Molina Healthcare of New Mexico, Inc.
Provider Services Agreement

This Provider Services Agreement (the "Agreement") is made and entered into effective by the parties as set forth below.

This Agreement includes the following attached hereto and incorporated herein:

- Provider Services Agreement
- Attachment A: Definitions
- Attachment B: Provider Identification Sheet *[TO BE COMPLETED BY PROVIDER]*
- Attachment C: Products/Programs
- Attachment D: Compensation Schedule
- Attachment D-1: Molina Medicaid Pay-For-Performance Program
- Attachment D-2: Molina Medicare Quality Partner Program
- Attachment E: State Required Provisions
- Attachment F: Medicare Program Requirements – Health Care Services
- Attachment F-1: Medicare Program Requirements – Delegated Services
- Attachment G: Provider Acknowledgements

*** * * SIGNATURE AUTHORIZATION * * ***

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth in the Agreement. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement. This Agreement is being executed in accordance with all applicable federal and state statutes, regulations, policies, procedures and rules.

Provider Name:_____ ("Provider")

Molina Healthcare of New Mexico, Inc., a New Mexico Corporation ("Health Plan")

Provider Signature:		Health Plan Signature:	
Signatory Name (Printed):		Signatory Name (Printed):	
Signatory Title (Printed):		Signatory Title (Printed):	
Signature Date:		Signature Date:	
Mailing Name and Address:		Mailing Name and Address:	Molina Healthcare of New Mexico, Inc. 8801 Horizon Blvd. NE Albuquerque, NM 87113

PROVIDER SERVICES AGREEMENT

This Agreement is made and entered into effective this [ ] ("Effective Date") by and between Health Plan and Provider with respect to the following:

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health products/programs ("Government Programs"). Health Plan intends to participate in additional Government Programs and offer other health products/programs as the opportunities become available.

B. Health Plan is a domiciled corporation that has been issued a certificate of authority by the appropriate licensing state agency to provide health care services to Members. Health Plan also is certified, licensed and/or approved by all other required agencies to provide health care services to eligible recipients.

C. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

D. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth in Attachment A.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provision of Provider Services.** Provider agrees to provide Provider Services to Members within the scope of Provider's business, practice and license, and in accordance with applicable Law and the terms of this Agreement including the Provider Manual, Health Plan's QI and UM Programs and applicable Accreditation Organization standards.

2.2 **Provider Standards.**

a. **Standard of Care.** Provider will provide Provider Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services will be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act. During the term of this Agreement, Provider attests to the following; (i) performed criminal background checks on its employees in order to demonstrate they are free of felony convictions and outstanding warrants for arrest, (ii) employees are U.S. citizens or maintain a permanent visa, and (iii) a negative pre-employment substance and drug screening test is completed on each of its employees and will maintain a random sampling program for continued monitoring.

c. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider will obtain the prior authorization of Health Plan in accordance with Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider will coordinate the provision of such Covered Services to Members and ensure continuity of care.

d. **Use of Participating Providers.** Except in the case of Emergency Services or where Provider obtains the prior authorization of Health Plan, Provider will utilize Health Plan's Participating Providers to provide Provider Services to Members. Should Health Plan have no Participating Provider to render Medically Necessary Provider Services, Health Plan will use reasonable efforts to coordinate an out of network agreement with an appropriate provider.

e. **Member Eligibility Verification.** Provider will verify eligibility of Members prior to rendering services unless the situation is one involving the delivery of Emergency Services.

f. **Admissions.** Provider will cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

g. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider will notify Health Plan within twenty-four (24) hours of the referral.

h. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider will abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider will obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

i. **Availability of Services.** Provider will make necessary and appropriate arrangements to assure the availability of Provider Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider will meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

j. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations. Health Plan's decision to terminate or refuse to contract with a Provider will not be based in whole or in part on the fact that the Provider discussed medical treatment options with a Member.

k. **Rights of Members.** Provider will observe, protect and promote the rights of Members.

2.3 **Subcontracts.** Provider will not enter into any subcontract agreement for the provision of Provider Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Provider for the delivery of Provider Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Provider Services.

2.4 **Promotional Activities.** At the request of Health Plan, Provider will: (i) display Health Plan promotional materials in its offices and facilities as practical, and (ii) cooperate with and participate in all reasonable Health Plan marketing efforts so long as it does not violate federal or state Law or regulations. Provider will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.5 **Nondiscrimination.**

a. **Enrollment.** Provider will not differentiate or discriminate in providing Provider Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will render Provider Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider will not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.6 **Recordkeeping.**

a. **Maintaining Member Medical Record.** Provider will maintain a medical and billing record for each Member to whom Provider renders health care services. Provider will open each Member's medical record upon the Member's first Encounter with Provider. The Member's medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable Government Programs, and all Health Plan policies and procedures. Provider will retain all such records for as long as required by applicable Law. This section will survive the termination of this Agreement.

b. **Confidentiality of Member Health Information.** Provider will comply with all applicable Law, Health Plan's policies and procedures, Government Program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision will not affect or limit Provider's obligation to make available medical records, Encounter Data and information concerning Member care to Health Plan, any authorized state or federal agency, or other providers of health care upon authorized referral.

c. **National Provider Identifier ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI

from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and Encounters (both electronic and paper formats) submitted to Health Plan.

d. **Delivery of Patient Care Information.** Provider will promptly deliver to Health Plan, upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable Government Programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, Encounter Data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS studies, Health Plan's Quality Improvement Program, Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Claims payment. Provider will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement.

e. **Member Access to Health Information.** Provider will give Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with applicable Law, applicable Government Programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement.

2.7 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in Health Plan's Grievance Program and will cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in Health Plan's Quality Improvement Program and will cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and will cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Provider Services.

d. **Participation in Credentialing.** Provider will cooperate with, participate in and satisfy all credentialing and re-credentialing criteria established by Health Plan prior to the Effective Date and provision of Covered Services set forth in and in accordance with and throughout the term of this Agreement. Provider will immediately notify Health Plan in writing of any change in the information submitted or relied upon by Provider in order to achieve or maintain credentialed status.

e. **Provider Manual.** Health Plan's Provider Manual is made available to Provider at Health Plan's website at http://www.molinahealthcare.com/medicaid/providers/nm/manual/pages/home.aspx for Medicaid and http://www.molinamedicare.com/en-us/providers/pages/provider_splash.aspx for Medicare. Provider will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which may be amended from time to time by Health Plan.

f. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through Government Programs, including the State Contract(s). Provider will comply with any term or condition of those Government Program contracts that are applicable to the Provider Services to be performed under this Agreement. Health Plan will give Provider a copy of the State Contract(s), and any other applicable contract, upon request by Provider.

g. **Health Education/Training.** Provider will participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and related efforts. Provider will also comply with all Health Plan health education, Health Plan's Cultural Competency Plan, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider will ensure prompt delivery to any constituent providers all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Provider Services to Members.

