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

**Medicaid Managed Care Services Agreement**

**Among**

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

**New Mexico Children, Youth, and Families Department,**

**New Mexico Early Childhood Education and Care Department,**

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**Presbyterian Health Plan**

**PSC 24-630-8000-0031 A4**

**CFDA 93.778**

**STATE OF NEW MEXICO HEALTH CARE AUTHORITY**

**MEDICAID MANAGED CARE SERVICES AGREEMENT**

**PROFESSIONAL SERVICES CONTRACT**

**"TURQUOISE CARE"**

**AMENDMENT No. 4**

This Amendment No. 4 to PSC: 24-630-8000-0031 (the "Agreement" or the "Contract") is made and entered into by and between the **New Mexico Health Care Authority** ("HCA") (formerly the "Human Services Department" ("HSD"); the **New Mexico Children, Youth, and Families Department** ("CYFD"); the **New Mexico Early Childhood Education and Care Department** ("ECECD"); the **New Mexico Behavioral Health Purchasing Collaborative** (the "Collaborative"); and **Presbyterian Health Plan** including any successors and/or assignees ("CONTRACTOR"); and is to be effective upon signatures by all parties.

**WHEREAS,** there are certain revisions to the Contract that are necessary.

**UNLESS OTHERWISE SET OUT BELOW, ALL OTHER PROVISIONS OF THE ABOVE REFERENCED AGREEMENT REMAIN IN FULL EFFECT AND IT IS MUTUALLY AGREED BETWEEN THE PARTIES THAT THE FOLLOWING PROVISIONS OF THAT AGREEMENT ARE AMENDED AS FOLLOWS:**

**Definitions are amended to add Rare Disease, to read as follows:**

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

**Section 4.1.4, HCA/CONTRACTOR Action On Updated Address Information, is added, to read as follows:**

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

**Section 4.5.9.3 is added, to read as follows:**

The CONTRACTOR's prenatal and postpartum care program shall include Doula services as a preventative service for individuals navigating pregnancy-related care before, during, and after pregnancy or childbirth. Doula services are provided as preventive services and must be recommended by a physician or other licensed practitioner of the healing arts within his or her scope of practice under state law to prevent perinatal complication and/or promote the physical and mental health of the beneficiary.

**Section 4.8.16.9 is amended, to read as follows:**

The CONTRACTOR shall update the rosters of agencies with a Regulation and Licensing Department (RLD) clinical supervisor designation and for provider additions related to behavioral health specialized services as required in NMAC 8.321.2. Within fifteen (15) Calendar Days of receipt of a clean roster provided to the CONTRACTOR, the CONTRACTOR shall complete the rostering updates so the CONTRACTOR's claims payment system can recognize and pay claims. The CONTRACTOR shall add rostered providers to their Provider directories.

**Section 4.10.3.10.22.1 is added, to read as follows:**

The CONTRACTOR shall not require more than one prior authorization per policy period for any single drug or category of item for diabetes treatment or its complications when prescribed as medically necessary by the covered Member's health care prescriber: (1) blood glucose monitors, including those for persons with disabilities, including the legally blind; (2) test strips for blood glucose monitors; 3) visual reading urine and ketone strips; (4) lancets and lancet devices; (5) insulin; (6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind; (7) syringes; (8) prescriptive oral agents for controlling blood sugar levels; (9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; (10) glucagon emergency kits.

**Section 4.10.3.10.22.2 is added, to read as follows:**

The CONTRACTOR shall not require step therapy or prior authorizations for FDA approved medications to treat autoimmune disorders, cancer, substance use disorders, and rare conditions when prescribed by a medical professional as medically necessary, except in cases in which a biosimilar, interchangeable biologic or generic version is available. Medical necessity determinations shall be automatically approved within seven days and within 24 hours for emergent cases where a delay in treatment can cause harm to the eligible member.

**Section 4.10.3.11.14 is amended, to read as follows:**

The CONTRACTOR's representation at the Medicaid DUR Board shall consist of one (1) physician or one (1) pharmacist.

