

**MEDICAID MANAGED CARE
TRANSITION MANAGEMENT AGREEMENT**

This Transition Management Agreement (“Agreement”) is entered into by the New Mexico Human Services Department (“HSD”) and Western Sky Community Care, Inc. and is to be effective upon signature.

WHEREAS, HSD has entered into four separate managed care contracts with the following entities to provide Medicaid services to eligible recipients in the State’s Centennial Care Program: Blue Cross, Molina, Presbyterian, and United and;

WHEREAS, HSD has proposed to provide all Medicaid services to eligible recipients through Centennial Care 2.0, currently scheduled to be operational on January 1, 2019; and

WHEREAS, on September 1, 2017, HSD issued its Request for Proposals No. 8-630-8000-0001 (“RFP”), for Medicaid Managed Care services through its program, Centennial Care 2.0, currently scheduled to be operational on January 1, 2019; and

WHEREAS, the Parties will enter into this Agreement, whereby each agrees to cooperate to effectively, and as seamlessly as possible, transition Medicaid members from one managed care organization (“MCO”) to another as may be necessary, including but not limited to the preservation and transition of program and member information from one MCO to another MCO, so that the integrity of the Centennial Care program is maintained and all member needs are met; and

WHEREAS, HSD will select from the RFP offerors (“Offerors”) and enter into contracts with MCOs to provide Medicaid Managed Care services under Centennial Care 2.0 (“Centennial Care 2.0 MCOs”); and

WHEREAS, immediately upon award notification of Centennial Care 2.0, selected MCOs not already a party to this Agreement, will be required to enter into this Agreement with HSD; and

WHEREAS, Centennial Care 2.0 MCOs shall participate in a readiness review period beginning March 2018 through December 2018 and must obtain HSD approval of all readiness elements prior to January 1, 2019; and

WHEREAS, during this readiness review period the Centennial Care 2.0 MCOs shall not be compensated for Centennial Care 2.0 readiness activities leading up to Go-Live; and

WHEREAS, HSD has identified four goals in transitioning from its current delivery system to Centennial Care 2.0: (1) to assure that Medicaid enrollees in the program receive the right amount of care, at the right time, and in the most cost effective or “right” setting; (2) to assure that the care being delivered is measured in terms of its quality and not quantity; (3) to bend the cost curve over time and advance payment reform initiatives; and (4) to streamline and

modernize the program for the increase in membership that occurred with the expansion of Medicaid to previously ineligible adults; and

WHEREAS, the parties to this Transition Management Agreement are bound by its terms and a fully executed Transition Management Agreement will be attached to the executed Centennial Care 2.0 contract as Exhibit B.

NOTE: FAILURE TO ABIDE BY THE TERMS OF THIS AGREEMENT AND TO PROVIDE RELEVANT MEMBER DATA TO THE CENTENNIAL CARE 2.0 MCOs SHALL OBLIGATE CURRENT MCOs TO CONTINUE TO PROVIDE AND PAY FOR SERVICES

IT IS AGREED BETWEEN THE PARTIES:

I. DEFINITIONS

Terms used throughout this Agreement have the following meaning, unless the context clearly indicates otherwise or as may be further defined herein:

Business Associates Agreement (BAA) means a contract between entities that will use protected health information (PHI) for administrative, research, pricing, billing or quality-assurance purposes.

Care Coordination Level (CCL) identifies the level of support a Member needs through Care Coordination services for the Member to improve or maintain, and manage their individual health needs effectively.

Centennial Care 2.0 Managed Care Organization (Centennial Care 2.0 MCO) means an entity under contract with HSD to provide Centennial Care 2.0 Services to eligible Medicaid members beginning January 1, 2019.

Centennial Care/Centennial Care 2.0 Services means covered services approved by CMS under the State's 1115(a) Waiver beginning January 1, 2019.

CMS means the Centers for Medicare and Medicaid Services, which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid.

Current MCOs means the managed care entities with contracts presently in effect with HSD to provide Centennial Care physical health, behavioral health, and long term services and supports through December 31, 2018; such entities are Blue Cross, Molina, Presbyterian, and United.

