STATE OF NEW MEXICO

HEALTH CARE AUTHORITY

PROFESSIONAL SERVICES CONTRACT

AMENDMENT No. 2

This Amendment No. 2 to Professional Services Contract (PSC) 24-630-8000-0001 is made and entered into by and between the State of New Mexico **Health Care Authority,** hereinafter referred to as "Department" or "HCA", and **Comagine Health,** hereinafter referred to as the "Contractor", and collectively referred to as the "Parties."

The purpose of this Amendment is to modify and extend term of contract. The Agreement to update the Contract Manager information, provide clarification regarding Technical/Administrative Denials for Level of Care (LOC) reviews, to modify the contractual requirement in regards to system interfaces, replace reference to Centennial Care to Turquoise Care, Remove reference to Omnicaid, amend Exhibit C to capture the renumbering of the required reports to add new reports W4 Pending Waiver LOCs Exceeding 21 Days, M11 Traditional DDW Budget Submissions and M12 New Mexico Phone Report, omit W3 RFI Pend Info Worklist and removing W2 Activity and TAT Jackson Class Report due to no longer in use.

IT IS MUTUALLY AGREED BETWEEN THE PARTIES THAT THE FOLLOWING PROVISIONS OF THE ABOVE-REFERENCED CONTRACT ARE AMENDED AS FOLLOWS:

Section 3. Terms is amended and reads as follows:

3. Term.

This Agreement is effective July 1, 2023 and shall terminate June 30, 2026, unless terminated pursuant to paragraph 4 (Termination), or paragraph 5 (Appropriations) per NMSA 1978, Section 13-11-98.1

Section 24. is amended and reads as follows:

24. Notices.

Any notice required to be given to either party by this Agreement shall be in writing and shall be delivered in person, by courier service or by U.S. mail, either first class or certified, return receipt requested, postage prepaid, as follows:

To the HCA: Christina Lucero, TPA Staff Manager
Exempt Services and Programs Bureau

Health Care Authority, Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
christina.lucero@hca.nm.gov

Exhibit A, Scope of Work is amended and restated in its entirety.

Exhibit B, Compensation is amended and restated in its entirety.

Exhibit C, Reports is amended and restated in its entirety.

All other articles of PSC 24-630-8000-0001 remain the same.

EXHIBIT A

Scope of Work

1. OVERHEAD SERVICES ARE NOT SEPARATELY REIMBURSABLE

1.1 PROGRAM ADMINISTRATION

I. Organizational Structure

A. This Professional Services Contract (PSC) establishes the Third-Party Assessor/Fee-For-Service Utilization Review (TPA/FFS UR) contract.

B. The Contractor shall ensure a fully staffed, professionally qualified organization that is capable of managing a complex UR program to meet the requirements as described in this Agreement. The Contractor, and its subcontractors, must be able to meet any and all administrative requirements related to appropriate state licensure, solvency, information systems and reporting, and compliance with all applicable federal and state laws and regulations.

C. The Contractor shall employ Medical Directors who are physicians currently licensed to practice medicine in the State of New Mexico and who will perform at least the following functions:

1. Develop and/or apply medical necessity review criteria;

2. Provide professional supervision of medical necessity review determinations;

3. Provide oversight of the quality of professional physician consultants;

4. Direct primary participation in specified reviews;

5. Consult with HCA staff, HCA Medical Director, and/or HCA Contract Manager, as appropriate;

6. Consult with the Medical Directors of other State agencies involved in Medicaid services and program management; and

7. Participate in fair hearings when directed by HCA.

D. The Contractor shall employ and/or contract with physician consultants. A physician consultant is defined as a person with the same or equivalent professional

degree as the professional provider who provided the justification for the medical necessity and/or the appropriateness of the setting, care, diagnosis, and coding. When the peer provider is a physician, the physician consultant may be the Contractor's Medical Director or any physician consultant, specialist, or generalist, designated by the Contractor's Medical Director.

1. For Behavioral Health UR determinations, the reviewing physician must be a board-eligible or certified psychiatrist **in New Mexico** with five years of experience and the clinical expertise to understand the treatments. The psychiatrist shall assist the Medical Director with the development of behavioral health criteria and utilization management (UM) functions as applicable.

E. The Contractor must employ a qualified individual to serve as the TPA/FFS UR Contract Manager for New Mexico operations. The TPA/FFS UR Contract Manager must be dedicated to overseeing this Agreement, work in partnership with the HCA Contract Manager, and be authorized and empowered to represent the Contractor on all matters pertaining to the Contractor's program and specifically this Agreement. The TPA/FFS UR Contract Manager must act as a liaison with the State and other state agencies, and has responsibilities that include but are not limited to the following:

1. Ensuring the Contractor's compliance with the terms of this Agreement, including securing and coordinating resources necessary for such compliance;

2. Overseeing all activities by the Contractor and all subcontractors;

3. Receiving and responding to all inquiries and requests by the State in time frames and formats reasonably acceptable by the State;

4. Meeting with the HCA Contract Manager, representatives of HCA/MAD, and other State Agencies on a periodic or as-needed basis and resolving issues that arise;

5. Making best efforts to promptly resolve any issues related to this Agreement identified by the State, or the Contractor; and,

6. Working cooperatively with other State of New Mexico contracting partners, including but not limited to the Fiscal Management Agent, Conduent; Turquoise Care Managed Care Organizations; and other contractors as, from time to time, identified by the State.

F. The Contractor shall inform HCA of any changes in the Contractor's key personnel prior to an employment offer. The term Key Personnel as used herein refers to the Contractor's TPA/FFS UR Contract Manager, and managers. Replacement of any

Contractor key personnel shall be with personnel with comparable ability, experience, and qualifications. The resumes of any replacement shall be submitted to the HCA Contract Manager for approval.

G. HCA reserves the right to require the Contractor to make changes in key personnel assignments if the key personnel is/are not, in HCA's sole discretion, meeting the needs and expectations of HCA or the needs of the recipients in implementing and enforcing the terms of this Agreement. Specific reasons shall be detailed by the HCA Contract Manager.

H. The Contractor shall establish at least one office in either Santa Fe or Albuquerque, New Mexico to facilitate a close working relationship with HHCA and other State agencies, the Fiscal Agent, providers, and Medicaid recipients.

1. At a minimum, the TPA/FFS Director and Contract Manager, key operational supervisory staff (preferred but not required with HCA approval), a medical director, psychiatrist, and clerical personnel shall reside in New Mexico;

2. The Contractor shall perform all reviews described in this Agreement.

3. The customer service function remotely, in accordance with the company's telework policy, while ensuring that New Mexico Medicaid members and HCA stakeholders are supported with the same level of service. If on-site presence is required for specific tasks, a mutually agreed-upon process for temporary or occasional in-person service will be established.

II. General Issues

A. The Contractor shall perform utilization review (UR) and assessment functions for Medicaid services provided in the fee-for-service environment, including Medicaid Alternative Benefit Plan (ABP) services as defined in section 2.1 of this Agreement. These will consist of medical necessity reviews, Prior Authorizations (PA), medical eligibility/Level of Care (LOC) determinations, Individual Service Plan (ISP)/Service and Support Plan (SSP) and budget reviews, and ABP exemptions. The principal goals of these functions are high-quality, timely, cost-effective UR and assessment activities with emphasis on the most appropriate use of covered services and responsiveness to providers and recipients.

B. The Contractor shall perform and process reviews in the least obtrusive manner consistent with HCA's utilization management needs and the state of current technology.

C. The Contractor shall make use of available industry technologies to

increase efficiencies and reduce errors in UM processes and activities. Such technologies may include electronic and web-based submissions, auto adjudications, and other such technology to allow for easier communication with providers.

D. The Contractor shall be flexible and committed to working in partnership with HCA on the successful implementation of all components of this Agreement. HCA intends to direct a flexible and responsive UR effort by periodically adjusting the focus of reviews toward areas of greatest benefit to providers and recipients and in the best interest of HCA.

In this regard, HCA reserves the right to make certain adjustments regarding reviews including but not limited to:

1. Change services from one Category of Review to another;

2. Change the timing of reviews (i.e. from prior authorization to post-payment);

3. Establish new categories of review or modify categories of review or drop existing ones;

4. Changes or additions to the Scope of Work and/or volume of reviews that may result from Turquoise Care and other Medicaid healthcare reform initiatives including Medicaid Expansion; and

5. The Contractor will be given a mutually agreed-upon time to implement such changes.

E. The Contractor shall coordinate as necessary and/or per HCA direction with multiple divisions of HCA, other HCA contractors, and stakeholders on the delivery of services to recipients and providers.

F. The Contractor shall coordinate as necessary with the Turquoise Care Managed Care Organizations (MCOs) to ensure that recipient and provider questions regarding authorizations are appropriately directed to the HCA-contractor that is responsible for the service authorization.

G. The Contractor shall conduct UR activities that meet the highest quality standards, are efficient, timely, cost-effective, and ensure that services provided to Medicaid recipients are medically necessary and appropriate in amount, scope, and duration. The Contractor shall ensure that recipients' health care needs are not delayed due to the UR and/or assessment process.

H. Unless otherwise stated whereby the Contractor shall apply state-defined criteria and standards, the Contractor shall base its UR decisions on HCA-approved nationally recognized and accepted criteria from professional organizations that integrate individual clinical expertise with the best available peer-reviewed scientific literature,

consistent with state and federal Medicaid policy, rules and regulations, and that are applied in a fair, impartial and consistent manner to serve the best interests of Medicaid recipients, incorporating individualized risks, benefits, and preferences.

I. The Contractor shall apply UR criteria that consider the goals and values of the individual recipient insofar as practical, and on the basis of health information provided by the following persons:

1. The recipient (as appropriate to his or her age and communicative abilities);
2. The recipient's family/guardian or legal representative;
3. The recipient's primary care physician; and
4. Other providers, programs, multidisciplinary teams, educational institutions, or agencies that have evaluated the recipient.

J. The Contractor shall submit evidence that it has reviewed the quality, effectiveness, and utility of the approved criteria at contractor-specified intervals, approved by HCA, and that the criteria have been updated, as necessary.

K. The Contractor shall determine medical necessity in a manner that is no more restrictive than that used by HCA as indicated in state statutes and regulations. A covered service or item/good is medically necessary if it meets the criteria identified in the NMAC 8.302.1.7 at the following link:

https://www.HCA.state.nm.us/providers/rules-nm-administrative-code/

L. Medical necessity must be determined on an individual basis and must consider the functional capacity of the person and those capacities that are appropriate for persons of the same age or developmental level, available research findings, health care practice guidelines, and standards issued by professionally recognized organizations or government agencies. The criteria for determination of medical appropriateness shall be clearly documented.

M. Medically necessary services must be delivered in a setting (e.g., an individual's home, school, childcare center, workplace, treatment facility, inpatient setting, or community-based agency) that is appropriate to the specific health needs of the individual.

N. The Contractor shall be responsive to recipients and providers in all review activities. The Contractor must, at a minimum, do the following:

1. Maximize the use of technology and automated processing methods to receive and respond to UR and assessment requests by US mail, telephonic, fax, or other secure electronic means;

2. Apply consistent and standardized procedures across all business functions covered by the Agreement;

3. Make medical necessity criteria sets for use in review activities readily available to providers upon request;

4. Use the Request for Information (RFI) process to obtain additional or missing information needed to make a review decision from a provider or recipient, as appropriate, without adversely prolonging the recipient's receipt of medical care and/or Medicaid services. The Contractor shall clearly explain and specify what information is lacking and/or needed to complete the review request and make a valid review decision;

5. For re-certifications/re-determinations, ensure that there are no gaps in approval dates of coverage;

6. Provide clear and concise explanations of the reason(s) and regulatory citation(s) for any denial, reduction, modification and/or termination of care and fair hearing rights;

7. Proactively educate and train providers on UR processes and procedures; and

8. Track UR requests from date of receipt to date of completion, including details on pended reviews.

O. The Contractor shall perform and maintain the following Methods of Reviews and Determinations:

1. Telephonic Review: This method of review is conducted by telephone, possibly with the aid of electronic processing equipment. The provider will call the Contractor and transmit the information needed to render a review decision. At a minimum, this review involves provider identifying information, recipient identifying information, diagnosis, recipient status, and any specific information required by the criteria being used for the specific Medicaid service being reviewed. The review decision is also rendered by telephonic or electronic communication. The request must be recorded and stored.