**Section 4.10.3.11.21 is amended, to read as follows:**

The CONTRACTOR shall cover all FDA approved rescue medications indicated for the emergency treatment of known or suspected opioid (natural or synthetic) overdose without requiring prior authorization or quantity limits provided by any legally authorized and allowable prescriber/dispenser and shall require their Contract Providers to comply with all aspects of the Pain Relief Act, NMSA 1978, § 24-2D, including but not limited to offering overdose counseling education.

**Section 4.10.13.2 is amended, to read as follows:**

HCA shall communicate the requirements of the non-risk arrangement to the CONTRACTOR through a Letter of Direction or via changes to the Managed Care Policy Manual.

**Section 4.20.1.18.5 is added, to read as follows:**

Effective October 1, 2020, Medicare is no longer the primary payer for Opioid Treatment Program (OTP) services for dually eligible beneficiaries. MCO is expected to pay the Medicaid coinsurance/deductible for OTP services once the claim has crossed over from Medicare.

**Section 4.25 is added, to read as follows:**

Starting July 1, 2025 and subject to final CMS approvals, the CONTRACTOR will offer the new benefits listed in Table X below, in accordance with the Turquoise Care 1115 Demonstration Special Terms and Conditions, Protocols, Implementation Plans, and other guidance documents, and as further detailed in the MCO Policy Manual. HCA - Please see attached document for table.

The State reserves the right to exclude from the Contractor's scope of services any category of care or benefit not funded by federal financial participation, by future direction or amendment.

**Attachment 1:** Turquoise Care Covered Services, is amended to add covered services
**Attachment 4:** Alternative Benefit Plan Covered Services, is amended to add covered services
**Attachment 11:** Non-Risk Arrangements
**Attachment X:** 2025 Turquoise Care 1115 Demonstration Waiver Initiatives

**All other Sections and Deliverables in PSC 24-630-8000-0029, as amended, remain unchanged.**

**THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK**

**IN WITNESS WHEREOF,** the parties have executed this Agreement as of the date of signature by all parties.

**CONTRACTOR**

Signed by: Antonio H. Hernandez
By: B871073C4EB4474... Date: 5/5/2025
Antonio (Tony) Hernandez, PHP Interim President
Presbyterian Health Plan

**STATE OF NEW MEXICO**

DocuSigned by: Kari Armijo
By: 1BA9EB5EAD00499... Date: 5/12/2025
Kari Armijo, Cabinet Secretary
Health Care Authority

DocuSigned by: Carolee A. Graham
By: FB15A98045214DA... Date: 5/9/2025
Carolee Graham, CFO
Health Care Authority

DocuSigned by: Teresa Casados
By: FE355BED9AF5442... Date: 5/9/2025
Teresa Casados, Cabinet Secretary
Children, Youth and Families Department

DocuSigned by: Elizabeth Groginsky
By: 6F1D4EE86EE94C2... Date: 5/7/2025
Elizabeth Groginsky, Cabinet Secretary
Early Childhood Education and Care Department

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

DocuSigned by: Kari Armijo
By: 1BA9EB5EAD00499... Date: 5/12/2025
Kari Armijo, Cabinet Secretary
Health Care Authority

Signed by: Gina DeBlassie
By: 2B5F58D60AD7441... Date: 5/9/2025
Gina DeBlassie, Cabinet Secretary
Department of Health

DocuSigned by: Teresa Casados
By: FE355BED9AF5442... Date: 5/9/2025
Teresa Casados, Cabinet Secretary
Children, Youth and Families Department

**APPROVED AS TO FORM AND LEGAL SUFFICIENCY:**

DocuSigned by: Mark Reynolds
By: 6241C19C1E01414... Date: 5/12/2025
Mark Reynolds, Chief Legal Counsel
Health Care Authority

