PSC 24-630-8000-0001
CFDA #93.778

STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
PROFESSIONAL SERVICES CONTRACT

THIS AGREEMENT is made and entered into by and between the State of New Mexico **Human Services Department**, hereinafter referred to as the "HSD" or the "Department", and **Comagine Health**, hereinafter referred to as the "Contractor."

WHEREAS, HSD's Chief Procurement Officer, Office of General Counsel, and Chief Financial Officer, have made a determination that this Agreement is exempt from the provisions of the New Mexico Procurement Code (NMSA 1978, 13-1-28 et seq.) pursuant to NMSA 1978, § 13-1-98.1, because the execution of the Agreement will likely reduce health care costs, improve quality of care and improve access to care; and

IT IS AGREED BETWEEN THE PARTIES:

1. Scope of Work.

A. The Contractor shall perform all services detailed in Exhibits A, Scope of Work, attached to this Agreement, and in accordance with all pertinent Federal and State statutes, regulations, rules, policies and/or procedures, including any supplemental directives issued by the Centers for Medicare and Medicaid Services (CMS).

2. Compensation.

A. The HSD shall pay to the Contractor in full payment for services satisfactorily performed according to the rates identified in Exhibit B, attached hereto, inclusive of gross receipts tax. The New Mexico gross receipts tax, if applicable, levied on the amounts payable under this PSC shall be paid by the Contractor. The parties do not intend for the Contractor to continue to provide services without compensation when the total compensation amount is reached. The Contractor is responsible for notifying the HSD when the services provided under this Agreement reach the total compensation amount. In no event will the Contractor be paid for services provided in excess of the total compensation amount without this Agreement being amended in writing prior to those services in excess of the total compensation amount being provided.

B. Payment is subject to availability of funds pursuant to the Appropriations Paragraph set forth below and to any negotiations between the parties from year to year pursuant to Paragraph 1, Scope of Work, and to approval by the DFA. All invoices MUST BE received by the HSD no later than fifteen (15) days after the termination of the Fiscal Year in which the services were delivered. **Invoices received after such date WILL NOT BE PAID.**

C. Contractor must submit a detailed statement accounting for all services performed and expenses incurred. If the HSD finds that the services are not acceptable, within thirty days after the date of receipt of written notice from the Contractor that payment is requested, it shall provide the Contractor a letter of exception explaining the defect or objection to the services,

and outlining steps the Contractor may take to provide remedial action. Upon certification by the HSD that the services have been received and accepted, payment shall be tendered to the Contractor within thirty days after the date of acceptance. If payment is made by mail, the payment shall be deemed tendered on the date it is postmarked. However, the agency shall not incur late charges, interest, or penalties for failure to make payment within the time specified herein.

3. Term.

This Agreement is effective July 1, 2023 and shall terminate June 30, 2025, unless terminated pursuant to paragraph 4 (Termination), or paragraph 5 (Appropriations) per NMSA 1978, Section 13-11-98.1

4. Termination.

A. Grounds. The HSD may terminate this Agreement for convenience or cause. The Contractor may only terminate this Agreement based upon the HSD's uncured, material breach of this Agreement.

B. Notice; HSD Opportunity to Cure.

1. Except as otherwise provided in Paragraph (4)(B)(3), the HSD shall give Contractor written notice of termination at least thirty (30) days prior to the intended date of termination.
2. Contractor shall give HSD written notice of termination at least thirty (30) days prior to the intended date of termination, which notice shall (i) identify all the HSD's material breaches of this Agreement upon which the termination is based and (ii) state what the HSD must do to cure such material breaches. Contractor's notice of termination shall only be effective (i) if the HSD does not cure all material breaches within the thirty (30) day notice period or (ii) in the case of material breaches that cannot be cured within thirty (30) days, the HSD does not, within the thirty (30) day notice period, notify the Contractor of its intent to cure and begin with due diligence to cure the material breach.
3. Notwithstanding the foregoing, this Agreement may be terminated immediately by HSD upon written notice to the Contractor (i) if the Contractor becomes unable to perform the services contracted for, as determined by the HSD; (ii) if, during the term of this Agreement, the Contractor is suspended or debarred by the State Purchasing Agent in accordance with subparagraph (B)(2) of Section 27, Debarment and Suspension; or (iii) the Agreement is terminated pursuant to Paragraph 5, "Appropriations", of this Agreement.

C. Liability. Except as otherwise expressly allowed or provided under this Agreement, the HSD's sole liability upon termination shall be to pay for acceptable work performed prior to the Contractor's receipt or issuance of a notice of termination; provided, however, that a notice of termination shall not nullify or otherwise affect either party's liability for pre-termination defaults under, or breaches of, this Agreement. The Contractor shall submit an invoice for such work within thirty (30) days of receiving or sending the notice of termination. *THIS PROVISION IS NOT*

EXCLUSIVE AND DOES NOT WAIVE THE AGENCY'S OTHER LEGAL RIGHTS AND REMEDIES CAUSED BY THE CONTRACTOR'S DEFAULT/BREACH OF THIS AGREEMENT.

D. Termination Management. Immediately upon receipt by either the HSD or the Contractor of notice of termination of this Agreement, the Contractor shall: 1) not incur any further obligations for salaries, services or any other expenditure of funds under this Agreement without written approval of the HSD; 2) comply with all directives issued by the HSD in the notice of termination as to the performance of work under this Agreement; and 3) take such action as the HSD shall direct for the protection, preservation, retention or transfer of all property titled to the HSD and records generated under this Agreement. Any non-expendable personal property or equipment provided to or purchased by the Contractor with contract funds shall become property of the HSD upon termination and shall be submitted to the agency as soon as practicable.

5. Appropriations.

The terms of this Agreement are contingent upon sufficient appropriations and authorization being made by the Legislature of New Mexico for the performance of this Agreement. If sufficient appropriations and authorization are not made by the Legislature, this Agreement shall terminate immediately upon written notice being given by the HSD to the Contractor. The HSD's decision as to whether sufficient appropriations are available shall be accepted by the Contractor and shall be final. If the HSD proposes an amendment to the Agreement to unilaterally reduce funding, the Contractor shall have the option to terminate the Agreement or to agree to the reduced funding, within thirty (30) days of receipt of the proposed amendment.

6. Status of Contractor.

The Contractor and its agents and employees are independent contractors performing professional services for the HSD and are not employees of the State of New Mexico. The Contractor and its agents and employees shall not accrue leave, retirement, insurance, bonding, use of state vehicles, or any other benefits afforded to employees of the State of New Mexico as a result of this Agreement. The Contractor acknowledges that all sums received hereunder are reportable by the Contractor for tax purposes, including without limitation, self-employment and business income tax. The Contractor agrees not to purport to bind the State of New Mexico unless the Contractor has express written authority to do so, and then only within the strict limits of that authority.

7. Assignment.

The Contractor shall not assign or transfer any interest in this Agreement or assign any claims for money due or to become due under this Agreement without the prior written approval of the HSD.

8. Subcontracting.

The Contractor shall not subcontract any portion of the services to be performed under this Agreement without the prior written approval of the HSD. No such subcontract shall relieve the primary Contractor from its obligations and liabilities under this Agreement, nor shall any subcontract obligate direct payment from the Procuring Agency.

9. Release.

Final payment of the amounts due under this Agreement shall operate as a release of the HSD, its officers and employees, and the State of New Mexico from all liabilities, claims and obligations whatsoever arising from or under this Agreement.

10. Confidentiality.

Any confidential information provided to or developed by the Contractor in the performance of this Agreement shall be kept confidential and shall not be made available to any individual or organization by the Contractor without the prior written approval of the HSD.