2. Medical Record Abstract Review: This method of review is conducted by paper or electronic means and may be a prior authorization review, LOC determination, retroactive review, or other type of review. The Contractor shall review documents specific to the type of review and the Medicaid service being reviewed. The package of documents to be reviewed may include

but are not limited to the following: a specified state-approved form and specific parts or abstracts of medical records, such as a history and physical examination report, functional assessment, care plan, service plan, discharge summary, and/or additional supporting documentation. The review decision is also rendered by paper communication and/or electronic communication.

3. Medical Record Review: This method of review is the same as a Record Abstract Review except that the entire medical record or equivalent record is reviewed. This review is always retrospective and may include a prior authorization review performed retroactively, post-payment review, or other type of review.

4. Service Plan/Budget Review: This method of review is electronic. This review is required for home and community-based waiver service plans and budgets for compliance with waiver requirements and covered benefits. The review decision is also by electronic and/or paper communication.

P. The Contractor shall be able to perform at least the following Categories of Reviews described in HCA/MAD Program Policy 8.302.5 NMAC, or its successor:

1. Prior Authorization: This Category of Review is performed on cases prior to the care being rendered or services provided in order to determine medical necessity for the specific service, LOC, and service setting, if relevant to the request.

2. Retroactive Prior Authorization: This Category of Review may be approved for review if performed as part of the process of determining Medicaid eligibility for certain categories, such as institutional care Medicaid or home and community-based services waiver (HCBSW) programs or the service is furnished before the determination of Medicaid eligibility or in cases of medical emergency.

3. Concurrent: This Category of Review is performed on cases for continued stay, continued service, or LOC reviews for medical necessity, such as acute/non-acute recipients who are hospitalized, residing in a long-term care setting, or receiving home and community-based waiver services. In behavioral health cases, examples include concurrent reviews performed for individuals in out-of-home placements or receiving continued community-based services. These reviews include a determination of appropriate admissions and length of stay, annual plan/budget review, or redetermination of LOC.

4. Prepayment: This Category of Review is performed after services

have been furnished and claims for payment have been filed by providers, such as Emergency Medical Services for Non-Citizens (EMSNC). If a service is not a covered Medicaid benefit, is not deemed medically necessary, or does not meet the benefit definition, HCA will deny payment for that service.

5. Retrospective: This Category of Review is performed on assigned cases after the equipment is delivered, or care has been rendered, and/or after discharge from a healthcare setting and after the claim has been processed and payment has been made. This type of review also involves reconsideration of a denial.

   ABP Exemption: This Category of Review is performed on cases to evaluate and authorize an exemption from the ABP.

Q. The Contractor will be issued Letters of Direction (LODs) to communicate, update, and clarify information concerning types of reviews, changes of review types, services to be reviewed, guidance on reviews, and other activities and services covered in the Scope of Work (SOW). These adjustments may result in significant changes to procedures or volumes of reviews. The CONTRACTOR must be receptive to these changes and continue to meet HCA's expected performance level as set forth in this PSC.

1. The Contractor shall have a maximum time of thirty (30) business days from the date of receipt to implement an LOD from HCA, unless otherwise directed by HCA. This time frame may be decreased or extended based on mutual agreement between HCA and the Contractor.

2. Only work that is specified as separately reimbursable in an LOD will be reimbursed by HCA.

III. Administrative Functions

A. Prior to the actual date of review operations, the Contractor shall develop and submit to HCA its written detailed TPA/FFS UR Policies and Standard Operating Procedures, workflows, and checklists developed for provider use for all functions described in this Agreement, including but not limited to reviews by program or review type, fair hearings, RFI, reporting, grievances, quality assurance, reconsiderations, and fraud and abuse. The Procedures must be consistent with the policies in the HCA/MAD Program Policy Manual, or its successor, and updated annually thereafter to ensure that documents are maintained and up to date.

B. The Contractor shall have HCA-approved written policies and procedures for transitioning recipient authorizations and related medical documents, including electronically stored information, to and from the Centennial Care MCOs.

C. Due to HCA-directed policy changes and other changes in the external

environment, the Contractor should anticipate frequent changes in procedures.

D. The Contractor shall provide to HCA for review and approval, written Policies and Standard Operating Procedures, quick start guides, workflows, and checklists developed for provider use as they are created and updated.

E. The Contractor may initiate a change at any time, but changes to Procedures as outlined in this Agreement must be submitted to the HCA for review and approval prior to implementation. HCA retains the right to request copies of the Contractor's TPA/FFS UR Policies and Standard Operating Procedures to review and make unilateral changes.

F. The Contractor shall respond to HCA-requested changes by forwarding revised detailed Policies and Standard Operating Procedures for review to HCA within fifteen (15) business days from the date of the written request, or as stipulated in the HCA request.

G. The Contractor shall ensure:

1. The current version of the policy and/or procedure in effect is followed;

2. Each procedure is assigned a number and dated with the effective date, or revision date, of the procedure;

3. Internal oversight processes to ensure policies and procedures are kept accurate and up to date and otherwise maintained; and

4. Periodic assessment of the quality, effectiveness, and utility of the HCA-approved procedures for potential modification.

H. The Contractor shall ensure all procedures for processing reviews by program or review type:

1. Specify each step in each review process including, but not limited to, exactly how the review is received, tracked, assigned, and processed; what criteria are applied; what forms and other documentation are required; how the decision is communicated to the requesting provider, HCA fiscal agent, state agency, state program, consultant, case manager, MCO, and/or other relevant entities; how the decision is communicated to the recipient; required turn-around-time; required data entry; and steps for quality assurance;

2. Are consistent with the policies in the HCA/MAD Program Rules, HCBS waivers Service Standards, and other utilization review guidance that HCA has made available to the Contractor and providers. The guidance may be in the form of a combination of

several documents and a series of meetings and/or discussions; and,

3. Ensure the detailed Policies and Standard Operating Procedures follow a standardized format across all review types.

IV. Meetings

A. The Contractor shall function as a partner with HCA. Examples of this partnership include attending, facilitating, and actively participating in meetings with HCA and DOH staff and offering input on a variety of TPA/FFS UR topics to HCA staff and stakeholders, as well as communicating with stakeholders to resolve issues. Some meetings will be regularly scheduled on a monthly, bi-monthly, or quarterly basis.

B. The Contractor shall attend regularly scheduled contract management and compliance meetings in a mutually agreed upon location. At a minimum, the Contractor's TPA/FFS UR Contract Manager will attend these meetings.

C. The Contractor shall, upon HCA request, participate in ad hoc meetings at the Contractor's location or in Santa Fe with HCA and associated state agencies, the fiscal agent, providers and MCOs, and other stakeholders involved with TPA/FFS UR activities.

D. The Contractor shall, upon HCA request, facilitate or otherwise lead work groups or meetings with HCA, associated state agencies, the fiscal agent, providers, consultants, and other stakeholders involved with TPA/FFS UR activities.

V. Hearings

A. The Contractor shall provide testimony for HCA administrative hearings and/or court proceedings concerning protests of actions taken as a result of CONTRACTOR TPA/FFS UR decisions. The Contractor shall be prepared to testify either by telephone or in person.

A. The Contractor's legal counsel shall be required to represent the Contractor at any administrative hearing only if the recipient is represented by his or her legal counsel. The Contractor's legal counsel is expected to coordinate closely with its TPA/FFS UR Contract Manager, Fair Hearing Unit, the HCA Contract Manager, and HCA Office of General Counsel, when required, regarding the case. Administrative hearings are not covered as Separately Reimbursable Services.

B. The Contractor is required to prepare documentation, including, but not limited to Summary of Evidence (SOE), SOE Addendums, and Motions to Dismiss. SOEs must be submitted to the Fair Hearing Unit fifteen (15) calendar days prior to the hearing to allow the Fair Hearing Unit to prepare the final SOE and mail the hearing documents to all interested parties. All SOEs need to clearly illustrate the review timeline and actions that lead to the denial. The document must be organized and clearly labeled.

C. It is the Contractor's responsibility to schedule and facilitate an Agency Review Conference (ARC) for all Fair Hearing requests. An ARC allows an opportunity to clarify issues, discuss the reason behind the requests and denials, and examine additional information related to the fair hearing requests. The ARC must be conducted via video conference and include all concerned parties, such as the Consultant, Community Support Coordinator, HCA and DOH Program Managers and claimants.

Within two (2) business days following the ARC, the TPA will send written notification to all concerned parties with the result of the ARC.

VI. Regulatory Standards

A. The Contractor shall conduct reviews/assessments according to federal and state regulations and HCA-approved UR criteria while following HCA-approved detailed standard operating procedures. The pertinent State Medicaid regulations are consolidated as the State of New Mexico Medical Assistance Division Program Rules, commonly referred to as the "Program Policy". Federal requirements for a statewide utilization control program for Medicaid services are found at 42 CFR, Part 456.

B. The Contractor shall be a designated QIO (Quality Improvement Organization) as described in 42 CFR Parts 475 and 476. The Contractor shall provide documentation of this designation prior to the actual date of review operations and continue to maintain this designation during the term of this PSC.

C. The Contractor shall identify to HCA the level of professionals for all review activities. The number and types of staff performing the reviews must be identified.

D. For behavioral health, reviewers shall be Masters level clinicians with a minimum of five year's experience in mental health and/or substance abuse.

E. The Contractor shall maintain oversight policies and procedures of all functions that ensure standards of performance are met and all state and federal regulations are followed.

F. The Contractor shall require a physician, or a dentist for dental services, to render the final decision for all reviews that result in a denial or reduction of services to a recipient based on medical necessity, the definition of an emergency, the appropriateness of diagnosis, or the appropriateness of procedure code.

G. The Contractor shall require physician consultants to render the final decision for validating breaches of professional quality or practice standards.

H. The Contractor shall ensure that the physician consultant documents his/her review decision, and that the Contractor can identify the physician consultant from that documentation.

I. The Contractor shall ensure the physician consultant documents the clinical rationale for all physician consultant-determined denials and for the authorization decisions made by the physician consultant in cases when one or more of the approved criteria are not met.

J. The Contractor shall protect (by first and last name initials) the anonymity of all reviewers, including the physician consultant, with certain conditions and exceptions. The identity of all reviewers must be known to the Contractor for every review and must be made known to HCA upon request.

K. The Contractor shall release, as required by HCA or a court of competent jurisdiction, the identity of the reviewer and/or physician consultant in cases of protested review decisions that proceed through due process to an administrative Fair Hearing and/or judicial proceeding. In these cases, actual testimony from the reviewer and/or physician consultant may also be required.

L. The Contractor shall operate a two or more-level review process whereby a professional who is not a peer of the requesting provider performs the initial review. In this case, the first-level nurse reviewer must have sufficient education, credentials, and experience to properly interpret the clinical review information and the criteria upon which authorization/denial is based. In this instance, the first-level reviewer can only approve the request, or if clinical information is not submitted, technically deny the request. First-level reviewers cannot clinically deny the request. All clinical denial a decisions must be made by a physician, or a dentist for dental services, who is responsible for justifying the medical necessity.

VII. Review Timelines

A. The Contractor shall make review decisions in a timely manner to accommodate the clinical urgency of the recipient's situation and minimize disruption in the provision and continuity of health care services.

B. Auto-Adjudication must be used to make a near-real-time determination to approve, deny, or pend a request for prior authorizations where possible.

C. The Contractor's turn-around-time (TAT) for a review decision is measured from the date the Contractor receives all materials necessary to conduct a review to the date the review process is completed in its entirety (e.g. MMIS entry) and notice of the review decision is available via the Contractor's provider portal. Mailed correspondence is excluded from TAT but limited to two business days after review decision.

D. For requests that are not auto adjudicated to approve or deny, the Contractor shall assign the review request to a reviewer (or assessor for the in-home) within two (2) business days from the date of receipt, or as appropriate to meet the required TAT. The number of days to assign the review is included within the TAT calculation. The Contractor shall maintain and update a tracking system so that Portal Users can track their request in the authorization process.

E. HCA shall allow TAT exceptions for events that are beyond the Contractor's control. These exceptions may include but are not limited to state-directed initiatives requiring mass revisions to authorizations; reviews pended due to a Request for Information (RFI); facility closures with associated mass transfers; the State's information system(s) is/are down; and HCA-approved special projects.