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

**TAXATION AND REVENUE DEPARTMENT**

BTIN: **02-084519-00-7**

By: Signed by: Nancy Lujan B5A4D3141D9245F... Date: 5/13/2025

## Attachment 1: Turquoise Care Covered Services

| Non-Community Benefit Services Included Under Turquoise Care[1] |
|---|
| Accredited Residential SUD Treatment Centers (Adult) |
| Accredited Residential Treatment Center Services |
| Applied Behavior Analysis (ABA) |
| Adult Psychological Rehabilitation Services |
| Ambulatory Surgical Center Services |
| Anesthesia Services |
| Assertive Community Treatment (ACT) Services |
| Bariatric Surgery[2] |
| Behavior Management Skills Development Services |
| Behavioral Health Professional Services: outpatient Behavioral Health and substance abuse services |
| Biomarkers Services |
| Case Management |
| Certified Community Behavioral Health Clinic (CCBHCs) |
| Chiropractic Services |
| Chronic Care Management services |
| Community Based Mobile Crisis |
| Community Health Worker and Community Health Representative Services |
| Community Interveners for the Deaf and Blind |
| Comprehensive Community Support Services |
| Crisis Services, including telephone, clinic, mobile, and stabilization centers |
| Crisis Triage Centers, including residential |
| Day Treatment Services |
| Dental Services, including fluoride varnish |
| Diagnostic Imaging and Therapeutic Radiology Services |
| Dialysis Services |
| Doula Services |
| Durable Medical Equipment and Supplies |
| Emergency Services (including emergency room visits and psychiatric ER) |
| Experimental or Investigational Procedures |
| Experimental or Investigational Procedures, Technology or Non-Drug Therapies[3] |
| Early and Periodic Screening, Diagnostic and Treatment (EPSDT) |
| EPSDT Personal Care Services |
| EPSDT Private Duty Nursing |

[1] At minimum, the CONTRACTOR shall cover all codes included on the Medicaid fee schedule.

[2] No limitation on number of surgeries, as long as medical necessity is met.

[3] Coverage for routine patient care costs incurred as a result of the Medicaid eligible recipient's participation in an approved QCT. HCA/MAD does not cover experimental or investigational medical, surgical or health care procedures or treatments, including the use of drugs, biological products, other products or devices

| Non-Community Benefit Services Included Under Turquoise Care[1] |
|---|
| EPSDT Rehabilitation Services |
| Evidence Based Practices (EBPs) |
| Family Planning |
| Family Peer Support Services |
| Family Support (Behavioral Health) |
| Federally Qualified Health Center Services |
| Hearing Aids and Related Evaluations |
| High Fidelity Wraparound Services |
| Home Health Services (limitations apply) |
| Hospice Services |
| Hospital Inpatient (including Detoxification services) |
| Hospital Outpatient |
| Human Donor Milk |
| Inpatient Hospitalization in Freestanding Psychiatric Hospitals |
| Inpatient/Outpatient Services |
| Institutions for Mental Disease (IMD) for SUD only |
| Intensive Outpatient Program Services |
| IV Outpatient Services |
| Laboratory Services |
| Lactation Care Provider Services |
| Medically Tailored Meals |
| Medication Assisted Treatment for Opioid Dependence |
| Midwife Services |
| Mobile Response Stabilization Services (MRSS) |
| Multi-Systemic Therapy Services |
| Non-Accredited Residential Treatment Centers and Group Homes |
| Nursing Facility Services |
| Nutrition Supports for Pregnant Members |
| Nutritional Services |
| Occupational Services |
| Outpatient Hospital based Psychiatric Services and Partial Hospitalization |
| Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital |
| Outpatient Health Care Professional Services |
| Peer Support Services |
| Pharmacy Services |
| Physical Health Services |
| Physical Therapy |
| Physician Visits |
| Podiatry Services |

| Non-Community Benefit Services Included Under Turquoise Care[1] |
|---|
| Pregnancy Termination Procedures |
| Preventive Services |
| Prosthetics and Orthotics |
| Psychosocial Rehabilitation Services |
| Qualified Clinical Trials |
| Radiology Facilities |
| Recovery Services (Behavioral Health) |
| Rehabilitation Option Services |
| Rehabilitation Services Providers |
| Reproductive Health Services |
| Respite (Behavioral Health) (annual limits may apply but may be exceeded based on the Member's health and safety needs) |
| Rural Health Clinics Services |
| School-Based Services |
| Screening, Brief Intervention, Referral to Treatment (SBIRT) Services |
| Speech and Language Therapy |
| Supportive Housing (limitations apply) |
| Swing Bed Hospital Services |
| Technology or Non-Drug Therapies |
| Telemedicine Services |
| Tobacco Cessation treatment and services (may include counseling, prescription medications, and products) |
| Tot-to-Teen Health Checks |
| Transplant Services |
| Transportation Services (medical) |
| Transitional Care Management services |
| Treatment Foster Care I |
| Treatment Foster Care II |
| Vision Care Services |