11. Product of Service - Copyright.

All materials developed or acquired by the Contractor under this Agreement shall become the property of the State of New Mexico and shall be delivered to the HSD no later than the termination date of this Agreement. Nothing developed or produced, in whole or in part, by the Contractor under this Agreement shall be the subject of an application for copyright or other claim of ownership by or on behalf of the Contractor.

12. Conflict of Interest; Governmental Conduct Act.

A. The Contractor represents and warrants that it presently has no interest and, during the term of this Agreement, shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance or services required under the Agreement.

B. The Contractor further represents and warrants that it has complied with, and, during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the Governmental Conduct Act, Chapter 10, Article 16 NMSA 1978. Without in anyway limiting the generality of the foregoing, the Contractor specifically represents and warrants that:

1. in accordance with Section 10-16-4.3 NMSA 1978, the Contractor does not employ, has not employed, and will not employ during the term of this Agreement any HSD employee while such employee was or is employed by the HSD and participating directly or indirectly in the HSD's contracting process;
2. this Agreement complies with Section 10-16-7(A) NMSA 1978 because (i) the Contractor is not a public officer or employee of the State; (ii) the Contractor is not a member of the family of a public officer or employee of the State; (iii) the Contractor is not a business in which a public officer or employee or the family of a public officer or employee has a substantial interest; or (iv) if the Contractor is a public officer or employee of the State, a member of the family of a public officer or employee of the State, or a business in which a public officer or employee of the State or the family of a public officer or employee of the State has a substantial interest, public notice was given as required by Section 10-16-7(A) NMSA 1978 and this Agreement was awarded pursuant to a competitive process;
3. in accordance with Section 10-16-8(A) NMSA 1978, (i) the Contractor is not, and has not been represented by, a person who has been a public officer

or employee of the State within the preceding year and whose official act directly resulted in this Agreement and (ii) the Contractor is not, and has not been assisted in any way regarding this transaction by, a former public officer or employee of the State whose official act, while in State employment, directly resulted in the HSD's making this Agreement;

4. this Agreement complies with Section 10-16-9(A) NMSA 1978 because (i) the Contractor is not a legislator; (ii) the Contractor is not a member of a legislator's family; (iii) the Contractor is not a business in which a legislator or a legislator's family has a substantial interest; or (iv) if the Contractor is a legislator, a member of a legislator's family, or a business in which a legislator or a legislator's family has a substantial interest, disclosure has been made as required by Section 10-16-9(A) NMSA 1978, this Agreement is not a sole source or small purchase contract, and this Agreement was awarded in accordance with the provisions of the Procurement Code;
5. in accordance with Section 10-16-13 NMSA 1978, the Contractor has not directly participated in the preparation of specifications, qualifications or evaluation criteria for this Agreement or any procurement related to this Agreement; and
6. in accordance with Section 10-16-3 and Section 10-16-13.3 NMSA 1978, the Contractor has not contributed, and during the term of this Agreement shall not contribute, anything of value to a public officer or employee of the HSD.

C. Contractor's representations and warranties in Paragraphs A and B of this Article 12 are material representations of fact upon which the HSD relied when this Agreement was entered into by the parties. Contractor shall provide immediate written notice to the HSD if, at any time during the term of this Agreement, Contractor learns that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances. If it is later determined that Contractor's representations and warranties in Paragraphs A and B of this Article 12 were erroneous on the effective date of this Agreement or have become erroneous by reason of new or changed circumstances, in addition to other remedies available to the HSD and notwithstanding anything in the Agreement to the contrary, the HSD may immediately terminate the Agreement.

D. All terms defined in the Governmental Conduct Act have the same meaning in this Article 12(B).

13. <u>Amendment.</u>

A. This Agreement shall not be altered, changed or amended except by instrument in writing executed by the parties hereto and all other required signatories.

B. If the HSD proposes an amendment to the Agreement to unilaterally reduce funding due to budget or other considerations, the Contractor shall, within thirty (30) days of receipt of the proposed Amendment, have the option to terminate the Agreement, pursuant to the termination provisions as set forth in Article 4 herein, or to agree to the reduced funding.

14. Merger.

This Agreement incorporates all the Agreements, covenants and understandings between the parties hereto concerning the subject matter hereof, and all such covenants, Agreements and understandings have been merged into this written Agreement. No prior Agreement or understanding, oral or otherwise, of the parties or their agents shall be valid or enforceable unless embodied in this Agreement.

15. Penalties for Violation of Law.

The Procurement Code, Sections 13-1-28 through 13-1-199, NMSA 1978, imposes civil and criminal penalties for its violation. In addition, the New Mexico criminal statutes impose felony penalties for illegal bribes, gratuities and kickbacks.

16. Equal Opportunity Compliance.

The Contractor agrees to abide by all federal and state laws and rules and regulations, and executive orders of the Governor of the State of New Mexico, pertaining to equal employment opportunity. In accordance with all such laws of the State of New Mexico, the Contractor assures that no person in the United States shall, on the grounds of race, religion, color, national origin, ancestry, sex, age, physical or mental handicap, or serious medical condition, spousal affiliation, sexual orientation or gender identity, be excluded from employment with or participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity performed under this Agreement. If Contractor is found not to be in compliance with these requirements during the life of this Agreement, Contractor agrees to take appropriate steps to correct these deficiencies.

17. Applicable Law.

The laws of the State of New Mexico shall govern this Agreement, without giving effect to its choice of law provisions. Venue shall be proper only in a New Mexico court of competent jurisdiction in accordance with Section 38-3-1 (G) NMSA 1978. By execution of this Agreement, Contractor acknowledges and agrees to the jurisdiction of the courts of the State of New Mexico over any and all lawsuits arising under or out of any term of this Agreement.

18. Workers Compensation.

The Contractor agrees to comply with state laws and rules applicable to workers compensation benefits for its employees. If the Contractor fails to comply with the Workers Compensation Act and applicable rules when required to do so, this Agreement may be terminated by the HSD.

19. Records and Financial Audit.

A. The Contractor shall maintain detailed time and expenditure records that indicate the date, time, nature and cost of services rendered during the Agreement's term and effect and retain them for a period of five (5) years from the date of final payment under this Agreement. The records shall be subject to inspection by the HSD, the Department of Finance and Administration and the State Auditor. The HSD shall have the right to audit billings both before and after payment. Payment under this Agreement shall not foreclose the right of the HSD to recover excessive or illegal payments.

B. The Contractor shall contract for an independent A-133 audit at the its expense, as applicable. The Contractor shall ensure that the auditor is licensed to perform audits in the State of New Mexico. The Contractor shall enter into a written contract with the auditor specifying the scope of the audit, the auditor's responsibility, the date by which the audit is to be completed and the fee to be paid to the auditor for this service. Single audits shall comply with procedures specified by the HSD. The audit of the contract shall cover compliance with Federal Regulations and all financial transactions hereunder for the entire term of the Agreement in accordance with procedures promulgated by OMB Circulars or by Federal program officials for the conduct and report of such audits. An official copy of the independent auditor's report shall be made available to the HSD and any other authorized entity as required by law within fifteen (15) days of receipt of the final audit report. The Contractor may request an extension to the deadline for submission of the audit report in writing to the HSD for good cause and the HSD reserves the right to approve or reject any such request. The HSD retains the right to contract for an independent financial and functional audit for funds and operations under this if it determines that such an audit is warranted or desired.

C. Upon completion of the audit under the applicable federal and state statutes and regulations, the Contractor shall notify the HSD when the audit is available for review and provide online access to the HSD, or the Contractor shall provide the HSD with four (4) originals of the audit report.

D. Within thirty (30) days thereafter or as otherwise determined by the HSD in writing, the Contractor shall provide the HSD with a response indicating the status of each of the exceptions or findings in the said audit report. If either the exceptions or findings in the audit are not resolved within thirty (30) days, the HSD has the right to reduce funding, terminate this Agreement, and/or recommend decertification in compliance with state and/or federal regulations governing such action.