Day or Days means calendar day(s), unless specified otherwise in this Agreement. Timeliness or due dates falling on a weekend or on a State or Federal holiday shall be extended to the first business day after the weekend or holiday.

Dual Eligible Special Needs Plans (D-SNP) means plans that enroll members who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid.

Dual Eligible means an individual, who, by reason of age, income, and/or disability qualifies for Medicare and full Medicaid benefits under section 1902(a)(10)(A) or 1902(a)(10)(C) of the Social Security Act, by reason of section 1902(f) of the Social Security Act, or under any other category of eligibility for medical assistance for full benefits.

Durable Medical Equipment (DME) means equipment and supplies that are primarily used to serve a medical purpose, that are medically necessary to individuals with an illness, physical disability, or injury and that are commonly used at home.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) means the federally required Early and Periodic Screening, Diagnosis and Treatment program, as defined in section 1905(r) of the Social Security Act and 42 C.F.R. Part 441, Subpart B for Members under the age of twenty-one (21). It includes comprehensive periodic and inter-periodic screening and diagnostic services to determine physical and Behavioral Health needs as well as the provision of all Medically Necessary Services listed in section 1902(a) of the Social Security Act even if the service is not available under the State's Medicaid plan.

Encounter means a record of any claim adjudicated by the Current MCO or any of its Major Subcontractors and Subcontractors for a Member, including Medicare claims for which there is no Medicaid reimbursement amount and/or a record of any service or administrative activity provided by the Current MCO or any of its Major Subcontractors or Subcontractors for a Member that represents a Member-specific service or administrative activity, regardless of whether that service was adjudicated as a claim or whether payment for the service was made.

Encounter Data is information about claims adjudicated by the Current MCO for goods and/or services rendered to its Members. Such information includes whether claims were paid or denied and any capitated and subcapitated arrangements.

Go Live means the date on which the MCO assumes responsibility for the provision of Covered Services to Members. For the purposes of this Agreement, the date on which Centennial Care 2.0 begins is January 1, 2019.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended and codified at 42 U.S.C. §§160, *et seq.* and its regulations to include provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), codified at 42 U.S.C §§17931 *et seq.*

Long-Term Services and Supports (LTSS) means services and supports provided to Members of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the Member to live or work in the setting of their choice, which may

include the Member's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Managed Care Organization (MCO) means an organization that participates in Centennial Care under contract with HSD to assist the State in meeting the requirements established under NMSA 1978, §27-2-12.

Member means a person who has been determined eligible for Centennial Care/Centennial Care 2.0 and who has enrolled in a MCO.

Nursing Facility Level of Care (NF LOC) means the Member's functional level is such that (2) two or more activities of daily living cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assistance. A Member must meet the NF LOC to be eligible for nursing facility and community benefit services.

Nursing Facility (NF) means a licensed Medicare/Medicaid facility certified in accordance with 42 CFR Part 483 to provide inpatient room, board, and nursing services to Members who require these services on a continuous basis but who do not require hospital care or direct daily care from a physician.

Personal Care Services (PCS) means those services established by HSD to assist individuals twenty-one (21) years of age or older who are eligible for full Medicaid coverage and meet the level of care criteria as defined by policy. PCS are provided to a Member unable to perform a range of activities of daily living and instrumental activities of daily living.

Patient Protection and Affordable Care Act (PPACA) means Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010)).

Setting of Care (SOC) identifies the various settings in which the member receives long term care services.

II. PREREQUISITES

- A. In the event that CMS does not approve the 1115(a) waiver by September 30, 2018, HSD may terminate this Agreement immediately without penalty by providing written notice to the Parties.
- B. To align with PPACA and Medicare open enrollment, the Centennial Care 2.0 MCOs must be able to accept enrollment data by October 1, 2018.
- C. All required transfers of data and information specified in this Agreement must be made electronically, unless otherwise directed by HSD.
- D. Current MCOs not selected as Centennial Care 2.0 MCOs must terminate D-SNP agreements with CMS for New Mexico Medicaid dual eligible Members and will

be required to provide HSD with a plan for its Members to select different Medicare coverage.