## Attachment 4: Alternative Benefit Plan Covered Services

| Alternative Benefit Plan Services Included Under Turquoise Care[1] |
|---|
| Allergy testing and injections |
| Annual physical exam and consultation[2] |
| Applied Behavior Analysis (ABA) |
| Bariatric surgery[3] |
| Behavioral health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management |
| Cancer clinical trials |
| Cardiovascular rehabilitation[4] |
| Chemotherapy |
| Chiropractic Services |
| Chronic Care Management services |
| Dental services[5] |
| Diabetes treatment, including diabetic shoes, medical supplies, equipment and education |
| Dialysis |
| Diagnostic imaging |
| Disease management |
| Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services |
| Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement[6] |
| Electroconvulsive therapy |
| Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age nineteen (19) to twenty (20) |
| Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care |
| Family planning and reproductive health services and devices, sterilization, pregnancy termination, contraceptives, and insertion and/or removal of contraceptive devices[7] |
| Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services |

[1] At minimum, the CONTRACTOR shall cover all codes included on the Medicaid fee schedule for these services.
[3] Includes a health appraisal exam, laboratory and radiological tests, and early detection procedures.
[3] Limited to one per lifetime. Criteria may be applied that considers previous attempts by the member to lose weight BMI and health status.
[4] Limited to short-term therapy (two consecutive months) per cardiac event.
[5] The ABP covers dental services for adults in accordance with NMAC 8.310.2. Recipients age 19-20 may receive dental services according to the increased periodicity schedule under EPSDT.
[6] Requires a provider's prescription. DME is limited to a periodicity schedule and must be medically necessary. Disposable medical supplies are limited to diabetic and contraceptive supplies. Foot orthotics, including shoes and arch supports, are covered only when an integral part of a leg brace, or are diabetic shoes.
[7] Sterilization reversal is not covered. Infertility treatment is not covered.

**Alternative Benefit Plan Services Included Under Turquoise Care[1]**

Genetic evaluation and testing[8]

Habilitative and rehabilitative services, including physical, speech and occupational therapy[9]

Hearing screening as part of a routine health exam[10]

Holter monitors and cardiac event monitors

Home health care, skilled nursing and intravenous services[11]

Hospice care services

Immunizations[12]

Inpatient physical and behavioral health hospital/medical services and surgical care[13]

Inpatient rehabilitative services/facilities[14]

Internal prosthetics

IV infusions

Lab tests, x-ray services and pathology

Maternity care, including delivery and inpatient maternity services, non-hospital births, and pre- and post-natal care

Medication assisted therapy for opioid addiction

Non-emergency transportation when necessary to secure covered medical services

Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity

Organ and tissue transplants[15]

Osteoporosis diagnosis, treatment and management

Outpatient surgery

Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions[16]

Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings[17]

Physician visits

Podiatry and routine foot care[18]

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[8] Limited to genetic testing outlined in NMAC 8.3.10.2. Does not include random genetic screening.

[9] Limited to short-term therapy (two consecutive months) per condition.

[10] Hearing aids and hearing aid testing by an audiologist or hearing aid dealer are not covered, except for Members age 19-20. The ABP does not cover audiology services.

[11] Home health care is limited to 100 visits per-year. A visit cannot exceed four hours.

[12] Includes ACIP-recommended vaccines.

[13] Includes services in a psychiatric unit of a general hospital and inpatient substance abuse detoxification. Surgeries for cosmetic purposes are not covered.

[14] Includes services in a nursing or long-term acute rehabilitation facility/hospital. Coverage is limited to temporary stays as a step-down level of care from an acute care hospital when medically necessary and the discharge plan for the Member is the eventual return home.

[15] Transplants are limited to two per lifetime.

[16] Other over-the-counter items may be considered for coverage only when the items are considered more medically or economically appropriate than a prescription drug, contraceptive drug or device, or for treating diabetes.

