner as shall not unduly interfere with the performance of the SE’s or any subcontractors’ activities. The SE shall be given ten (10) business days to respond to any findings of an audit before the Collaborative shall finalize its findings. All information so obtained shall be accorded confidential treatment as provided in applicable law.

ARTICLE 23 – CONFIDENTIALITY

23.1 Any confidential information, as defined in State or Federal law, code, rules or regulations or otherwise applicable by the Code of Ethics, regarding the Collaborative’s recipients or providers given to or developed by the SE and its subcontractors shall not be made available to any individual or organization by the SE and its subcontractors without the prior written approval of the Collaborative, unless otherwise permitted by law or the terms of this Contract.

23.2 The SE shall:

A. Notify the Collaborative promptly of any unauthorized possession, use, knowledge, or attempt thereof, of the Collaborative’s data files or other confidential information; and

B. Promptly furnish the Collaborative full details of the unauthorized possession, use of knowledge or attempt thereof, and assist investigating or preventing the recurrence thereof.

23.3 In order to protect the confidentiality of recipient information and records:

A. The SE shall adopt and implement written confidentiality policies and procedures that conform to Federal and State laws and regulations.

B. The SE shall ensure that an appropriate system is in effect to protect substance abuse consumer records from inappropriate disclosure in accordance with 42 U.S.C. 300x-53(b), 45 CFR 96 132(e), and 42 CFR Part 2.

C. The SE’s subcontracts with practitioners and other providers shall explicitly state expectations about confidentiality of consumer information and records.

D. The SE shall afford consumer and/or legal guardians, or consumer-designated surrogate decision-maker the opportunity to approve or deny the release of identifiable personal information by the SE to a person or agency outside of the SE, except to duly authorized subcontractors, providers or review organizations, or when law requires such release, State regulation, or quality standards.
E. When release of information is made in response to a court order, the SE shall notify the consumer and/or legal guardian or consumer-designated surrogate decision-maker of such action in a timely manner.

F. The SE shall have specific written policies and procedures that direct how confidential information gathered or learned during the investigation or resolution of a grievance is maintained, including the confidentiality of the consumer’s status as a grievant.

G. The SE shall comply with all applicable HIPAA requirements.

**ARTICLE 24 – RELEASE**

24.1 Upon final payment of the amounts due under this Contract, the SE and Collaborative shall negotiate in good faith the terms of a release of the Collaborative, its officers and employees and the State of New Mexico from all liabilities and obligations whatsoever under, or arising from this Contract. The SE agrees not to purport to bind the State of New Mexico.

24.2 Payment to the SE by the Collaborative or any member agency shall not constitute final release of the SE. Should audit or inspection of the SE’s records or the SE’s recipient complaints subsequently reveal outstanding SE liabilities or obligations, the SE shall remain liable to the Collaborative for such obligations. Any payments by the Collaborative to the SE shall be subject to any appropriate recoupment by the Collaborative in accordance with the terms of this Contract.

24.3 Notice of any post-termination audit or investigation of complaint by the Collaborative shall be provided to the SE, and such audit or investigation shall be initiated in accordance with CMS or other applicable requirements. The Collaborative shall notify the SE of any claim or demand within thirty (30) days after completion of the audit or investigation or as otherwise authorized by CMS or applicable regulations. Any payments by the Collaborative to the SE shall be subject to any appropriate recoupment by the Collaborative in accordance with the provisions of this Contract.

**ARTICLE 25– INDEMNIFICATION**

25.1 The SE agrees to indemnify, defend, and hold harmless the State of New Mexico, its officers, agents and employees from any and all claims and losses accruing or resulting from any and all SE employees, agents or subcontractors, in connection with the performance of this Contract, and from any and all claims and losses accruing or resulting to any person, association, partnership, entity, or corporation who may be injured or damaged by the SE in the performance or failure in the performance of this Contract. The provisions of this section shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, the Collaborative, or any of its agencies, officers, employees, or agents.

25.2 The SE shall at all times during the term of this Contract, indemnify and hold harmless the Collaborative and its member agencies against any and all liability, loss, damage, costs or expenses that they may sustain, incur or be required to
pay by reason of any recipient suffering personal injury, death or property loss or damage of any kind as a result of the erroneous or negligent acts or omissions of the SE either while participating with or receiving care or services from the SE under this Contract, or while on premises owned, leased, or operated by the SE or while being transported to or from said premises in any vehicle owned, operated, leased, chartered, or otherwise contracted for or in the control of the SE or any officer, agent, subcontractor or employee thereof. The provisions of this section shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, the Collaborative, or any of its agencies, officers, employees, or agents.

25.3 The SE shall agree to indemnify and hold harmless the Collaborative, its officers or employees, the State of New Mexico, and any members of the Collaborative or the governmental entities or offices they represent from any and all claims, causes of action, suits, judgments, losses, or damages, including court costs and attorney fees, or causes of action, caused by reason of SE’s erroneous or negligent acts or omissions, including the following:

A. Any claims or losses attributable to any persons or firm injured or damaged by erroneous or negligent acts, including without limitation, disregard of Federal or State Medicaid regulations or statutes by the SE, its officers, employees, or subcontractors in the performance of the Contract, regardless of whether the Collaborative knew or should have known of such erroneous or negligent acts; unless the State of New Mexico, or any of its officers, employees or agents directed, by regulatory authority or otherwise, performance of such acts;

B. Any claims or losses attributable to any person or firm injured or damaged by the SE’s publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under the Contract in a manner not authorized by the Contract or by Federal or State regulations or statutes, regardless of whether the Collaborative knew or should have known of such publication, translation, reproduction, delivery, performance, use, or disposition unless the State of New Mexico, or any of its officers, employees or agents directed such publication, translation, reproduction, delivery, performance, use or disposition; and

C. The provisions of this Article shall not apply to any liabilities, losses, charges, costs or expenses caused by, or resulting from, the acts or omissions of the State of New Mexico, the Collaborative, or any of its officers, employees, or agents.

25.4 The SE, including its subcontractors, agrees that in no event, including but not limited to nonpayment by the SE, insolvency of the SE or breach of this Contract, shall the SE or its subcontractor or contracted providers bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from or have any recourse against any consumer, or person (other than the SE) acting on their behalf, for services provided pursuant to this Contract except for any consumer or person required to make co-payments under their benefit plan or the requirements of the Collaborative. In no case, shall the State, the Collaborative, any members of the Collaborative or the governmental entities or offices they represent and/or consumers be liable for any debts of the SE.
25.5 The SE agrees that the above indemnification provisions shall survive the termination of this Contract, regardless of the cause giving rise to termination. This provision is not intended to apply to services provided after this Contract has been terminated.

