STATE OF NEW MEXICO
HUMAN SERVICES DEPARTMENT
PROFESSIONAL SERVICES CONTRACT

AMENDMENT NO. 3

THIS AMENDMENT No. 3 to Professional Services Contract (PSC) 19-630-8000-0021 is made and entered into by and between the State of New Mexico **Human Services Department,** hereinafter referred to as "Department" or "HSD", and **Comagine Health,** hereinafter referred to as the "Contractor", and collectively referred to as the "Parties".

The purpose of this Amendment is to update contract with new state requirements regarding turn around time per SB 188; add the Supports Waiver to the Scope of Work; modify Exhibit B, Rate Schedules, to include the reimbursement rate for Supports Waiver reviews; and, amend Exhibit C, Reports, with new naming conventions and reports.

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

Article 1, Scope of Work is amended to read as follows:

1. Scope of Work

Scope of Work. The Contractor shall perform the work as outlined in the Scope of Work, Amended Exhibit A, attached hereto and incorporated herein by reference.

Exhibit A, Amended Scope of Work Section 1, OVERHEAD SERVICES ARE NOT SEPARATELY REIMBURSABLE, Section 1.1, Program Administration, VII, Review Timelines, is restated in its entirety to include the 2019 Prior Authorization Act requirements, attached hereto and incorporated herein by reference.

Exhibit A, Amended Scope of Work, Section 2, SEPARATELY REIMBURSABLE SERVICES, Section 2.11, HOME AND COMMUNITY-BASED SERVICE WAIVERS is amended in its entirety to include the Supports Waiver, attached hereto and incorporated herein by reference.

Exhibit B, Amended Rate Schedules, is restated in its entirety adding Supports Waiver reimbursement rates and reimbursement rate increase attached hereto and incorporated herein by reference.

Exhibit C, Amended Reports, is restated in its entirety with new naming conventions and report descriptions, attached hereto and incorporated herein by reference.

All other articles of PSC 19-630-8000-0021, as amended and all other provisions of Exhibit A, Amended Scope of Work, remain the same.

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

DocuSigned by:
By: David Scrase ____________________ Date: 6/10/2020
9DBE7E2D1E53422...
HSD Cabinet Secretary

DocuSigned by:
By: Danny Sandoval ____________________ Date: 6/9/2020
B66DFEE70E10413...
HSD Chief Financial Officer

DocuSigned by:
By: ____________________ Date: 6/9/2020
5709D27EDEC4AA...
HSD General Counsel

By: ____________________ Date: 06/08/2020
Contractor

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

ID Number: 03-295345-00-3

DocuSigned by:
By: AnnMarie Lucero ____________________ Date: 6/10/2020
Taxation and Revenue Department

Exhibit A,
Amended Scope of Work

Section 1, OVERHEAD SERVICES ARE NOT SEPARATELY REIMBURSABLE, Section 1.1, Program Administration, VII, Review Timelines, is restated in its entirety to include the 2019 Prior Authorization Act requirements, attached here to referenced herein.

I. 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. The Contractor's turn-around-time (TAT) for a review decision is measured from the date the Contractor receives all materials necessary to conduct a review to the date the review process is completed in its entirety (e.g. Omnicaid entry) and notice of the review decision is available via the Contractor's provider portal.

C. 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.

D. 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.

E. 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):

Non-Behavioral Health	
Type of Review	**TAT**
Prior approval requests allowed by HSD to be submitted via telephone request	2 days

Prior approval requests submitted in writing	7 days – Routine 1 business day – Expedited
ISP/budget and SSP/budget requests	7 days – Routine 1 business day– Expedited
EMSA requests submitted in writing	7 days – Routine 1 business day – Expedited
Reconsideration of TPA/FFS UR Decision	7 days
LOC Without in-home assessment	7 days – Routine 1 business day – Expedited
LOC With in-home assessment In-home assessment	7 days – Routine 1 business day– Expedited 30 days (including IHA and review determination)
Acute General Hospital Inpatient Retrospective Post-Payment review	6 months 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	One (1) business day	One (1) business day	Verbal, electronic or written	Facility

Behavioral Health Residential Treatment Centers/Treatment Foster Care/Group Home				
Review Type	**TAT from Receipt of Request to Decision**	**TAT from Decision to Notification**	**Notification Method**	**Who Must Be Notified?**
Initial	Five (5) working days	One (1) working day	Verbal, electronic or written	Facility
Concurrent	Five (5) working days	One (1) working 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).

F. 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. At the first request, 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 21 calendar days of issuance of the written RFI. The RFI shall also inform the provider/recipient that failure to return the RFI with all necessary documentation within 21 calendar days may result in a technical denial of the review request.

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

H. Expedited Prior Authorization requests shall be deemed granted for

determinations not made within one (1) business day and seven (7) business days for routine Prior Authorization requests. Once the Prior Authorization request has exceeded the turnaround time, the TPA is directed to not request reimbursement for the episode.

