BLUE CROSS AND BLUE SHIELD OF NEW MEXICO
NEW MEXICO MEDICAID MANAGED CARE AGREEMENT
(FACILITIES)

PARTIES

This New Mexico Medicaid Managed Care Agreement ("Agreement"), is made and entered into by and among **Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** organized under the laws of, and domiciled in, the State of Illinois and lawfully operating in New Mexico pursuant to certification from the New Mexico Office of the Superintendent of Insurance (sometimes referred to herein as "Corporation"), and **<<PROVIDER NAME>>**, organized under the laws of _____ {STATE} and lawfully operating in New Mexico pursuant to licensure or certification from _____ _____ {NEW MEXICO AGENCY} and if required by law, registration, in good standing, with the New Mexico Secretary of State ("Medical Services Entity"). Collectively BCBSNM or Corporation and Medical Services Entity may also be referred to as the "Parties" and individually as a "Party."

PURPOSE

BCBSNM administers a New Mexico Medicaid managed care plan pursuant to the Medicaid Managed Care Services Agreement ("MMCSA") currently held by HCSC Insurance Services Company (HISC) with the State of New Mexico Human Services Department ("HSD") and New Mexico Behavioral Health Purchasing Collaborative ("Collaborative") for the New Mexico Medicaid program that is operated under federal waiver and/or demonstration projects; and

As of January 1, 2019, the New Mexico Medicaid program is known as "Centennial Care 2.0", and BCBSNM, for and in furtherance of the New Mexico managed care plan it administers, obtains and maintains contracts with medical, behavioral health, and long-term care services entities and other entities to provide Covered Services and be compensated for those Covered Services, sufficient to serve Members; and Medical Services Entity desires to perform the duties related to, and required for, participation in the network serving a New Mexico Medicaid managed care plan administered at any time by BCBSNM.

In consideration of the mutual promises herein, the Parties agree as follows:

ARTICLES

I. DEFINITIONS

Defined terms used in this Agreement are set forth herein as well as in the Attachments as necessary. Those terms that are also defined by New Mexico Statutes and New Mexico Insurance Division regulations will be used in a manner consistent with any definitions contained in said laws and regulations.

A. **Agency-Based Community Benefit.** The consolidated benefit of Home and Community Based Services (HCBS) and personal care services that are available to Members meeting the nursing facility level of care.

B. **BCBSNM's Medicaid Managed Care Provider Reference Manual or Medicaid PRM.** The policy and procedure manual prepared by Corporation, which may be amended at Corporation's option from time to time, setting forth the basic policies and procedures to be

followed by Medical Services Entity in carrying out the terms and conditions of this Agreement. The Medicaid PRM, as amended from time to time, is incorporated herein by reference.

C. **Behavioral Health.** The umbrella term for mental health (including psychiatric illnesses and emotional disorders) and substance abuse (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health and substance abuse disorders.

D. **Claim.** A billing, a reporting of services or adjustment to such billing, submitted on a form approved by Corporation or through a method of automated transmission developed for direct entry into Corporation's claim processing system.

E. **CMS.** The Centers for Medicare and Medicaid Services.

F. **Centennial Care 2.0.** The State of New Mexico's Medicaid program operated under section 1115(a) of the Social Security Act waiver authority as of the Effective Date hereof that is administered by HSD/MAD.

G. **Code of Federal Regulations or CFR.** The codified set of regulations published by the Office of the Federal Register, National Archives and Records Administration. Most references for Medicaid programs and policies are found in 42 CFR.

H. **Community Benefit.** The Agency-Based Community Benefit and the Self-Directed Community Benefit subject to the annual allotment as determined by HSD on an annual basis.

I. **Contractual Adjustment.** Any portion of a charge for a Covered Service which shall be absorbed by Medical Services Entity. These include, but are not limited to, the portion of charge in excess of Corporation's Maximum Allowable Fee as determined by Corporation; adjustments required by Corporation's billing policy and procedure; adjustments required through Utilization Management/Quality Improvement policy and procedure; other contractual provisions. Contractual Adjustments shall be absorbed by Medical Services Entity and shall not be charged to Member or Corporation.