25.6 To the extent, if at all, Section 56-7-1 NMSA (2003) as amended, is applicable to this Contract, any agreement to indemnify, hold harmless, insure or defend another party contained in this Contract shall not extend to liability, claims, damages, losses or expenses, including attorney fees, arising out of bodily injury to persons or damage to property caused by or resulting from, in whole or in part, the negligence, act or omission of the indemnitee, its officers, employees or agents.

ARTICLE 26 – CONFLICT OF INTEREST

26.1 The SE warrants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services required under this Contract, and further warrants that signing of this Contract shall not be creating a violation of the Governmental Conduct Act, § 10-16-1 et seq., NMSA 1978.

26.2 If during the term of this Contract and any extension thereof the SE becomes aware of an actual or potential relationship that may be considered a conflict of interest, the SE shall immediately notify the Contract Manager in writing. Such notification includes when the SE employs or contracts with a person on a matter related to this Contract, and that person is a former employee of a Collaborative agency who has an obligation to comply with § 10-16-1 et seq. NMSA 1978, or was substantially and directly involved in the development or enforcement of this Contract.

ARTICLE 27 – DISPUTES

27.1 The entire agreement shall consist of:
A. This Contract, including the Scope of Work, items incorporated by reference and any amendments;
B. The RFP, the Collaborative written clarifications to the RFP and SE responses to RFP questions where not inconsistent with the terms of this Contract or its amendments;
C. The SE’s Best and Final Offer; and,
D. The SE’s additional responses to the RFP where not inconsistent with the terms of this Contract or its amendments, all of which are incorporated herein or by reference.

27.2 In the event of a dispute under this Contract, various applicable documents shall be referred to for the purpose of clarification or for additional detail in the order of priority and significance, specified below:
A. Amendments to the Contract in reverse chronological order followed by;
B. Article 2 of this Contract and the default provision contained therein including any management letters that further define a specific Scope of Work requirement followed by;

C. This Contract, including items incorporated by reference, followed by:

D. The RFP, including attachments thereto and the Collaborative’s written responses to written questions and the Collaborative’s written clarifications, and the SE’s responses to the RFP, including both technical and cost portions of the response (but only those portions of the SE’s response including both technical and cost portions of the response that do not conflict with the terms of this Contract and its amendments).

27.3 Any dispute concerning sanctions imposed under this Contract shall be reported in writing to the Collaborative within 15 days of the date the reporting party received notice of the sanction. The decision of the Collaborative shall be delivered to the parties in writing within 30 days and shall be final and conclusive unless, within 15 days from the date of the decision, either party files with the Collaborative a written appeal of the decision of the Collaborative Co-Chairs.

A. Any other dispute concerning performance of the Contract shall be reported in writing to the Collaborative within 30 days of the date the reporting party knew of the activity or incident giving rise to the dispute. The decision of the Collaborative shall be delivered to the parties in writing within 30 days and shall be final and conclusive unless, within 15 days from the date of the decision, either party files with the Collaborative a written appeal of the decision of the Collaborative Co-Chairs.

B. Failure to file a timely appeal shall be deemed acceptance of the Collaborative’s decision and waiver of any further claim.

C. In any appeal under this Article, the SE and the Collaborative shall be afforded an opportunity to be heard and to offer evidence and argument in support of their position to the Collaborative or its designee. The appeal is an informal hearing which shall not be recorded or transcribed, and is not subject to formal rules of evidence or procedure.

D. The Collaborative Co-Chairs or a designee shall review the issues and evidence presented and issue a determination in writing which shall conclude the administrative process available to the parties. The Collaborative Co-Chairs shall notify the parties of the decision within 30 days of the notice of the appeal, unless otherwise agreed to by the parties in writing or extended by the Collaborative Co-Chairs for good cause.

E. Pending decision by the Collaborative Co-Chairs, both parties shall proceed diligently with performance of the Contract, in accordance with the Contract.

F. Failure to initiate or participate in any part of this process shall be deemed waiver of any claim.

ARTICLE 28 – APPLICABLE LAW
28.1 The laws of the State of New Mexico shall govern this Contract. All legal proceedings arising from unresolved disputes under this Contract shall be brought before the First Judicial District Court in Santa Fe, New Mexico.

28.2 Each party agrees that it shall perform its obligations hereunder in accordance with all applicable Federal and State laws, rules and regulations now or hereafter in effect.

28.3 If any provision of this Contract is determined to be invalid, unenforceable, illegal or void, the remaining provisions of this Contract shall not be affected, providing the remainder of the Contract is capable of performance, the remaining provisions shall be binding upon the parties hereto, and shall be enforceable, as though said invalid, unenforceable, illegal, or void provision were not contained herein.

ARTICLE 29 – LIABILITY

29.1 The SE shall be wholly at risk for those covered services specified in the RFP and shall administer all other covered services on an administrative services only (ASO) basis as specified in the RFP and this Contract. No additional payment shall be made by the Collaborative other than that specified in this Contract, nor shall any payment be collected from a consumer, except for co-payments authorized by the Collaborative or federal or State laws or regulation.

29.2 The SE is solely responsible for ensuring that it issues no payments for services for which it is not liable under this Contract. The Collaborative shall accept no responsibility for refunding to the SE any such excess payments unless the Collaborative or the Contract Manager directed such services to be rendered or payment made.

29.3 The SE, its successors and assignees shall procure and maintain such insurance and other forms of financial protections as are identified in this Contract.

ARTICLE 30 – ERRONEOUS ISSUANCE OF PAYMENT OR BENEFITS

30.1 In the event of an error that causes payment(s) to the SE (or benefits to others) to be issued in error, the SE shall reimburse the State within 30 days of written notice of such error for the full amount of the payment. Interest shall accrue on all payments issued in error at the statutory rate upon any amounts not paid and determined to be due after the 30th day following the receipt of the notice by the SE. Any disputed amount shall be handled as provided by this Contract in Article 27.
ARTICLE 31 – EXCUSABLE DELAYS

31.1 The SE shall be excused from performance hereunder for any period that it is prevented from performing any services hereunder in whole or in part as a result of an act of nature, war, civil disturbance, epidemic, court order, or other cause beyond its reasonable control, and such nonperformance shall not be a default hereunder or ground for termination of the Contract.

ARTICLE 32 – MARKETING

32.1 The SE shall maintain written policies and procedures governing the development and distribution of marketing materials for consumers;

32.2 The Collaborative shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at consumers before use. Examples include written materials, billboards, and radio, television advertisements and websites.