E. This audit shall contain a schedule of financial expenditures for each program to facilitate ease of reconciliation by the HSD. This audit shall also include a schedule of depreciation for all property or equipment with a purchase price of $5,000 or more pursuant to OMB Circulars A-21, A-87, A-110, A-122 and A-133 where appropriate.

F. This audit shall include a report on compliance with requirements applicable to each major program and internal control over compliance in accordance with OMB Circulars A-21, A-87, A-110, A-122 and A-133 where appropriate.

20. <u>Indemnification.</u>

The Contractor shall defend, indemnify and hold harmless the HSD and the State of New Mexico from all actions, proceeding, claims, demands, costs, damages, attorneys' fees and all other liabilities and expenses of any kind from any source which may arise out of the performance of this Agreement, caused by the negligent act or failure to act of the Contractor, its officers, employees, servants, subcontractors or agents, or if caused by the actions of any client of the Contractor resulting in injury or damage to persons or property during the time when the Contractor or any officer, agent, employee, servant or subcontractor thereof has or is performing services pursuant to this Agreement. In the event that any action, suit or proceeding related to the

services performed by the Contractor or any officer, agent, employee, servant or subcontractor under this Agreement is brought against the Contractor, the Contractor shall, as soon as practicable but no later than two (2) days after it receives notice thereof, notify the legal counsel of the HSD and the Risk Management Division of the New Mexico General Services Department by certified mail.

21. New Mexico Employees Health Coverage.

A. If Contractor has, or grows to, six (6) or more employees who work, or who are expected to work, an average of at least 20 hours per week over a six (6) month period during the term of the contract, Contractor certifies, by signing this agreement, to have in place, and agree to maintain for the term of the contract, health insurance for those employees and offer that health insurance to those employees if the expected annual value in the aggregate of any and all contracts between Contractor and the State exceed $250,000 dollars.

B. Contractor agrees to maintain a record of the number of employees who have (a) accepted health insurance; (b) declined health insurance due to other health insurance coverage already in place; or (c) declined health insurance for other reasons. These records are subject to review and audit by a representative of the state.

C. Contractor agrees to advise all employees of the availability of State publicly financed health care coverage programs by providing each employee with, as a minimum, the following web site link to additional information https://www.bewellnm.com/

22. Invalid Term or Condition.

If any term or condition of this Agreement shall be held invalid or unenforceable, the remainder of this Agreement shall not be affected and shall be valid and enforceable.

23. Enforcement of Agreement.

A party's failure to require strict performance of any provision of this Agreement shall not waive or diminish that party's right thereafter to demand strict compliance with that or any other provision. No waiver by a party of any of its rights under this Agreement shall be effective unless express and in writing, and no effective waiver by a party of any of its rights shall be effective to waive any other rights.

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 HSD: La Risa Rodges, Contract Manager
Exempt Services and Programs Bureau
Human Services Department, Medical Assistance Division
PO Box 2348
Santa Fe, NM 87504-2348
LaRisa.Rodges@nm.hsd.gov

To the Contractor: Foster C. "Bud" Beall Jr., MA
Vice President, Care Management
10700 Meridian Ave North, Suite 300
PO Box 33400
Seattle, WA 98133
BBeall@comagine.org

25. Debarment and Suspension

A. Consistent with either 7 C.F.R. Part 3017 or 45 C.F.R. Part 76, as applicable, and as a separate and independent requirement of this PSC the Contractor certifies by signing this PSC, that it and its principals, to the best of its knowledge and belief: (1) are not debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal department or agency; (2) have not, within a three-year period preceding the effective date of this PSC, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; (3) have not been indicted for, or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with, commission of any of the offenses enumerated above in this Paragraph A; (4) have not, within a three-year period preceding the effective date of this PSC, had one or more public agreements or transactions (Federal, State or local) terminated for cause or default; and (5) have not been excluded from participation from Medicare, Medicaid or other federal health care programs pursuant to Title XI of the Social Security Act, 42 U.S.C. § 1320a-7.

B. The Contractor's certification in Paragraph A, above, is a material representation of fact upon which the HSD relied when this PSC was entered into by the parties. The Contractor's certification in Paragraph A, above, shall be a continuing term or condition of this PSC. As such at all times during the performance of this PSC, the Contractor must be capable of making the certification required in Paragraph A, above, as if on the date of making such new certification the Contractor was then executing this PSC for the first time. Accordingly, the following requirements shall be read so as to apply to the original certification of the Contractor in Paragraph A, above, or to any new certification the Contractor is required to be capable of making as stated in the preceding sentence:

1. The Contractor shall provide immediate written notice to the HSD's Program Manager if, at any time during the term of this PSC, the Contractor learns that its certification in Paragraph A, above, was erroneous on the effective date of this PSC or has become erroneous by reason of new or changed circumstances.

2. If it is later determined that the Contractor's certification in Paragraph A, above, was erroneous on the effective date of this PSC or has become erroneous by reason of new or changed circumstances, in addition to other remedies available to the HSD, the HSD may immediately terminate the

PSC.

C. As required by statute, regulation or requirement of this PSC, and as contained in Paragraph A, above, the Contractor shall require each proposed first-tier subcontractor whose subcontract will equal or exceed $25,000, to disclose to the Contractor, in writing, whether as of the time of award of the subcontract, the subcontractor, or its principals, is or is not debarred, suspended, or proposed for debarment by any Federal department or agency. The Contractor shall make such disclosures available to the HSD when it requests subcontractor approval from the HSD. If the subcontractor, or its principals, is debarred, suspended, or proposed for debarment by any Federal, state or local department or agency, the HSD may refuse to approve the use of the subcontractor.

26. Certification and Disclosure Regarding Payments to Influence Certain Federal Transactions

A. The applicable definitions and exceptions to prohibited conduct and disclosures contained in 31 U.S.C. § 1352 and 45 C.F.R. Part 93 or Subparts B and C of 7 C.F.R. Part 3018, as applicable, are hereby incorporated by reference in subparagraph (B) of this certification.

B. The Contractor, by executing this PSC, certifies to the best of its knowledge and belief that:

1. No Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement; and

2. If any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with this solicitation, the offeror shall complete and submit, with its offer, OMB standard form LLL, Disclosure of Lobbying Activities, to the Contracting Officer.

C. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

D. This certification is a material representation of fact upon which reliance is placed when this PSC is made and entered into. Submission of this certification is a prerequisite

for making and entering into this PSC imposed under 31 U.S.C. § 1352. It shall be a material obligation of the Contractor to keep this certification current as to any and all individuals or activities of anyone associated with the Contractor during the pendency of this PSC Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision, shall be subject to: (1) a civil penalty of not less than $10,000 and not more than $100,000 for such failure; and/or (2) at the discretion of the HSD, termination of the PSC.

27. Non–Discrimination

A. The Contractor agrees to comply fully with Title VI of the Civil Rights Act of 1964, as amended; the Rehabilitation Act of 1973, Public Law 93-112, as amended; and the Americans With Disabilities Act of 1990, Public Law 101-336; in that there shall be no discrimination against any employee who is employed in the performance of this PSC, or against any applicant for such employment, because of age, color, national origin, ancestry, race, religion, creed, disability, sex, or marital status.

B. This provision shall include, but not be limited to, the following: employment, promotion, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training including apprenticeship.

C. The Contractor agrees that no qualified handicapped person shall, on the basis of handicap, be excluded from participation or be denied the benefits of, or otherwise be subjected to discrimination under any program or activity of the Contractor. The Contractor further agrees to insert similar provisions in all subcontracts for services allowed under this PSC under any program or activity.

D. The Contractor agrees to provide meaningful access to services for individuals with Limited English Proficiency (LEP) in accordance with Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency."