J. **Coordination of Benefits (COB).** Coordinating with other valid coverage for payment of Covered Services. All other group and nongroup or direct-pay insurance policies or health care benefits (excluding Indian Health Service and Medicaid coverage) that provide payments for medical or other care services constitute other valid coverage.

K. **Copayment, Coinsurance, Deductibles.** The amounts required to be paid by the Member directly to the Medical Services Entity for a Covered Service.

L. **Corporation Maximum Allowable Fee.** The maximum amount of reimbursement allowed for a Covered Service as determined by Corporation, and as may be revised by Corporation from time to time.

M. **Covered Services.** Those physical, Behavioral Health and Long-Term Care services covered by the New Mexico Medicaid managed care insurance programs as set forth in BCBSNM's Medicaid PRM, the Medical Assistance Division Program Policy Manual, Attachment 2 to the MMCSA, as the foregoing may be amended or succeeded, or other applicable rules, regulations or guidelines.

N. **Cultural Competence.** Cultural Competence means a set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enables them to work effectively in cross-cultural situations. Cultural competency involves integrating and transforming knowledge, information and data about individuals and groups of people into specific clinical standards, service approaches, techniques and marketing programs that match an individual's culture to increase the quality and appropriateness of health care and outcomes.

O. **HIPAA.** The Health Insurance Portability and Accountability Act and its implementing regulations, as amended.

P. **HSD.** The New Mexico Human Services Department responsible for the administration of New Mexico Medicaid program.

Q. **Long-Term Care.** The overarching term that refers to the Community Benefit, the services of a Nursing Facility, and the services of an institutional facility.

R. **MAD.** The Medical Assistance Division of HSD which directly administers the New Mexico Medicaid program.

S. **Medicaid Fraud and Elder Abuse Division or MFEAD.** The division by that name within the New Mexico Attorney General's office.

T. **Managed Care Organization (MCO).** An entity that participates in Centennial Care under contract with HSD to assist the State in meeting the requirements established under the Public Assistance Act §27-2-12 NMSA 1978, as amended.

U. **Medical Necessity.** Medically Necessary Services, means clinical and rehabilitative physical, mental or Behavioral Health services that: (a) are essential to prevent, diagnose or treat medical conditions or are essential to enable the Member to attain, maintain or regain the Member's optimal functional capacity; (b) are delivered in the amount, duration, scope, and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical and Behavioral Health care needs of the Member; (c) are provided within professionally accepted standards of practice and national guidelines; and (d) are required to meet the physical and Behavioral Health needs of the Member; and (e) are not primarily for the convenience of the Member, the provider or BCSBNM; and (f) are reasonably expected to achieve appropriate growth and development as directed by HSD.

V. **Member.** A person who has been determined eligible for New Mexico Medicaid managed care and who is currently enrolled in a New Mexico Medicaid managed care plan administered by BCBSNM.

W. **Noncovered Services.** Services that are not Covered Services. Member may be financially liable to the Medical Services Entity for such services.

X. **Nursing Facility.** A licensed Medicare/Medicaid facility certified in accordance with 42 C.F.R. Part 483 to provide inpatient room, board and nursing services to Members who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician.

Y. **Participating Provider.** A professional, institutional, or any other provider who or that has entered into a written agreement with Corporation to provide certain Covered Services to Members, and if applicable, upon appropriate referral by the Member's Primary Care Provider

and/or Corporation. A nonparticipating provider is a provider who has not entered into any written agreement with Corporation.

Z. **Primary Care.** All health and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician's assistant or certified nurse practitioner.

AA. **Primary Care Provider (PCP) or Primary Care Provider or (PCP).** An individual who is a BCBSNM contracted provider and has the responsibility for supervising, coordinating and providing Primary Care to members, initiating referrals for specialist care, and maintaining the continuity of Member's care.

BB. **Quality Management (also called, "Quality Assurance" "Quality Improvement").** Policies, procedures, processes, protocols, and guidelines established and operated by the Corporation or its designee that relate to the quality of contracted services.

CC. **Self-Directed Community Benefit.** Self-Directed Community Benefit (SDCB) means certain Home and Community-Based Services that are available to Members meeting nursing facility level of care.

DD. **State.** The State of New Mexico.

EE. **Utilization Management.** The processes established by Corporation for reviewing the appropriate and efficient allocation of medical services and medical resources provided or to be provided to Members in accordance with the requirements of New Mexico Medicaid managed care programs.