2.8 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider will provide evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider will immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been and is not currently excluded from, and will immediately notify Health Plan in the event it becomes excluded from, participation in Medicare and/or state health care programs pursuant to Section 1128 of the Social Security Act (42 U.S.C. 1320a-7) ("Section 1128") for any of the following: (i) conviction of a crime; (ii) assessment of a civil penalty; (iii) entered into a contractual relationship with an entity convicted of a crime, and/or (iv) taken any other action that would prohibit it from participation in Medicare and/or state health care programs, all as set forth under Section 1128.

c. **Malpractice and Other Actions.** Provider will give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Provider; (iii) any convictions of Provider for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Staffing Privileges for Providers.** Consistent with community standards, Provider will have staff privileges with at least one Health Plan contracted hospital as necessary to provide services to Members under this Agreement, and will authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of Provider's hospital privileges.

e. **Liability Insurance.** Throughout the term of this Agreement, Provider will maintain premises and professional liability insurance (i) in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities; and (ii) in compliance with applicable law and Government Program requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy(ies). Provider will deliver copies of such insurance policy(ies) to Health Plan within five (5) business days of a written request by Health Plan, and will give at least fifteen (15) business days advance written notice to Health Plan prior to reduction, cancellation or termination of such insurance coverage.

2.9 **Claims Payment.**

a. **Submitting Claims.** Provider will promptly submit to Health Plan Claims for Provider Services rendered to Members. All Claims will be submitted in a standard form (CMS-1500, UB-04 or successor format) acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by applicable Law and Government Programs, Provider will not be eligible for payment on any Claims that are not submitted within the greater of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) ninety (90) days of providing the Provider Service.

b. **Compensation.** Health Plan will pay Provider for Clean Claims for Provider Services provided to Members, including Emergency Services, in accordance with applicable Law, Government Program requirements, and in accordance with the compensation schedule set forth in Attachment D. Such payment will be made within the greater of: (i) the timeframes specified by applicable Law and Government Program requirements, or (ii) sixty (60) days of the date such Clean Claim is delivered by Provider to Health Plan and Health Plan determines such claim is a Clean Claim for Provider Services and/or Emergency Services. Provider agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Provider Services provided to Members as deemed Medically Necessary and appropriate under this Agreement, Health Plan's Quality Improvement and Utilization Review and Management Programs. Provider will not balance bill Members for any Provider Services.

c. **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances and deductibles, if any.

d. **Member Hold Harmless.** Provider agrees that in no event, including but not limited to nonpayment, insolvency, or breach of this Agreement by the Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or

reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or co-payments as specifically provided in the Member's evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision will survive the termination of Agreement regardless of the reason for the termination, including the insolvency of Health Plan.

e. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider will immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in Section 2.9.b (Compensation).

f. **Offset.** In the event that a Claim has been overpaid or paid in duplicate, or in the event that funds were paid which were not provided for under this Agreement or applicable Government Program, Provider will make repayment to Health Plan within thirty (30) days of receipt of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment or within thirty (30) days of Provider's identification of the overpayment, duplicate payment, or other excess payment as required by applicable law and Government Program requirements. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) days notice. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized under applicable law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

g. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of Claims and payments by providing access to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

h. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives capitation from Health Plan and is responsible for arranging for Provider Services through subcontractual arrangements ("Capitated Provider"), that Provider will look solely to the Capitated Provider, and not Health Plan, for payment of Provider Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers.

i. **Timely Submission of Encounter Data**. Provider understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable Provider shall submit Encounter Data to Health Plan within ninety (90) days of the delivery of service.

2.10 **Compliance with Law.** Provider will comply with all applicable Laws governing the delivery of Provider Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Provider Services rendered pursuant to this Agreement are subject to applicable state licensing statutes, regulations and the State Contract(s). Accordingly, Provider will abide by those provisions set forth in Attachment E and Attachment E-1.

b. Provider acknowledges that all Provider Services rendered to Medicare Members are subject to the additional provisions set forth in Attachment F and Attachment F-1, the effect of which provisions is limited solely to activities and Provider Services related to the Medicare program.

2.11 **Provider Non-solicitation Obligations.** Provider will not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider without the prior written approval of Health Plan. Nor will Provider solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.12 **Fraud and Abuse Reporting.** Provider will report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider will establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider will consult with the appropriate state agency prior to and during the course of any such investigations.

2.13 **Advance Directive.** Provider will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

2.14 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment of Members to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Health Plan reassigns Member(s), Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

2.15 **Reciprocity Agreements.** Provider will cooperate with Health Plan's Participating Providers and affiliates of Health Plan and agrees to provide Provider Services to Members enrolled in various Government Programs and other health products, and various government sponsored health programs and other health products of affiliates, and to assure reciprocity of health care services. Without limiting the foregoing, if any Member receives services or treatment constituting Provider Services from Provider and a capitated Participating Provider is financially responsible for such services, such Participating Provider will be solely responsible for compensating Provider for any Provider Services provided by the Provider in accordance with Section 2.9.h (Payments which are the Responsibility of a Capitated Provider). Payment by the Participating Provider will be at; (i) the rates agreed by the Participating Provider and Provider, or (ii) if there is no applicable agreement, at one hundred percent (100%) of the governing rates provided by applicable Law specific to the Member's enrolled benefit plan (i.e. Medicaid, Medicare, etc) in place at the time services are rendered, or (iii) at the election of the Participating Provider, at the rates set forth in this Agreement. Provider agrees that the provisions of Section 2.9.b (Compensation) will continue to be binding upon Provider, especially in that Provider will not balance bill Members for any Provider Services. Provider will comply with the procedures established by Health Plan or its affiliates and this Agreement for reimbursement of such services or treatment. Provider will not encourage Members to receive Provider Services from non-Participating Providers. Breach of this section will constitute breach of a material term of the Agreement and will give rise to cause for termination of this Agreement pursuant to Section 4.3 (Termination with Cause). Provider will abide by all provisions of this Agreement relating to non-billing of Members with respect to all services and treatment subject to this reciprocity arrangement.