The Contractor shall consider the TAT as a maximum time limit and therefore strive to complete reviews in a shorter timeframe, if possible, while maintaining the integrity of the review outcome. The Contractor shall complete reviews within the following maximum timeframes (business days):

Type of Review	**TAT**
Prior approval requests allowed by HCA to be submitted via telephone request	2 business days
Prior approval requests submitted in writing	7 business days – Routine 1 business day - Expedited
ISP/budget and SSP/budget requests	10 business days – Routine 1 business day - Expedited
EMNC requests submitted in writing	7 business days – Routine 1 business day - Expedited
Reconsideration of TPA/FFS UR Decision	7 business days
LOC Without in-home assessment	10 business days - Routine 1 business day – Expedited
LOC With in-home assessment In-home assessment	10 business days – Routine 1 business day – Expedited 30 days (including IHA and review determination)
Acute General Hospital Inpatient Retrospective Post-Payment review	45 business days of receipt of review request from HCA

Behavioral Health **Inpatient/Acute Reviews**

Review Type	TAT from Receipt of Request to Decision	TAT from Decision to Notification	Notification Method	Who Must Be Notified?
Initial	72 hours	Within the same 72 hours that decision was made	Verbal, electronic or written	Facility
Concurrent	1 business day	1 business day	Verbal, electronic or written	Facility

Behavioral Health Residential Treatment Centers/Treatment Foster Care/Group Home/Substance Use Disorders				
Review Type	**TAT from Receipt of Request to Decision**	**TAT from Decision to Notification**	**Notification Method**	**Who Must Be Notified?**
Initial	5 business days	1 business day	Verbal, electronic or written	Facility
Concurrent	5 business days	1 business day	Verbal, electronic or written	Facility

Note on Children, Youth, and Families Department Juvenile Justice System recipients in detention: For recipients in detention, and for whom an RTC authorization request has been submitted, determination TAT is one (1) business day. In some cases, additional information may be requested or a peer review to the requesting provider conducted.

"Expedited" is applied to those services, supplies, and/or equipment of that would reasonably be expected to result in a deterioration of the recipient's health or a delay in appropriate transition to alternative placement (including discharge to home or community setting).

F. The Contractor shall issue an RFI to notify the provider when a review request is incomplete or lacks the necessary documentation that is needed to complete the review and render an appropriate review decision. The Contractor shall begin the RFI process by notifying the provider (and/or recipient as applicable to the review type) within two (2) days of assignment to a reviewer. The provider shall be notified at least three (3) times to

request the additional information. The Contractor shall send a written RFI to the provider (and/or recipient) instructing the provider/recipient to respond to the RFI with all necessary documentation within 7 calendar days of issuance of the written RFIs. The RFI shall also inform the provider/recipient that failure to return the RFI with all necessary documentation within 21 calendar days may result in a technical denial of the review request.

G. The Contractor shall determine, track, and report the timeliness of every review and assessment, including incomplete reviews and RFIs, and implement the infrastructure, systems, and procedural measures necessary to ensure the integrity of this tracking system to the satisfaction of HCA.

VIII. Recipient and Provider Notices

A. The Contractor shall use HCA-approved letter templates to notify recipients, providers, state program managers, case managers, consultants, or community support coordinators, as applicable to the program type, within two (2) business days of the review decision.

B. The Contractor shall have a process to track all letter templates and revisions. This includes receiving, storing, and maintaining letter templates that can be produced and provided to the HCA upon request.

C. In addition to the recipient letter, the Contractor shall notify the provider of the review decision by returning a completed copy of the HCA-approved review request form initially submitted by the provider. For example, review request forms include, but are not limited to (as applicable to the review and/or program type): New Mexico Uniform Prior Authorization Form, MAD 378, MAD 379, DOH 378; MAD 046, DDW budget worksheet for Individual Service Plans; and MAD 331 for inpatient rehabilitation. Detailed forms and information shall be provided by HCA.

D. For the Home and Community-Based Services (HCBS) waivers, the Contractor shall provide notification to the eligible recipient, consultant, case manager, or community support coordinator, as applicable to the waiver program, of the annual LOC at least 90 days before the LOC expires. If there is no response from the eligible recipient, the Contractor shall also send a final reminder notice to the eligible recipient 45 calendar days before the LOC expires.

IX. Performance Tracking - Reports

A. The Contractor shall comply with all reporting requirements established by HCA.

B. The Contractor shall adhere to HCA-defined standards and templates for all reports and reporting requirements. HCA shall provide the Contractor with all appropriate reporting templates, formats, instructions, submission timetables, and technical assistance as required. HCA may, at its discretion, change the content, format, or frequency of reports.

C. The Contractor shall submit reports timely and in proper format. The submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report.

D. Unless otherwise defined by HCA, each report must include an analysis and attestation, which shall include at a minimum: certification, as to the accuracy, completeness, and truthfulness of the data in the report; identification of any changes compared to previous reporting periods as well as trending over time; an explanation of said changes; an action plan or performance improvement activities addressing any negative changes; and any other additional information pertinent to the reporting period.

E. The Contractor shall review, as part of its continuous improvement activities, timeliness and accuracy of reports submitted to HCA to identify instances and patterns of non-compliance. The Contractor shall perform an analysis identifying any patterns or issues of non-compliance and shall implement quality improvement activities to improve overall performance and compliance.

F. HCA may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

G. The Contractor shall submit all reports to HCA, unless indicated otherwise in this PSC, according to the schedule below.

DELIVERABLE	DUE DATE
Weekly Report	Tuesday of the following week
Monthly Report	15th Calendar Day of the following month
Quarterly Report	30th Calendar Day of the following month
Semi-Annual Report	January 31 and July 31 of the Calendar year
Annual Report	90 Calendar Days after the end of the Calendar year
Ad-Hoc Report	Within 10 business days from the date of the request unless otherwise specified by HCA

H. If a report due date falls on a weekend or a State of New Mexico holiday, receipt of the report the next business day is acceptable.

I. The Contractor shall submit all reports electronically to HCA's FTP site unless directed otherwise by HCA. The email generated by the FTP upload will be used as the time stamp for the submission of the report(s).

J. The Contractor shall submit the list of reports indicated in Exhibit C.

K. HCA shall notify the Contractor in the event that a report is no longer required.

L. HCA's requirements regarding reports, report content, and frequency of submission are subject to change at any time during the term of this Agreement. The Contractor shall comply with all changes specified in writing by HCA, after HCA has discussed such changes with the Contractor. HCA shall notify the Contractor, in writing, of new reports and changes to existing required report content, format or schedule. Contractor shall implement changes to existing reports within thirty (30) days of receipt of a complete set of HCA-approved requirements or specifications, and within sixty (60) days of HCA-approved requirements or specifications for new reports. In the event a request for a report changes or new report requires the development of new system functionality to collect newly defined data elements, Contractor shall notify HCA in writing, the time required to complete the request with a comprehensive workplan within fourteen (14) calendar days of receipt of report requirements.

X. Transition Management

A. The Contractor shall enter into a Transition Management Agreement with the prospective contractor, no later than 180 days prior to the last date of this Agreement to outline the requirements for the transition of information and services to the Contractor. The Contractor shall work with the prospective contractor to transition data and client/provider documents, standard operating procedures, reporting requirements, interface specifications, state-approved letter templates, and other pertinent documents identified by the Contractor or HCA to ensure a smooth transition of the services set forth in the scope of work.

B. The Contractor shall enter into a Transition Management Agreement with HCA 180 days prior to the end of this agreement to outline requirements for the transition of information and services to the prospective contractor.

C. The Contractor shall enter into a Business Associates Agreement with the prospective contractor for the exchange of data to include at a minimum, IT security protections for protected health information.

D. The Contractor shall attend meetings with HCA and the prospective contractor to ensure a smooth and non-disruptive transition of services.

E. The Contractor must have system capacity and interface capability in addition to the capability to upload Level of Care (LOC) daily to the Automated System Program and Eligibility Network (ASPEN) system.

1.2 SERVICES

I. Customer Service

A. The Contractor shall have customer services staff to receive, respond to, or refer requests from providers and recipients for information concerning the TPA utilization review policy, status of particular reviews, complaints, appeals, and due process, and other customer-related inquiries. These activities and any others will be performed in a friendly, courteous, and timely manner.

B. The Contractor shall have the customer service function to accommodate both telephonic and electronic inquiries and responses. The amount of demand for this service and the service issues may vary greatly from time to time due to changes in the review criteria, policy, and/or procedures and other Medicaid program changes. The Contractor shall anticipate and meet customer service demands to the satisfaction of HCA.

C. The Contractor shall establish a TPA/FFS UR website, approved by HCA, for information needed by providers and/or recipients that explains the scope of contracted services and review types, and provides contact information, provider forms, required TPA/FFS UR documents, provider trainings, and other information relevant to the scope of work. The Contractor shall monitor the website and update information as needed or determined by HCA. Website modifications requested by HCA shall be completed within 48 hours of the request.

E. The Contractor shall maintain a sufficient number of dedicated toll-free telephonic and fax lines for the use of providers and other callers during normal business hours. If the number of telephonic lines becomes insufficient to provide effective telephonic review access and customer service, the Contractor will install and maintain additional lines as needed or as directed by HCA. Telephonic response time standards shall be proposed by the Contractor.

F. The Contractor shall implement a call monitoring system to support quality assurance monitoring and training. The system shall also support a hundred percent (100%) call recording. The Contractor shall provide HCA with full access to call recordings for review of escalated calls.

G. The Contractor shall provide certain TPA/FFS UR forms related to utilization review either electronically or in hard copy upon request. HCA will send the Contractor all required forms related to this PSC. The required forms shall also be accessible on the Contractor's TPA/FFS UR website.

H. The Contractor shall implement and submit to HCA the step-by-step customer service process and procedures. The Contractor shall monitor the process and quality of service, and report (M12 New Mexico Phone Reports) to HCA on a monthly basis, the total number of calls received, the average speeds of calls answered, and abandonment rates.

I. The Contractor shall maintain an average speed of answer of 30 seconds or less for telephone inquiries.

J. The Contractor shall provide guidance to providers to assist in the submission of complete review packets, minimizing disruption to the review process.

K. The Contractor shall have the ability to trace and report the status of submitted review requests from receipt date and review from start to finish. The Contractor shall provide the status of any review that has been date stamped "received" to a valid requester within one (1) business day. The Contractor shall ensure that the TPA/FFS UR review database is completely supported and consistent with the review documentation required.

L. The Contractor shall work proactively with providers, appropriate state agency staff, MCOs, case managers, consultants, community support coordinators, and other stakeholders.

M. The Contractor shall ensure a sufficient number of trained TPA/FFS UR staff in order to maintain the proposed standard response time in the event of a sudden increase in customer service requests.

N. The Contractor shall be equipped to handle calls and provide translation services for callers with Limited English Proficiency as well as calls from recipients who are Hearing Impaired.

O. The Contractor shall have access to bilingual staff based on the threshold of a prevalent non-English language. The prevalent language includes all languages spoken by approximately five percent (5%) or more of the population.

P. The Contractor shall have a method in place by which providers or recipients can deliver paper review packets directly to the New Mexico location.

II. Provider Relations, Education, and Training

A. The Contractor shall work proactively with providers and stakeholders to ensure a clear understanding of the UR, LOC, and assessment process. The Contractor shall be available to interact with HCA staff, providers, and stakeholders as necessary for presentations and trainings.

B. The Contractor shall, upon request, mail/fax/email to providers all pertinent forms. The cost of this service will be borne by the Contractor.

C. The Contractor shall arrange and bear the cost of the shipping, transporting, or transmitting of any materials required unless otherwise specified by this Agreement.

D. The Contractor shall train providers regarding TPA/FFS UR, LOC, and assessment policy, procedures, and criteria as needed. The need for such training will be determined by the Contractor's experience working with providers, upon the request of a provider or provider group or association, or as determined by HCA.

E. The trainings may be delivered through electronic means, using Internet technology or other alternatives as agreed upon by HCA and the Contractor. HCA and the Contractor will work in conjunction to identify the need for training sessions and schedules.

F. The Contractor shall provide HCA copies of all training and other material prior to dissemination to providers for HCA approval.

G. The Contractor shall identify providers who routinely have reviews returned and proactively initiate direct provider contact, training, and education to help in reducing

problematic review packets.