28. Drug Free Workplace

A. *Definitions.* As used in this paragraph—

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act, 21 U.S.C 812, and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

"Conviction" means a finding of guilt (including a plea of *nolo contendere*) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession, or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract where employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a contractor directly engaged in the performance of work under a Government contract. "Directly engaged" is defined to include all direct cost employees and any

other contractor employee who has other than a minimal impact or involvement in contract performance.
"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

B. The Contractor, if other than an individual, shall:

1. Publish a statement notifying its employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

2. Establish an ongoing drug-free awareness program to inform such employees about:
   (i) The dangers of drug abuse in the workplace;
   (ii) The Contractor's policy of maintaining a drug-free workplace:
   (iii) Any available drug counseling, rehabilitation, and employee assistance programs; and
   (iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

3. Provide all employees engaged in performance of the PSC with a copy of the statement required by subparagraph B(1);

4. Notify such employees in writing in the statement required by subparagraph (B)(1) of this clause that, as a condition of continued employment on this PSC, the employee will:
   (i) Abide by the terms of the statement; and
   (ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than five (5) days after such conviction;

5. Notify the HSD Program Manager in writing within ten (10) days after receiving notice under (B)(4)(ii) of this paragraph, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee;

6. Within thirty (30) days after receiving notice under B(4)(ii) of this paragraph of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:
   (i) Taking appropriate personnel action against such employee, up to and including termination; or

(ii) Require such employee to satisfactorily participate in drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

7. Make a good faith effort to maintain a drug-free workplace through implementation of B (1) through B(6) of this paragraph.

C. The Contractor, if an individual, agrees by entering into this PSC not to engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance while performing this contract.

D. In addition to other remedies available to the HSD, the Contractor's failure to comply with the requirements of subparagraph B or C of this paragraph will render the Contractor in default of this PSC and subject the Contractor to suspension of payments under the PSC and/or termination of the PSC in accordance with paragraph 4, above.

29. Performance

In performance of this contract, the Contractor agrees to comply with and assume responsibility for compliance by its employees and its subcontractors and/or Business Associates with the following acknowledged definitions and requirements:

A. Definitions:

Personally Identifiable Information (PII) is information that can be used on its own or with other information to identify, contact, or locate a single person, or to identify an individual in context. PII may involve any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history, and information which can be used to distinguish or trace an individual's identity, such as their name, social security number, date and place of birth, mother's maiden name, biometric records, etc., including any other personal information which is linked or linkable to an individual.

PII Breach shall mean a loss of PII control amounting to actual or potential or temporary compromise, including: unauthorized acquisition or access; or any similar situation involving unauthorized use through inappropriate PII access, potential or confirmed; regardless of format whether physical (e.g., paper) or electronic.

B. All work will be performed under the supervision of the Contractor or the Contractor's responsible employees.

C. Contractor agrees that any personally identifiable information (PII) made available shall be used only for the purpose of carrying out the provisions of this contract. Information contained in such material shall be treated as confidential and will not be divulged or made known in any manner to any person or entity except as may be necessary in the performance of this contract. Inspection by or disclosure to any person or entity other than an officer or employee of the Contractor is prohibited.

D. All PII will be accounted for upon receipt and properly stored before, during, and after processing. In addition, all related output will be given the same level of protection as required for the source material.

E. The Contractor certifies that any PII data remaining in any storage component after the work is completed will be safeguarded to prevent unauthorized disclosures.

F. Any spoilage or any intermediate hard copy printout that may result during the processing of PII will be given to the Procuring Agency or his or her designee. When this is not possible, the Contractor will be responsible for the destruction of the spoilage or any intermediate hard copy printouts, and will provide the agency or his or her designee with a statement containing the date of destruction, description of material destroyed, and the method used.

G. All computer systems, office equipment, and portable media receiving, processing, storing, or transmitting Protected Health Information (PHI), or personally identifiable information(PII) must meet the requirements defined in HIPAA Security Rule, 45 CFR 160. To meet functional and assurance requirements, the security features of the environment must provide for the managerial, operational, and technical controls. All security features must be available and activated to protect against unauthorized use of and access to Federal tax information.

H. The Contractor will provide signed acknowledgments for its staff and its subcontractors and/or BA staff, to provide certification that information security awareness and training was completed. These signed certifications will be provided to the agency contract manager upon contract start and annually thereafter.

I. The Procuring Agency will have the right to terminate the contract if the Contractor or its subcontractors or BAs fail to provide the safeguards described above, consistent with the termination clause herein.

30. <u>Criminal/Civil Sanctions</u>

A. It is incumbent upon Contractor to inform its officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C.552a. Specifically, 5 U.S.C. 552a(i)(1), which is made applicable to contractors by 5 U.S.C. 552a(m)(1), provides that any officer or employee of a contractor, who by virtue of his/her employment or official position, has possession of or access to Procuring Agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is so prohibited, willfully discloses the material in any manner to any person not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

B. Contractor agrees that granting access to PII must be preceded by certifying that each individual understands the Procuring Agency's applicable security policy and procedures for safeguarding PII.

31. Inspection

The Procuring Agency shall have the right to send its officers and/or employees into the offices and plants of the contractor for inspection of the facilities and operations provided for the performance of any work related Protected Health Information (PHI) and/or Personally Identifiable Information (PII) under this contract. On the basis of such inspection, specific measures may be required in cases where the contractor is found to be noncompliant with contract safeguards.

32. Contractor's Responsibility for Compliance With Laws and Regulations

A. The Contractor is responsible for compliance with applicable laws, regulations, and administrative rules that govern the Contractor's performance of the Scope of Work of this Agreement and Exhibit A, including but not limited to, applicable State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements and licensing provisions.

B. The Contractor is responsible for causing each of its employees, agents or subcontractors who provide services under this Agreement to be properly licensed, certified, and/or have proper permits to perform any activity related to the Scope of Work of this Agreement and Exhibit A.

C. If the Contractor's performance of its obligations under the terms of this agreement makes it a business associate of the Procuring Agency as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder, the CONTRACTOR agrees to the terms of the HSD HIPAA Business Associate Agreement (BAA), attached hereto as Exhibit D.

33. Contractor's Responsibility for Compliance With Laws and Regulations Relating to Information

A. The Contractor and all its employees, subcontractors, consultants, or agents performing the Services under this Agreement must comply with the following insofar as they apply to Contractor's processing or storage of Procuring Agency's data:

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. The New Mexico Administrative Code (NMAC) 1.12.20, *et seq*.

24. Authority.

If Contractor is other than a natural person, the individual(s) signing this Agreement on behalf of Contractor represents and warrants that he or she has the power and authority to bind Contractor, and that no further action, resolution, or approval from Contractor is necessary to enter into a binding contract.

The remainder of this page intentionally left blank.

IN WITNESS WHEREOF, the Parties have executed this Agreement as indicated by signature of all Parties below.

By: DocuSigned by: Kari Armijo 1BA9EB5EAD00499... Date: 4/4/2023
HSD Cabinet Secretary

By: DocuSigned by: Carolee A. Graham FB15A98045214DA... Date: 3/30/2023
HSD Chief Financial Officer

Approved as to form and legal sufficiency:

By: DocuSigned by: 5709D277B0FC4AA... Date: 3/30/2023
HSD Office of General Counsel

By: DocuSigned by: Foster C. "Bud" Beall, Jr., MD 92B767E4E580408... Date: 3/29/2023
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.

TBIN: 03-295345-00-3

By: DocuSigned by: AnnMarie Lucero A1E23200AE974AA... Date: 4/4/2023
Taxation and Revenue Department

EXHIBIT

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 HSD staff, HSD Medical Director and/or HSD 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 HSD.