[17] Includes US Preventive Services Task Force "A" and "B" recommendations; preventive care and screening recommendations of the HRSA Bright Futures program; and additional preventive services for women recommended by the Institute of Medicine.

[18] Covered when medically necessary due to malformations, injury, acute trauma or diabetes.

**Alternative Benefit Plan Services Included Under Turquoise Care[1]**

Prescription medicines

Primary Care to treat illness/injury and chronic disease management

Pulmonary therapy[19]

Radiation therapy

Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease

Skilled nursing[20]

Sleep studies[21]

Specialist visits

Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)[22]

Telemedicine services

Tobacco Cessation treatment and services (may include counseling, prescription medications, and products)

Transitional Care Management services

Urgent care services/facilities

Vision care for eye injury or disease[23]

Vision hardware (eyeglasses or contact lenses)[24]

[19] Limited to short-term therapy (two consecutive months) per condition.
[20] Subject to the 100-visit home health limit when provided through a home health agency.
[21] Limited to diagnostic sleep studies performed by certified providers/facilities.
[22] The ABP does not cover behavioral health supportive services: Family Support, Recovery Services and Respite Services.
[23] Refraction for visual acuity and routine vision care are not covered, except for Members age 19-20.
[24] Covered only following the removal of the lens from one or both eyes (aphakia). Coverage of materials is limited to one set of contact lenses or eyeglasses per surgery, within 90 days following surgery. Vision hardware and routine vision care are covered for recipients age 19-20 following a periodicity schedule.

## Attachment 10: Directed Payments

Directed Payments are subject to change each year, and any changes will be outlined in Letters of Direction.

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| Health Care Quality Surcharge (HCQS) | January 1, 2020 | Nursing Facilities per the following classifications:<br><br>I: Less than 60 beds<br><br>II: 60 or more beds and less than 90,000 annual Medicaid bed days<br><br>III: 60 or more beds and 90,000 or more annual Medicaid bed days | A uniform dollar increase to Nursing Facility per diem rates for the market basket index (MBI) factor and per diem add-on for each respective class of Nursing Facility as defined in New Mexico statute, §7-41-4 and §7-41-6, and Quality incentive payments incorporated in the rates as a separate payment term to Nursing Facilities for achieving performance targets across quality measures. Achievement is validated by the HCA-selected data intermediary and the MCOs distribute the earned amounts to each Nursing Facility on a quarterly basis as specified by HCA | Monthly Capitation (Per Diem and MBI) and Quarterly Separate Payment Term (Quality) | Per claim for per diem and MBI factor<br><br>Quarterly for quality |
| Nursing Facility Value-Based Purchasing (NF VBP) Payment Arrangement | January 1, 2020 | Nursing Facilities that meet the following criteria: a Medicaid certified facility with Medicaid utilization, contracted with at least one (1) MCO, submits Minimum Data Sets (MDS) to the HCA-selected data intermediary, and has a signed data use agreement with the data intermediary. | A uniform dollar amount through foundational, secondary, and per diem add-on payments based on Medicaid bed days and quality scores. Achievement of these payments is calculated by HCA selected data intermediary. | Monthly Capitation | Quarterly payments based on quality scorecards issued by the HCA-selected data intermediary. The MCO is to make payment in accordance with the contract terms between the MCO and the Nursing Facility. |
| University of New Mexico Medical Group (UNMMG) | January 1, 2019 | The University of New Mexico Health Sciences Center clinical delivery system including: UNM Medical Group, UNM Hospitals, and associated clinics and programs | Uniform percentage increase to contracted rates between the practice plans and the MCOs. | Quarterly Separate Payment Term based on HCA's analysis of utilization data from the MCOs. | As directed by HCA upon the MCOs' receipt of payment from HCA |
| Community Tribal Hospital | January 1, 2020 | Community hospitals that serve a disproportionate share of Native American Members as measured relative to their total Medicaid utilization as defined | Uniform percentage increase to contracted rates between the classes of covered hospitals and the MCOs for inpatient and outpatient hospital services. | Monthly Capitation | Per claim |