III. Criteria Development, Revision, and Use

A. Unless otherwise directed by HCA, the Contractor shall apply criteria approved by HCA to all reviews based on medical necessity. Request for any service that does not have established criteria will be reviewed by a physician/dental consultant of the same or similar credentialing/specialty to treat the condition in question. The physician/dental consultant may approve or deny it as "not a medically necessary service."

B. The Contractor shall share non-proprietary medical necessity criteria with the providers. The criteria set must be academically defensible; based on national standards of practice when such are available; acceptable to the Contractor's medical director, physician/dental consultants, and relevant local providers; and must meet utilization needs as determined by HCA.

C. Unless the documentation clearly indicates that denial is an appropriate review decision, the Contractor will defer authorization/denial action until the appropriate information is received.

D. The Contractor shall, whenever possible, establish criteria for the Medicaid definition of "medically necessary services" that is evidence-based and consistent with existing criteria sets under the Centennial Care.

E. The Contractor shall ensure that each page of the written criteria is dated with the effective date of HCA authorization.

F. The Contractor shall offer consultation and advice to HCA on initiatives outside of the scope of work presented in this Agreement, the cost of which will be negotiated between the parties.

G. The Contractor shall utilize quality criteria that are medically defensible when challenged by medical professionals in a court of law.

H. The Contractor shall be proactive in making recommendations to HCA regarding outdated criteria or cost savings approaches to better utilize contract funds, including, but not limited to, reducing procedure/treatment modalities requiring prior authorization if cost-effective.

IV. Special Access and Research

A. The Contractor shall allow special access to recipient records by recipients themselves, providers, advocates, legal counsel, HCA, DOH, and/or the Attorney General's office. Only relevant HCA employees, the Attorney General's office, and recipients themselves are allowed to access information without an explicit release of information form, signed by the recipient or legal guardian. Anyone presenting an authorized release of information form to the

Contractor must have a picture identification verifying their identity and, if applicable, documentation verifying they are with the organization identified on the release form.

B. The Contractor shall be expected to provide authorized requestors with access to the requested forms or files at a private location on site for the form/file review within five (5) business days of receipt of the request.

C. The Contractor shall be prepared to make one copy of the file or requested documents upon request. The Contractor is encouraged to provide the copies at the time of the visit, but if circumstances (such as the volume of the paper in the file) make this impossible, the copies must be made available to the requestor within three (3) business days from the day of the request.

D. The Contractor shall be expected to comply with requests made by HCA or the Attorney General's office for reports or specific information on recipients for research on suspected fraud cases. The request for these services will be routed through the HCA TPA/FFS UR Contract Manager, who will forward the request to the Contractor. The Contractor will propose a timeframe for project completion and provide the requestor with the necessary information within that timeframe.

V. Future Services at a Negotiated Rate

A. The Contractor shall negotiate with HCA for the specific work requirements and the reimbursement for future services not specified in this PSC. These requested services may be in response to Congressional, Legislative, or HCA actions.

B. The Contractor shall perform services as necessary not otherwise specified in this Agreement, including special projects, as directed by specific Letters of Direction from HCA which may include negotiated reimbursement to the Contractor where applicable.

1.3 PROVIDER AND RECIPIENT RIGHTS AND PROTECTIONS

The Contractor shall be responsible for carrying out activities related to due process and administrative hearings. This includes preparing and sending notice of adverse action decisions and due process rights, including continuation of benefits, to recipients, processing provider reconsideration reviews; collaborating with HCA and/or DOH on agency conferences, preparing and submitting complete summaries of evidence; processing continuation of benefits requests; and designating staff to participate in fair hearing proceedings.

I. Due Process – Denials and Reconsiderations

A. Clinical Denial: A clinical denial occurs when the TPA/FFS UR request does not meet evidence-based principles for medical necessity criteria, LOC criteria, and/or Medicaid Program policy.

B. Technical Denial: A technical/administrative denial is defined as a TPA/FFS UR request that is denied for non-clinical reasons. Technical/Administrative

denials may result, but are not limited to, when the provider or recipient fails to respond to a Contractor-initiated RFI or RFA with the appropriate information in a timely manner, with the exception of 1915c waiver recipient's annual LOC, or is non-compliant with an in-home assessment. Reviews lacking clinical documentation can be technically/administratively denied by non-medical affairs staff.

1. If the information needed to complete the RFI is not provided to the Contractor within 21 calendar days of issuance of the request, the Contractor may notify the provider or recipient of a technical/administrative denial (8.350.2 NMAC, Reconsideration of Utilization Review Decisions).

2. 1915c waiver LOCs may be invoiced after TPA has completed three (3) RFIs and information is not received within 21 calendar days of request date while the review(s) remains pending due to lack of information.

C. Reconsideration: A provider or recipient, as applicable to the program type, who is dissatisfied with a medical necessity or LOC decision made by the Contractor may request reconsideration. The Contractor shall perform a reconsideration review in accordance with 8.350.2 NMAC, Reconsideration of Utilization Review Decisions, including performing and furnishing the reconsideration decision within 7 business days.

II. Due Process – Required Notification

A. The Contractor shall prepare and send communication of review decisions that include a denial (includes both clinical and technical/administrative denials), termination, suspension, modification or reduction of services (includes initial and reconsideration decisions) to both the provider and recipient in accordance with requirements in 42 CFR 431.210, Fair Hearings for Applicants and Recipients and NMAC 8.352.2 Administrative Hearings, Claimant Hearings, unless otherwise directed by HCA.

1. For Level of Care reviews that result in a denial, the Contractor must ensure a successful interface with the ASPEN system to inform the Income Support Division (ISD) of the denial.

B. The Contractor shall use HCA-approved letter templates. The notification must include specific policy references directly related to the decision, reason(s) for the denial specific to the individual recipient's case, and specific reference to the recipient due process rights.

1. In cases of service categories such as but not limited to: Durable Medical Equipment (DME) and Service and Support Plan (SSP)/budget, the specific item or service for which the denial has taken place must be mentioned in the body of the letter. For example, in DME, "diapers", "nutritional supplements" or "hearing aids" must be

specified. Simply citing a denial for "Durable Medical Equipment" in the letter is not sufficient. For example, Living Supports for Mi Via must specify "Homemaker", "Home Health Aide Services", "Assisted Living", etc.

C. The Contractor shall have a quality assurance system in place to ensure the accuracy, quality and consistency of recipient and provider letters. Letters should be formatted appropriately, and margins should be set so that language does not interrupt with current business and/or program logos.

III. Due Process – Fair Hearings

A. The Contractor will receive an "Acknowledgement of Hearing Request" from the Fair Hearings Bureau or the MAD Fair Hearing Unit (FHU). The Contractor shall initiate an Agency Review Conference (ARC) with the claimant and appropriate staff, which may include but is not limited to, MAD program managers and Department of Health (DOH) program staff. The Contractor shall also process a Continuation of Benefits (COB) if an individual requests that the benefit that is the subject of an adverse action continue while his or her HCA administrative hearing proceeds. The continuation of a benefit is only available to an individual who is currently receiving the appealed benefit and will be the same as the individual's current allocation, budget, or LOC. The Contractor must provide information in its notice of action of an individual's rights and limitations to continue a benefit during his or her HCA administrative hearing process and of the responsibility to repay MAD for the continued benefit if the HCA administrative hearing final decision is against the individual, as cited in NMAC 8.352.2.12

B. COB notification timelines are defined and determined by Specific waiver/program/service regulations.

C. Within two (2) business days following the ARC, the Contractor shall send written notification to HCA of its decision or recommendation via secure email. HCA will reply with the approval or denial of the Contractor's decision or recommendation. Once HCA's provides a response, the Contractor shall issue written notification to the claimant with the final outcome of the ARC.

D. In instances where a denial is overturned after an ARC is conducted, the Contractor is responsible for submitting a Motion to Dismiss to the Fair Hearings Bureau within two (2) business days after the overturned decision.

E. If the issue is not resolved after the ARC has been conducted, the Contractor shall prepare and deliver a Summary of Evidence (SOE) to the HCA or DOH, as determined by the program that is the subject of the hearing, at least fifteen (15) business days, when possible, prior to the fair hearing in order to comply with and adhere to NMAC 8.352.2.14. The SOE shall give detailed, clinically or technically defensible reasons for the action taken based on the documentation provided for the review. All documentation used in making the review decision must be submitted as part of the SOE, and shall, at a minimum as cited in NMAC 8.352.2.14, contain:

1. the claimant's name, and as applicable, his or her authorized representative's or legal counsel's telephone number and address, and the status of any previous or concurrent appeal through the Contractor;

2. the adverse action against the claimant;
3. the documentation supporting the Contractor basis for the intended or taken adverse action; and

4. any applicable federal or state statutes, regulations, rules, or any combination of these; however, a failure by the Contractor to submit an applicable statute, regulation, or rule shall not constitute per se grounds for the Administrative Law Judge to find that MAD or the Contractor failed to meet its burden of proof.

F. The Contractor shall:

1. provide upon request to the claimant or his or her authorized representative, any document in its possession concerning its adverse action against the claimant that is not already in its SOE; and

2. provide the claimant or the claimant's authorized representative the requested documents; such documents will be provided by MAD, or Contractor to the claimant or the claimant's authorized representative in a timely manner and without charge.

G. The Contractor shall be represented by a qualified physician, nurse reviewer, dental consultant, or behavioral health clinician who has detailed knowledge of the case to offer testimony at the fair hearing via telephone; in rare circumstances, the individual may be required to provide the testimony in person. The individual must be qualified and disposed to give both prepared and spontaneous statements and answer questions related to the medical and policy justification for medical necessity determinations made by the Contractor. HCA permits physician/dental consultant anonymity at administrative and judicial hearings to the extent permissible by law. Although not all requests for fair hearings require a formal hearing, the majority do.

H. The Contractor must provide legal counsel for cases in which the recipient has legal counsel.

I. The Contractor shall have the following information available for persons authorized by HCA to have access: Date that Contractor received the SOE request form, the name and qualifications of the Contractor's representative scheduled to attend the hearing, and notice of the date that the SOE was mailed.

1.4 DATA SUPPORT SYSTEMS AND MANAGEMENT

I. General Information

The Contractor shall implement and maintain their web-based care management system for this Agreement. This Management Information System (MIS) must be sufficient to meet system requirements and allow for future configurations, additions, and/or modifications that may be required for the State of NM Medicaid program. The system must also be configured to use New Mexico program terminology and abbreviations.

A. The Contractor must have effective operational interfaces for the transmission or exchange of HCA-defined TPA/FFS UR data to HCA, or its designee. The Contractor shall have the capacity to interface with the HCA Medicaid Management Information System (MMIS), the Automated System Program and Eligibility Network (ASPEN) system, and their successors. The Medicaid Fiscal Agent maintains the MMIS/Omnicaid and FMA online systems. The ASPEN system is maintained by HCA.

1. The Contractor shall use the 114 ASPEN error report to ensure the electronic exchange is operational and shall correct any errors that occur during the exchange timely.

B. HCA-defined TPA/FFS UR data includes but is not limited to, at a minimum and according to review and file type: the recipient's name; recipient Medicaid number (in some cases two numbers); ASPEN MCI (Master Client Index); date of birth; Medicaid provider number; service type and dates of services; procedure codes and/or descriptor, if applicable; units of service; unique authorization or authorization control number; level of care, if applicable; and, service plan and budgets, if applicable. The exact data requirements vary with the specific service and review type.

C. The Contractor shall transmit to HCA the following TPA/FFS UR data by method of transmission on a daily basis:

Transmission Method	Review/Program Type
Submit Electronic File(s) to HCA MMIS	FFS prior authorizations, LTC Spans for ICF-IID, Nursing Facilities, and some BH LTC spans
Exchange Electronic Interface File to HCA/ASPEN	Waiver LOC, PACE LOC, ICF-IID, Nursing Facilities
Direct data entry into MMIS system, FMA online system	Support Waiver Agency Based budgets, Developmental Disabilities Waiver budgets, ABA, EMSNC, some BH reviews. Mi Via, MVMF and SW PD

1. The Contractor shall submit to HCA electronic interface files containing prior authorization data.

2. HCA shall provide VDI tokens to the Contractor to access the web-based

VDI server and user IDs and passwords for designated Contractor staff involved in the daily direct entry of prior authorization data into the MMIS system for all required reviews.