A. The MCO/SE shall provide to enrolled Medicaid Managed Care consumers the member/consumer handbook and provider directory within thirty (30) calendar days of enrollment or as otherwise required by regulation;

B. The SE shall send a provider directory to any person requesting a copy;

C. The SE shall provide a one-page, two-sided summary of its benefits which may be distributed by the Collaborative at its discretion; and

D. The SE shall maintain policies and procedures governing the development and distribution of marketing materials for consumers.

32.3 The marketing and outreach material shall meet the following minimum requirements:

A. Marketing and/or outreach materials shall meet requirements for all communication with Medicaid consumers, as set forth in Section MAD 606.4.8, Medicaid Managed Care Marketing Guidelines.

B. All marketing and/or outreach materials produced by the SE under the Medicaid managed care agreement shall state that such services are funded pursuant to a Contract with the State of New Mexico.

32.4 Marketing and outreach activities not permitted regardless of the method of communication (verbal, written) or whether the activity is performed by the SE directly, its participating providers, its subcontractors, or any other party affiliated with the SE:

A. Asserting or implying that a consumer shall lose Medicaid benefits if he/she does not enroll with the SE or inaccurately depicting the consequences of choosing a particular MCO;

B. Designing a marketing or outreach plan that discourages or encourages provider selection based on behavioral or physical health status or risk;
C. Making inaccurate, false, materially misleading or exaggerated statements;
D. Asserting or implying that the SE offers unique covered services when another entity provides the same or similar service;
E. The use of gifts such as diapers, toasters, infant formula, or other incentives to entice people to enroll with the SE;
F. Directly or indirectly conducting door-to-door, telephonic, or other “cold call” marketing; and
G. Conducting any other marketing activity prohibited by the Collaborative during the course of this Contract.

32.5 The SE shall take reasonable steps to prevent subcontractors and participating providers from committing the acts described herein; the SE shall be held liable only if it knew or should have known that its subcontractors or participating providers were committing the act described herein and did not timely take corrective actions. The Collaborative reserves the right to prohibit additional marketing activities at its discretion.

32.6 The SE may initiate marketing and outreach activities at any time.

32.7 The Medicaid Managed Care Marketing Guidelines are incorporated into this Contract by reference. This Contract shall incorporate all revisions to the Guidelines produced during the course of the Contract.

32.8 Behavioral Health Education and Outreach materials may be distributed to consumers by mail or in connection with exhibits or other organized events, including but not limited to health fairs, booths at community events and SE-hosted behavioral health improvement events.

A. Behavioral Health Education means programs, services or promotions that are designed or intended to inform the SE’s actual or potential consumers about the issues related to behavioral health lifestyles, situations that affect or influence behavioral health status or methods or modes of behavioral health treatment.

B. Outreach is the means of educating or informing the SE’s actual or potential recipients about behavioral health issues.

C. Behavioral Health Education and Outreach materials include but are not limited to general distribution brochures, consumer newsletters, posters, and consumer handbooks. The SE will work with the Collaborative to develop and implement outreach programs consistent with the policies of the Collaborative and the Comprehensive Behavioral Health Plan and to meet the goals of the Collaborative.

32.9 All marketing material that is verbally presented or in written form must be linguistically appropriate and culturally sensitive. This includes, but is not limited to, the following criteria:

A. Commonly understood language and avoidance of professional jargon;
B. Availability of interpreters (both for sign language and when the primary home language is other than English);
C. Written materials provided in a variety of formats for consumers and families to ensure access to information, and may include reduced reading level, large print, and/or translation into languages other than English; and

D. Electronic format, including audiotapes and computer disks.

ARTICLE 33 – PROHIBITION OF BRIBES, GRATUITIES & KICKBACKS

33.1 Pursuant to Sections 13-1-191, 30-24-1 et seq., 30-41-1 and 30-41-3 NMSA 1978, the receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited.

33.2 No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Contract. No individual employed by the State of New Mexico shall be admitted to any share or part of the Contract or to any benefit that may arise there from.

33.3 The Collaborative may, by written notice to the SE, immediately terminate the right of the SE to proceed under the Contract if it is found, after notice and hearing by the Collaborative or its duly authorized representative, that gratuities in the form of entertainment, gifts or otherwise were offered or given by the SE or any agent or representative of the SE to any officer or employee of the State of New Mexico with a view toward securing the Contract or securing favorable treatment with respect to the award or amending or making of any determinations with respect to the performing of such Contract. In the event the Contract is terminated as provided in this section, the State of New Mexico shall be entitled to pursue the same remedies against the SE as it would pursue in the event of a breach of contract by the SE and as a penalty in addition to any other damages to which it may be entitled by law.

ARTICLE 34 – LOBBYING

34.1 The SE certifies, to the best of its knowledge and belief, that:

A. No Federal appropriated funds have been paid or shall be paid, by or on behalf of the SE, to any person for influencing or attempting to influence an officer or employee of any agency, a recipient of Congress, or an employee of a recipient of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

B. If any funds other than Federal appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, recipient of Congress, an officer or employee of Congress or an employee of a recipient of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the SE shall complete and submit Standard Form – LLL “Disclosure Form to Report Lobbying,” in accordance with its instructions.
34.2 The SE shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

34.3 This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. 1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

ARTICLE 35 – COOPERATION CONCERNING FRAUD

35.1 The SE shall report to the Collaborative any reasonable suspicion or knowledge of fraud and/or abuse, including but not limited to the false or fraudulent filings of claims and/or the acceptance of or failure to return monies allowed or paid on claims known to be false or fraudulent. Where required by law, the reporting entity shall not attempt to investigate or resolve the reported suspicion, knowledge or action without informing the Collaborative.

35.2 The SE shall cooperate fully in any investigation or subsequent legal action that may result from such investigation. The SE and its subcontractors and participating network providers shall, upon request, make available to the Collaborative any and all administrative, financial and medical records relating to the delivery of items or services for which the Collaborative monies are expended, unless otherwise provided by law. In addition, the Collaborative shall be allowed to have access during normal business hours to the place of business and all records of the SE and its subcontractors and participating network providers, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by the Collaborative.

35.3 The SE shall disclose to the Collaborative, and to any other state or federal agency charged with overseeing the Medicaid program, full and complete information regarding ownership, significant financial transactions or financial transactions of which the SE has knowledge relating to or affecting the Salud! program and persons related to the SE convicted of criminal activity related to Medicaid, Medicare, or the federal Title XX programs.