- E. Centennial Care 2.0 MCOs must have an agreement with CMS to offer a D-SNP to dually eligible members effective January 1, 2019.

III. TRANSITION TEAM– STAFFING & ROLES

- A. In order to effectuate a smooth transition, each Current and Centennial Care 2.0 MCO is required to identify key staff to HSD within thirty (30) calendar days after the effective date of this Agreement. MCOs must maintain sufficient key staff and support staff based in New Mexico to support all the functions and operations described below. At a minimum, such key staffing shall include a Transition Team (TT) Lead Coordinator and eight (8) support teams with a designated lead for each team: (i) Provider Management, (ii) Member and Provider Support Services, (iii) Member/Provider Communications (iv) Data/Information Technology, (v) Financial Reporting and Reconciliation, (vi) Managed Care Reporting, (vii) Long Term Services and Supports, and (viii) Care Coordination. Transition Team responsibilities shall include, but are not limited to:

1. Provider Management, which shall include, but is not limited to, claims and Encounter Data submissions, provider contracting and credentialing, subcontract oversight, and developing/maintaining a complete provider network.
2. Member and Provider Support Services, which shall include, but is not limited to, call centers, pharmacy services, grievances and appeals processes, and prior authorizations.
3. Member/Provider Communications, which shall include, but are not limited to, Member and provider letters, Member handbook, provider directory, website, training, and cultural competency.
4. Data/Information Technology (IT), which shall include, but is not limited to, data storage and transfer, reports and support, enrollment, NF LOC/Setting of Care (SOC) submissions, claims/encounters, and system configuration.
5. Financial Reporting and Reconciliation, which shall include, but is not limited to, the submission of financial reports to include the evaluation and closing of reconciliations.
6. Managed Care Reporting, which shall include, but is not limited to, the submission of contractually required reports.

7. Long Term Services & Supports (LTSS), which shall include, but are not limited to, identification, transition and continuity of LTSS for Members with a Nursing Facility Level of Care (NF LOC) to include the transition of the NF LOC/SOC dates for Members receiving LTSS.
 8. Care Coordination, which shall include, but is not limited to, identification of complex cases, Members in out-of-state placement, those with special health care needs, and in special situations (such as health homes, homeless, and justice-involved Members).
- B. The Transition Team shall: (i) assist with Member transitions from a Current MCO to a Centennial Care 2.0 MCO and ensure the sharing of documentation such as active prior authorizations, current assessments and care plans, and other necessary information to support continuity of care, and (ii) assist with Member transitions, as necessary, depending on provider contracting circumstances.
- C. Transition Project Plan: Within thirty (30) calendar days of the effective date of this Agreement, the Current MCOs and the Centennial Care 2.0 MCOs shall submit for HSD approval, a transition project plan, describing in detail how the MCO will meet the requirements of this agreement.

IV. MEMBERSHIP TRANSITION PERIODS

A. Open Enrollment Period

1. All Current MCO Members are eligible for an open enrollment period to select a Centennial Care 2.0 MCO beginning October 1, 2018 and ending November 30, 2018 for an effective start date of January 1, 2019.
2. If the Member's Current MCO is a Centennial Care 2.0 MCO, the Member may stay with that MCO or select a new Centennial Care 2.0 MCO. If the Member fails to select a Centennial Care 2.0 MCO by the first auto-assignment cycle that begins December 1, 2018, the Member will default to their Current MCO that is a Centennial Care 2.0 MCO.
3. If the Member's Current MCO is not a Centennial Care 2.0 MCO and the Member fails to select a Centennial Care 2.0 MCO, the Member will be auto-assigned to a Centennial Care 2.0 MCO in the first auto-assignment cycle that begins December 1, 2018.
4. If a Current MCO is not selected as a Centennial Care 2.0 MCO, HSD will cease new enrollment effective beginning November 1, 2018.