3. The Contractor shall access the FMA online system for daily direct entry of Mi Via and Supports Waiver (Participant-Directed) plans and budget authorizations.

D. Accessing the VDI server requires that the Contractor use personal computers that meet the following minimum specifications: a modern dual-core processor (e.g., Intel i3 or higher), 4GB of RAM, and 10GB of available disk space. Additionally, the computer must be connected to the internet via a reliable connection, such as DSL, T1, cable, fiber, or broadband, providing a minimum of 5 Mbps download and upload speeds. Dial-up modem connections are not sufficient to provide acceptable access to the VDI.

E. The Contractor shall assign specific TPA/FFS UR staff to have access to the MMIS system via a VDI token for direct data entry. The Contractor shall ensure that the MMIS system is only accessed and used for TPA/FFS UR business operations.

F. The Contractor shall ensure that TPA/FFS UR staff who have access to the MMIS and FMA online systems have received training on the MMIS/and FMA online.

G. systems and the prior authorization system inquiry and update capabilities and LOC prior to performing data entry procedures. HCA, or its designee, may provide periodic training but is not responsible for training new staff as they are hired. The Contractor shall have an MMIS/ and FMA online system training plan for new and current staff.

H. The Contractor shall be able to receive, store, and use a daily MMIS/ system file from HCA containing recipient demographic and eligibility data. The Contractor shall be able to set daily reminders to trigger when eligibility has been updated for a recipient in the Contractor's system after processing the daily MMIS system file from HCA.

I. The Contractor shall be able to receive, store, and use a daily MMIS system file from HCA containing provider demographic and enrollment data.

J. The Contractor shall collect, maintain, and store or access review documentation for a total of ten (10) years unless the transfer is specifically directed by HCA or by the terms of the Contract. The documentation maintained must be sufficient to allow an uninvolved reader to be able to understand and reconstruct all aspects of any review.

K. The Contractor shall be capable of producing, within one (1) business day of the request, all documentation for any specific review conducted by the Contractor.

L. The Contractor shall be capable of producing and reading electronic files from HCA's personal computer (PC) application software for word processing, electronic spreadsheet, and database management.

M. The Contractor shall cooperate with HCA, providers, and the Medicaid Fiscal Agent in performing reconciliations of changes in Medicaid Provider numbers, sometimes requiring batch and individual changes in the prior authorization historical databases of both the Contractor and MMIS system.

N. The Contractor shall have a one hundred percent (100%) dedicated IT and technical support team available to assist with major system malfunctions and HCA system requests.

O. The Contractor shall allow HCA read-only access to the Contractor's utilization review system for the ability to view recipient and provider records, documentation, and activity or status of a review, and shall allow DOH read-only access to the Contractor's utilization review system for the ability to view recipient and provider records, documentation and activity or status of a review for Medicaid programs.

P. The Contractor must accept and store, as specified by HCA, for reference the historical databases from the current TPA/UR contractor.

Q. The Contractor must upload all relevant MAD forms and letters into their system. The Contractor should allow Providers to electronically complete MAD forms. Once the form is completed, the Contractor's system must populate the Providers' responses onto the MAD form and store the submission in the Contractor's system for potential audits.

R. The Contractor's system must immediately notify Providers if authorization is not required.

II. Contractor's Responsibility for Compliance with Laws and Regulations Relating to Information Security

A. The Contractor, and all its subcontractors, consultants, or agents performing the Services under this Agreement must comply with the following:

1. The Federal Information Security Management Act of 2002 (FISMA);

2. The Health Insurance Portability and Accountability Act of 1996 (HIPAA);

3. The Health Information Technology for Technology for Economic and Clinical Health Act (HITECH Act);

4. Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;

5. Social Security Administration (SSA) Office of Systems Security Operations Management Guidelines;

6. Affordable Care Act of 2013

7. NMAC 1.12.20, et seq.

B. The Contractor (including subcontractors) shall be HIPAA compliant in transmissions and coding procedures.

C. The Contractor (including subcontractors) shall utilize only HIPAA-compliant data systems and comply with all aspects of HIPAA security, confidentiality, and transaction requirements.

III. Business Continuity and Disaster Recovery (BC-DR) Plan

A. Regardless of the architecture of its systems, the Contractor shall develop and be continually ready to invoke a BC-DR plan that has been reviewed and approved in writing by HCA by July 1, 2023.

B. At a minimum the Contractor's BC-DR plan shall address the following scenarios:

1. The central computer installation and resident software are destroyed or damaged;

2. System interruption or failure resulting from the network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage;

3. System interruption or failure resulting from the network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system; and

4. System interruption or failure resulting from network, operating hardware, software, or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the system, i.e., causes unscheduled system unavailability.

C. The Contractor's BC-DR plan shall specify projected recovery times and data loss for mission-critical systems in the event of a declared disaster.

D. The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower-level failures and provide the results of this testing to HCA.

1.5 QUALITY STANDARDS AND MANAGEMENT

A. The Contractor shall demonstrate its ability to meet HCA's quality standards in areas of staffing, procedures, criteria, regulatory standards, review management, and internal quality management of fraud, abuse prevention and detection.

B. The Contractor shall ensure its TPA/FFS UR staff possesses sufficient and relevant current knowledge of the requirements of this Scope of Work; the Medical Assistance Division Program Rules and the applicable Federal regulations; HCA-approved review criteria; and HCA-approved detailed review procedures.

C. The Contractor shall maintain a level of work performance consistent with high professional standards in the industry. All employees assigned to perform work relating to this PSC will be capable, efficient, and no less qualified than other employees of the Contractor performing the same or similar work.

D. The Contractor shall cooperate with HCA when a decision is made to audit the Contractor's work and performance or is otherwise required for the purpose of assessing program performance measures and reporting assurances to the federal Centers for Medicare and Medicaid Services (CMS). The Contractor shall cooperate fully with HCA to prepare complete documentation, participate in audits, provide a workspace and workstation for use by the HCA auditor, and otherwise allow HCA to access its utilization management system to view recipient and provider records and documentation.

At a minimum, the Contractor's compliance will be evaluated in the following areas:

1. The New Mexico Medical Assistance Division Program Rule was followed for each review;

2. HCA-approved review criteria and tools were properly applied to each review;

3. HCA-approved Standard Operating Procedures were followed; and

4. HCA-approved Turn-Around-Times were followed.

HCA will inform the Contractor in the event that additional performance measures are required.

I. Corrective Action Plans

A. If HCA determines that the Contractor is not in compliance with one or more requirements in this Agreement, HCA may issue a notice of deficiency, identifying the deficiency or deficiencies and follow-up recommendations and/or requirements (either in the form of a Corrective Action Plan (CAP) or an HCA Directed Corrective Action Plan (DCAP). A notice from HCA of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HCA determines that monetary sanctions are also necessary.

B. The Contractor shall be required to provide CAP(s) to HCA within fourteen (14) Calendar Days of receipt of a noncompliance notice from HCA. CAP(s) are subject to review and approval by HCA.

C. If HCA imposes a DCAP on the Contractor, the Contractor will have fourteen (14) Calendar Days to respond to HCA.

D. If the Contractor does not effectively implement the CAP or DCAP within the timeframe specified in the CAP or DCAP, HCA may impose additional remedies or sanctions.

E. If HCA staff is required to spend more than 10 hours or more per week monitoring a CAP(s) or DCAP(s), HCA will provide notice to the Contractor that the Contractor must contract with a third party either designated by HCA or approved by HCA to oversee the Contractor's compliance with the CAP(s) or DCAP(s).

II. Intermediate Sanctions

A. Monetary penalties of up to five percent (5%) of the Contractor's payment for each month in which the penalty is assessed or a recoupment of a review rate(s), depending on the severity of the infraction.

B. The DEPARTMENT, in its sole discretion may reallocate monies withheld as a sanction. The Contractor shall have neither claim upon nor opportunity to recoup monies withheld as a sanction per this section.

C. The DEPARTMENT will remove its sanction upon determining that the Contractor has met its performance obligations during a subsequent month. The payment process will then resume.

III. Internal Quality Management Program

A. The Contractor shall establish and maintain an internal quality management program following the basic principles of Total Quality Management (TQM) and Continuous Quality Improvement (CQI) that are presently used throughout most industries. This program will be applied to all aspects of the Contractor's performance under this contract. The Contractor shall share TQM and CQI results with HCA.

B. The Contractor shall have a quality improvement/quality management program description, work plan, and program evaluation that is updated each contract year and provided

to HCA for review and approval in a manner to be specified.

C. The Contractor's internal quality management program will include procedures for conducting quarterly internal audits by each HCBS waiver type on a representative random sample of level of care reviews, level of care determinations, service plans, and budgets to validate consistent and accurate application of criteria, and that utilization review functions are performed according to established timeframes. Results will be reported to HCA/MAD.

D. The Contractor shall conduct regular monitoring of inter-rater reliability of individuals performing UM activities and shall ensure that a remediation process is established and utilized for individuals not meeting at least 90 percent of agreement on sample cases.

E. The Contractor's quality management program shall include data entry accuracy.

IV. Internal Fraud and Abuse Prevention and Detection

A. The Contractor shall establish and maintain an internal fraud and abuse, prevention and detection, preliminary investigation, and reporting program.

B. The Contractor shall report any indication of suspicious activity to HCA immediately.

C. The Contractor shall promptly conduct a preliminary investigation and report the results of the investigation to HCA. A preliminary investigation entails the Contractor doing internal research to gather documentation that either substantiates or disproves the suspected activity. If, after this preliminary investigation, the activity still appears suspicious, the relevant documentation and information will be sent to HCA for a formal investigation.

D. The Contractor shall not conduct a formal investigation, but the full cooperation of the Contractor during the investigation will be required.

E. The Contractor shall fully cooperate with the New Mexico Attorney General's Office (NMAG) Medicaid Fraud and Elder Abuse Division (MFEAD) and other investigatory agencies.

F. The Contractor shall have policies and procedures to address prevention, detection, preliminary investigation, and reporting of potential and actual Medicaid fraud and abuse, including written policies for all Contractor's employees, agents, or contractors that provide services to this Agreement. Such policies and procedures still comport with the requirements of the New Mexico Medicaid False Claims Act, NMSA 1978 §§ 22-14-1 et seq. and the Federal False Claims Act, 31 U.S.C. §§ 3729 et seq.

G. The Contractor shall have a system in place to monitor service utilization for fraud and abuse. The Contractor shall not retaliate against any employee, agent or contractor who makes a good faith complaint, whether it is an internal or external complaint, about potential Medicaid fraud and abuse.

2. SEPARATELY REIMBURSABLE SERVICES

2.1 ALTERNATIVE BENEFIT PLAN

A. The Contractor shall determine a recipient's exemption from the New Mexico Medicaid Expansion Alternative Benefit Plan (ABP) based on criteria and procedures established by HCA.

B. The following individuals are exempt from mandatory participation in an ABP and may choose to receive full Medicaid State Plan benefits:

1. Individuals who qualify for medical assistance on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individuals are eligible for Supplemental Security Income benefits;
2. Individuals who are terminally ill and are receiving benefits for hospice care;
3. Individuals who are medically frail or who have special medical needs. The following individuals are considered to be medically frail:

    a) Individuals with disabling mental disorders, including adults with serious mental illness;
    b) Individuals with chronic substance use disorders;
    c) Individuals with serious and complex medical conditions;
    d) Individuals with a physical, intellectual, or developmental disability that significantly impairs their ability to perform one or more activities of daily living; and
    e) Individuals with a disability determination based on Social Security criteria.

C. The Contractor shall perform utilization reviews of HCA-specified ABP Services according to the applicable Method and Categories of Reviews currently in place for Medicaid services (see sections 1.1(2) M and 1.1(2) N of this PSC).