35.4 Any actual or potential conflicts of interest within the SE’s Salud! program shall be referred by the SE to the Collaborative. The SE also shall refer to the Collaborative any instance where a financial or material benefit is given by any SE representative, agent or employee to the Collaborative or any other party with direct responsibility for this Contract. In addition, the SE shall notify the Collaborative and the Contract Manager if it hires or enters into any business relationship with any person who, within two years previous to that hiring or contract, was employed by the Collaborative in a capacity relating to Medicaid or the Salud! program or any other party with direct responsibility for this Contract.

35.5 Any recoupment received from the SE by the Collaborative pursuant to the provisions of this Contract herein shall not preclude the Collaborative from
exercising its right to criminal prosecution, civil prosecution, or any applicable civil penalties, administrative fines or other remedies.

35.6 Upon request to the SE, the Collaborative and the Contract Manager shall be provided with copies of all grievances and resolutions affecting Medicaid consumers.

35.7 Should the SE know about or become aware of any investigation being conducted by the Collaborative, any Collaborative member agencies, the SE and its representative, agents and employees shall maintain the confidentiality of this information.

35.8 The SE shall have in place and enforce policies and procedures to educate Medicaid consumers of the existence of, and role of, the Collaborative.

35.9 The SE shall have in place and enforce policies and procedures for the detection and deterrence of fraud. These policies and procedures shall include specific requirements governing who within the SE’s organization is responsible for these activities, how these activities shall be conducted, and how the SE shall address cases of suspected fraud and abuse.

35.10 All documents submitted by the SE to the Collaborative, if developed or generated by the SE, or its agents, shall be deemed to be certified by the SE as submitted under penalty of perjury.

35.11 Employee education regarding false claims. The SE and all subcontractors shall:

A. Establish written policies for all employees, agents, or contractors, that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq.; and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statement established under chapter 38 of title 31, United States Code, including but not limited to, preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f) of the Social Security Act). 

B. Include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste and abuse; and

C. Include in any employee handbook, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the CONTRACTOR’S OR subcontractor’s policies and procedures for detecting and preventing fraud, waste, and abuse.

ARTICLE 36 – WAIVERS

36.1 No term or provision of this Contract shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing by the party claimed to have waived or consented.

36.2 A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or Contract herein contained.
ARTICLE 37 – NOTICES

37.1 A notice shall be deemed duly given upon delivery, if delivered by hand, or three days after posting if sent by first class mail, with proper postage affixed. Notice may also be tendered by facsimile transmission, with original to follow by first class mail.

37.2 All notices or information required to be given to the Collaborative under this Contract shall be sent to the Collaborative Chief Executive Officer (CEO) at:

Behavioral Health Collaborative CEO
Human Services Department
PO Box 2348
Santa Fe NM 87504-2348
Physical address for special or overnight deliveries:
2025 S. Pacheco St.
Santa Fe NM 87505
(505) 827-1344 – phone / (505) 827-3185 – fax

Any information or notice required to be provided to the Collaborative or to Collaborative member agency staff or CAT leaders shall be copied to the Collaborative CEO. The Collaborative CEO may designate in writing other individuals to receive specific information, reports or plans required to be submitted pursuant to this Contract, but may not designate another individual to receive formal notices required by this Contract.

37.3 All notices required to be given to the SE under this Contract shall be sent to:

Chief Executive Officer
ValueOptions of New Mexico
2400 Louisiana Blvd. NE, Building 5 – 7th Floor
P.O. Box 30650
Albuquerque, NM 87190-0650
(505) 346-9500 – phone / (505) 346-9400 – fax

With a copy provided to:

President, Value Options of New Mexico, Inc.
Norfolk, VA

37.4 Any notice or information available in electronic form may be sent to the Contract Manager at bhcollaborative@state.nm.us and to Ms. Galbraith at pamela.galbraith@valueoptions.com.
ARTICLE 38 – ENTIRE AGREEMENT

38.1 This Contract incorporates all the agreements, covenants, and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, agreements and understandings have been merged into this written Contract. No prior agreement or understanding, verbal or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Contract. All attachments are incorporated and made a part of this Contract.

ARTICLE 39 – AMENDMENTS

39.1 This Contract shall not be altered, changed or amended, except as provided for in Article 40, other than by an instrument in writing executed by the parties to this Contract. Amendments may be signed by the Co-Chairs of the Collaborative and any affected funding Collaborative member agency or agencies. Amendments shall become effective and binding when signed by the parties, approved by the Department of Finance and Administration, and written approvals have been obtained from any necessary State and Federal agencies. All necessary approvals shall be attached as exhibits to this Contract or any amendments.

ARTICLE 40 – CONTRACT MODIFICATION

40.1 In the event that changes in Federal or State statute, regulation, rules, policy, or changes in Federal or State appropriation(s) or other circumstances, require a change in the way the Collaborative manages its Medicaid program or any other program covered by this Contract, this Contract shall be subject to substantial modification by amendment. Such amendment shall be effected by the Collaborative sending written notice to the SE. The Collaborative’s decision as to the requirement for change in the scope of the program shall be final and binding.

40.2 The amendment(s) shall be implemented by Contract renegotiation in accordance with this Article. In addition, in the event that approval of the Collaborative’s 1915(b) waiver is contingent upon amendment of this Contract, the SE agrees to make any necessary amendments to obtain such waiver approval. Notwithstanding the foregoing, any material change in the cost to the SE of providing the services herein that is caused by CMS in granting the waiver or by any other amendment necessary due to statutory, regulatory or programmatic change(s) shall be negotiated and mutually agreed to between the Collaborative and the SE. The results of the negotiations shall be placed in writing in compliance with the applicable provision of this Contract.

40.3 Minor modifications of the Scope of Work under Articles 2 through 6 or clarifications of terms in the RFP or the Proposal of SE may be accomplished by a Management Letter, pursuant to Article 2, between the two parties without formal amendment. All other modifications or clarifications shall be subject to the provisions of this Article and Article 39.
40.4 Any renegotiation of rates, amounts or service system pursuant to Article 11.3 A.4 (Compensation and Payment) shall act as a modification to the Contract under this Article.

ARTICLE 41 - WORKERS' COMPENSATION ACT

41.1 The SE agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the SE fails to comply with the Workers Compensation Act and applicable rules when required to do so, the Collaborative may terminate this Contract.

ARTICLE 42 – THIRD-PARTY BENEFICIARIES & RIGHTS

42.1 This Contract is not intended to, and does not, create any rights in any third parties or third party beneficiaries.

