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

**Medicaid Managed Care Services Agreement**

**Among**

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

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

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

**New Mexico Behavioral Health Purchasing Collaborative**

**and**

**Presbyterian Health Plan**

**PSC 24-630-8000-0031 A3**
**CFDA 93.778**

**STATE OF NEW MEXICO HEALTH CARE AUTHORITY**

**MEDICAID MANAGED CARE SERVICES AGREEMENT**

**PROFESSIONAL SERVICES CONTRACT**

**"TURQUOISE CARE"**

**AMENDMENT No. 3**

This Amendment No. 3 to PSC: 24-630-8000-0031 (the "Agreement" or the "Contract") is made and entered into by and between the **New Mexico Health Care Authority** ("HCA") (formerly the "Human Services Department" ("HSD")); the **New Mexico Children, Youth, and Families Department** ("CYFD"); the **New Mexico Early Childhood Education and Care Department** ("ECECD"); the **New Mexico Behavioral Health Purchasing Collaborative** (the "Collaborative"); and **Presbyterian Health Plan** including any successors and/or assignees ("CONTRACTOR"); and is to be effective upon signatures by all parties.

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

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

**4.19.2.1.4** The CONTRACTOR shall provide the quarterly statement of the account balance for the restricted insolvency protection account that will allow HCA to examine and confirm compliance with the Agreement, Section 4.19.2.1. Based upon total capitation payments paid to the CONTRACTOR, the required account balance each quarter will be determined by HCA.

**4.22.1.18** Reporting Requirements

HCA shall provide an acknowledgement of receipt of the report to the CONTRACTOR within fifteen (15) Business Days from the due date of the report.

**Attachment 8: CAHPS Supplemental Questions, is amended to provide child and adult supplemental questions.**

**Attachment 10: Directed Payments, is amended to provide the current inventory of state-directed payments.**

**Attachment 11: Non-Risk Arrangements, is amended to remove COVID-19 provisions.**

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

**CONTRACTOR**

Signed by:
Antonio H. Hernandez
B871073C4EB4474...

By: _____ Date: 4/23/2025

Antonio (Tony) Hernandez, PHP Interim President
Presbyterian Health Plan

**STATE OF NEW MEXICO**

DocuSigned by:
Kari Armijo
1BA9EB5EAD00499...

By: _____ Date: 5/5/2025

Kari Armijo, Cabinet Secretary
Health Care Authority

DocuSigned by:
Carolee A. Graham
FB15A98045214DA...

By: _____ Date: 5/2/2025

Carolee Graham, CFO
Health Care Authority

DocuSigned by:
Teresa Casados
FE355BED9AF5442...

By: _____ Date: 5/1/2025

Teresa Casados, Cabinet Secretary
Children, Youth and Families Department

DocuSigned by:
Elizabeth Groginsky
6F1D4EE86EE94C2...

By: _____ Date: 4/23/2025

Elizabeth Groginsky, Cabinet Secretary
Early Childhood Education and Care Department

**THE NEW MEXICO BEHAVIORAL HEALTH PURCHASING COLLABORATIVE**

DocuSigned by:
Kari Armijo
1BA9EB5EAD00499...

By: _____ Date: 5/5/2025

Kari Armijo, Cabinet Secretary
Health Care Authority

Signed by:
Gina DeBlassie
2B5F58D60AD7441...

By: _____ Date: 4/30/2025

Gina DeBlassie, Cabinet Secretary
Department of Health

DocuSigned by:
Teresa Casados
FE355BED9AF5442...

By: _____ Date: 5/1/2025

Teresa Casados, Cabinet Secretary
Children, Youth and Families Department

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

DocuSigned by:
Mark Reynolds
6241C19C1E01414...

By: _____ Date: 5/2/2025

Mark Reynolds, Chief Legal Counsel
Health Care Authority

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

**TAXATION AND REVENUE DEPARTMENT**

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

DocuSigned by:
By: AnnMarie Lucero Date: 5/5/2025
A1E23200AE974AA...
AnnMarie Lucero, District Manager, Santa Fe District Office
Tax and Revenue Department

## Attachment 8: CAHPS Supplemental Questions

| NCQA Tracking Number | Child Questions | Response Categories<br>Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always) | If Required by State Medicaid Agency, which one? | NCQA Decision |
|---|---|---|---|---|
| 990231 | Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation? | Yes; No [Insert Skip Pattern if Necessary] | New Mexico | Approved |
| 990232 | In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it? | Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months] | New Mexico | Approved |
| 990233 | In the last 6 months, how often did the help with transportation meet your needs? | Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months] | New Mexico | Approved |
| 990234 | In the last 6 months, how long did it take to get an appointment for regular or routine care? (For example, preventive care or a complete physical) | 1–7 days; 8–21 days; 22–30 days; 31 days or more; My child did not need an appointment for regular or routine care | New Mexico | Approved |