FF. All capitalized terms not defined in this Agreement shall have the meaning as set forth in the Agreement, the MMCSA or the Medicaid regulations.

II. OBLIGATIONS OF MEDICAL SERVICES ENTITY

A. Services

1. Provision of Services Generally. Within the lawful scope of its practice and/or that of its providers, as applicable, and in accordance with the terms and conditions of this Agreement, Medical Services Entity shall ensure the availability and provision of those Covered Services to Members that Medical Services Entity usually and customarily makes available and provides to its patients.

    a. Additionally, Medical Services Entity shall furnish Covered Services to Members in a manner consistent with the requirements of Medicaid statutes, regulations, HSD/MAD pronouncements, Corporation's policies and procedures, as well as professionally recognized standards of health care.

    b. Medical Services Entity shall further ensure that Covered Services are provided in a Culturally Competent manner to Members, including those with a hearing impairment, Limited English Proficiency, a speech or language disorder, physical disabilities, developmental disabilities, differential disabilities or diverse cultural and ethnic backgrounds.

c. Medical Services Entity shall offer hours of operation that are no less than the hours of operation offered to commercially insured patients.

d. Medical Services Entity shall report to Corporation any changes in its capacity to take new Members or serve current Members.

2. Members' Access to Covered Services. Medical Services Entity acknowledges that a Member may choose to access Covered Services through his or her PCP or by self-direction without a referral. Medical Services Entity agrees to participate in and otherwise foster and facilitate such access by, without limitation, (i) informing the Member about BCBSNM's website and customer service, case management and/or care coordination departments, as applicable, (ii) providing to the Member available BCBSNM health education and other resource materials tailored to the Member's unique needs; and (iii) actively participating in the provision and coordination of the overall health care of Members, including, without limitation, issuing and accepting appropriate referrals to/from other participating providers, as the foregoing are more fully described in the Medicaid PRM.

3. Compliance with Laws and Non-Discrimination. Medical Services Entity shall comply with all applicable State and federal statutes, rules and regulations, and executive orders, including the prohibition against discrimination.

   a. Medical Services Entity shall adhere to requirements and other appropriate accrediting in effect during the term of this Agreement as stated in the Credentialing and Recredentialing Policy of Corporation.

   b. Medical Services Entity must also conform to MAD program rules and instructions as specified in MAD's "Program Policy Manual," its appendices, and program directions and billing instructions, as updated and applicable to Medicaid managed care. Medical Services Entity will (i) follow coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services, (ii) verify that individuals are eligible for a specific health care program administered Corporation, (iii) verify the eligible recipient's enrollment status at the time services are furnished, (iv) determine if an eligible recipient has other health insurance, and (v) maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

4. Abidance by Member Rights and Responsibilities. Medical Services Entity shall abide by the Member Rights and Responsibilities as set forth in the Medicaid PRM, the same being derived from the MMCSA.

5. Acceptance of Corporation's Members as Patients. Medical Services Entity and any sub-contractors of the Medical Services Entity shall accept as patients Corporation's Members, without regard to their health care needs. Medical Services Entity agrees (i) not to differentiate or discriminate in the treatment of its patients or in the quality of services delivered to Members on the basis of race, gender, sexual orientation, age, national origin, ancestry, religion, place of residence, health status or disability, and without regard to the source of payment, and (ii) to observe, protect, and promote the rights of Members as patients.

6. Advise Patients. Medical Services Entity and/or its providers, as applicable, may advise patients about their health status or medical care or treatment and Corporation does not prohibit or otherwise restrict such advice as provided in Section 1932(b)(3) of the Social

Security Act, 45 CFR § 438.102 or in contravention of the Patient Protection Act §§ 59A-57-1 to 59A-57-11, NMSA 1978, as amended.