ARTICLE 43 – DEBARMENT AND SUSPENSION

43.1 Pursuant to 45 CFR Part 76 and other applicable federal regulations, the SE certifies by signing this Contract, that it and its principals, to the best of its knowledge and belief: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (2) have not, within a three (3)-year period preceding the effective date of this Contract, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) contract or subcontract; violation of Federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with, commission of any of the offenses enumerated above in this Article 43.1; (4) have not, within a three (3)-year period preceding the effective date of this Contract, had one or more public agreements or transactions (Federal, State or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid or other federal health care programs or federal behavioral health care programs pursuant to Title XI of the Social Security Act, 42 USC § 1320a-7 and other applicable federal statutes.

43.2 The SE’s certification in Article 43.1 is a material representation of fact upon which the Collaborative relied when this Contract was entered into by the parties. The SE shall provide immediate written notice to Collaborative’s Contract Manager if, at any time during the term of this Contract, the SE learns that its certification in Article 43.1 was erroneous on the effective date of this Contract or has become erroneous by reason of new or changed circumstances. If it is later determined that the SE’s certification in Article 43.1 was erroneous on the effective date of this Contract or has become erroneous by reason of new or
changed circumstances, in addition to other remedies available to the Collaborative, the Collaborative may terminate the Contract.

43.3 As required by 45 CFR Part 76, the SE shall require each proposed first-tier subcontractor whose subcontract will equal or exceed $25,000, to disclose to the SE, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any Federal department or agency. The SE shall make such disclosures available to the Collaborative when it requests subcontractor approval from the Collaborative pursuant to Article 19, Subcontracts. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any Federal department or agency, the Collaborative may refuse to approve the use of the subcontractor.
IN WITNESS WHEREOF, the parties have executed this Contract as of the date of execution by the State Contracts Officer, below.

STATEWIDE ENTITY

By:                                                              Date: _____________________
Title:

STATE OF NEW MEXICO

Approved as to Form and Legal sufficiency:

By:                                                              Date: _____________________
Counsel for the Collaborative

DEPARTMENT OF FINANCE AND ADMINISTRATION

By:                                                              Date: _____________________
State Contracts Officer

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: _____________________
IN WITNESS WHEREOF, the following statutory members of the NM Interagency Behavioral Health Purchasing Collaborative have executed this Contract on the behalf of their respective agencies and organizations only to the extent of their statutory authority as members of the Collaborative.

Deborah Armstrong, Secretary
Aging and Long-Term Services Department

Dorian Dodson, Acting Secretary
Children, Youth and Families Department

Joseph R. Williams, Secretary
Corrections Department

Katherine Miller, Interim Secretary
Department of Finance and Administration

Michelle Lujan Grisham, Secretary
Department of Health

Conroy Chino, Secretary
Department of Labor

Rhonda Faught, Secretary
Department of Transportation

Date
Patrick Putnam, Executive Director  
Developmental Disabilities Planning Council

Gary Beene, Assistant Secretary  
Division of Vocational Rehabilitation, PED

Mary Keener Beresford, Executive Director  
Governor’s Commission on Disability

Michelle Welby  
Governor’s Senior Health Policy Advisor

Patricio C. Larragoite, Executive Director  
Health Policy Commission

Pamela S. Hyde, Secretary  
Human Services Department

Benny Shendo, Jr., Secretary  
Indian Affairs Department

Jay Czar, Executive Director  
Mortgage Finance Authority

Veronica Garcia, Secretary  
Public Education Department
IN WITNESS WHEREOF, the following ex-officio members of the NM Interagency Behavioral Health Purchasing Collaborative have acknowledged their support for this Contract:

John Bigelow  
Chief Public Defender  
Ex Officio

Claire Dudley  
Children’s Cabinet  
Ex Officio

Reese Fullerton  
Office of Workplace Training and Development  
Ex Officio

Beverlee McClure  
Department of Higher Education  
Ex Officio

ATTACHMENT A – Regional Map  
ATTACHMENT B – Local Collaborative Geographic Areas Map  
ATTACHMENT C – Medicaid Cohort Rates (Not Public)  
ATTACHMENT D – Medicaid Administrative Rate (Not Public)
<table>
<thead>
<tr>
<th>Area</th>
<th>Approximate Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Prevention Framework/Prevention Program</td>
<td>9/1/2006</td>
</tr>
<tr>
<td>Funding of and Coordination with State-Operated Facilities</td>
<td>9/30/2006</td>
</tr>
<tr>
<td>Coordination with Medicaid Waiver Programs</td>
<td>12/31/2006</td>
</tr>
<tr>
<td>Other Areas as Determined by the Collaborative or requested by the SE and Agreed to by the Collaborative</td>
<td>TBD</td>
</tr>
</tbody>
</table>

The SE shall update and implement policies and procedures to ensure access to care coordination for all enrolled ISHCNs, as defined in NMAC 8.305.15.9, or who are individuals at high risk.

Care coordination is defined as a service that includes identification of the physical and behavioral health needs of such individuals and provides arrangement and coordination of services that are designed to meet the identified needs. Such services shall be person-centered, family-focused when appropriate, culturally competent and strength-based.

Care coordination services are provided on an as-needed basis. Care coordination operates within the SE with dedicated care coordination staff functioning independently, but structurally linked to, the other SE systems, such as quality assurance, utilization management (UM) and grievances.

For clarification purposes, activities provided through care coordination at the SE level differ from case management activities provided as part of the specific case management programs included in the Medicaid benefit package. The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC [8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04; A, 7-1-05]

The SE shall, with the assistance of the Collaborative, develop criteria for determining which consumers/families with multiple, complex and special cognitive, behavioral and/or physical health care needs will have their care coordinated by the SE.

Criteria will include such issues as acuity of need, need for multiple services and/or systems, past high use of behavioral health services, and high risk of needing intensive behavioral health services. The criteria will be approved by the Collaborative, published and widely distributed and utilized as standard criteria throughout the State.

The SE shall adhere to the following requirements for care coordination:

- Identify the eligible populations and their needs proactively;
- Provide a designated person to be responsible for coordinating the health services furnished to a specific consumer and to serve as the single point of contact for the consumer;
- Communicate to the consumer the care coordinator’s name and contact information;
Ensure access to a qualified provider who is responsible for developing and implementing a comprehensive plan of care to be followed by all providers delivering services for the individual;

Ensure the provision of necessary services as clinically appropriate and actively assist consumers and providers in obtaining such services;

Ensure appropriate coordination between physical and behavioral health services and coordinate care among other applicable agencies in the Collaborative;

Link to and coordinate with the designated MCO care coordinators and physical or behavioral health care service providers as appropriate;

Monitor progress of consumers to ensure that medically, clinically, or psychosocially necessary services are received; to assist in resolving identified problems; and to prevent duplication of services;

Ensure access to care coordination for all Medicaid-eligible ISHCN, as required by federal regulations;

Ensure the development of an individual plan of care, based on a comprehensive assessment of the goals, capacities and medical condition of the consumer and the needs and goals of the family;

Ensure an evaluation process occurs that measures the consumer’s response to care and revision of the plan as needed;

Ensure the consumer and his/her family, as appropriate, is involved in the development of the plan of care;

Ensure that all SE care coordination functions include responsibility for sharing the plan of care with key providers; this information sharing is required to ensure optimum care and communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems involved with providing services for consumers; and

A consumer or family shall have the right to refuse care coordination or case management, except where required by law, a court, or a custodial or supervisory agency.