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| | | in the approved preprint for the respective contract year. | | | |
| University of New Mexico Hospital (UNMH) | January 1, 2020 | The eligible class of providers is defined as a hospital that, pursuant to a lease agreement, has assumed a New Mexico county's perpetual contractual obligation to the United States government, through the Indian Health Service, to provide guaranteed access to care for Native Americans. | Uniform dollar amount for inpatient and outpatient hospital services with a portion at-risk for meeting specified performance metrics. | Quarterly Separate Payment Term based on HCA's review of utilization. HCA reviews UNMH's performance on the specified quality metrics for the rating period and distributes one (1) separate payment for this component of the directed payment. | As directed by HCA upon the MCOs' receipt of payment for the utilization increase and for the earned quality-related funds. |
| HealthCare Delivery Access Act (HDAA)<br><br>Formerly Hospital Value Based Payment Program (HVBP) CY23<br><br>Formerly Hospital Access Program (HAP) CY2020 – CY 2022) | July 1, 2024 | Provider Types included in the HDAA Class:<br><br>• 201 Acute Care Hospital<br>• 202 PPS Exempt; Rehab Hospital<br>• 203 Rehab Hospital<br>• 204 PPS Exempt Psych Hospital<br>• 205 Psych Hospital | A uniform dollar amount for inpatient and outpatient hospital services based on actual utilization for Provider Types 201-205. Quality incentive payments are incorporated in the rates as a separate payment term to HDAA hospitals for achieving performance targets across quality measures. Achievement is validated by the HCA-selected data intermediary and the MCOs distribute the amounts earned to each HDAA hospital on an annual basis as specified by HCA | Quarterly Access Separate Payment Term<br><br>Annual Quality Separate Payment Term | As directed by HCA upon the MCOs' receipt of payment from HCA<br><br>Annually for quality |

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| Primary Care Payment Reform<br>Value Based Program (PCPR-VBP) | July 1, 2024 | Primary Care Providers are identified by a combination of provider type and provider specialty at both a practice and affiliate level. There are two avenues for a practice to determine eligibility for the Primary Care Payment Reform. First is a single step definition based on the practice billing type and specialty. If a practice has a billing provider type OR billing provider specialty shown on the lists below, the entire practice is qualified for participation in the Primary Care Payment reform.<br><br>Single Step Qualification<br>List A - Eligible Billing Provider Types:<br>Certified Nurse Midwife<br>Nurse Practitioner<br>Clinic Federally Qualified Health Center (FQHC)<br>Clinic, Rural Health Medical, freestanding<br>Clinic, Rural Health Medical, hospital-based<br>List B - Eligible Billing Provider Specialties:<br>Pediatric Physician, Development and Behavioral<br>OB-GYN Physician<br>Family Medicine Physician<br>Family Medicine Physician, Addiction Medicine<br>General Pediatric Physician<br>Geriatric Medicine Physician<br>General Practice Physician<br>Internal Medicine Physician | Uniform percentage increase for eligible utilization at provider class practices, amounts incorporated in the rates as a separate payment term. | Quarterly Separate Payment Term (Quality) | Per claim and quarterly for quality |

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| | | Internal Medicine Physician, Addiction Medicine<br>Family Nurse Practitioner<br>Pediatric Nurse Practitioner<br>Nurse Practitioner, General<br>Women's Health Nurse Practitioner<br>Logic: List A or List B<br>The second avenue for practice eligibility requires review of the practice-level billing type as well as the provider type/specialty for affiliated providers. Practices with a billing provider type on the following list AND a rendering provider type from either of the lists above.<br>Two-Step Qualification<br>List C - Billing Provider Types:<br>Behavioral Health Agency<br>Only if integrating physical health into a behavioral health space<br>School based health clinics<br>Birth Center, Licensed<br>Only if also performing primary care for women's health<br>Clinic, Mental Health Center – DOH Certified (CMHC)<br>Only if integrating physical health into a behavioral health space<br>Schools<br>List D - Rendering Provider Types:<br>Certified Nurse Midwife<br>Nurse Practitioner<br>List E - Rendering Provider Specialties: | | | |