2.16 **Notification of Network Change.** Where Provider is a medical group, independent practice association, or any other similar entity/organization, Provider will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Provider. Said written notification will be in compliance with applicable Law or Government Program requirements.

2.17 **Members Condition Changes or Deaths.** Upon becoming aware of or suspecting; (i) a significant change in a Member's health or functional status that could affect Member's level of care determination, (ii) a Member is being abused or neglected, or (iii) a Member death, Provider will notify Health Plan's Member Services Department as soon as possible but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan will pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan will timely respond to requests for prior authorization and/or determination of Provider Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Provider Services, including determinations of level of care and length of stay benefits available under the Member's health program will govern. The primary concern with respect to all medical determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Provider Services, limitations and exclusions, and coordination of benefits information. Health Plan will make available a Provider Services Department which among other Health Plan duties will be available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will retain a physician as medical director who will be responsible for the management of the scientific, technical, medical and behavioral health aspects of Health Plan.

ARTICLE FOUR – TERM AND TERMINATION

4.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect for one (1) year; thereafter, it will automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments hereto.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least ninety (90) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have sixty (60) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this sixty (60) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such sixty (60) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement or unless otherwise mutually agreed to in writing by both parties, either party may immediately terminate this Agreement, and Health Plan may transfer Member(s) to another provider, by giving written notice to the other party in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Either party fails to maintain insurance required by this Agreement, applicable law and Government Program requirements;

c. Provider loses, or is unable to cure the revocation, suspension or limitation of, its credentialed status;

d. Either party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility and/or equipment is insufficient to render Provider Services to Members;

g. Either party is excluded from participation in Medicare and state health care programs pursuant to Section 1128;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either party engages in fraud or deception, or knowingly permits fraud or deception by another in connection with each party's obligations under this Agreement;

j. Health Plan reasonably determines that health care services are not being properly provided, or arranged for by Provider, and that such failure poses a threat to Members' health and safety; or

k. Provider violates any state or federal law, statute, rule, regulation or executive order.

4.5 **Continuation of Care.** Where Provider is a primary care provider or practitioner, Provider will furnish health care services to each Member assigned to their panel for ninety (90) days after the date of the notice of a termination for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure statute, for each assigned Member:

a. Who was receiving health care services from Provider before the notice of termination; and

b. Who after receiving notice of the termination of Provider, requests to continue receiving health care services from Provider.

4.6 **Notice of Nonrenewal or Termination.** Health Plan will provide written notice of nonrenewal or termination of Provider to the Members served by Provider as soon as practicable, but in no event later than fifteen (15) days following termination. Provider will not contact Health Plan's Members upon termination of this Agreement. Immediate written notice will be provided without sixty (60) days notice in the event Provider's license has been disciplined by a State licensing board.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 **Indemnification.** Each party will indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor will any third party have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** This Agreement will be governed by the Laws of the State of New Mexico.

5.4 **Entire Agreement.** This Agreement, together with Attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the parties and relating to the subject matter of this Agreement are of no force or effect.

5.5 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

5.6 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between Health Plan and Provider. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.7 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any applicable Law, policy, directive, or Government Program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider sent by certified mail. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment will be deemed accepted by and will be binding upon Provider.

5.8 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this

Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name will be deemed an assignment.

5.9 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement will be resolved, to the fullest extent possible and in accordance with Law, through the Grievance Program, Health Plan's internal appeals process, informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy will be resolved through binding arbitration conducted by a single arbitrator in accordance with the American Arbitration Association ("AAA") Commercial Arbitration Rules, then in effect, in Albuquerque, New Mexico; provided, however, matters that primarily involve Provider's professional competence or conduct will not be eligible for arbitration. If possible, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care. The parties will conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator will have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor will the arbitrator have the authority to award punitive damages. Each party will bear its own costs and expenses, including its own attorneys' fees, and will bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.10 **Notice.** All notices required or permitted by this Agreement will be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and will be deemed sufficiently given if served in the manner specified in this section. The mailing names and addresses set forth under the Signature Authorization section of this Agreement will be the particular party's address for delivery or mailing of notice purposes. Each party may change their name and address through written notice in compliance with this section. Any notice sent by registered or certified mail, return receipt requested, will be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery will be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice will be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

ATTACHMENT A
Definitions

Capitalized words or phrases in this Agreement mean the following:

1. **Accreditation Organization** means any organization, including, without limitation, the National Committee for Quality Assurance ("NCQA"), engaged in accrediting or certifying Health Plan or Provider.
2. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
3. **Agreement** means this Provider Services Agreement, all attachments and incorporated documents or materials.
4. **Claim** means an invoice for Provider Services rendered to a Member by Provider, submitted in a format approved by Health Plan and with all service and Encounter information required by Health Plan.
5. **Clean Claim** means a Claim for Provider Services that is submitted on an industry standard form (e.g. CMS-1500, UB-04), and has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.
6. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.
7. **Community Benefit Provider** means those entities that provide the home and community based services and personal care services that are available to Members meeting the nursing facility level of care as identified by the Member's benefit program**.**
8. **Covered Services** means those health care services, supplies and benefits that are (i) Medically Necessary, (ii) benefits of the applicable Health Plan Product(s)/Program(s) set forth in Attachment C, and (iii) required to be provided by Health Plan pursuant to the State Contract(s) as applicable, which covers the Member(s).
9. **Cultural Competency Plan** means a plan that that ensures Covered Services are provided to Members in a manner that takes into account, but is not limited to: developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds and limited English proficiency.
10. **Emergency Care Services** are health care services furnished in the emergency department of a hospital for the treatment of a medical emergency; ancillary services routinely available to the emergency department of a hospital for the treatment of a medical emergency; and emergency medical services transportation.
11. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition will not be defined on the basis of lists of diagnoses or symptoms.
12. **Encounter** means a distinct set of services provided to a Member enrolled by Health Plan on the dates that the services were delivered.
13. **Encounter Data** means (i) all data captured during the course of a single health care Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices and equipment associated with a Member receiving services during the Encounter; (ii) the identification of the Member receiving and the provider delivering the health care services during the single Encounter; and (iii) a unique, i.e. unduplicated, identifier for the single Encounter.
14. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
15. **Health Plan** means Molina Healthcare of New Mexico, Inc.
16. **HEDIS Studies** means Healthcare Effectiveness Data and Information Set.
17. **Law(s)** mean all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder, including but not limited, to the Health Insurance Portability and Accountability Act ("HIPAA"), Provider Manual, and the State Contract(s).
18. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