V. TRANSITION WORKGROUP

A Transition Workgroup will be established immediately upon announcement of the Centennial Care 2.0 awards. The Workgroup will consist of key MCO staff outlined in section III of this Agreement as well as key staff from HSD, to work collaboratively on transition issues as identified by HSD. Current MCOs not selected Centennial Care 2.0 MCO will be required to collaboratively participate on the Transition Workgroup until all Members, data, and information has been transitioned as determined by all Parties to this Agreement.

VI. TRANSITIONING OF MEMBER DATA

- A. By October 1, 2018 (90 days prior to Centennial Care 2.0 Go-Live), the Current MCOs shall be prepared to exchange the following data for all Members choosing a new Centennial Care 2.0 MCO:
1. All claims data;
 2. All Authorization data;
 3. All Long-Term Care data identifying the NF LOC/SOC dates, Comprehensive Needs Assessment (CNA) date spans, Comprehensive Care Plan (CCP) date spans, Individual Plan of Care (IPoC), special needs, NF LOC date spans, and providers involved in service delivery and service coordination, annual budget, budget utilization, and budget date spans, as appropriate; and
 4. All Behavioral Health data identifying special needs, care coordination, and any providers involved in service delivery and service coordination.
- B. The Current MCO shall send data for the transferring Member to the Centennial Care 2.0 MCO within fifteen (15) calendar days from the date the Current MCO is notified by HSD of the Member's choice of a Centennial Care 2.0 MCO, continuing through the period of open enrollment and auto-assignment, and as otherwise directed by HSD.
- C. After the initial exchange of data, the Current MCO will continue to transmit on a weekly basis any new and updated data on a Member for whom data was previously sent (e.g., new authorizations, claims paid after the date of the initial data exchange, etc.). The format, required data elements, and method of transmission for each type of data listed in Subparagraph A above, will be determined by HSD on or about May 1, 2018.
- D. The Parties agree that the most recent 12 months of information regarding Member specific data shall be exchanged in a format to be provided on a template developed by the Transition Workgroup that can be readily accessed by Centennial Care 2.0 MCOs and shall include, but are not limited to, the following elements for all members, as applicable:

1. Category of Eligibility (COE)
2. Setting of Care (SOC), including date spans
3. Nursing Facility Level of Care (NF LOC), including date spans
4. Annual budget and budget utilization for Members enrolled in the Self Directed Community Benefit.
5. Medically Frail indicator (For Other Adult Group members exempt from Alternative Benefit Plan/Adult Benefit Plan)
6. Care Coordination Level Assigned
7. Health Risk Assessment (HRA)
8. CNA, if applicable
9. CCP, if applicable

E. The Parties agree that the most recent 12 months of information regarding Member specific data shall be exchanged in a format to be provided on a template developed by the Transition Workgroup that can be readily accessed by Centennial complex Care 2.0 MCOs and shall include, but are not limited to, the following medical conditions, as applicable:

1. Newborns with complex needs;
2. Members with high risk pregnancies and/or at late stage of pregnancy;
3. Members in evaluation for or in the process a transplant (and type of transplant);
4. Members with terminal illness (including diagnoses);
5. Members receiving dialysis;
6. Members receiving wound care;
7. Members with NF LOC and receiving LTSS;
8. Members enrolled in hospice;
9. Members scheduled for surgery after January 1, 2019;

10. Members receiving substance abuse services;
11. Members receiving behavioral health in out of home and/or inpatient placements;
12. Members assigned to Core Services Agencies (CSAs);
13. Members receiving radiation/chemotherapy;
14. Members receiving family planning services;
15. Members receiving Breast & Cervical cancer services;
16. Members with a serious infirmity, such as traumatic brain injury, cancer, and/or Members with chronic disease(s);
17. Members receiving Durable Medical Equipment (DME);
18. Members considered individuals with special health care needs;
19. Members with complex behavioral health needs and co-morbidities;
20. Members engaged in Disease Management;
21. Members engaged in complex case processes;
22. Members enrolled in a Patient-Centered Medical Home (PCMH); and
23. Members enrolled in a CareLink NM Health Home.