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 that 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 oversee this Agreement, work in partnership with the HSD 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 HSD Contract Manager, representatives of HSD/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; Centennial Care Managed Care Organizations; and other contractors as, from time-to-time, identified by the State.

F. The Contractor shall inform HSD of any changes in the Contractor's key personnel within 30 days of hire. The term Key Personnel as used herein refers to the Contractor's TPA/FFS UR Contract Manager, supervisors and/or 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 HSD Contract Manager for approval.

G. HSD reserves the right to require the Contractor to make changes in key personnel assignments if the key personnel is/are not, in HSD's sole discretion, meeting the needs and expectations of HSD or the needs of the recipients in implementing and enforcing the terms of this Agreement. Specific reasons shall be detailed by the HSD 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 HSD 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, primary reviewers, medical director, and clerical personnel shall reside in New Mexico;

2. The Contractor shall perform all reviews described in this Agreement and the customer service function at the New Mexico location(s).

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, and 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 HSD'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 work in partnership with HSD on the successful implementation of all components of this Agreement. HSD 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 HSD.

In this regard, HSD 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 Centennial Care and other Medicaid health care 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 HSD direction with the New Mexico Department of Health (DOH), other HSD contractors, and stakeholders on the delivery of services to recipients and providers.

F. The Contractor shall coordinate as necessary with the Centennial Care Managed Care Organizations (MCOs) to ensure that recipient and provider questions regarding authorizations are appropriately directed to the HSD-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 HSD-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 HSD, 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 HSD 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.hsd.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, child care 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 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 an 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 HSD/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, HSD will deny payment for that service.

5. Retrospective: This Category of Review is performed on assigned

cases after 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.

6. 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 HSD's expected performance level as set forth in this PSC.

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

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

III. Administrative Functions

A. Prior to actual date of review operations, the Contractor shall develop and submit to HSD 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 HSD/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 HSD-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 HSD-directed policy changes and other changes in the external environment, the Contractor should anticipate frequent changes in procedures.

D. The Contractor shall provide to HSD 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 HSD for review and approval prior to

implementation. HSD 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 HSD-requested changes by forwarding revised detailed Policies and Standard Operating Procedures for review to HSD within fifteen (15) business days from the date of the written request, or as stipulated in the HSD 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 HSD-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 is applied; what forms and other documentation are required; how the decision is communicated to the requesting provider, HSD 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 HSD/MAD Program Rules, HCBS waivers Service Standards and other utilization review guidance that HSD 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 HSD. Examples of this partnership

includes attending, facilitating and actively participating in meetings with HSD and DOH staff and offering input on a variety of TPA/FFS UR topics to HSD 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 HSD request, participate in ad hoc meetings at the Contractor's location or in Santa Fe with HSD and associated state agencies, the fiscal agent, providers and MCOs, and other stakeholders involved with TPA/FFS UR activities.

D. The Contractor shall, upon HSD request, facilitate or otherwise lead work groups or meetings with HSD, 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 HSD 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.

B. 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 HSD Contract Manger, and HSD Office of General Counsel, when required, regarding the case. Administrative hearings are not covered as Separately Reimbursable Services.

C. The Contractor is required to prepare documentation, to include, but not limited to Summary of Evidence (SOE), SOE Addendums, and Motions to Dismiss. SOE's 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 SOE's need to clearly illustrate the review timeline and actions that lead to the denial. The document must be organized and clearly labeled.

D. 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, HSD and DOH Program Mangers and claimant.

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 HSD-approved UR criteria while following HSD-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 HSD 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 years' 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 HSD upon request.

K. The Contractor shall release, as required by HSD 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, not deny or technically deny, the request. All denial and technical denial 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 (eg. MMIS entry) and notice of the review decision is available via the Contractor's provider portal and correspondence is mailed.

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. HSD 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 HSD-approved special projects.

F. 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 HSD 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	7 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	7 business days - Routine 1 business day – Expedited
LOC With in-home assessment In-home assessment	7 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 HSD

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 which 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).

G. The Contractor shall issue a RFI to notify the provider when a review request is incomplete or lacking 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.

H. 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 insure the integrity of this tracking system to the satisfaction of HSD.

VIII. Recipient and Provider Notices

A. The Contractor shall use HSD-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) days of the review decision, or as otherwise defined in this Agreement. Time taken for notification is included within the TAT calculation for review decisions.

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 HSD 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 HSD-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 HSD.

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 HSD.

B. The Contractor shall adhere to HSD defined standards and templates for all reports and reporting requirements. HSD shall provide the Contractor with all appropriate reporting templates, formats, instructions, submission timetables, and technical assistance as required. HSD 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 HSD, 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 HSD 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. HSD may, at its discretion, require the Contractor to submit additional reports, both ad hoc and recurring.

G. The Contractor shall submit all reports to HSD, 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 HSD

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 HSD's FTP site unless directed otherwise by HSD. 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. HSD shall notify the Contractor in the event that a report is no longer required.

L. HSD'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 HSD, after HSD has discussed such changes with the Contractor. HSD shall notify the Contractor, in writing, of changes to existing required report content, format or schedule at least fourteen (14) Calendar Days prior to implementing the reporting change. When possible, HSD shall notify the Contractor, in writing, of new reports at least forty-five (45) Calendar Days prior to implementing the new report.

X. Transition Management

A. The Contractor shall enter into a Transition Management Agreement with the prospective contractor, no later than 120 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 and interface specifications, state approved letter templates and other pertinent documents identified by the Contractor or HSD 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 HSD 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 HSD 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, timely manner.

B. The Contractor shall have the customer service function to accommodate both telephonic and electronic inquires 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 HSD.

C. The Contractor shall establish a TPA/FFS UR website, approved by HSD, 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 HSD. Website modifications requested by HSD 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 become insufficient to provide effective telephonic review access and customer service, the Contractor will install and maintain additional lines as needed or as directed by HSD. 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 HSD 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 hard copy upon request. HSD 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 HSD the step-by-step customer service process and procedures. The Contractor shall monitor the process and quality of service, and report to HSD on a monthly basis, the number of calls received by review type by provider or recipient, the average speeds of answer 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 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 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 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 HSD 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 HSD.

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

F. The Contractor shall provide HSD copies of all training and other material prior to dissemination to providers for HSD 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 HSD, the Contractor shall apply criteria approved by HSD 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 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 HSD.

C. Unless the documentation clearly indicates that a 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 HSD authorization.

F. The Contractor shall offer consultation and advice to HSD 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 HSD 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, HSD, DOH, and/or the Attorney General's office. Only relevant HSD 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 onsite for the form/file review within five (5) business days of receipt of 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 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 HSD 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 HSD 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 necessary information within that timeframe.

V. Future Services at Negotiated Rate

A. The Contractor shall negotiate with HSD 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 HSD 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 HSD 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 HSD 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 principals 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 with the appropriate information in a timely manner, fails to

renew the recipient's annual LOC, or is non-compliant with an in-home assessment.

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).

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 HSD.

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 HSD-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 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 HSD administrative hearing proceeds. A request for a continuation of the benefit shall be afforded to any claimant who requests the continuation within 10 calendar days of the mailing of the notice of action by MAD or the Contractor. The continuation of a benefit is only available to an individual that 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 HSD administrative hearing process and of the responsibility to repay MAD for the continued benefit if the HSD 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 HSD of its decision or recommendation via secure email. HSD will reply with the approval or denial of the Contractor's decision or recommendation. Once HSD'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 to 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 HSD or DOH, as determined by 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 that 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. HSD 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 HSD to have access: Date that Contractor received the SOE request form, 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 HSD-defined TPA/FFS UR data to HSD, or its designee. The Contractor shall have the capacity to interface with the HSD 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 HSD.