19. **Medically Necessary** means the care which, in the opinion of the treating physician, is reasonably needed to: (i) prevent the onset or worsening of an illness, condition, or disability; (ii) establish a diagnosis; (iii) provide palliative, curative, or restorative treatment for physical and/or mental health conditions; (iv) assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of same age; and (v) not primarily long-term institutional care services unless long-term institutional services is a Covered Service that the Provider has agreed to provide. In addition, there must be no other effective and more conservative or substantially less costly treatment, service and setting available.
20. **Medicare** means the various insurance health plans provided under Title XVIII of the Social Security Act, as amended.
21. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to receive Covered Services.
22. **Overpayments** means any payment Provider receives or retains in which Provider, after applicable reconciliation, is not entitled to receive such payment pursuant to state or federal Law or the terms of this Agreement.
23. **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.
24. **Provider** means the person(s) and/or entity(ies), any constituent physicians, allied health professionals, staff persons, and any employed, subcontracted and/or affiliated entities, which are identified in Attachment B, and are all bound by the terms and conditions of this Agreement.
25. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.
26. **Provider Services** are those Covered Services that are within the normal scope of practice and licensure of Provider. Provider Services will be provided in accordance with the products/programs identified in Attachment C.
27. **Quality Improvement Program ("QI Program")** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.
28. **State Children's Health Insurance Program** means the program established pursuant to Title XXI of the Social Security Act, as amended.
29. **State Contract(s)** means the contract(s) between the New Mexico Human Services Department and Health Plan that govern the provision of Medicaid-covered healthcare services to Members, as may be amended from time to time.
30. **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

ATTACHMENT B
Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

☐ Primary Care Physician / specialty: _____

☐ Specialist: type(s) _____

_____

☐ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

☒ Hospital

☐ Ancillary Provider: type _____

_____

☐ Pharmacy

☐ Other: _____

The following must match the W-9 supplied by Provider. Please enter "N/A" if not applicable or not available:

Provider Name	East El Paso Physician's Medical Center, LLC	Billing Address: 1416 George Dieter El Paso, TX 79936
DBA Name (if applicable)		
Telephone No.	915-598-4240	
Facsimile No.	915-598-4412	
Tax I.D. No. (TIN)	26-1281512	
License No.		Physical Address (if different than above): 1416 George Dieter El Paso, TX 79936
DEA No.		
State ID No. (if applicable)		
NPI (or UPIN if NPI not yet designated)	NPI: 1669655601 UPIN:	
Email Address		

(Use continuation pages if multiple entities under common ownership of/by Provider will submit bills under this Agreement.)

ATTACHMENT C
Products/Programs

Provider agrees to participate as a Participating Provider for the following products/programs and successor(s). Provider agrees that Health Plan may from time to time add additional products/programs for which Provider agrees to participate as a Participating Provider.

1. **Medicaid –** including but not limited to Centennial Care.
2. **Medicare –** including but not limited to Molina Medicare Options (Medicare Advantage), Molina Medicare Options Plus (MA-SNP), and Dual Options (Medicaid-Medicare Program (MMP)).

ATTACHMENT D
Compensation Schedule

Fee for Service Payments

Health Plan agrees to compensate Provider for Clean Claims for Provider Services rendered to Members, in accordance with products/programs as specified in Attachment C, on a fee-for-service basis, at the lesser of; (i) Provider's billed charges, or (ii) the allowable amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

- **Medicaid:**

  All Covered Services provided to Enrolles of this Program shall be reimbursed as indicaded below. Reimbursment will be paid either at the contracted rate or the billed charges, whichever is lesser and is inclusive of New Mexico gross recipts tax and Enrollee copayment/coinsurance.

- **INPATIENT SERVICES**

  100% of the current NM MEDICAID Border DRG amount, including capital pass through.

- **OUTPATIENT SERVICES**

  100% of the current NM MEDICAID Hospital Outpatient Prospective Payment System Rates

- **PROFESSIONAL FEES**

  100% of the New Mexico Medicaid FFS rate.

  Health Plan will reimburse Provider the percent discounts as outlined in this Exhibit based on the Provider's charge master in effect as of the effective date. In the event Provider increases its overall charge master by more than five percent (5%) annually, Provider will provide Health Plan with sixty (60) days advanced written notification of any fee increase/decrease (change) to Provider's charge master. Health Plan may adjust the percent discount off billed charges to ensure that the reimbursement Health Plan pays to Provider based to Provider based on percent discount does not change by more than five percent (5%) each year during the contract term.

  All reimbursement rates negotiated in this Exhibit are subject to change (increase or decrease) at the direction of HSD. If after the effective date do the Agreement the New Mexico Medicaid Fee Schedule is modified, both parties agree that reimbursment shall be based on the new rates set forth therein; however, any increase in the New Mexico Medicaid Fee Schedule is subject to the Health Plan's receipt of additional funding from HSD for such increase. Any modification in the rates directed by HSD shall become effective upon notice of such change from HSD. No such changes will be made retroactively.

- **Medicare – Molina Medicare Options (Medicare Advantage) and Molina Medicare Options Plus (MA-SNP):**

  Provider Services will be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date(s) of service.

- **Medicare – Dual Options (CFAD):**

  Provider Services will be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date(s) of service.

  CMS and participating states have indicated that member cost sharing (co-payments, co-insurance, and Medicare deductibles) will not apply in the Capitated Financial Alignment Demonstration. Notwithstanding any other provisions of this Agreement including but not limited to Provider's responsibility for collection of co-payments and deductibles, Provider acknowledges cost sharing is inapplicable to services provided to Members who are enrolled in this product/program. Health Plan will not apply or deduct any cost sharing for payments under this product/program.