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| | | Pediatric Physician, Development and Behavioral<br>OB-GYN Physician<br>Family Medicine Physician<br>Family Medicine Physician, Addiction Medicine<br>General Pediatric Physician<br>Geriatric Medicine Physician<br>General Practice Physician<br>Internal Medicine Physician<br>Internal Medicine Physician, Addiction Medicine<br>Family Nurse Practitioner<br>Pediatric Nurse Practitioner<br>Nurse Practitioner, General<br>Women's Health Nurse Practitioner<br>Logic: List C and (List D or List E)<br><br>and has submitted at least one Medicaid claim and successfully reported on the PCPR quality metrics during the specified performance period. | | | |
| Ambulance Supplemental Payment Program (ASPP) | January 1, 2024 | Government Owned Emergency Transport providers who submitted a cost report for the prior year, enrolled in Medicaid, and provide services to Medicaid beneficiaries. | A uniform dollar amount to EMS Providers based on per trip EMS ground ambulance encounters from MCOs | Quarterly Separate Access Payment Term | As directed by HCA upon the MCOs' receipt of payment from HCA. |
| Minimum Fee Schedule | July 1, 2024 | Any Contract provider, Non-Contract Nursing Facility provider, or Non-Contract Hospital provider enrolled as a Medicaid provider. | Minimum fee schedule based on State Plan approved rates | Monthly Capitation | Per encounter |
| Non-Contract Providers Minimum Fee Schedule | July 1, 2024 | Non-Contract Providers except as otherwise precluded by law and/or specified for I/T/Us, FQHCs/RHCs, family planning | Minimum fee schedule based on 95% of State Plan approved rates | Monthly Capitation | Per Encounter |

| Name of Directed Payment | Effective Date | Provider Class | Type of Directed Payment | Payment Terms to MCO | Frequency of Payments to Providers |
|---|---|---|---|---|---|
| | | Providers, Emergency Service Providers, Nursing Facilities, and hospitals. | | | |
| Home and Community Based Services (HCBS) and Evidence Based Practice (EBP) | July 1, 2024<br><br>Sunsets December 31, 2024 | Providers of HCBS and EBP subject to the State plan amendment to implement the temporary economic recovery payments for HCBS and EBP | Uniform percentage increase to contracted rates as approved in New Mexico's APRA HCBS Spending Plan. | Separate Payment Term | As directed by HCA upon the MCOs' receipt of payment from HCA. |
| Twenty (20) Smallest Rural Hospitals | January 1, 2025<br><br>(Sunsets June 30, 2025) | The provider class is defined as the twenty (20) hospitals in rural or underserved New Mexico counties, with active provider type 201 with 98 beds of less | A uniform dollar amount for inpatient and outpatient hospital services based on actual utilization for this provider class | Separate Payment Term | As directed by HCA upon the MCOs' receipt of payment from HCA. |
| Agency Based Community Benefit Services (ABCB) | January 1, 2025 | All providers billing for Agency Based Community Services | Uniform percentage increases to Agency-Based Community Benefit (ABCB) services rendered for Medicaid enrollees. | Monthly Capitation | Per Encounter |
| Turquoise Care 1115 Waiver Food as Medicine Meals for Pregnant Members | July 1, 2025 | Providers billing for Food as Medicine Meals for Pregnant Members services. | Minimum fee schedule based on 1115 Waiver-approved rates. | Turquoise Care 1115 Waiver Food as Medicine Meals for Pregnant Members | July 1, 2025 |

- The CONTRACTOR must comply with Section **Error! Reference source not found.** Directed Payments.
- The effective dates of the directed payments are contingent on CMS approval and subject to annual renewal unless otherwise noted. Directed payments without a specified end date are anticipated to be in place for the duration of the term of this Agreement and will be removed from this Attachment if ended prior to the termination of the contract term.
- For directed payments operationalized through a Separate Payment Term, the amount of the payment each quarter will be based on emerging utilization data. The CONTRACTOR is required to submit utilization and paid amounts by procedure code, rate cohort and month in which the service occurred for each quarter. Each subsequent quarter will include a look-back period to account for claims lag.