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. HSD-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 HSD the following TPA/FFS UR data by method of transmission on a daily basis:

Transmission Method	Review/Program Type
Submit Electronic File to HSD MMIS	FFS prior authorizations, LTC Spans for ICF-IID, Nursing Facilities, and some BH LTC spans
Exchange Electronic Interface File to HSD/ASPEN	Waiver LOC, PACE LOC, ICF-IID, Nursing Facilities
Direct data entry into MMIS/Omnicaid 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 HSD daily electronic interface files containing prior authorization data.

2. HSD 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/Omnicaid 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. The VDI server access requires that the Contractor use Personal Computers which meet minimum specifications of Pentium 3 with 256mg RAM and 200 mg free disc space and provide internet access with minimum DSL or T1 lines (modem access will not provide acceptable access).

E. The Contractor shall assign specific TPA/FFS UR staff to have access to

MMIS/Omnicaid system via a VDI token for direct data entry. The Contractor shall ensure that the MMIS/Omnicaid 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/Omnicaid and FMA online systems have received training on the MMIS/Omnicaid and FMA online

G. systems and the prior authorization system inquiry and update capabilities and LOC prior to performing data entry procedures. HSD, 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/Omnicaid 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/Omnicaid system file from HSD 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/Omnicaid system file from HSD.

I. The Contractor shall be able to receive, store, and use a daily MMIS/Omnicaid system file from HSD 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 transfer is specifically directed by HSD 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 HSD's personal computer (PC) application software for word processing, electronic spreadsheet, and data base management.

M. The Contractor shall cooperate with HSD, 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/Omnicaid 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 HSD system requests.

O. The Contractor shall allow HSD 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 HSD, 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 an 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 transactions 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 HSD 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 network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage;

3. System interruption or failure resulting from network, operating hardware, software or operational errors that compromises 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 HSD.

1.5 QUALITY STANDARDS AND MANAGEMENT

A. The Contractor shall demonstrate its ability to meet HSD'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; HSD-approved review criteria; and HSD-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 HSD 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 HSD to prepare complete documentation, participate in audits, provide a workspace and workstation for use by the HSD auditor and otherwise allow HSD to access to 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. New Mexico Medical Assistance Division Program Rule was followed for each review;

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

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

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

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

I. Corrective Action Plans

A. If HSD determines that the Contractor is not in compliance with one or more requirements in this Agreement, HSD 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 HSD Directed Corrective Action Plan (DCAP). A notice from HSD of noncompliance directing a CAP or DCAP will also serve as a notice for sanctions in the event HSD determines that monetary sanctions are also necessary.

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

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

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

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

II. Intermediate Sanctions

A. Monetary penalties of up 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 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 HSD.

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 HSD 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 HSD/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 HSD immediately.

C. The Contractor shall promptly conduct a preliminary investigation and report the

results of the investigation to HSD. 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 HSD 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 HSD.

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 HSD-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 HSD 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 HSD 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 HSD 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 HSD 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 HSD 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 HSD Contract Manger, and HSD 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 services, 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 HSD 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.

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

2.5 DENTAL SERVICES

A. The Contractor shall perform utilization review of HSD 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 for 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 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 HSD 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 type of services requested. The focus for 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 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 a requested service (reduction of care) if that amount exceeds the documented needs.

E. The Contractor shall complete the MAD 303 Form and communicate the review decision to the requestor in accordance with policies and procedures approved by HSD.

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. HSD Notification of Authorization of Application for Emergency Services for Non-Citizens (MAD 310 or MAD 778 Form or HSD/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 stays medical record pertinent to the service for which the provider seeks reimbursement.

    a) The Contractor shall run a report through MMIS/Omnicaid 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 HSD-approved letter template.

2.9 GENERAL HOSPITAL INPATIENT (IN-STATE)

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

A. As specifically directed by HSD, 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 HSD. The report contains the sample of acute general hospital inpatient paid hospitalizations selected using HSD-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 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 which 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 the 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 who is still in need of acute inpatient care but who 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 HSD 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 for 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 HSD and DOH 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 health care facility type. The chart below shows each waiver program for which the Contractor will have responsibilities, the corresponding

section of HSD 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 HSD)
Developmental Disabilities (DD)	8.314.5 NMAC	ICF-IID	DOH
Medically Fragile (MF)	8.314.3 NMAC	ICF-IID	DOH
Mi Via Waiver	8.314.6 NMAC	ICF-IID	DOH
Supports Waiver	8.314.7 NMAC	ICF-IID	DOH

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 allocants 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 HSD. 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 an 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 plan 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) DD LOC Reviews – Initial and Continuing/Annual

i. 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 a 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) DD LOC Increase Requests – (Does not apply to discharge LOC increases)

i. Requests for increases in LOC must originate from the DDSD Regional Office (RO), and must have a Regional Office Review of LOC Increase Form attached and completed. The LOC packet contains the same assessment information required as part of the LOC determination. The Contractor reviews the LOC packet, as well as the RO recommendation, and attached documentation of change of condition/ health status which meets criteria for the LOC change.

c) DD ISP/Budget Reviews – Initial, Annual, Initial Residential and Revision, and Professional Services:

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/Omnicaid system 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/Omnicaid system .

v. The Contactor will send the MMIS/Omnicaid 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 assure 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/Omnicaid 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 provision of services in two models: 1) agency based service delivery model; 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. Participants 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 a 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.

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 Contactor 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 in 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 HSD 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

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 HSD 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 HSD. 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 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 HSD-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 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. HSD 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 HSD.

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

A. The Contractor shall determine NF LOC for potential PACE members 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.
2. Medical Social Worker with a minimum of 1 year of relevant experience.
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 HSD. The Contractor shall develop internal reviewer trainings and evaluation using HSD approved materials. The Contractor shall submit an initial training material, evaluation and calendar of training events to HSD for approval. After final approval is given, HSD 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 HSD. 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 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 HSD 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 HSD, 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 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 HSD 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
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	$ 204.03 Annual Per Recipient

	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.	
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	**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.
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.
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.
W2	**Activity and TAT Jackson Class Report**	Weekly TAT Assessments for Budget Reviews for DDW Jackson Class Members. Report includes client level detail for all activity and aggregate summary.

EXHIBIT D

HIPAA Business Associate Agreement

This Business Associate Agreement ("BAA") is entered into between the New Mexico Human Services Department ("Department") and Comagine Health, hereinafter referred to as "Business Associate" , in order to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act"), including the Standards of the Privacy of Individually Identifiable Health Information and the Security Standards at 45 CFR Parts 160 and 164.

BUSINESS ASSOCIATE, by this PSC 24-630-8000-0001 has agreed to provide services to, or on behalf of the HSD which may involve the disclosure by the Department to the Business Associate (referred to in PSC 24-630-8000-0001 as "Contractor") of Protected Health Information. This Business Associate Agreement is intended to supplement the obligations of the Department and the Contractor as set forth in PSC 24-630-8000-0001, and is hereby incorporated therein.

THE PARTIES acknowledge HIPAA, as amended by the HITECH Act, requires that Department and Business Associate enter into a written agreement that provides for the safeguarding and protection of all Protected Health Information which Department may disclose to the Business Associate, or which may be created or received by the Business Associate on behalf of the Department.

1. Definition of Terms

A. Breach. "Breach" has the meaning assigned to the term breach under 42 U.S.C. § 17921(1) [HITECH Act § 13400 (1)] and 45 CFR § 164.402.

B. Business Associate. "Business Associate", herein being the same entity as the Contractor in PSC 24-630-8000-0001, shall have the same meaning as defined under the HIPAA standards as defined below, including without limitation Contractor acting in the capacity of a Business Associate as defined in 45 CFR § 160.103.

C. Department. "Department" shall mean in this agreement the State of New Mexico Human Services Department.

D. Individual. "Individual" shall have the same meaning as in 45 CFR §160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR §164.502 (g).