F. Prior and Concurrent Authorization Data to be transmitted:

1. Requesting provider name and national provider identification number (NPI), rendering provider name and NPI, service type, frequency, date of service (if the NPI is applicable), Member name, Member Medicaid ID, Social Security Number (SSN), and Member date of birth;
2. Scheduled surgeries prior to and after December 31, 2018;
3. Pharmacy utilization (include pharmacy lock-in); and
4. Primary Care Provider (PCP) lock-in.

G. Assessment(s) for Members accessing and expected to access LTSS as of January 1, 2019:

1. Individualized Service Plan (ISP), CNA, and CCP, NF LOC/SOC date spans, and annual budget and budget utilization as appropriate.

H. Continuity of Care (Information Exchanged)

1. Approved prior authorizations must be honored for the first sixty (60) calendar days after December 31, 2018 (all open authorizations), unless otherwise specified in this Agreement, to include, but not limited to the following:
 - Transplant/surgery services already approved for the first sixty (60) calendar days after December 31, 2018;
 - Pharmaceuticals already approved for the first ninety (90) calendar days after December 31, 2018 (formulary or preferred drug list, prior authorizations), including specialty drugs;
 - Pharmaceuticals for those Members on a pharmacy-lock in and those who have short term duration prescription (e.g., 5-day, 7-day supply);
 - DME already approved for the first sixty (60) calendar days after December 31, 2018;
 - Scheduled hospitalizations for the first sixty (60) calendar days after December 31, 2018 (inpatient and BH);
 - Institutional care and hospice;
 - Out-of-State placements.
2. New prior authorization requests for services on or after December 31, 2018, and after a Member has identified his/her Centennial Care 2.0 MCO, must be submitted to the Centennial Care 2.0 MCO within 24 hours after receipt of the request.
3. Pregnancy data to include third trimester or high risk pregnancy;
4. EPSDT visits due within the first ninety (90) calendar days after December 31, 2018; and
5. Behavioral Health Out-of-Home placements,
6. Community benefits approved in the CNA and CCP until annual re-assessment.

I. Member Transfers

1. Current MCOs shall identify Members who are transferring out of the Current MCO and shall ensure that Member data and clinical information is transmitted to the receiving Centennial Care 2.0 MCO within fifteen (15) calendar days after notification from HSD that a Member will transfer to the Centennial Care 2.0 MCO effective January 1, 2019.
2. For members receiving care coordination a warm transfer as defined in the contract will be made to the receiving Centennial Care 2.0 MCO.
3. Those Members already in Care Coordination Levels 2 or 3 will continue to receive care coordination and existing LTSS with the Centennial Care 2.0 MCOs effective January 1, 2019.
4. For existing Community Benefit Members who meet a Nursing Facility Level of Care (NF LOC):
 - (a) Monthly capitations to the Current MCO for Members whose NF LOCs expire in January-February 2019 and are not completed by December 31, 2018 are subject to recoupment.

Example: Member's NF LOC expires on February 1, 2019. The Current MCO is required to complete the Member's NF LOC assessment and approve or deny the NF LOC no later than December 1, 2018. If the NF LOC is not completed and submitted via the system interfaces by December 1, 2018, the capitation payment for December 2018 is subject to recoupment.

5. If applicable, Centennial Care 2.0 MCOs shall continue providing services previously authorized by HSD or its designee in the Member's approved CNA/CCP or behavioral health treatment or service plan without regard to whether such services are being provided by contract or non-contract providers.
6. The Centennial Care 2.0 MCO shall not reduce services previously authorized in the CNA/CCP, IPoC or behavioral health treatment or service plan until the Member's care coordinator has conducted a comprehensive needs assessment (CNA) and developed a comprehensive care plan.

VII BUSINESS ASSOCIATE AGREEMENTS (BAA) AND TRANSITION MEETINGS

- A. Within ninety (90) calendar days of HSD's award notification of the Centennial Care 2.0 MCOs, the Parties hereto shall enter into a BAA with the Centennial Care 2.0 MCOs for the exchange of data. Such BAA shall include, at minimum, IT security protections for protected health information.
- B. Transition Meetings for High Need Members. HSD shall schedule transition meetings, if necessary. Attendance by the Current MCOs, Centennial Care 2.0 MCOs, and other contractors is required. Such meetings shall include clinical and/or operational matters and any other such matters necessary to ensure the smooth and non-disruptive transition of Members.