The SE shall track outcomes related to these high-risk populations as mutually agreed upon by the SE and the Collaborative.

The SE shall ensure that its Care Coordinators, in conjunction with the community case manager if applicable, are responsible for monitoring the implementation of the plan of care for consumers receiving behavioral health services from multiple providers.

The SE shall work with the Collaborative to develop a clinical-home pilot project. The behavioral health provider designated as the clinical home in this pilot project shall take responsibility for developing and implementing the consumer’s behavioral health plan of care in coordination with the consumer, parent or legal guardian and other providers, when clinically indicated.

The SE shall ensure that multiple behavioral health providers shall coordinate the consumer’s treatment plans to provide optimum care for the consumer according to the overall plan of care.
TANF Block Grant funds, Federal grant number CFDA 93.558 to provide TANF Substance Abuse Intensive Outpatient Treatment Programs (IOP) shall provide for non-Medicaid substance abuse IOPs statewide for TANF recipients as a first priority as referred by HSD and the New Mexico Works (NMW) contractors.

As a second priority population, TANF funds may also be used to serve individuals with a gross family monthly income of less than one hundred (100) percent of the federal poverty guidelines for the size of their family when the individual is either a pregnant woman or the parent or relative caretaker of at least one dependent child living in their home.

These IOP services must provide time-limited, multi-faceted-approach treatment services for eligible persons who require structure and support to achieve and sustain recovery. Services may be court-ordered.

The IOP program must provide for nine (9) to twenty (20) hours of structured programming per week as determined by an individualized treatment plan. In the case of TANF recipients, services shall be coordinated and monitored in cooperation with the NMW case manager.

TANF substance abuse funding shall not be utilized for Medicaid covered services and shall be coordinated with other substance abuse service providers or other related support service providers to minimize or prevent duplication of services and maximize services already available through Medicaid or at no cost or minimal costs to low-income populations.

TANF substance abuse service providers shall provide substance abuse awareness training to Income Support Division and NMW contractor staff as needed.

The SE shall provide HSD with a budget prior to June 30, 2006, indicating how the FY 2007 allocation will be spent and a budget prior to May 1, 2007, indicating how the FY 2008 allocation will be spent.

At the end of each year, the SE will submit a final expenditure report to allow for mandatory reconciliation of expended TANF block grant funds.

The SE shall provide HSD with monthly data reports by the 15th of each month for the prior month. The SE and the Collaborative shall agree on the content and format of these reports pursuant to article 5.14.

At a minimum, fifty (50) percent of the individuals with substance use issues served by the SE who have ASI scores shall have an ASI Drug/Alcohol Use subscale of four (4) or higher at the time of enrollment.
The SE shall implement a plan to ensure that behavioral health providers work in cooperation with public schools and school-based health centers (SBHC) throughout New Mexico to guarantee the provision of needed services and coordination of care.

The SE shall work with the Collaborative to increase access to behavioral health services for children served in schools and SBHCs and their families.

The SE shall maintain funding for school-based behavioral health services currently funded by Collaborative agencies. The SE shall further develop the continuum of school-based behavioral health programs and services by implementing screening, assessment, and early intervention and treatment services.

The SE shall expand, in collaboration with the DOH Office of School and Adolescent Health (OSAH), HSD, PED, and CYFD, the continuum of school-based mental health programs and services by developing and implementing prevention, screening, assessment, early intervention, and treatment services, including those provided by community mental health providers working in schools, those working as part of SBHCs, and those provided by schools and school behavioral health professionals.

Funding provided by DOH shall be for the sole purpose of providing access to behavioral health services for students who have no other source of payment.

Where funding is available, the SE shall ensure that the following school-based services are available: Behavioral health screening; general health screening; crisis intervention; behavioral health assessment; individual, group and family counseling and treatment services; and school-based case management services, including linking and referring students and their families to other services or resources where particularly needed health care services are provided.

Components of this requirement, including data tracking and reporting, are as follows:

Work with schools, as requested, to increase school-based behavioral health screening for youth in schools and SBHCs as part of a needs assessment;

Improve access to behavioral health care delivered in the school and SBHC setting by recruiting additional network providers as needed to provide behavioral health evidence-based screening and services in schools;

Continue to reimburse SBHCs for all service codes used in the delivery of school-based behavioral health care, and track this data;

Work with the Collaborative to identify a primary behavioral health care provider to work in any district that requests assistance;

Ensure coordination and integration of behavioral health care with health care services delivered in school-based settings,
including BIA and tribal schools, broadly and through 504 plans, IFSPs and IEPs specifically;

Participate in the development and expansion of school-based suicide prevention and response program activities in partnership with the Collaborative, including screening, training and protocol development and implementation for public, tribal and BIA schools;

Ensure a smooth school transition for students moving between in-patient, residential treatment center, and community-based settings;

Fully participate in the development and implementation of policies, procedures and methods designed to improve delivery and funding for school-based behavioral health services;

To the extent feasible, link data collection systems between SBHC Pro and other behavioral health data collection systems. In collaboration with OSAH, the SE will develop a code for SBHCs that do not use SBHC Pro that can be used for billing purposes, tracking of clinical information, and reimbursement. The code shall identify the place (school or SBHC) where services were delivered, specifically which school;

Encourage the development of and equitably work with and reimburse SBHCs for behavioral health services;

Work with student assistance teams, school-based positive behavioral support teams, local community health care systems, and local collaboratives to ensure access to the behavioral health services provided in and outside of schools and SBHCs as requested;

Improve the sustainability of school behavioral health services through diversification of funding, including increased financial and in-kind support from school districts, foundations and government grants, and the development of community partnerships;

Partner with the Collaborative on the appropriate use of behavioral health screening, assessment, and evidence-based interventions and school-based services as related to Section 504 and Special Education services;

Assist schools in increasing their capacity to access Medicaid reimbursements and other funding sources within the control of the SE and the Collaborative for behavioral health services;

Partner with the Collaborative on the development of a regional mentorship model for schools with effective school-based behavioral health services to mentor schools in the earlier stages of service development;

Fully participate with the Collaborative in the development and implementation of state standards for behavioral health services provided in schools;

Partner with the Collaborative and the State Consortium for Behavioral Health Training and Research (CBHTR) to support training for school staff, students and families on multiple behavioral health issues;
Support the development of and participate in school crisis response teams for critical incident debriefing and counseling; Participate in the development of telehealth models of behavioral health consultation, including reimbursement mechanisms for school-based behavioral health services; Participate in the HSD School-Based Health Center/MCO Project; Work for the appropriate use of prevention funds and evidence-based prevention programs in schools; appropriate use of safe and drug-free school funds for behavioral health programs, crisis response planning and implementation; and training around behavioral health issues; Provide data regarding collaboration with Title IV, health educators, school nurses and counselors; implementation of prevention/intervention/post-intervention strategies; and identification of programs.