In the event a Provider Service is covered by Medicaid but not Medicare, the Provider Service will be paid at an amount equivalent to the payable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of New Mexico in effect on the date(s) of service.

Provider acknowledges that CMS and the State of New Mexico have not released the joint-capitation rate to be paid to Health Plan for this product/program. If, after the capitation rate is released, Health Plan determines that the above compensation for this product/program is unsustainable, Provider agrees to negotiate a new compensation rate with Health Plan in good faith. If Health Plan and Provider cannot agree to a new rate before the product/program begins, Health Plan or Provider may immediately terminate the product/program from this Agreement, in compliance with any applicable laws and regulations.

ATTACHMENT E

Division of Insurance Program Provisions

This Attachment E sets forth the Division of Insurance requirements that are required to be incorporated into contracts and/or agreements between a Health Plan and their Providers. The provisions of this Attachment shall apply to all of Health Plan's Members, except for any Members enrolled in Health Plan's Medicare Advantage, Medicare Advantage Special Needs Plan, or Capitated Financial Alignment Demonstration Products. In the event that any provisions in Attachment E-1, Attachment F or Attachment F-1 of the Agreement conflict with the provisions of this Attachment, the provisions of Attachment E-1, Attachment F or Attachment F-1 shall govern. The Agreement and this Attachment shall be automatically modified to conform to subsequent regulatory requirements.

1. **Member Hold Harmless**. Provider agrees that in no event, including but not limited to nonpayment, insolvency, or breach of this Agreement by the Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the Member's evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor. This provision will survive the termination of Agreement regardless of the reason for the termination, including the insolvency of Health Plan.
2. **Interpretative Services**. Health Plan shall provide interpreters for limited English proficient individuals and interpretive services for patients who qualify under the Americans with Disabilities Act.
3. **Interest Payment on Clean Claim Covered Expenses**. Health Plan shall pay interest at the rate of one and one-half (1½) times the rate established by a bulletin entered by the superintendent in January of each calendar year for:
   (a) The amount of a Clean Claim submitted by a Provider and not paid within forty-five (45) days of receipt; or
   (b) The amount of a Clean Claim submitted by a Member for out of pocket covered expenses that is not paid within forty-five (45) days of receipt.
4. **Terms used in Contract**. In the event that any of the terms used in the Agreement are defined by New Mexico statutes and division regulations, such terms shall be used in a manner consistent with any definitions contained in said statutes or regulations.
5. **Offset**. Health Plan may only make retroactive adjustments for overpayment within eighteen (18) months absent health care professional miscoding, claim submission error, suspected fraud and abuse, or retroactive adjustments required by other federal or state agencies.
6. **Contracted Providers**. Before Health Plan can deny a referral to a non-Participating Provider, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

ATTACHMENT E-1
Medicaid Required Provisions

This attachment sets forth the applicable Government Program requirements that are required by the State of New Mexico to be included in contracts and/or agreements between; (i) health plans / health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by the State of New Mexico to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment, the applicable statute(s) or section(s).

1. The following provisions are required to be included in this Agreement between the Health Plan and the Provider pursuant to the New Mexico Medical Assistance Division (MAD), Human Services Department (HSD), the New Mexico Administrative Code (NMAC) and New Mexico Medicaid program:
   (a) Provider agrees that it will maintain records relating to services provided to Members for ten (10) years. (NMAC 8.305.3.10 B(3)(f))
   (b) Provider will comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and its regulations, including 45 CFR Parts 160, 162, and 164
   (c) Provider agrees that Member information be kept confidential, as defined by federal or state law, and be HIPAA compliant. (NMAC 8.305.3.10 B (3)(g))
   (d) Provider will comply with State laws and regulations regarding Mental Health and Developmental Disability Records (NMSA 1978, §43-1-19); Genetic Information, including genetic test results (NMSA 1978, §§24-21-1 et seq.); Sexually Transmitted Disease ("STD") testing or results (NMSA 1978, §§24-1-9 et seq.); Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS") testing, treatment or results (NMSA 1978, §§24-2B-1 et seq.); Contraception information (NMSA 1978, §24-8-5); Pregnancy diagnosis, prenatal care, delivery and/or postnatal care information (NMSA 1978, §24-1-13.1); Victim counseling information (NMSA 1978, §§31-25-1 et seq.)
   (e) Provider will comply with Federal laws and regulations regarding Drug/Alcohol/Substance Abuse records (42 CFR Ch. I, Subch. A, Pt. 2; 42 USC Ch. 6a, Subch. III-a, Pt. D)
   (f) Provider will provide authorized representatives of HSD, interagency behavioral health purchasing collaborative (the "Collaborative") or other State and Federal agencies reasonable access to facilities, personnel and records for financial and medical audit purposes. (NMAC 8.305.3.10 B (3)(h))
   (g) Provider will release to the Health Plan any information necessary to perform any of its obligations and Health Plan will monitor the Provider's performance on an ongoing basis subjecting the Provider to formal periodic review. (NMAC 8.305.3.10 B (3)(i))
   (h) Provider will accept payment from the Health Plan for any services included in the benefit package and cannot request payment from HSD for services performed under the Agreement. (NMAC 8.305.3.10 B (3)(j))
   (i) If the Agreement includes primary care, provisions for compliance with Primary Care Physician ("PCP") requirements delineated in the Health Plan contract with HSD apply. (NMAC 8.305.3.10 B (3)(k))
   (j) If Provider offers laboratory services, it must meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.
   (k) Provider agrees that the Agreement may be terminated, rescinded, or canceled for violation of applicable HSD requirements or if HSD determines it to be in the best interest of the State.(NMAC 8.305.3.10 B (3)(m))
   (l) Provider agrees that nothing in this Agreement will prohibit Provider from entering into a contractual relationship with another Managed Care Organization ("MCO"). (NMAC 8.305.3.10 B (3)(n))
   (m) Provider agrees that nothing in this Agreement includes any incentives or disincentives that encourage a provider or other subcontractor not to enter into a contractual relationship with another MCO. (NMAC 8.305.3.10 B (3)(o))
   (n) Provider agrees that subcontracts will not contain any gag order provisions or sanctions against providers who assist Members in accessing the grievance process or otherwise protecting Member's interests. (NMAC 8.305.3.10 B (3)(p))

(o) Provider agrees that Health Plan may monitor the quality of services delivered under this Agreement and may place the Provider under a corrective action plan when necessary to improve the quality of care, in accordance with that level of medical, behavioral health or long term care is recognized as acceptable professional practices and/or the standards established by HSD. Provider will abide by and take action to correct any deficiencies indicated in the corrective action plan. Failure to complete the requirements of the corrective action plan may result in termination of this Agreement in accordance with Section 4.4 (Immediate Termination).