E. HIPAA Standards. "HIPAA Standards" shall mean the legal requirements as set forth in the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act of 2009, and the regulations and policy guidance, as each may be amended over time, including without limitation:

i. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information in 45 CFR Part 160 and Part 164, Subparts A and E.

ii. Breach Notification Rule. "Breach Notification" shall mean the Notification in the case of Breach of Unsecured Protected Health Information, 45 CFR Part 164, Subparts A and D

iii. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C, including the following:

F. Security Standards. "Security Standards" hereinafter shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.306.

G. Administrative Safeguards. "Administrative Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.308.

H. Physical Safeguards. "Physical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.310.

I. Technical Safeguards. "Technical Safeguards" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.312.

J. Policies and Procedures and Documentation Requirements. "Policies and Procedures and Documentation Requirements" shall mean the Standards for the Protection of Electronic Protected Health Information at 45 CFR §164.316.

K. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as in 45 CFR §160.103, limited to the information created, maintained, transmitted or received by Business Associate, its agents or subcontractors from or on behalf of Department.

L. Required By Law. "Required By Law" shall have the same meaning as in 45 CFR §164.103.

M. Secretary. "Secretary" shall mean the Secretary of the U. S. Department of Health and Human Services, or his or her designee.

N. Covered Entity. "Covered Entity" shall have the meaning as the term "covered entity" defined at 45 CFR §160.103, and in reference to the party to this BAA, shall mean the State of New Mexico Human Services Department.

Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the HIPAA Standards. All terms used and all statutory and regulatory references shall be as currently in effect or as subsequently amended.

2. Obligations and Activities of Business Associate

A. General Rule of PHI Use and Disclosure. The Business Associate may use or disclose PHI it creates for, receives from or on behalf of, the Department to perform functions, activities or services for, or on behalf of, the Department in accordance with the specifications set forth in this BAA and in this PSC 24-630-8000-0001; provided that such use or disclosure would not violate the HIPAA Standards if done by the Department; or as Required By Law.

i. Any disclosures made by the Business Associate of PHI must be made in accordance

with HIPAA Standards and other applicable laws.

ii. Notwithstanding any other provision herein to the contrary, the Business Associate shall limit uses and disclosures of PHI to the "minimum necessary," as set forth in the HIPAA Standards.

iii. The Business Associate agrees to use or disclose only a "limited data set" of PHI as defined in the HIPAA Standards while conducting the authorized activities herein and as delineated in PSC 24-630-8000-0001 , except where a "limited data set" is not practicable in order to accomplish those activities.

iv. Except as otherwise limited by this BAA or PSC 24-630-8000-0001, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

v. Except as otherwise limited by this BAA or PSC 24-630-8000-0001, Business Associate may disclose PHI for the proper management and administration of the Business Associate provided that the disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

vi. Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR § 164.502(j).

vii. Business Associate may use PHI to provide Data Aggregation services to the Department as permitted by the HIPAA Standards.

B. Safeguards. The Business Associate agrees to implement and use appropriate Security, Administrative, Physical and Technical Safeguards, and comply where applicable with subpart C of 45 C.F.R. Part 164, to prevent use or disclosure of PHI other than as required by law or as provided for by this BAA or PSC 24-630-8000-0001. Business Associate shall identify in writing upon request from the Department all of those Safeguards that it uses to prevent impermissible uses or disclosures of PHI.

C. Restricted Uses and Disclosures. The Business Associate shall not use or further disclose PHI other than as permitted or required by this BAA or PSC 24-630-8000-0001, the HIPAA Standards, or otherwise as permitted or required by law. The Business Associate shall not disclose PHI in a manner that would violate any restriction which has been communicated to the Business Associate.

i) The Business Associate shall not directly or indirectly receive remuneration in exchange for any of the PHI unless a valid authorization has been provided to the Business Associate that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving the PHI of that individual, except as provided for under the exceptions listed in 45 C.F.R. §164.502 (a)(5)(ii)(B)(2).

ii) Unless approved by the Department, Business Associate shall not directly or indirectly perform marketing to individuals using PHI.

D. Agents. The Business Associate shall ensure that any agents that create, receive, maintain or transmit PHI on behalf of Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, in accordance with 45 C.F.R. § 164.502(e)(1)(ii), and shall make that agreement available to the Department upon request. Upon the Business Associate's contracting with an agent for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement.

E. Availability of Information to Individuals and the Department. Business Associate shall provide, at the Department's request, and in a reasonable time and manner, access to PHI in a Designated Record Set (including an electronic version if required) to the Department or, as directed by the Department, to an Individual in order to meet the requirements under 45 CFR § 164.524. Within three (3) business days, Business Associate shall forward to the Department for handling any request for access to PHI that Business Associate receives directly from an Individual. If requested by the Department, the Business Associate shall make such information available in electronic format as required by the HIPAA Standards to a requestor of such information and shall confirm to the Department in writing that the request has been fulfilled.

F. Amendment of PHI. In accordance with 45 CFR § 164.526, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Department directs or agrees to, at the request of the Department or an Individual, to fulfill the Department's obligations to amend PHI pursuant to the HIPAA Standards. Within three (3) business days, Business Associate shall forward to the Department for handling any request for amendment to PHI that Business Associate receives directly from an Individual.

G. Internal Practices. Business Associate agrees to make internal practices, books and records, including policies, procedures and PHI, relating to the use and disclosure of PHI, available to the Department or to the Secretary within seven (7) days of receiving a request from the Department or receiving notice of a request from the Secretary, for purposes of the Secretary's determining the Department's compliance with the Privacy Rule.

H. PHI Disclosures Recordkeeping. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for the Department to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with the HIPAA Standards and 45 CFR § 164.528. Business Associate shall provide such information to the Department or as directed by the Department to an Individual, to permit the Department to respond to an accounting request. Business Associate shall provide such information in the time and manner reasonably designated by the Department. Within three (3) business days, Business Associate shall forward to the Department for handling any accounting request that Business Associate directly receives from an individual.

I. PHI Disclosures Accounting. Business Associate agrees to provide to the Department or an Individual, within seven (7) days of receipt of a request, information collected in accordance with Section 2 (h) of this Agreement, to permit the Department to respond to a request for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

J. Security Rule Provisions. As required by 42 U.S.C. § 17931 (a) [HITECH Act Section 13401(a)] , the following sections as they are made applicable to business associates under

the HIPAA Standards, shall also apply to the Business Associate: 1) Administrative Safeguards; 2) Physical Safeguards; 3) Technical Safeguards; 4) Policies and Procedures and Documentation Requirements; and 5) Security Standards. Additionally, the Business Associate shall either implement or properly document the reasons for non-implementation of all safeguards in the above cited sections that are designated as "addressable" as such are made applicable to Business Associates pursuant to the HIPAA Standards.

K. Civil and Criminal Penalties. Business Associate agrees that it will comply with the HIPAA Standards as applicable to Business Associates, and acknowledges that it may be subject to civil and criminal penalties for its failure to do so.

L. Performance of Covered Entity's Obligations. To the extent the Business Associate is to carry out the Department 's obligations under the HIPAA Standards, Business Associate shall comply with the requirements of the HIPAA Standards that apply to the Department in the performance of such obligations.

M. Subcontractors. The Business Associate shall ensure that any subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate, agree in writing to the same restrictions and conditions that apply to the Business Associate with respect to PHI, with 45 C.F.R. § 164.502(e)(1)(ii), and shall make such information available to the Department upon request. Upon the Business Associate's contracting with an agent for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement. Upon the Business Associate's contracting with a subcontractor for the sharing of PHI, the Business Associate shall provide the Department written notice of any such executed agreement.