2.2 BEHAVIORAL HEALTH

A. The Contractor shall conduct utilization reviews by individuals who meet the MAD professional qualifications and have direct knowledge and experience in HCA-specified Behavioral Health Services. Specifically, prior authorization is required for the following Behavioral Health Services:

1. Inpatient Psychiatric Care in a Free-Standing Psychiatric Hospital or Psychiatric Units of Acute Care Hospitals

2. Accredited Residential Treatment Center (ARTC) Services

3. Non-Accredited Residential Treatment Center (RTC) Services and Group Homes

4. Treatment Foster Care (TFC)

5. Treatment Foster Care II (TFCII)

6. Applied Behavior Analysis (ABA)-Stage 3

The NMAC rules for these services are 8.311.2, Hospital Services; 8.321.2, Specialized Behavioral Health Services; or their respective successors.

a. A provider initiates a review with an HCA designated Behavioral Health prior authorization form along with required supporting documents.

b. The Contractor shall determine if a requested service meets the criteria outlined in the HCA Behavioral Health Level of Care Guidelines. The Contractor shall provide targeted technical assistance to an ABA provider to complete RFI(s) for an ABA prior authorization request.

c. The Contractor shall receive approval from HCA prior to issuing an ABA prior authorization denial.

d. For any ABA reviews that result in a Fair Hearing, the Contractor shall provide testimony for HCA administrative hearings and/or court proceedings concerning protests of actions taken as a result of CONTRACTOR ABA UR decisions. The Contractor shall be prepared to testify either by telephone or in person.

   i. The Contractor's legal counsel shall be required to represent the Contractor at any administrative hearing only if the recipient is represented by his or her legal counsel. The Contractor's legal counsel is expected to coordinate closely with its TPA UR Contract Manager and Appeals Manager and with the HCA Contract Manager, and HCA Office of General Counsel when required, regarding the case.

2.3 COMPREHENSIVE REVIEW OF PRACTICE

A. In the event that quality concerns arise with a contracted behavioral health provider's service, the Contractor may be asked to perform an audit. Each review is different, and the amount of effort and mix of professionals required (physician, nurse, clerk, etc.) may vary. Reviews may be conducted statewide. A Letter of Direction will specifically direct each

requested review. After receiving the Letter of Direction, but prior to each review, the Contractor will provide HCA with an anticipated number of hours for completing the review and the parties will negotiate reimbursement for the Contractor.

B. The Contractor shall be capable of performing extensive and intensive reviews of records of specific providers.

2.4 CONTACT LENSES

A. The Contractor shall perform prior approval reviews for requests for contact lenses by Record Abstract Review.

C. The policy for these services is in 8.310.2 NMAC, 8.324.5, or its successors. The provider initiates the review with an HCA-designated prior authorization form and other supporting documents. The focus of the review is a determination of medical necessity.

2.5 DENTAL SERVICES

A. The Contractor shall perform a utilization review of HCA specified Dental Service by Record Abstract Review. The policies for these services are in 8.310.07 NMAC, Dental Services, and 8.310.7UR, Dental Services Utilization Review Instructions. A New Mexico licensed dentist initiates the review with an ADA claim form, along with required supporting documentation and other material. Each request usually contains more than one type of service. Each request "package" constitutes a single review.

B. The dental consultant may be a general dentist for all reviews except those for orthodontics and oral maxillofacial surgery that require a specialist in those areas.

C. The focus of the review is a determination of the medical/dental necessity of the requested services and the amounts. The Contractor shall ensure that a dental consultant(s) determines if a requested service meets the criteria. Services requiring prior authorization include diagnostic, preventive, restorative, endodontic, periodontics, removable prosthodontics, maxillofacial prosthetic, oral surgery, and orthodontic services, and for all reviews requiring interpretation radiographs, diagnostic casts, diagnostic models, or study models.

2.6 DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS AND ORTHOTICS, AND NUTRITION SERVICES

A. The Contractor shall perform prior approval for requests for DME including oxygen and oxygen delivery equipment and specified nutritional supplements and supplies by Record Abstract Review.

B. The policy for these services is in 8.324.5 NMAC, Durable Medical Equipment and Supplies, 8.324.8 NMAC, Prosthetics and Orthotics, and 8.324.9, Nutrition Services. A vendor, discharge planner, case manager, or other provider initiates the review with HCA -

designated prior authorization form and other supporting documents. The health care provider acting within his/her scope of practice must order the requested services and document the medical necessity of such services. Each request "package" constitutes a single review, regardless of the number of types of services requested. The focus of the review is a determination of the medical necessity of the requested services and the amounts, and in some cases, whether purchase or rental is indicated.

C. The Contractor shall determine if a requested service meets the criteria. If it does not, that service will be denied. Since a physician or other practitioner is responsible for justifying the medical necessity, any needed clarification should be directed to the practitioner.

D. The Contractor shall reduce the amount of requested service (reduction of care) if that amount exceeds the documented needs.

E. The Contractor shall complete the New Mexico Uniform Prior Authorization Form and communicate the review decision to the requestor in accordance with policies and procedures approved by HCA.

2.7 EPSDT PERSONAL CARE SERVICES

A. The Contractor shall review all prior approval requests for all fee-for-service recipients for EPSDT Medicaid Personal Care Services. EPSDT Personal Care Services provide a range of services to eligible consumers under the age of 21 who are unable to perform some/all activities of daily living (ADLs) or independent activities of daily living (IADLs) because of disability or functional limitation(s). The policy for these services is 8.323.2, NMAC.

B. The focus for the review is a determination of the medical necessity of the requested services in accordance with the coverage criteria at 8.323.2.13, NMAC.

C. An eligible New Mexico Medicaid provider initiates the prior approval review by providing to the Contractor the documentation outlined in the MAD Program Policy Manual, Sections 8.323.2.16 and 8.323.2.18, or its successors.

2.8 EMERGENCY MEDICAL SERVICES FOR NON-CITIZENS (EMSNC)

A. The Contractor shall perform reviews for Emergency Medical Services for Non-Citizens by medical record review for services other than labor and delivery.

B. Medicaid covers strictly defined emergency services for eligible non-citizens. Eligibility is determined by ISD for each episode of illness/injury and is valid only for the specified health care services involved in that episode. The Medicaid policy for these services is covered in 8.325.10 NMAC.

The provider initiates the review by sending the Fiscal Agent the following documents:

1. HCA Notification of Authorization of Application for Emergency Services

for Non-Citizens (MAD 310 or MAD 778 Form or HCA/ISD approval notice of emergency services);

2. The provider billing form(s) (UB-04 and/or CMS-1500, or its successor);

3. Itemized expense sheet (inpatient services only); and

4. The complete emergency room or inpatient stay medical record pertinent to the service for which the provider seeks reimbursement.

   a) The Contractor shall run a report through the MMIS system on a daily basis to obtain all incoming provider and facility EMSNC review requests.

   b) The Contractor shall determine the services for which the provider or facility is seeking reimbursement were medically necessary and provided to treat only an emergency condition as defined.

   c) The Contractor shall review the submission and forward the authorization to the Fiscal Agent for payment.

   d) Any submission that does not meet these criteria will be denied.

   e) Several providers may seek reimbursement for the same episode. The review of the inpatient stay, or the outpatient stay associated with an emergency room visit is considered one review, and all other submissions associated with the inpatient stay or emergency room visit are included in that review. Documentation submitted by one provider may serve for the review of several providers involved in the same episode of illness/injury as long as it is sufficient.

   f) The Contractor shall notify the provider using the HCA-approved letter template.

2.9 GENERAL HOSPITAL INPATIENT (IN-STATE)

(1) Retrospective Pre-Payment and Post-Payment Reviews

A. As specifically directed by HCA, the Contractor shall perform retrospective pre-payment and post-payment reviews of Acute General Hospital Inpatient services by Medical Record Review. The policy for these services is in 8.311.2 NMAC, Hospital Services. These reviews are initiated by a report from HCA. The report contains the sample of acute general hospital inpatient paid hospitalizations selected using HCA-determined sampling criteria. This report contains such information as the hospital provider, recipient, and dates of services, which allows the Contractor to identify the specific recipient's medical records to be reviewed.

(2) Acute General Hospital Transfers

A. The Contractor shall perform prior authorization reviews of all transfers (discharge and admission) from one Acute General Hospital to another Acute General Hospital. These reviews will be performed by telephonic/electronic review and are initiated by the transferring facility that must justify the transfer.

B. The Contractor shall approve those transfers that are medically necessary and deny those that are not. The medical necessity criteria will be the same as those used for the Retrospective Post-Payment Reviews of Acute General Hospitals plus validation of the non-availability of necessary service(s) at the transferring facility and availability of the service (s) at the transferred facility. Transfers to a hospital with lesser capability may only be authorized in the following unique circumstances:

1. For purposes of maternal bonding when a recipient in a Level III Neonatal Unit could be managed at a lower-level unit in or near the community where the mother resides, and when this community is a considerable distance away from the Level III unit;

2. In the best interest of public health when the Level III Neonatal Units are at capacity, another bed is required, and a recipient in a Level III Neonatal Unit could be managed at a lower-level unit, in or out of the area; or

3. If an Indian Health Service (IHS) recipient at a tertiary care facility is still in need of acute inpatient care but could be managed at an IHS hospital near the home community.

C. The Contractor shall perform prior authorization reviews retroactively (after-the fact) for cases of a transfer (discharge and admission) from one Acute General Hospital to another Acute General Hospital provided the circumstances for the provider not obtaining prior authorization before-the-fact are in accordance with 8.302.5 NMAC, Prior Authorization and Utilization Review. These retroactive prior authorizations will be performed by a review of the pertinent medical record from the transferring hospital and are initiated by the transferring facility that must justify the transfer.

2.10 HEARING AID SERVICES

A. The Contractor shall perform prior authorization reviews for hearing aid dispensing, purchase, rental, and replacement and for repairs exceeding one hundred dollars ($100).

B. The policy for these services is in 8.324.6 NMAC. A vendor initiates the review with an HCA-designated prior authorization form and other supporting documents. Documentation that the attending physician ordered or prescribed the requested equipment or supply that is specifically designated as a purchase or rental and justification of the medical necessity is required. Each request usually contains more than one type of service. Each request

"package" constitutes a single review. The focus of the review is a determination of the medical necessity of the requested services and the amounts.

2.11 HOME AND COMMUNITY-BASED SERVICE WAIVERS

A. Medicaid Home and Community-Based Services (HCBS) are provided under separate 1915 (c) waivers through the federal Centers for Medicare and Medicaid Services (CMS) to allow state Medicaid agencies to cover home and community-based services for individuals that require long-term support and services in order to enable recipients to reside in the community rather than in institutions.

B. The Contractor shall work in partnership with HCA on the New Mexico HCBS waiver programs: Development Disabilities, Medically Fragile, Mi Via Self-Direction, and the Supports Waiver.

C. The waivers specify that certain medical/clinical criteria must be met. One criterion requires the recipient to meet LOC criteria for a particular healthcare facility type. The chart below shows each waiver program for which the Contractor will have responsibilities, the corresponding section of HCA Program Manual, LOC criteria that are followed, and management entities.

Home and Community-Based Service Waivers

Waiver	Program Manual Section	Level of Care	Administering Entity (Oversight by HCA)
Developmental Disabilities (DD)	8.314.5 NMAC	ICF-IID	HCA - DDSD
Medically Fragile (MF)	8.314.3 NMAC	ICF-IID	HCA - DDSD
Mi Via Waiver	8.314.6 NMAC	ICF-IID	HCA – DDSD
Supports Waiver	8.314.7 NMAC	ICF-IID	HCA – DDSD

D. The Contractor shall ensure that each LOC evaluation follows the required standard operating procedure utilizing the correct instruments and tools that are specified in the waiver.

E. In cases of LOC requests pertaining to HCBS waiver allocates whose Medicaid eligibility has not yet been decisioned by ISD, the Contractor shall determine the LOC and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is otherwise directed by HCA. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has received approval of eligibility.

F. The Contractor may need to re-evaluate the LOC more often than annually if

there is an indication that the eligible recipient's health condition or LOC has changed, however, LOC evaluations are only billed once annually per client.

G. The Contractor shall establish procedures to track and monitor new waiver allocations or waiver changes. The Department of Health (DOH) communicates waiver allocations and waiver changes via a completed Primary Freedom of Choice (PFOC) or Waiver Change Form (WCF).

H. The Contractor shall perform prior authorizations of Individual Service Plan (ISP)/Service and Support Plan (SSP) and budgets. The Contractor may need to review and authorize service plans and budgets more often than annually if there is an indication that the eligible recipient's waiver services supports and needs have changed.