Section 2, SEPARATELY REIMBURSABLE SERVICES, Section 2.11, HOME AND COMMUNITY-BASED SERVICE WAIVERS is amended in its entirety to include the Supports Waiver and reads as follows:

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:

1. <u>DD LOC Reviews – Initial and Continuing/Annual</u>

    a. 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.

2. <u>DD LOC Increase Requests – (Does not apply to discharge LOC increases)</u>

    a. 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.

3. DD ISP/Budget Reviews – Initial, Annual, Initial Residential and Revision, and Professional Services:

    a. 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 or the Outside Reviewer (OR), as applicable.

    b. 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.

    c. The Outside Reviewer will send the approved budget worksheet to the Contractor for entry into the Omnicaid system and assignment of a prior authorization number. The Contractor will enter the approved services from the MAD 046 or budget worksheet into the Omnicaid 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 Omnicaid system.

    d. The Contactor will send the Omnicaid-entered budgets with the prior authorization number to the case manager.

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 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 FOCos 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 FOCos system.

7. The Contractor shall update 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. <u>LOC Reviews – Initial and Continuing/Annual</u>

   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 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. <u>SW ISP/Budget Reviews – Initial, Annual, and Revision:</u>

a. For participants under the agency based service delivery model a Community Supports Coordinator (CSC) 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 FOCos 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 FOCos system.
    iii. The Contractor shall complete the Long-Term Care (LTC) span in the appropriate system once the budget has been approved.

EXHIBIT B
Amended Rate Schedules

Utilization Review and Assessment Services	Description	Rate
Prior Authorization Review	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.	$86.99 Per Review
EMSA Review	Retrospective medical necessity review for Emergency Medical Services for Aliens.	$116.70 Per Review
Behavioral Health Review	Prior authorization for initial, concurrent and retro review. Accredited Residential Treatment Centers (ARTC), Group Homes (GH), Treatment Foster Care (TFC)	$347.98 Annual Per Recipient
	Prior authorization for inpatient psychiatric care.	$132.61 Per Review
	Prior authorization for Applied Behavioral Analysis (excluding Fair Hearing)	$466.59 Per Review
	Applied Behavioral Analysis Denial - Fair Hearing	$376.98 Per Fair Hearing
	Applied Behavioral Analysis Denial - Fair Hearing **with** legal counsel	$4,728.73 Per Fair Hearing
	Prior authorization for Substance Use Disorder (SUD)-Inpatient Psychiatric Care and Residential Treatment reviews*	$402.08 Per Review*
	Partial Hospitalization for Substance Use Disorder (SUD) reviews*	$375.95 Per Review*
Level of Care Mi Via	Initial and annual ICF/IID level of care determination plus the in-home assessment for Mi Via adults and children requiring ICF/IID level of care.	$689.58 Annual Per Recipient
Level of Care Supports	Initial and annual ICF/IID level of care determination for Supports Waiver participants.	$213.09 Annual Per Recipient

Waiver		
Level of Care All Others	Initial and annual ICF/IID level of care determinations for adults and children in the Developmental Disabilities Medically Fragile under the home and community-based waiver programs. Initial and annual ICF/IID level of care for recipients receiving long-term care services in an ICF/IID facility. Nursing facility level of care determinations for recipients in the Program of All-Inclusive Care for the Elderly.	$206.88 Annual Per Recipient
ISP and Budgets-Initial and Annual Supports Waiver	Review and approval of Initial and Annual Individual Service Plans and budgets for Supports Waiver participants.	$148.86 Per Review
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 participants.	$100.78 Per Review
ISP and Budgets-Revisions Supports Waiver	Review and approval of Individual Service Plans budget revisions for Supports Waiver participants.	$148.86 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 Participants.	$100.78 Per Review

3. *If after the first two (2) months following the execution of Amendment #2, BH-SUD prior authorizations experience a denial rate equal to or greater than 25% for any two (2) consecutive months, HSD and Comagine Health will reopen rate negotiations. Likewise, if after the first two (2) months following the execution of

Amendment #2, BH-SUD prior authorizations experience a denial rate less than 15% for any two (2) consecutive months, HSD and Comagine Health will reopen rate negotiations.

Exhibit C
Amended 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.
M5	**Activity and TAT Report - FFS**	Monthly client detail and summary to review activity (approvals and denials for FFS Prior Authorizations) by Service Type and Status with TAT tracking.

M5	**Activity and TAT Report – Behavioral Health and Alternative Benefit Plan**	Monthly client detail and summary to review activity (approvals and denials for BH and ABP 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 Audit Report**	Monthly report that captures all LOC 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
W2	**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.
W3	**Request for Information-UNM-OR**	Monthly report that captures request for information specifically for DDW UNMOR with Client detail and Provider information, date of initial request, date(s) RFI and an aggregate summary.
W4	**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.