3. Business Associate Obligations for Notification, Risk Assessment, and Mitigation

During the term of this BAA or PSC 24-630-8000-0001, the Business Associate shall be required to perform the following pursuant to the Breach Notification Rule regarding Breach Notification, Risk Assessment and Mitigation:

Notification

A. Business Associate agrees to report to the Department Contract Manager or HIPAA Privacy and Security Officer any use or disclosure of PHI not provided for by this BAA or PSC 24-630-8000-0001, and HIPAA Standards, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, as soon as it (or any employee or agent) becomes aware of the Breach, and in no case later than three (3) business days after it (or any employee or agent) becomes aware of the Breach, except when a government official determines that a notification would impede a criminal investigation or cause damage to national security.

B. Business Associate shall provide the Department with the names of the individuals whose unsecured PHI has been, or is reasonably believed to have been, the subject of the Breach and any other available information that is required to be given to the affected individuals, as set forth in 45 CFR §164.404(c), and, if requested by the Department, provide information necessary for the Department to investigate promptly the impermissible use or disclosure. Business Associate shall continue to provide to the Department information concerning the Breach as it becomes available to it, and shall also provide such assistance and further information as is reasonably requested by the Department.

Risk Assessment

C. When Business Associate determines whether an impermissible acquisition, use or disclosure of PHI by an employee or agent poses a low probability of the PHI being compromised, it shall document its assessment of risk in accordance with 45 C.F.R. § 164.402 (in definition of "Breach", ¶ 2) based on at least the following factors: (i) the nature and extent of the protected health information involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the protected health information or to whom the disclosure was made; (iii) whether the protected health information was actually acquired or viewed; and (iv) the extent to which the risk to the protected health information has been mitigated. Such assessment shall include: 1) the name of the person(s) making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons documenting the determination of risk of the PHI being compromised. When requested by the Department, Business Associate shall make its risk assessments available to the Department.

D. If the Department determines that an impermissible acquisition, access, use or disclosure of PHI, for which one of Business Associate's employees or agents was responsible, constitutes a Breach, and if requested by the Department, Business Associate shall provide notice to the individuals whose PHI was the subject of the Breach. When requested to provide notice, Business Associate shall consult with the Department about the timeliness, content and method of notice, and shall receive the Department's approval concerning these elements. The cost of notice and related remedies shall be borne by Business Associate. The notice to affected individuals shall be provided as soon as reasonably possible and in no case later than 60 calendar days after Business Associate reported the Breach to the Department.

Mitigation

E. In addition to the above duties in this section, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI, by Business Associate in violation of the requirements of this Agreement or the HIPAA Standards. Business Associate shall draft and carry out a plan of corrective action to address any incident of impermissible use or disclosure of PHI. If requested by the Department, Business Associate shall make its mitigation and corrective action plans available to the Department.

F. The notice to affected individuals shall be written in plain language and shall include, to the extent possible, 1) a brief description of the Breach, 2) a description of the types of Unsecured PHI that were involved in the Breach, 3) any steps individuals can take to protect themselves from potential harm resulting from the Breach, 4) a brief description of what the Business Associate and the Department are doing to investigate the Breach, to mitigate harm to individuals and to protect against further Breaches, and 5) contact procedures for individuals to ask questions or obtain additional information, as set forth in 45 CFR §164.404(c).

Notification to Clients

G. Business Associates shall notify individuals of Breaches as specified in 45 CFR §164.404(d) (methods of individual notice). In addition, when a Breach involves more than 500 residents of a State or jurisdiction, Business Associate shall, if requested by the

Department, notify prominent media outlets serving such location(s), following the requirements set forth in 45 CFR §164.406.

4. Obligations of the Department to Inform Business Associate of Privacy Practices and Restrictions

A. The Department shall notify Business Associate of any limitation(s) in the Department's Notice of Privacy Practices, implemented in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. The Department shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. The Department shall notify Business Associate of any restriction in the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. The Department shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Department.

5. Term and Termination

a. Term. This BAA terminates concurrently with PSC 24-630-8000-0001, except that obligations of Business Associate under this BAA related to final disposition of PHI in this Section 5 shall survive until resolved as set forth immediately below.

b. Disposition of PHI upon Termination. Upon termination of this PSC 24-630-8000-0001 and BAA for any reason, Business Associate shall return or destroy all PHI in its possession, and shall retain no copies of the PHI. In the event that Business Associate determines that returning or destroying the PHI is not feasible, Business Associate shall provide to the Department notification of the conditions that make return or destruction of PHI not feasible. Upon consideration and mutual agreement of the Parties that return or destruction of the PHI is infeasible, Business Associate shall agree, and require that its agents, affiliates, subsidiaries and subcontractors agree, to the extension of all protections, limitations and restrictions required of Business Associate hereunder.

c. If Business Associate breaches any material term of this BAA, the Department may either:

i. provide an opportunity for Business Associate to cure the Breach and the Department may terminate this PSC 24-630-8000-0001 and BAA without liability or penalty in accordance with Article 4, Termination, of PSC 24-630-8000-0001, if Business Associate does not cure the breach within the time specified by the Department; or,

ii. immediately terminate this PSC 24-630-8000-0001 without liability or penalty if the Department determines that cure is not reasonably possible; or,

iii. if neither termination nor cure are feasible, the Department shall report the breach to the Secretary.

The Department has the right to seek to cure any breach by Business Associate and this

right, regardless of whether the Department cures such breach, does not lessen any right or remedy available to the Department at law, in equity, or under this BAA or PSC 24-630-8000-0001, nor does it lessen Business Associate's responsibility for such breach or its duty to cure such breach.

6. Penalties and Training.

Business Associate understands and acknowledges that violations of this BAA or PSC 24-630-8000-0001 may result in notification by the Department to law enforcement officials and regulatory, accreditation, and licensure organizations. If requested by the Department, Business Associate shall participate in training regarding use, confidentiality, and security of PHI.

7. Miscellaneous

A. Interpretation. Any ambiguity in this BAA, or any inconsistency between the provisions of this BAA or PSC 24-630-8000-0001, shall be resolved to permit the Department to comply with the HIPAA Standards.

B. Business Associate's Compliance with HIPAA. The Department makes no warranty or representation that compliance by Business Associate with this BAA or the HIPAA Standards will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

c. Change in Law. In the event there are subsequent changes or clarifications of statutes, regulations or rules relating to this BAA or PSC 24-630-8000-0001, the Department shall notify Business Associate of any actions it reasonably deems necessary to comply with such changes, and Business Associate shall promptly take such actions. In the event there is a change in federal or state laws, rules or regulations, or in the interpretation of any such laws, rules, regulations or general instructions, which may render any of the material terms of this BAA unlawful or unenforceable, or which materially affects any financial arrangement contained in this BAA, the parties shall attempt amendment of this BAA to accommodate such changes or interpretations. If the parties are unable to agree, or if amendment is not possible, the parties may terminate the BAA and PSC 24-630-8000-0001 pursuant to its termination provisions.

d. No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Department, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

E. Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and any agents, affiliates, subsidiaries, subcontractors or workforce members assisting Business Associate in the fulfillment of its obligations under this BAA and PSC 24-630-8000-0001 available to the Department, at no cost to the Department, to testify as

witnesses or otherwise in the event that litigation or an administrative proceeding is commenced against the Department or its employees based upon claimed violation of the HIPAA standards or other laws relating to security and privacy, where such claimed violation is alleged to arise from Business Associate's performance under this BAA or PSC 24-630-8000-0001, except where Business Associate or its agents, affiliates, subsidiaries, subcontractors or employees are named adverse parties.

F. Additional Obligations. Department and Business Associate agree that to the extent not incorporated or referenced in any Business Associate Agreement between them, other requirements applicable to either or both that are required by the HIPAA Standards, those requirements are incorporated herein by reference.