VIII. GENERAL TRANSITION REQUIREMENTS

- A. Provider Management. Current MCOs shall maintain effective communications with its providers.
 - 1. Current MCOs that are not selected as Centennial Care 2.0 MCOs shall:
 - (a) Inform providers, in writing, at least sixty (60) calendar days prior to January 1, 2019, of the termination of their respective contracts and of the process for providers to submit claims for services provided through December 31, 2018, but submitted after that date. The letter shall be submitted to HSD for review and approval at least thirty (30) calendar days prior to its issuance to providers and must include at a minimum, the following for claims submissions:
 - (1) Contact information (including telephone and fax numbers);
 - (2) Billing address;
 - (3) Electronic submission instructions (if different than billing address) for claims submissions; and
 - (4) Designated point of contact for questions.
 - (b) Allow providers the following timeframes to submit claims for services provided prior to January 1, 2019:
 - (1) 120 calendar days from date of service to submit original claims;
 - (2) 90 calendar days from the paid date for adjusted claims;
 - (3) 210 calendar days from the date of service for claims that have third-party liability or are Medicare crossover claims; and

- (4) 730 calendar days from the date of service for I/T/Us to submit any claim.
 - (c) Continue to meet the timeframes established by contract for processing all claims and submission of encounters to HSD; and
 - (d) Meet all regulatory requirements regarding notification to HSD of terminated providers.
 2. All MCOs, including any Current MCOs selected for Centennial Care 2.0 must develop provider networks as required under the Centennial Care 2.0 contract.
 3. All Provider telephone lines shall remain open for at least ninety (90) calendar days after the implementation of Centennial Care 2.0.
- B. Member Support Services. All MCOs shall maintain effective communications with Members or potential Members to include:
 1. All MCOs shall respond to inquiries about: (i) transitioning of care; (ii) open enrollment; (iii) provider networks; (iv) Medicaid benefits and value added services; and (v) general questions relating to Centennial Care 2.0 or make referrals to the appropriate entity to get answers.
 2. Current MCOs that are not selected as Centennial Care 2.0 MCOs shall:
 - (a) Inform members in writing at least sixty (60) calendar days prior to January 1, 2019 of the transitioning of services, and other specific information as requested by HSD; such communication shall be submitted to HSD for review and approval at least thirty (30) calendar days prior to issuance of the communication; and
 - (b) Develop “final” telephone, email, and website messages directing Members to sources of current information about Centennial Care 2.0. These final messages shall be sent to HSD for review and approval no later than November 1, 2018 and, once approved, shall remain active until March 31, 2019 for all telephonic, email, and website communications. All Member telephone lines shall remain open for at least ninety (90) calendar days after the implementation of Centennial Care 2.0.
 3. All MCOs, including any Current MCOs selected for Centennial Care 2.0 must provide HSD with all new and/or changes to existing marketing and Member materials for review and approval as required under the Centennial Care 2.0 contract.

C. Grievances and Appeals

1. Grievances: A Current MCO that is not selected as a Centennial Care 2.0 MCO shall resolve all open grievances within timeframes specified by the Centennial Care contract.
2. Appeals based on adverse benefit determinations made after the service is rendered: The Current MCO shall retain responsibility for these pending appeals and shall make its determination as to the resolution to the appeal according to timeframes specified in the Centennial Care contract.
3. Appeals based on adverse benefit determinations made prior to rendering services: The Current MCO shall notify the receiving Centennial Care 2.0 MCO of all pending appeals based on adverse benefit determinations for all transferring members. The Centennial Care 2.0 MCO shall review the pending appeal and render a determination within timeframes specified in the Centennial Care 2.0 contract and will assume full responsibility from the Current MCO. Timeframes for resolution shall be based on initial date of appeal.