| | | | | |
|---|---|---|---|---|
| 990235 | In the last 6 months, if you had a problem getting the care, tests, or treatment you thought you needed through your health plan, what was the main problem you had? | Plan did not approve my child's care, tests, or treatment; Care, tests, or treatment delayed while waiting for plan's approval; Providers I wanted my child to see were not in plan or network; Could not get an appointment with provider at a convenient time; The cost to me for my child's care, tests, or treatment was too high; Brand name medications I wanted cost more than the generic available; The cost of my child's medications was too high; Problem getting plan to pay claims after getting care, tests, or treatment; Problem getting a referral to a specialist; Other (Please Specify): _____; I did not have a problem getting care, tests, or treatment | New Mexico | Approved |
| 990236 | In the last 6 months, if you needed non-emergency care after your doctor's office was closed, where did you get it? | I received help from my doctor's office; I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care; I did not need after hours care | New Mexico | Approved |
| 990237 | In the last 6 months, if you needed non-emergency care during doctor's office hours, and your provider was not available, where did you receive care? | I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care | New Mexico | Approved |
| 990238 | In the last 6 months, if you needed to see a mental health or substance use disorder specialist how often was it easy to get an appointment as soon as needed? | Never; Sometimes; Usually; Always; I did not see a mental health or substance use disorder specialist in the last 6 months [Insert skip pattern, if necessary] | New Mexico | Approved |

| NCQA Tracking Number | Adult Questions | Response Categories<br>Response categories must be confined to one cell. Separate each response option with a semicolon (e.g., Never; Sometimes; Usually; Always) | If Required by State Medicaid Agency, which one? | NCQA Decision |
|---|---|---|---|---|
| 990239 | Some health plans help with transportation to doctors' offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation? | Yes; No [Insert Skip Pattern if Necessary] | New Mexico | Approved |
| 990240 | In the last 6 months, when you phoned to get help with transportation from your health plan, how often did you get it? | Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months] | New Mexico | Approved |
| 990241 | In the last 6 months, how often did the help with transportation meet your needs? | Never; Sometimes; Usually; Always; [I did not phone my child's health plan for help with transportation in the last 6 months] | New Mexico | Approved |
| 990242 | In the last 6 months, how long did it take to get an appointment for regular or routine care? (For example, preventive care or a complete physical) | 1 – 7 days; 8 – 21 days; 22 – 30 days; 31 days or more; I did not need an appointment for regular or routine care | New Mexico | Approved |

| | | | | |
|---|---|---|---|---|
| 990243 | In the last 6 months, if you had a problem getting the care, tests, or treatment you thought you needed through your health plan, what was the main problem you had? | Plan did not approve my care, tests, or treatment; Care, tests, or treatment delayed while waiting for plan's approval; Providers I wanted to see were not in my plan or network; Could not get an appointment with a provider at a convenient time; The cost for care, tests, or treatment was too high for me; Brand name medications I wanted cost more than the generic available; The cost of my medications was too high; Problems getting my plan to pay claims after getting care, tests, or treatment; Problems getting a referral to a specialist; Other (Please Specify):_____; I did not have a problem getting care, tests, or treatment | New Mexico | Approved |
| 990244 | In the last 6 months, if you needed non-emergency care after your doctor's office was closed, where did you get it? | I received help from my doctor's office; I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care; I did not need after hours care | New Mexico | Approved |
| 990245 | In the last 6 months, if you needed non-emergency care during doctor's office hours, and your provider was not available, where did you receive care? | I received care at an in Network Urgent Care Center; I received care at the Emergency Room; I was unable to get care | New Mexico | Approved |
| 990246 | In the last 6 months, if you needed to see a mental health or substance use disorder specialist how often was it easy to get an appointment as soon as needed? | Never; Sometimes; Usually; Always; I did not see a mental health or substance use disorder specialist in the last 6 months [Insert skip pattern, if necessary] | New Mexico | Approved |

# Attachment 10: Directed Payments

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

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

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

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

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

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

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

- The CONTRACTOR must comply with Section **Error! Reference source not found.** Directed Payments.
- The effective dates of the directed payments are contingent on CMS approval and subject to annual renewal unless otherwise noted. Directed payments without a specified end date are anticipated to be in place for the duration of the term of this Agreement and will be removed from this Attachment if ended prior to the termination of the contract term.
- For directed payments operationalized through a Separate Payment Term, the amount of the payment each quarter will be based on emerging utilization data. The CONTRACTOR is required to submit utilization and paid amounts by procedure code, rate cohort and month in which the service occurred for each quarter. Each subsequent quarter will include a look-back period to account for claims lag.
- For directed payments operationalized through capitation, HCA may request ad hoc reporting to verify accuracy of information used to determine payment and will take action on any Provider complaints on the respective directed payment, and review and potentially reconcile the state directed payment, as needed.
- HCA will also rely on sanctions, including monetary penalties, for noncompliance as specified in Section **Error! Reference source not found.** Sanctions.

## Attachment 11: Non-Risk Arrangements

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

| Non-Risk Arrangement | Services subject to the non-risk arrangement | Frequency of payment from HCA to the CONTRACTOR based on reported utilization |
|---|---|---|
| **Reserved.** | | |