The SE shall ensure that the following eligibility criteria are used for students served:

State general funds target high-risk students that are not currently eligible for Special Education Services in accordance with Individuals with Disabilities Education Act (IDEA).
Funds may not be used to pay for services that Special Education departments are legally required to provide.
The number of service hours per site is determined by contract. For sites where new SBHC expansion funds are designated, the hours of service will follow the applicable level of service found in the OSAH Guidelines for Models of School-Based Health Centers.

By July 31, 2006, the SE shall maintain a move-in assistance/eviction prevention loan fund to ensure access to housing for consumers who are homeless or at risk of becoming homeless. The SE shall update and submit local move-in assistance and eviction prevention loan fund management plans that include eligibility criteria, loan agreements, and loan repayment schedules.

The SE shall commence implementation of Supported Housing initiatives, as identified in the Regional Housing Plans and in coordination with the Collaborative.

The SE shall continue to ensure the presence of a regional housing specialist for each of the six (6) service regions.

Housing specialists shall conduct regional housing needs assessments, serve as a central repository of move-in assistance/eviction prevention data, train local providers on housing/services issues, and serve as regional representative on local, regional and state homeless task forces.

Housing specialists shall liaison with local supportive housing efforts in partnership with Collaborative consumers, to include federal, state and local supportive housing initiatives for all eligible populations.
The SE shall develop by August 31, 2006, and begin to implement within by September 30, 2006, Regional Housing Plans that identify regional training and education needs and strategies. The plans will be developed in cooperation with the Collaborative to include at least MFA, DOH, CYFD, and HSD.

The SE shall document regional housing efforts in the monthly report to the Collaborative, including housing needs assessments, status of regional housing plans, utilization of the move-in assistance/eviction prevention loan fund, and any planning and training efforts.

A portion of the CoSIG budget transferred to the SE, in the amount of $70,000, is be designated for the creation of a staff position at the SE to assist solely in the achievement of the CoSIG project's goals for FY07. The SE is expected to agree with the DOH CoSIG Project Manager the exact roles and responsibilities of the SE staff person to be paid by CoSIG funds and to hire the staff person during the first quarter of FY07.

The SE shall provide $120,000 for the evaluation of the behavioral health system with input and approval from the Collaborative. The amount shall be payable in equal quarterly installments payable on the first day of each calendar year.

Any funds unexpended of the Year One $120,000 for the evaluation of the behavioral health system shall be expended in FY07 or FY08 at the direction of the Collaborative.
NMCD - Community Programming

General Fund or Community Corrections Grant Fund*

$4,379,100

Includes:
DOH transfer: $850,000
SVORI Federal Grant: $60,000
NMCD GF: 3,173,900

97 percent

3 percent

1 Amounts are subject to final federal, state and other fund source appropriations, awards, approvals or final negotiated amounts.

2 Unless otherwise specified, percentage available for non-direct services; can include operating costs as well as other non-direct costs such as operational activities, training, evaluation
Individuals under NMCD supervision in the community, either probation or parole, or discharging from prison or jail to community supervision.

Outpatient services for BH, Residential Substance Abuse programming, and life maintenance services

See General Fund Appropriations; NMCD Strategic Plan, Budget-based Performance Measures

Community Corrections Grant Fund

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<tr>
<td>2,718,849</td>
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<td>97 percent</td>
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<td>3 percent</td>
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</table>

Individually under NMCD supervision in the community, either probation or parole, or discharging from prison or jail to community supervision.

Outpatient services for BH, Residential Substance Abuse programming, and life maintenance services

NMCD Strategic Plan, Budget-based Performance Measures; Community Corrections Statute: NMSA 33.9.1 - 33.9.10 (1989)

MFA

Federal

$200,000

100 percent

0 percent
Individuals who are homeless

Homeless shelter services

For specific providers in FY 2007

ALTSD

General Fund

$59,401

100 percent

0 percent

Persons age 55 and older

Provide individual and group peer counseling services. Such services shall be provided in home and community-based settings, including senior centers.

HSD

Medicaid: Managed Care, Federal

$134,413,000

86 percent

14 percent
All Medicaid-eligible individuals enrolled in managed care

All Medicaid BH services

Final amounts depend on negotiated rates and actual number of enrolled individuals

Medicaid: Managed Care, State

<table>
<thead>
<tr>
<th>Medicaid: Managed Care, State</th>
<th>$51,611,000</th>
<th>86 percent</th>
<th>14 percent</th>
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</thead>
</table>

Medicaid: Coordinated FFS, Federal

<table>
<thead>
<tr>
<th>Medicaid: Coordinated FFS, Federal</th>
<th>$40,305,000</th>
<th>100 percent</th>
<th>3 percent</th>
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3 100 percent claims pass-through; includes negotiated administrative fee
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<td>All Medicaid BH services</td>
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<td>Same plus actual services</td>
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<td>Medicaid: Coordinated FFS, State</td>
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<td>$18,241,000</td>
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<td>All Medicaid-eligible individuals not enrolled in managed care</td>
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<td>All Medicaid BH services</td>
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<td>Same plus actual services</td>
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<td>TANF (Federal)</td>
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<td>$800,000</td>
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<td>TANF-eligible individuals</td>
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<td>Substance abuse services that assist the individual to be ready for employment</td>
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<tr>
<td>CYFD</td>
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### General Fund

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<thead>
<tr>
<th>Program</th>
<th>Budget</th>
<th>%</th>
<th>%</th>
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<tbody>
<tr>
<td><strong>Federal</strong></td>
<td>$7,283,031</td>
<td>97%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Children’s BH Services</strong></td>
<td>$2,840,959</td>
<td>97%</td>
<td>3%</td>
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<tr>
<td><strong>Shelter Care/Family Shelter Care and Safehouse Services</strong></td>
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**CYFD and non-CYFD involved/ referred youth (to age 21); those at risk of CYFD involvement**
Newborns and their families

Home Visiting services in Doña Ana, Santa Fe, and other counties.