(p) Provider agrees that it may bill Members or accept payment for services only if all of the following requirements are satisfied:

(1) Members are advised by the Provider before services are furnished that a particular service is not covered by Medicaid or that the particular Provider does not accept patients whose medical services are paid for by Medicaid;

(2) Members are provided with information about the necessity, options, charges for the service, and the option of going to a provider who furnishes services to Medicaid Members; and

(3) Members agree in writing to have specific services provided with knowledge that they are financially responsible for payment. The Provider may bill the Member, if an administrative error resulting in Health Plan's denial of payment was caused by the failure of the Member to furnish identification before receiving services. (NMAC 8.302.1.16)

(q) Provider will maintain appropriate records in accordance with federal and State statutes and regulations relating to the Health Plan's performance under this Agreement, including but not limited to records relating to services provided to Members, including a separate medical record for each Member.Member records will be maintained on paper and/or electronic format and in a manner that is timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Member medical records will reflect all aspects of patient care, including ancillary services. The Provider will, at a minimum, comply with the following documentation standards:

(1) patient identification information (on each page or electronic file);

(2) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(3) date of data entry and date of encounter;

(4) provider identification (author of entry);

(5) allergies and adverse reactions to medications;

(6) past medical history for patients seen two or more times;

(7) status of preventive services provided or at least those specified by HSD, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(8) diagnostic information;

(9) medication history including what has been effective and what has not, and why;

(10) identification of current problems;

(11) history of smoking, alcohol use and substance abuse;

(12) reports of consultations and referrals;

(13) reports of emergency care, to the extent possible;

(14) advance directive for adults; and

(15) record legibility to at least a peer of the author. (NMAC 8.305.8.17)

(r) The Provider's standards for a Member's medical record will include the following minimum detail for individual clinical encounters:

(1) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;

(2) plan of treatment;

(3) diagnostic tests and the results;

(4) drugs prescribed, including the strength, amount, directions for use and refills;

(5) therapies and other prescribed regimens and the results;

(6) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);

(7) consultations and referrals and the results; and

(8) any other significant aspect of the Member's physical or behavioral health care. (NMAC 8.305.8.17)

(s) The Provider will provide HSD, the Collaborative or other State and Federal agencies or its designee appropriate access to its medical records. (NMAC 8.305.8.17)

(t) The Provider will allow appropriate access to the Members' medical records for purposes of in-state quality reviews conducted by HSD. (NMAC 8.305.8.17)

(u) Provider agrees to comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, the Health Insurance Portability and Accountability Act (HIPAA), and the state Medicaid Fraud Act. Provider also agrees to conform to MAD policies and instructions as specified in the MAD manual and appendices, as updated. (NMAC 8.302.1.11)

(v) Provider will submit Clean Claims electronically unless Provider can demonstrate to Health Plan of its inability to meet this requirement. Health Plan, with approval from MAD, if applicable, may waive this requirement on a case by case basis. Consistent with the requirements of MAD Program Manual Section 8.305.11.9.C (1) NMAC, which applies to clean claims submitted electronically, and NMSA Section 59A-2-9.2, Health Plan will pay interest at the rate of two percent (2%) a month on:

(1) the amount of a Clean Claim related to I/T/Us, day activity providers, assisted living providers, nursing facilities and home care agencies including Community Benefit providers that are electronically submitted by a contracted provider and not paid within fourteen (14) days of the date of receipt;

(2) the amount of a Clean Claim electronically submitted, that is not covered in the preceding paragraph by a contracted provider and not paid within thirty (30) days of the date of receipt;

(3) the amount of a Clean Claim manually submitted by a contracted provider and not paid within forty-five (45) days of the date of receipt;

(4) interest payments will accrue and begin on the 31st day for electronic submissions and the 46th day for hard copy.

(w) Provider will conduct abuse registry screenings in accordance with the Employee Abuse Registry Act, and §§7.1.12 and 8.11.6.1 NMAC.

(x) Provider will immediately report any changes in capacity to accept new Members or capacity to serve existing Members to Health Plan. This provision will not be deemed to relieve Provider of requirements as identified in Section 2.2 Standards for Provision of Care.

(y) Provider will perform criminal background checks for all required entities and individuals, whether employed or contracted, that are providing services under this Agreement, as specified in 7.1.9 NMAC ("Caregivers Criminal History Screening Requirements"). This background check will include, but is not limited to, verification against the List of Excluded Individuals/Entities ("LEIE") and other applicable governmental exclusion databases. Provider is prohibited from employing or contracting with any individual or entity that is excluded under 7.1.9 NMAC, the LEIE or other applicable governmental exclusion database.

(z) Provider hereby agrees to hold harmless the State of New Mexico and Members in the event that the Health Plan cannot or will not pay for services performed by Provider, pursuant to this Agreement. This provision will survive termination of the Agreement. This provision will be construed to be for the benefit of the Members.

(aa) Provider understands and agrees that pursuant to Executive Order 2007-049 issued on November 30, 2007 ("Executive Order"), Health Plan, as a Contractor to the State of New Mexico, is required to obtain assurances from Provider (as provided below) regarding Provider's provision of health insurance to Provider's employees. From time to time the State of New Mexico may promulgate laws, rules, and regulations or issue other guidance regarding the interpretation of the Executive Order. Provider agrees that upon the enactment of any such law, rule, regulation, or the publication of any interpretive policy, opinion or guidance regarding the Executive Order this Agreement will be automatically deemed amended to comply with such law, rule, regulation or guidance. Health Plan may, but will not be obligated to, by written notice to Provider, formally amend this Agreement to comply with such law or regulation

by providing thirty (30) days' written notice to Provider. Such amendment will be binding upon Provider at the end of the thirty (30)day period and will not require the written consent of the Provider.