- For directed payments operationalized through capitation, HCA may request ad hoc reporting to verify accuracy of information used to determine payment and will take action on any Provider complaints on the respective directed payment, and review and potentially reconcile the state directed payment, as needed.
- HCA will also rely on sanctions, including monetary penalties, for noncompliance as specified in Section **Error! Reference source not found.** Sanctions.

## Attachment 11: Non-Risk Arrangements

This attachment sets forth the services under the CONTRACT that are under a non-risk arrangement, in accordance with 42 C.F.R. § 447.362.

| Non-Risk Arrangement | Services subject to the non-risk arrangement | Frequency of payment from HCA to the CONTRACTOR based on reported utilization |
|---|---|---|
| 1. Medical Respite Services | Medical Respite Services | Quarterly |

## Attachment X: 2025 Turquoise Care 1115 Demonstration Waiver Initiatives

With the exception of Medical Respite, starting July 1, 2025, and subject to final CMS approvals, THE CONTRACTOR will offer the new benefits listed in Table X below, in accordance with the Turquoise Care 1115 Demonstration Special Terms and Conditions (STC), Protocols, Implementation Plans, and other guidance documents, and as further detailed in the MCO Policy Manual and NMAC. The start date for Medical Respite is contingent on CMS approval.

Table X: Turquoise Care Initiatives to be Implemented in 2025

| Initiative Name | Initiative Description | Service Definition | Additional Information |
|---|---|---|---|
| **Medical Respite** | Acute and post-acute medical care for people who are homeless who are too ill to recover from sickness or injury on the street or in a shelter, but not sick enough to warrant hospital level care | Short-term post-hospitalization housing with room and board for up to six months per rolling year, only where integrated, clinically-oriented recuperative or rehabilitative services and supports are provided. Post-hospitalization housing services are limited to a clinically appropriate amount of time. | See Attachment 11: Non-Risk Arrangements.<br><br>Additional information on program limits, implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC. |
| **Food is Medicine: Nutrition Supports for Pregnant Members** | Delivery of prepared meals or grocery boxes that provide the nutritional equivalent of up to three meals per day and will be available for up to the length of the pregnancy and up to twelve months postpartum. | Home delivered meals (medically-tailored meals) and food boxes, tailored to health risk, for pregnant individuals who meet risk and needs-based criteria. | Additional information on program limits, implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC.<br><br>The Contractor will implement nutrition supports that are nutritionally tailored, culturally relevant, and that elevate local food systems and vendors.<br><br>The Contractor must submit an implementation plan for HCA approval, highlighting their support of local vendors and path to meet HCA's goals for Food is Medicine Nutrition Supports to HCA no later than June 1, 2025. |
| **Food is Medicine: Nutrition Supports for Community Benefit Members** | Provide individuals enrolled in the Community Benefit program meeting eligibility criteria up to two meals per day. | Services to provide and deliver home delivered meals on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Services are furnished consistent with the participant's person-centered service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). | Additional information on program implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC.<br><br>The Contractor will implement nutrition supports that are nutritionally tailored, culturally relevant, and that elevate local food systems and vendors.<br><br>The Contractor must submit an implementation plan for HCA approval, highlighting their support of local vendors and path to |

| | | | |
|---|---|---|---|
| | | | meet HCA's goals for Food is Medicine Nutrition Supports to HCA no later than June 1, 2025. |
| **JUST Health Plus** | The JUST Health Plus program will offer Pre-release services including but not limited to case management, medication assisted treatment, and 30 days of prescription medication at release for Medicaid members in a correctional facility who are within 90 days of release.<br><br>JUST Health Plus builds upon the foundation of the JUST Health program, phasing-in expansions to enhance pre-release services and post-release continuity of care. The Contractor will coordinate justice liaison and transition of care services for JUST Health Plus, and will not be at risk for pre-release medical services.<br><br>JUST Health Plus will be phased in by facility. Until JUST Health Plus has been implemented in a correctional facility, the Contractor is required to follow the requirements for JUST Health as stated in the contract. | The Contractor shall follow existing Turquoise Care service definitions for the HCA-specified pre-release services. | Implementation will be phased in to select NMCD and CYFD facilities in 2025 as specified by HCA.<br><br>Additional information on program implementation, billing, and reporting will be incorporated into the MCO Policy Manual and/or NMAC. |