---

4 Amounts are subject to final federal, state and other fund source appropriations, awards, approvals or final negotiated amounts.

5 Unless otherwise specified, percentage available for non-direct services; can include operating costs as well as other non-direct costs such as operational activities, training, evaluation
DOH

General Fund

$30,587,140

Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria

Mental Health Inpatient & Outpatient Services; Jail Diversion; Sexual Assault Svcs; School-Based MH Svcs; Substance Abuse Residential, , Outpatient Svcs; Detox; Opioid Replacement Therapy; Native American Svcs; Women’s Comprehensive Svcs. Outreach; Supported Employment; Housing Svcs; Mobile Crisis Teams

Some funds must be used for specific providers in FY 07 Hire one prevention manager

Special Appropriation

$2,000,000

TBD

TBD

7 These dollars may include several special appropriations for specific services or geographic areas pursuant to the FY 2007 operating and special appropriations budgets.

7 Includes $742,396 for reinvestment funding.
Increase in services for Mental Health and Substance Abuse

Contingent on Plan Approval with Management Letter guidance

Special Appropriation General Fund

$324,000

100 percent

0 percent

Non-Medicaid Individuals who meet certain clinical and financial criteria.

Alcohol and Substance Abuse prevention and treatment programs

Funds must be used for specific providers. Details TBD in Management Letter pursuant to Section 2.2

401B

$199,800

100 percent

0 percent

Non-Medicaid Individuals who meet certain clinical and financial criteria.

Alcohol and Substance Abuse prevention and treatment programs
Funds must be used for specific providers. Details TBD in Management Letter pursuant to Section 2.2

<table>
<thead>
<tr>
<th>Prevention</th>
<th>General Fund</th>
<th>$3,124,857</th>
<th>86.7 percent</th>
<th>13.3 percent</th>
</tr>
</thead>
</table>

Evidence-Based Prevention

| Community MH Block Grant – Federal    | $1,119,519   | 100 percent | 0 percent    |

Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria

Mental Health Outpatient Services; Sexual Assault Services; School-Based MH Services

---

8 Federal dollars in these grants can be used only for direct services
Some funds must be used for specific providers in FY 07

<table>
<thead>
<tr>
<th>Program</th>
<th>Funding</th>
<th>Percent</th>
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<tbody>
<tr>
<td>SAPT Block Grant – Federal</td>
<td>$6,352,663</td>
<td>100%</td>
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<tr>
<td>Access to Recovery (ATR) -Federal</td>
<td>$7,241,885</td>
<td>100%</td>
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</tbody>
</table>

Treatment: Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria.
Prevention: targeted to individuals, families and communities not in need of treatment services. Specific services 0 – 6 year olds; K – 6th grade; 12 – 17 year olds; and targeted community services.

Non-Medicaid-eligible adults (age 18+) who meet certain clinical and financial criteria

Voucher-based substance abuse treatment referral system

---

9 Funding includes 0.74 percent ($52,000) for one FTE with possible future monies for potential vacancies.
Some funds must be used for specific providers in FY07.

Receive 2 FTE through the grant

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<td>SBIRT – Federal</td>
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<td>$3,211,838</td>
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<tr>
<td>Individuals seen in primary care settings who are not being treated in BH settings</td>
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<tbody>
<tr>
<td>Screening in primary care settings, brief intervention and/or referral for substance abuse treatment if needed</td>
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<tr>
<td>Some funds must be used for specific providers in FY07</td>
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<tr>
<td>Co-SIG – Federal</td>
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<td>$715,900</td>
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<tr>
<td>Individuals with co-occurring mental health and substance use issues</td>
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<th>Page 98: [37] Deleted</th>
<th>monstott</th>
<th>4/4/2007 4:26:00 PM</th>
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<tbody>
<tr>
<td>Infrastructure Development to provide co-occurring treatment. Contracts for 3 pilot sites plus system development and data</td>
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</table>

$^{10}$ Funding includes 21 percent ($186,000) for two FTEs with possible future monies for potential vacancies.
Some funds must be used for specific providers in FY07
Receive 2 FTE through the grant.
$70,000 will be available for one-time operational costs upon approval of the federal authorities.

Safe and Drug Free Schools Federal Funds, Governor's portion

$582,000

School-age children, K – 17 years old

Evidence-Based Prevention

Title IV of the Elementary and Secondary Education Act

Strategic Prevention Framework

$1,945,000

Local Communities

Developing the use of a framework that includes assessment, capacity, planning, implementation, and, evaluation.

---

11 Funding includes 12.5 percent (250,000) for training and evaluation.
<table>
<thead>
<tr>
<th>Department</th>
<th>Funding Source (Fed/State)</th>
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<tbody>
<tr>
<td></td>
<td>Total Funding</td>
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<td>12</td>
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<td>Min. Percent Req. Direct Services</td>
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<td>Percent Other Allowed</td>
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<td>13</td>
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<td>Individuals Served</td>
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<td>Programs/Services Provided</td>
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<td>Special Parameters</td>
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</tbody>
</table>

**SIG-E Federal Funds**

- $318,175
- 100%
- 0%

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12 Amounts are subject to final federal, state and other fund source appropriations, awards, approvals or final negotiated amounts.

13 Unless otherwise specified, percentage available for non-direct services; can include operating costs as well as other non-direct costs such as operational activities, training, evaluation
Non-Medicaid Individuals who meet certain clinical and financial criteria

Evidence-Based Prevention

Details TBD in Management Letter pursuant to Section 2.2

Special Appropriation
Methamphetamine

$649,300
$121,000

TBD
TBD

TBD

Offer a continuum of services from prevention to recovery to stop the growing meth problem.

Details TBD in Management Letter pursuant to Section 2.2

DOH

Data Infrastructure Grant

$101,350

100 percent

0 percent

BHSD and CYFD identified providers
Assessment of the DOH and CYFD provider networks to determine data infrastructure needs to meet Mental Health Block Grant and other DOH/CYFD reporting requirements

Funding breakout:
$10,000 – VO admin.
$31,950 – BHSD
$59,400 – CYFD

State Operated Programs - General Fund

$20M - $30M (amount TBD)

90 percent or more

Up to 10 percent

Non-Medicaid individuals in need of inpatient or residential treatment services.

Inpatient services at state-operated facilities

Details TBD in Management Letter pursuant to Section 2.2

State Operated Programs – Federal

$10 - $12,000,000 (amount TBD)

100 percent

0 percent

14 Contingent on increased billings. See Article 4.1B(24(b)