(bb) If Provider has, had, or anticipates having, six (6) or more employees who work, or who worked, are working, or are expected to work, an average of at least twenty (20) hours per week over a six (6) month period with said six (6) month period being at any time during the year prior to seeking the contract with the Effective Date of this Agreement, Provider certifies by signing this Agreement to:

(1) Have in place, and agree to maintain for the term of this Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than the Effective Date, if the expected annual value in the aggregate of any and all contracts or subcontracts between Provider and the State or its contracted entities exceeds one million dollars ($1,000,000.00); or

(2) Have in place, and agree to maintain for the term of this Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2009, if the expected annual value in the aggregate of any and all contracts or subcontracts between Provider and the State or its contracted entities exceeds five hundred thousand dollars ($500,000.00); or

(3) Have in place, and agree to maintain for the term of this Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts or subcontracts between Provider and the State or its contracted entities exceeds two hundred and fifty thousand dollars ($250,000.00); and

a. agree to maintain a record of the number of employees who have: (i) accepted health insurance; (ii) declined health insurance due to other health insurance coverage already in place; or (iii) declined health insurance for other reasons

b. agree to make available records for review and audit by the State or its representative; and

c. advise all New Mexico employees in writing of the availability of State publicly financed health coverage programs by providing each employee with, at a minimum, the following web site link for additional information http://www.insurenewmexico.state.nm.us; and

d. demonstrate to Health Plan its compliance with this provision. Health Plan will report any failure to comply with this provision to the State. Failure to cure the deficiency can result in immediate termination of Provider's participation in the Medicaid and SCI portions of this Agreement.

(cc) Provider will comply with the requirements of the Deficit Reduction Act of 2005 (DRA) which requires that health care entities who receive at least $5 million in Medicaid funds per year comply with Section 6032, Employee Education About False Claims Recovery. The section maintains that these entities must have written policies for all employees, contractors, and agents that provide detailed information in terms of:

(1) The Federal False Claims Act and any state laws pertaining to civil or criminal penalties for false claims and statements, including whistleblower protections granted in these laws;

(2) How the provider will detect and prevent fraud, waste and abuse; and,

(3) The rights of the employee to be protected as whistleblowers and reiteration of the entity's policy for detecting and preventing fraud, waste and abuse in the employee handbook (if an employee handbook is in use by the health care entity).

(dd) Provider acknowledges that Health Plan will monitor Provider's performance on an ongoing basis and that Provider is subject to formal periodic review.

(ee) Provider agrees that Health Plan may apply corrective action plans if indicated, sanctions and/or termination (subject to Sections 4.2, 4.3 and 4.4 of the Agreement) for any violation of applicable HSD/MAD, state or federal statutes, rules and regulations.

(ff) Provider will timely furnish to the Health Plan, HSD/MAD or to the Secretary of the Department of Health and Human Services information related to certain business transactions with particular subcontractors, wholly owned suppliers and subcontractors, and to otherwise meet the obligations of 42 CFR 455.105(a) and 42 CFR 455.105(b).

(gg) Before signing or renewing a contract, or upon request, Provider will timely disclose to Health Plan, HSD/MAD or to the Secretary of the Department of Health and Human Services the identity of any individual or entity with more than five percent (5%) of beneficial ownership of the Provider's equity that has been convicted of a criminal offense related to the Medicare program, the Medicaid program or the Title XX service program, and to otherwise meet the obligations of 42 CFR 455.106.

(hh) HSD reserves the right to direct the Health Plan to terminate or modify the Agreement when HSD determines it to be in the best interest of the State of New Mexico.

(ii) Upon Termination of this Agreement, Provider agrees to immediately make available to HSD or its designated representative in a usable form any or all records whether medical or financial related to the Provider's activities under this Agreement. This provision of such records will be at no expense to HSD.

(jj) Pursuant to the State of New Mexico statutes and regulations, the giving, receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited. Violation of these statutes and regulations is grounds for immediate termination by Health Plan.

(kk) Provider certifies by signing this Agreement to the best of its knowledge and belief, that federal funds have not been used for lobbying in accordance with 45 C.F.R. Part 93 and 31 U.S.C. § 1352. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. § 1352. Any person who fails to file the required certification will be subject to a civil penalty of not less than ten thousand dollars ($10,000) and not more than one hundred thousand dollars ($100,000) for such failure. Provider will disclose any lobbying activities using non-federal funds in accordance with 45 C.F.R. Part 93.

(ll) Provider represents and warrants that it has complied with, and during the term of this Agreement, will continue to comply with all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978.

(mm) At all times during the term of this Agreement, Provider will indemnify and hold HSD harmless from all claims, losses, or suits relating to activities undertaken by the Provider pursuant to this Agreement.

(nn) Provider acknowledges that it is not a third-party beneficiary of the contract between Health Plan and HSD or between Health Plan and the State of New Mexico, and that all applicable rights and responsibilities of Provider are included solely in this Agreement.

(oo) Provider must display notices of the Member's right to appeal adverse action affecting services in public areas of the Provider's facility(s) in accordance with HSD rules and regulations and subsequent amendments.

(pp) Provider will comply with all Program Integrity provisions that are set forth in Health Plan's contracts with HSD and outlined in the Provider Manual.

(qq) If Provider is an Agency-Based Community Benefit provider, it must provide at least thirty (30) calendar days advance notice to the Health Plan when it is no longer willing or able to provide Covered Services to a Member, including the reason for the decision, and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers.

(rr) If Provider is a Community Benefit provider, compensation will be contingent upon the provision of services to an eligible Member in accordance with applicable federal and State requirements and the Member's care plan as authorized by the Health Plan.

(ss) If Provider is a Community Benefit provider it must immediately report any deviations from a Member's service schedule to the Member's care coordinator.

(tt) If Provider is a residential facility, Provider will ensure that Member pays the Member Liability and payments to Provider will only be net of the applicable Member liability amount.

(uu) Provider agrees to comply with all federal and state laws, regulations, and executive orders relevant to the provision of services. Provider must also conform to MAD program rules and instructions as specified in its manual, its appendices, and program directions and billing instructions, as updated. Provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. Provider must verify that Members are eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the Member's enrollment status at the time services are furnished. Provider must determine if Members has other health insurance. Provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to Member.