D. Centennial Care Reporting

1. The Current MCOs shall continue to submit all regularly scheduled and Ad Hoc reports as required by the Centennial Care contract.
2. The run out period for report submissions shall be considered complete as determined by HSD. Run out reports shall include, but are not limited to, Centennial Care reports, financial reports, Healthcare Effectiveness Data and Information Set (HEDIS), Tracking Measures (TMs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports, and reports for Delivery System Improvement Performance Targets (DSIPT).

IX. NETWORK ADEQUACY

- A. Current MCOs are required to maintain their provider network, per contract and changes made to their provider network, shall follow the requirements outlined in the Managed Care Policy Manual. Current MCOs and Centennial Care 2.0 MCOs shall provide HSD with information related to the establishment and maintenance of their provider networks in a format and frequency as directed by HSD that contains at a minimum NPI, service type, contracting status, and other elements as described below:
1. Primary Care Providers;
 2. Specialty Providers (i.e. SBHCs, CSAs);
 3. Border Providers;

4. Long-Term Care Providers (Nursing Facilities and Community Benefit providers);
 5. IHS and Tribal 638 Facilities;
 6. Single Case Agreements;
 7. Patient-Centered Medical Homes (PCMH);
 8. CareLink NM Health Homes;
 9. Behavioral Health providers;
 10. Hospital providers;
 11. FQHCs and RHCs;
 12. Telemedicine; and
 13. Major Subcontractors (e.g., including, but not limited to transportation, pharmacy, dental, and DME), Preferred Vendors, and Sole Source Providers, as defined in contract.
- B. Current MCOs are required to maintain Subcontractor agreements. Current MCOs and Centennial Care 2.0 MCOs shall provide HSD with information related to the establishment and maintenance of their subcontracts in a format and frequency as directed by HSD.

XI. PERFORMANCE MEASURES AND DELIVERY SYSTEM IMPROVEMENT PERFORMANCE TARGETS

- A. Requirements for Current MCOs:
1. Performance Measures included in Contract Amendment #8 will continue to be in effect through December 31, 2018 for the Current MCOs. Current MCOs will be required to deliver their audited HEDIS for Calendar Year 2018 to HSD by June 30, 2019.
 2. Delivery System Improvement Performance Targets (DSIPTs) included in Contract Amendment #8 will continue to be in effect through December 31, 2018 for the Current MCOs.
- B. Centennial Care 2.0 MCOs will be required to be in compliance with all Performance Measures and DS IPT requirements effective January 1, 2019.

XI. OTHER COMMUNICATION

- A. All public communications regarding Centennial Care 2.0 initiated by an MCO must be submitted to HSD for review and approval at least thirty (30) calendar days prior to issuance of the communication.
- B. All requests for information made to any MCO regarding Centennial Care and Centennial Care 2.0 from the media, advocates, other entities, etc. and the MCO proposed responses must be submitted to HSD for review and approval at least three (3) business days prior to issuance of the communication.
- C. The Current MCOs and the Centennial Care 2.0 MCOs shall jointly develop Frequently Asked Questions and talking points regarding transition issues within thirty (30) Calendar Days of the Centennial Care 2.0 awards for HSD for approval.

XII. EMPLOYMENT PRACTICES

Within sixty (60) calendar days of HSD's award notification of the Centennial Care 2.0 MCOs, all Current MCOs and Centennial Care 2.0 MCOs shall identify to HSD a designated "Recruitment Specialist" within their Human Resources Department who will coordinate the recruitment, retention, and hiring of experienced and qualified staff to ensure continuity of care for Members.

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IN WITNESS WHEREOF, the parties have executed this Agreement to be effective upon the date of HSD's signature.

Western Sky Community Care, Inc.

By: Brent Dwyer

Date: 1/10/18

Title: EUP, Chief Business Development Officer

STATE OF NEW MEXICO

By: [Signature]
Brent Earnest, Cabinet Secretary
Human Services Department

Date: 1/8/18

Approved as to Form and Legal sufficiency:

By: [Signature]
Christopher Collins, Chief Legal Counsel
Human Services Department

Date: 1/18/18