I. The Contractor shall perform the following services for the Developmental Disabilities (DD) Waiver according to the DD waiver program rule NMAC 8.314.5.17, Developmental Disabilities Home and Community-Based Services Waiver:

a) <u>DD LOC Reviews – Initial and Continuing/Annual</u>

i. The DD waiver case manager will submit a completed ICF-IID and DD HCBS Long Term Care Assessment Abstract (MAD 378) and required supporting documentation to the Contractor. The LOC review is done initially to determine medical necessity, annually thereafter, and whenever an LOC change is requested. The reviewer will assess for medical necessity by comparing medical/clinical material contained in the history and physical and assessment information and other supporting documentation of the LOC criteria for the DD Waiver.

b) <u>DD ISP/Budget Reviews – Initial, Annual, Initial Residential and Revision, and Professional Services:</u>

i. A case manager initiates the ISP/budget request using the MAD 046 form or DDW budget worksheet, as applicable, and supporting documentation. The MAD 046 or budget worksheet specifies the request for services and is submitted to the Contractor.

ii. Other than annual reviews, the instances in which the case manager's ISPs need to be reviewed for medical necessity are: 1) the case manager has requested residential services for the first time or after a break in residential services or 2) there is a request for professional services. Additionally, Outlier Services must be accompanied by a DDSD RO Approval Form, and a MAD 046 or budget worksheet, with Outlier Services indicated as well as staff signature.

iii. The Contractor will conduct independent clinical reviews of individual service plans, associated budgets, and revisions to service plans.

iv. The Contractor will enter the approved services from the MAD 046 or budget worksheet into the MMIS system and assign a prior authorization number. The Contractor will document authorization, denial, pending, or modification of the request on the MAD 046 form or budget worksheet, as applicable, along with the certification period. The approved services, including any changes due to reconsiderations or revisions, are then entered into the MMIS system.

v. The Contactor will send the MMIS system-entered budgets with the prior authorization number to the case manager.

vi. The Contractor will also send the initial and annual budgets to the member. Revised budgets do not need to be mailed to the members.

J. The Contractor shall perform the following services for the Medically Fragile (MF) Waiver according to the Medically Fragile program rule, NMAC 8.314.3.16, Medically Fragile Home and Community-Based Services Waiver Services:

1. MF Waiver Level of Care (LOC) Reviews – Initial and Continuing/Annual
   a. MF waiver case manager will initiate the LOC review process by submitting a completed Medically Fragile Long-Term Care Assessment Abstract (DOH 378 or its successors) and required supporting documentation. The Contractor will review the packet to determine medical eligibility for ICF-IID and Medical Fragility LOC for individuals who are newly allocated to the waiver, and at least annually thereafter.

2. MF LOC Re-Admission Reviews
   a. The Contractor will complete LOC re-admission reviews for MF waiver recipients who have been admitted to a hospital for three or more midnights. Specific components for LOC re-admission reviews are described in the Contractor's standard operating procedures.

3. MF Waiver Individual Service Plans (ISP) and Budget Reviews – Initial and Continuing
   a. The Contractor will conduct utilization reviews of initial, annual, and revised ISPs and MAD 046s to ensure that waiver requirements are met. The Contractor will ensure the ISP budget does not exceed the capped dollar amount and only waiver services are included on the MAD 046. Specific components of the ISP and MAD 046 utilization review are described in the standard operating procedures.

   b. The approved services, including any changes due to reconsiderations or revisions, are then entered directly into the

MMIS system.

K. The Contractor shall perform the following services for the Mi Via Waiver according to the Mi Via program rule, NMAC 8.314.6, Mi Via Home and Community-Based Services Waiver:

1. The Contractor shall conduct LOC determinations, initial and continual/annual, utilizing ICF-IID LOC criteria.

2. The Mi Via participant will initiate the LOC review by submitting a completed ICF/IID and Home & Community Based Services Waiver Long Term Care Assessment Abstract form and required supporting documentation.

3. Upon receipt of the completed Abstract form, the Contractor shall conduct an in-home assessment with the Mi Via participant. The in-home assessment is conducted in the eligible recipient's home or at a location that is approved in advance by the State.

4. The Contractor shall coordinate, as indicated, with each individual Mi Via participant, his or her consultant, and the Financial Management Agency (FMA) Contractor concerning the participant's Service and Support Plan (SSP) and budget, developed by the participant with the assistance of his/her consultant. This includes communication on RFIs, reconsiderations, and Requests for Administrative Action (RFA) administered through the FMA online system.

5. The Contractor shall conduct a review of each medically eligible individual participant's SSP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's SSP authorization review criteria; and (3) Medicaid Mi Via rule, NMAC 8.314.6, Mi Via Home and Community-Based Services Waiver.

6. The Contractor shall enter the SSP and budget authorization (denied, pending, or modification) into the FMA online system.

7. The Contractor shall complete the appropriate Long-Term Care (LTC) span in the appropriate system once the determination has been made on the Mi Via budget.

L. The Contractor shall perform the following services for the Supports Waiver (SW) according to the Supports Waiver program rule 8.314.7 NMAC:

The Supports Waiver allows for the provision of services in two models: 1) agency-based service delivery model; and 2) participant-directed service delivery model. Participants have a choice of which service delivery model best supports

them in their community and aligns with their personal goals, health, and safety needs.

1. LOC Reviews – Initial and Continuing/Annual

    a. The Contractor shall conduct LOC determinations, initial and continual/annual, utilizing ICF-IID LOC criteria.

        i. For SW participants receiving services through the agency-based service delivery model, the Community Support Coordinator (CSC) will submit a completed ICF-IID Long Term Care Assessment Abstract (MAD 378) and required supporting documentation to the Contractor.

        ii. Community Support Coordinators under the participant-directed service delivery model will submit the completed MAD 378 and required supporting documentation directly to the Contractor via the Contractor's provider portal.

    b. The LOC review is done initially to determine medical necessity, annually thereafter, and whenever an LOC change is requested. The reviewer will assess for medical necessity by comparing medical/clinical material contained in the history and physical and assessment information and other supporting documentation of the LOC criteria for the Supports Waiver.

2. SW ISP/Budget Reviews – Initial, Annual, and Revision:

    a. For participants under the agency-based service delivery model, a CCSC initiates the ISP/budget request using the SW budget worksheet, and as applicable, supporting documentation. The budget worksheet specifies the request for services and is submitted to the Contractor.

        i. The Contractor shall conduct a review of each medically eligible individual participant's ISP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's ISP authorization review criteria; and (3) Medicaid SW rule, 8.314.7 NMAC.

        ii. The Contractor will enter the approved services from the SW budget worksheet into the appropriate system and assign a prior authorization number. The Contractor will document the authorization, denial, pending or modification of the request on the budget worksheet, as applicable, along with the certification period. The approved services, including any changes due to reconsiderations or revisions, are to be entered into the appropriate system.

iii. The Contractor shall complete the Long-Term Care (LTC) span in the appropriate system once the budget has been approved.

iv. The Contractor will provide the approved budget and the prior authorization number to the CSC.

b. For participants under the participant-directed service delivery model, the Contractor shall coordinate, as indicated, with each individual participant, his or her CSC, and the Financial Management Agency (FMA) Contractor concerning the participant's Individualized Service Plan (ISP) and budget, developed by the participant with the assistance of his/her CSC. This includes communication on RFIs, reconsiderations, and Requests for Administrative Action (administered through the FMA online system).

i. The Contractor shall conduct a review of each medically eligible individual participant's ISP and budget utilizing: (1) documentation from the participant's medical eligibility LOC determination and review; (2) the State's ISP authorization review criteria; and (3) Medicaid SW rule, 8.314.7 NMAC.

ii. The Contractor shall enter the ISP and budget authorization (denied, pending, or modification) into the FMA online system.

iii. The Contractor shall complete the Long-Term Care (LTC) span in the appropriate system once the budget has been approved.

2.12 HOME HEALTH SERVICES

A. The Contractor shall perform prior authorization reviews for all Home Health Services by Record Abstract Review. The policy for these services is MAD-768. The requests are initiated by the home health service provider using the New Mexico Uniform Prior Authorization Form and supporting documentation. Each request usually contains a "package" of several types of covered services. Each "package" constitutes a single review. The focus of the review is a determination of the medical necessity for skilled nursing and/or ancillary services, the amounts requested, and the adequacy of services requested given the complete clinical, social, and functional history.

B. The Contractor shall be sensitive to cases of possible neglect and/or abuse based on the information provided by the provider. The Contractor shall refer such cases to the Aging and Long-Term Services Department Adult Protective Services unless the provider indicates that such a referral has already been made.

C. The Contractor shall report to HCA all abuse and neglect referrals made by the Contractor or noted to have been made by the provider.

2.13 INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID)

A. The Contractor shall determine ICF-IID LOC according to Medicaid ICF-IID provider policy (8.313.2 NMAC, Long Term Care Services – Intermediate Care Facilities) and process (8.350.3 NMAC, Abstract Submission for Level of Care Determinations). The Contractor shall review initial and continued stay LOC requests using the HCA ICF-IID admission criteria. The Contractor shall close the review for discharges.

B. The Contractor shall perform LOC review by Record Abstract Review of all admissions and continued stay requests for ICF-IID residents. The provider submits a MAD 378 Form and required supporting documentation.

C. The Contractor shall review the request against the ICF-IID criteria for the three (3) levels of care and approve for a specific number of days, or deny the requested LOC.

D. In cases of LOC requests pertaining to ICF-IID recipients whose Medicaid eligibility has not yet been decisioned by ISD, the Contractor shall determine the LOC and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is directed by HCA. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has received approval of eligibility.

E. The Contractor shall perform re-admission reviews by telephonic/electronic review in cases in which a recipient who is an ICF-IID resident with an approved LOC is admitted to an Acute General Hospital and re-admission to the ICF-IID is planned. LOC for specified days can be approved as the result of a Telephonic/electronic Review under certain circumstances. See 8.313.2 NMAC.

2.14 NURSING FACILITY

A. The Contractor shall perform NF LOC reviews for Medicaid recipients exempt from Centennial Care enrollment and who are seeking hospice care in a nursing facility.

B. The Contractor shall perform NF LOC reviews for Medicaid recipients exempt from Centennial Care enrollment who are receiving short-term (30 days or less) rehabilitation or skilled nursing services in a nursing facility.

2.15 OUT-OF-STATE (OOS) SERVICES

A. The Contractor shall perform prior authorization reviews of requests for non-emergency OOS Services by Out-of-State Review. Every review decision must be determined or approved by the Contractor's medical director who must consult with pertinent specialists when necessary to render a professionally defensible decision.

B. Reviews for OOS transplants usually include three (3) separate reviews:

a. A review of the on-site recipient evaluation as conducted by an out-of-state provider.

b. Documentation related to the transplant procedure.

c. Follow-up evaluations conducted by out-of-state provider(s).

C. The policy for these services is in 8.302.4, Out-Of-State and Border Area Providers. The requested services must be otherwise covered benefits of the Medicaid Program; cannot be considered experimental, investigational, or unproven as a technology for the underlying condition; and must not be available in New Mexico.

D. Typically, a New Mexico physician initiates these reviews by letter and justifies the medical necessity. A written, telephonic, or electronic communication may also initiate the review process depending on the emergent nature of the situation.

E. Due to the costs and/or financial risk associated with these services, the Contractor must confirm that Medicaid recipient eligibility has been established and is on file with the Fiscal Agent.

F. Commonly, requests for OOS are for organ transplant services. For OOS organ transplant reviews, the Contractor will also follow section 2.7 Transplant Services (In-State).

G. For reviews that are approved, the Contractor shall give an HCA-designated provider all information that will allow for the coordination and/or arrangement of transportation and/or other required support.

H. The Contractor shall approve out-of-state services that are medically necessary, do not involve experimental technology, are not available in New Mexico, and are to be rendered by a professionally qualified provider(s).

I. The Contractor shall deny requests that do not fit the aforementioned criteria.

J. The Contractor shall maintain a detailed file of all pertinent correspondence, memos of telephonic/electronic conversations, and documentation for each review.

K. The Contractor shall notify in writing both the requesting provider and the involved out-of-state provider(s) for cases that have been approved. This notification must include the Medicaid Fiscal Agent's contact information to obtain general instructions on how to become a New Mexico Medicaid provider (able to bill) and obtain billing instructions.