(vv) If Provider accepts delegation of any function on behalf of Health Plan, Provider agrees with the following:

(1) Provider will require any of its subcontractors to comply with Sections (a)–(uu) and (ww)–(xx) of this Attachment;

(2) if Provider, or its subcontractors receive as a benefit of this Agreement in excess of one hundred thousand dollars ($100,000) it will comply with all applicable standards, orders or requirements issued under section 306 of the

Clean Air Act (42 U.S.C. 1857 (h)), section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 C.F.R. Part 15);

(3) Provider will require its subcontractors to hold harmless the State and the Health Plan's Members in the event that the Health Plan cannot or will not pay for services performed by the Provider pursuant to the subcontract. The hold harmless provision will survive the effective termination of this Agreement for authorized services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and will be construed to be for the benefit of the Members.

(ww) The following marketing activities are prohibited, regardless of the method of communication, whether oral or written, or whether the activity is performed by Health Plan or Provider:

(1) Asserting or implying that a Member will lose Medicaid benefits if Member does not enroll with Health Plan or inaccurately depicting the consequence of choosing another managed care organization;

(2) Designing a marketing plan that discourages or encourages selection of a managed care organization based on health status or risk;

(3) Initiating an enrollment request on behalf of a Member;

(4) Making inaccurate, false or materially misleading exaggerated statements;

(5) Asserting or implying Health Plan offers unique Provider Services when another managed care organization provides the same or similar services. Such provision does not apply to the value-added services offered by Health Plan;

(6) Using gifts or other incentives to entice people to join a specific managed care organization;

(7) Directly or indirectly conducting door-to-door, telephonic, electronic or other cold-call marketing. Health Plan may send informational material regarding its benefit package to potential Members;

(8) Conducting any other marketing activities prohibited by HSD during the term of this Agreement; and

(9) Including any statement that Health Plan or Provider is endorsed by CMS, the federal or state government or a similar entity.

(xx) Overpayments.

(1) Provider shall cooperate with the retrospective claim review activities of the Medicaid Recovery Audit Contractor (RAC), complying with all requirements and expectations set forth in Section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor Program, and in accordance with guidance from CMS and state rules.

(2) Identification Process For Overpayments

a. Provider is required to report Overpayments to Health Plan by the later of: (i) the date which is sixty (60) calendar days after the date on which the Overpayment was identified; or (ii) the date any corresponding cost report is due, if applicable. A person has identified an Overpayment if the person has actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference of the Overpayment.

b. An Overpayment shall be deemed to have been "identified" when:

i. Provider reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement.

ii. Provider learns that a Member death occurred prior to the service date on which a Claim that has been submitted for payment.

iii. Provider learns that Provider Services were provided by unlicensed or excluded individual on its behalf.

iv. Provider performs an internal audit and discovers that an Overpayment exists.

v. Provider is informed by a government agency of an audit that discovered a potential Overpayment.

vi. Provider is informed by the Health Plan of an audit that discovered a potential Overpayment.

vii. Provider experiences a significant increase in Medicaid revenue and there is no apparent reason – such as a new partner added to a group practice or new focus on a particular area of medicine – for the increase.

viii. Provider has been notified that the Health Plan or a government agency has received a hotline call or email.

ix. Provider has been notified that the Health Plan or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the Provider submitted a Claim for payment.

(3) Self-Reporting

a. Within sixty (60) calendar days from the date on which the Provider identifies an Overpayment, the Provider shall send an "Overpayment Report" to the Health Plan and HSD which shall include:

i. Provider's name;

ii. Provider's tax identification number and National Provider Identifier (NPI) Number;

iii. How the Overpayment was discovered;

iv. The reason for the Overpayment;

v. The health insurance Claim number, as appropriate;

vi. Date(s) of service;

vii. Medicaid Claim control number, as appropriate;

viii. Description of a corrective action plan to ensure the Overpayment does not occur again;

ix. Whether the Provider has a Corporate Integrity Agreement (CIA) with the United States Health and Human Services Department Office of Inspector General (OIG) or is under the OIG Self-Disclosure Protocol;

x. The specific dates (or time-span) within which the problem existed that cause the Overpayments;

xi. If a statistical sample was used to determine the Overpayment amount, a description of the statistically valid methodology used to determine the Overpayment; and

xii. The Refund amount.

(4) Refunds

a. All self-reported refunds for Overpayments shall be made by the Provider to the Health Plan as an intermediary and are property of the Health Plan unless HSD, a Recovery Audit Contractor (RAC) or Medicaid Fraud and Elder Abuse Division (MFEAD) independently notified the Provider that an Overpayment existed. The Provider may:

i. request that the Health Plan permit installment payments of the refund, such request be agreed to by the Health Plan and the Provider; or

ii. in cases where HSD, the RAC, or MFEAD identify the Overpayment, HSD shall seek recovery of the Overpayment in accordance with NMAC §8.351.2.13.

(5) Failure To Self-Report And/Or Refund Overpayments

a. Overpayments that have been identified by the Provider and not self-reported within the sixty (60) day timeframe are presumed to be false claims and are subject to referrals as Credible Allegations of Fraud.

ATTACHMENT F
Medicare Program Requirements – Health Care Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans / health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its downstream, related entity(ies), and transferees that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii))

2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii).)

3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a:

a. Medicare Advantage Special Needs Planwill not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.

b. Capitated Financial Alignment Demonstration/Medicare-Medicaid Plan will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Member.

5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment F-1 of this Agreement. (42 CFR 422.504(i)(3)(ii).)

6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4).)

7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within six (6) months of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b).)

8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)

9. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

10. Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).)

11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

ATTACHMENT F-1
Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Provider of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans / health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein.

2. Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii).)

5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 504(a)(8).)

6. Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii).)

7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii).)

8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 422.504(i)(5).)

9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4).)

10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

ATTACHMENT G
Provider Acknowledgements

1) Provider hereby agrees to the following terms:
    a. Health Plan's Provider Manual was made available to Provider for review prior to Provider's decision to enter into this Agreement;
    b. Provider will register for Health Plan's Provider Self Services Web Portal at http://www.molinahealthcare.com/medicaid/providers/nm/Pages/home.aspx. Health Plan's Provider Self Services has a variety of tools to simplify your transactions whether you need to check eligibility, locate your assigned member panel (for primary care practitioners), check prior authorization or check claim status;
    c. Provider will complete the annual Molina Provider Survey; and
    d. Provider will file claims via electronic media.

Date: _____

Initials of authorized
representative of Provider _____