2.16 PRIVATE DUTY NURSING SERVICES

A. The Contractor shall perform PA reviews for all requests for Private Duty Nursing

Services by Record Abstract Review. The policy for these services is in 8.323.4 NMAC, EPSDT Private Duty Nursing Services. These services are covered only for children under the age of 21 years. A case manager initiates the review with a letter, a history and physical examination report, a treatment plan, Early Periodic Screening and Diagnostic Treatment (EPSDT) Service Plan (a budget/authorization sheet), and other required documents. Each request usually contains a package of several services. Each "package" constitutes a single review.

B. The Contractor shall focus the review on the appropriateness of the treatment plan and the medical necessity of the requested services and service amounts. HCA will provide the medical necessity criteria.

C. If the Contractor determines that the documentation does not substantiate the medical necessity for the service, the request will be denied. The Contractor will reduce the amount of service requested (partial denial) if that amount exceeds the documented needs.

D. The Contractor shall complete the EPSDT Service Plan to document and communicate the review decision to the provider in accordance with policies and procedures approved by HCA.

2.17 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. The Contractor shall determine NF LOC for potential PACE members who are not in Medicaid Managed Care. The Contractor shall review initial and annual/continued stay LOC requests for PACE using the Medicaid Nursing Facility (NF) criteria and instructions. The Contractor shall approve or deny the requested NF LOC.

B. The Contractor shall ensure that its PACE reviewers meet the following minimum criteria for education and experience:

1. Active Nursing license in New Mexico or compact license (RN or LPN) with a minimum of one (1) year of relevant experience, or;
2. Medical Social Worker with a minimum of 1 year of relevant experience, or;
3. Physical, Occupational, or Rehab Therapists with a minimum of one (1) year of relevant experience.

C. The Contractor shall perform PACE LOC reviews by Record Abstract Review of all enrollment requests. The provider submits a MAD 379 Form, History and Physical, physician order, and required supporting documentation.

D. The Contractor shall attend the initial NF LOC criteria and instructions training held by HCA. The Contractor shall develop internal reviewer trainings and evaluation using HCA-approved materials. The Contractor shall submit an initial training material, evaluation, and calendar of training events to HCA for approval. After final approval is given, HCA will attend the initial Contractor internal trainings. The Contractor shall ensure that all reviewers have at a minimum, initial and annual training.

E. In cases of LOC requests pertaining to recipients whose PACE Medicaid eligibility has not yet been decisioned by ISD, the Contractor shall determine the LOC, and send the LOC data to the ISD office via the ASPEN interface, or by fax if the interface is unavailable or if the Contractor is otherwise directed by HCA. The Contractor is to assign a temporary alternative ID number and later merge the member profile with the assigned Medicaid ID when the ID determines that the participant has received approval of eligibility.

F. For new PACE-eligible members transferring from a Medicaid Managed Care MCO, an existing NF LOC determination and functional assessment performed by the MCO can be used for NF LOC for PACE certification and TPA/FFS UR data entry.

2.18 REHABILITATION SERVICES (INPATIENT)

A. The Contractor shall perform prior authorization reviews of inpatient rehabilitation hospital admissions.

B. The Contractor shall perform record Abstract Review for continuing stays. The Contractor shall determine medical necessity, appropriateness of setting, and length of stay for Medicaid recipients being admitted to inpatient rehabilitation centers with a primary emphasis on PT, OT, and/ or ST.

2.19 REHABILITATION SERVICES (OUTPATIENT)

A. The Contractor shall perform a prior authorization review for Speech Therapy (ST) for evaluation and treatment for recipients 21 years of age and older. Recipients under 21 years of age do not require authorization for ST evaluation.

B. Physical Therapy (PT) and Occupational Therapy (OT) do not require prior authorization for evaluation. PT and OT do require prior authorization for therapy services. The Contractor shall perform authorization review on Record Abstract Review, including the HCA designated prior authorization form and supporting information submitted by the provider to justify specific requested amounts of service by procedure code consistent with clinical needs.

C. The Contractor shall focus on medical necessity and appropriateness of setting.

D. An eligible recipient less than 21 years of age who is eligible for a home and community-based waiver program receives medically necessary rehabilitation services through the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) rehabilitation services. The Contractor shall approve a twelve (12) month prior authorization period for outpatient rehabilitation therapies when the medical conditions are expected to be of long-term duration and will require ongoing rehabilitative therapy. Maintenance therapy may be approved.

2.20 SECOND OPINION REVIEWS

The Contractor shall, at the request of HCA, perform second opinion reviews on non-fee-for-service recipients for non-fee-for-service programs with clinical criteria that may differ from that generally used in the fee-for-service reviews. The parties will negotiate reimbursement for the Contractor.

2.21 TRANSPLANT SERVICES (IN-STATE)

A. The Contractor shall perform prior authorization by record abstract review of requests for in-state organ transplant services.

B. Medicaid covers all organ transplants that are not considered experimental, investigational, or unproven as a technology or for the underlying condition according to the criteria specified in 3.301.3 NMAC, General Non-covered Services.

Corneal and kidney transplants currently do not require prior authorization. Presently, the following transplants are considered covered and require prior authorization: heart, lung, heart-lung, liver, and bone marrow/stem cell transplant/replacement (rescue). The practitioner, who must justify the medical necessity, initiates these reviews.

C. The reviews described here apply to transplants to be performed within the state. Frequently, requests for these transplants involve out-of-state services. Out-of-state transplant cases will be reviewed in accordance with this section and the "Out-of-State" review section. The focus of the review will be medical necessity and qualification of the provider.

D. The Contractor shall approve those transplants that are medically necessary and deny those that are not.

E. The Contractor shall develop criteria for any transplant not listed above when such a transplant is no longer considered experimental, investigational or unproven and forward them to HCA for review and authorization.

EXHIBIT B

COMPENSATION

Utilization Review and Assessment Services	Description	Rate
Prior Authorization Review	Prior authorization for the following Developmental Disabilities waiver services: adult nursing, therapies, and behavioral support consultation. Prior authorization for service or programs that are exempt from managed care, including physical health and Alternative Benefit Plan and Alternative Benefit Plan Medically Fragile exemption.	$ 101.12 Per Review
EMSNC Review	Retrospective medical necessity review for Emergency Medical Services for Non-Citizens.	$ 201.39 Per Review
Behavioral Health Review	Prior authorization for initial, concurrent, and retro reviews. Accredited Residential Treatment Centers (ARTC), Group Homes (GH), Treatment Foster Care (TFC)	$ 372.30 Annual Per Recipient
	Prior authorization for inpatient psychiatric care.	$144.85 Per Review
	Prior authorization for Applied Behavioral Analysis (includes any potential Fair Hearings).	$ 224.95 Per Review
	Prior authorization for Substance Use Disorder (SUD)-Inpatient Psychiatric Care and Residential Treatment reviews.	$ 167.06 Per Review
	Prior authorization for Substance Use Disorder (SUD)-Partial Hospitalization	$ 104.75 Per Review
	Prior authorization for Days Awaiting Placement	$101.12 Per Review
Level of Care Mi Via /Developmental Disability Waivers	Initial and annual ICF/IID level of care determination plus the in-home assessment for Mi Via and Developmental Disability waiver adults and children requiring ICF/IID level of care.	$ 711.99 Annual Per Recipient

Level of Care All Others	Initial and annual ICF/IID level of care determinations for adults and children in the Medically Fragile and Supports Waiver home and community-based waiver programs. Initial and annual ICF/IID level of care for recipients receiving long-term care services in an ICF/IID facility. Nursing facility level of care determinations for recipients in the Program of All-Inclusive Care for the Elderly.	$ 204.03 Annual Per Recipient
ISP/SSP and Budgets-Initial and Annuals	Review and approval of Initial and Annual Individual Service Plans and budgets for Developmental Disabilities Waiver (DDW) and Medically Fragile Waiver (MFW). Review and approval of Service and Support Plans and budgets for Mi Via (MV) and Supports Waiver (SW) Participants.	$ 237.49 Per Review
ISP/SSP and Budgets-Revisions	Review and approval of Individual Service Plans and budget revisions for DDW and MFW. Review and approval of Service and Support Plans and budget revisions for Mi Via and Supports Waiver Participants	$ 213.37 Per Review

***Fair Hearings are not separately reimbursable services.**

***Rate changes may be granted with one (1) year advanced notice, prior to the upcoming fiscal year, with appropriate justification for rate changes to include, but not limited to, labor and system costs.**

EXHIBIT C

REPORTS

NUMBER	TITLE	DESCRIPTION
A1	**Internal Quality Management**	Annual report that captures the description of program, description of processes, description of procedures, and shares TQM & CQI Results.
A2	**Pay Equity Reporting Requirements**	Annual completion of the PE10-249 for Contractor that has ten (10) or more employees OR has eight (8) or more employees in the same job classification.
A3	**Business Continuity and Disaster Recovery (BC-DR) Plan**	Annual report that captures the BC-DR plan and addresses scenarios specified in the contract.
Q1	**Fair Hearings Report**	Quarterly report that captures detailed provider and participant reconsiderations, and fair hearings as received by TPA. Includes aggregate summary.
Q2	**Grievance/Customer Service Calls**	Quarterly report that captures customer service calls and includes data regarding the types of calls received and the resolution.
Q3	**Critical Incident Reporting**	Quarterly report that provides description of adverse event with client and provider details.
Q5	**Client Portal Usage**	Quarterly report that captures the HCA users' activity in Jiva.
M1	**Mi Via Master List**	Monthly detailed participant list of all current and past (active and inactive) participants and their most recent budget and LOC for Mi Via (MFW and DDW).
M2	**Activity and TAT Report - Long Term Care**	Monthly report that captures client detail and summary for monthly Level of Care Reviews By Service Type and Status with TAT tracking.
M3	**Activity and TAT Report - Mi Via**	Monthly TAT Reports Assessments, Level of Care Reviews, and Budget Reviews for Mi Via (MFW and DDW). Report includes client level detail for all activity and aggregate summary.
M4	**Activity and TAT Report - Waiver**	Monthly TAT Assessments, Level-of-Care Reviews, Budget Reviews for Traditional MFW and DDW. Report includes client level detail for all activity and aggregate summary. Report should also collect the types of services requested.

M5	**Activity and TAT Report – ABP-BH-FFS-**	Monthly client detail and summary to review activity (approvals and denials for ABP, BH and FFS Prior Authorizations) by Service Type and Status with TAT tracking.
M6	**DD waiver Late Log**	Monthly client detail from filter of TAT Report M4 of Late DD LOC or ISP submissions.
M7	**Request for Information**	Monthly report that captures request for information by Program Type with Client detail and Provider information; Date RFI Requested and Information received by TPA.
M8	**LOC and Budget Audit Report**	Monthly report that captures all LOC and budget reviews completed in the specified month by Program Type. Report includes client level detail, final decision and aggregate summary.
M9	**Pending Medicaid**	Monthly report that captures clients whose COE is pending.
M10	**Supports Waivers LOC and Budgets**	Monthly TAT Reports Assessments, Level of Care Reviews, and Budget Reviews for the Supports Waiver. Report includes client level detail for all activity and aggregate summary.
M11	**Traditional DDW Budget Submissions**	Monthly report that captures how timely or untimely Traditional DDW budget reviews were submitted in the specified month. The report includes episode-level detail, submission volume per agency, and late submission trends.
M12	**New Mexico Phone Reports**	Monthly report that captures the number of calls received, the average speeds of answer, and abandonment rates.
W1	**Activity and TAT Report-ICF-IID**	Monthly report that captures client detail and summary for monthly ICF-IID Level of Care Reviews and Status with TAT tracking.
W4	**Pending Waiver LOCs Exceeding 21 Days**	Weekly Waiver LOC report that captures pending requests for information that have exhausted 21 calendar day without response.

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

DS DF

By: DocuSigned by: Kari Armijo 1BA9EB5EAD00499... Date: 6/7/2025
HCA Cabinet Secretary

By: DocuSigned by: Carolee A. Graham FB15A98045214DA... Date: 6/5/2025
HCA Chief Financial Officer

By: DocuSigned by: Mark Reynolds 6241C19C1E01414... Date: 6/5/2025
HCA General Counsel

By: Signed by: Foster C. Bud" Beall Jr. 92B767E4F580408... Date: 6/3/2025
Contractor

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.

ID Number: 03-295345-00-3

By: DocuSigned by: AnnMarie Lucero A1E23200AE974AA... Date: 6/13/2025
Taxation and Revenue Department