7. Additional Requirements for Certain Provider Types. The requirements set forth in this Article II.A apply to Medical Services Entity only if Medical Services Entity and/or its providers are the type of provider identified herein.

   a. Primary Care Providers shall meet and fulfill all PCP requirements and responsibilities pursuant to the MMCSA as set forth in the Medicaid PRM, including but in no way limited to: (i) providing 24-hour, seven-day-a-week access to care, (ii) ensuring the coordination and continuity of care with providers within and outside of Corporation's network (including Behavioral Health and Long-Term Care providers) according to Corporation's policy, and (iii) ensuring that the Member receives appropriate prevention services for the Member's age group.

   b. Laboratory service providers shall meet and fulfill all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

   c. Nursing Facility providers shall promptly notify Corporation of (i) a Member's admission or request for admission to the Nursing Facility regardless of payer source for the Nursing Facility stay, (ii) a change in a Member's known circumstances and (iii) a Member's pending discharge.

   d. Nursing Facility providers shall notify the Member and/or the Member's Representative in writing prior to discharge in accordance with State and federal requirements.

   e. Agency-Based Community Benefit providers shall provide at least thirty (30) Calendar Days' advance notice to Corporation when the provider is no longer willing or able to provide 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.

   f. Community Benefit providers shall immediately report any deviations from a Member's service schedule to the Member's care coordinator.

   g. Emergency Services providers shall provide such services without the requirement of prior authorization of any kind.

   h. Omission in this Article II.A.7 of additional requirements for the foregoing provider types or any provider type not identified in this Article does not waive or excuse requirements established by State and federal statutes, rules and regulations and/or set forth in the Medicaid PRM or elsewhere in the Agreement, as may be applicable to a particular provider type.

   i. Community Benefit providers shall immediately report any deviations from a Member's service schedule to the Member's care coordinator.

   j. Community Benefit providers shall comply with all applicable federal requirements for HCBS settings requirements.

8. Provisions Apply to Subcontractors. All provisions of this Agreement, unless clearly inapplicable, shall apply with equal force to the persons affiliated, contracted or employed

with Medical Services Entity who or which are, or should have been, identified in this Agreement as providing Covered Services to Members or otherwise performing services directly related to this Agreement, and Medical Services Entity shall ensure their compliance herewith.

B. Compensation and Billing

1. Generally. Medical Services Entity shall accept payment from Corporation as set forth in the reimbursement attachment(s) to this Agreement as full and final payment for Covered Services provided to Members and cannot request payment from HSD or the Member, unless the Member is required to pay a copayment.

    a. Accordingly, Medical Services Entity shall accept payment or appropriate denial made by Corporation (or, if applicable, payment by Corporation that is supplementary to the Member's third party payer) in accordance with the reimbursement attachments to this Agreement plus the amount of any applicable Member cost sharing responsibilities, as payment in full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Member in excess of the amount of applicable cost sharing responsibilities.

    b. Furthermore, in no event, including but not limited to nonpayment by Corporation, insolvency of Corporation or breach of this Agreement, shall Medical Services Entity bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against the State or a Member or persons (other than Corporation) acting on their behalf, and shall therefore hold them harmless, for services provided pursuant to this Agreement, except for any Member required to make copayments under HSD's policy. Remaining balances shall be treated as Contractual Adjustments by Medical Services Entity and shall not be billed to the Member.

        i This provision shall survive the termination of this Agreement, regardless of the cause giving rise to termination.

        ii This provision does not apply to services provided after the effective date of this Agreement's termination.

2. Claims Submission. Medical Services Entity shall submit claims for Members as set forth in the Medicaid PRM, and as further provided herein.

    a. Medical Services Entity is expected to submit Claims within 90 days from the date of service and must submit Claims no later than 180 calendar days from the date of service or the Claims will be ineligible for reimbursement by Corporation and Medical Services Entity may not seek payment from the Member, HSD or the State.

    b. Medical Services Entity shall promptly submit information needed for Corporation to make payment.

    c. As a condition of receiving any amount of payment from Corporation for Covered Services furnished under this Agreement, Medical Services Entity must comply with Section 4.17 of the MMCSA, including, but not necessarily limited to, all program integrity requirements described in Article II.C.2 of this Agreement and as may be set forth in the Medicaid PRM.

d. Medical Services Entity shall submit claims electronically to Corporation in a standard format (HCFA-1500, UB-92 or successor). Corporation may expressly waive electronic claims submission in accordance with applicable law and HSD requirements.

3. Timely Notice. If Medical Services Entity disagrees with the action taken or the amount paid by Corporation on any claim submitted under this Agreement, Medical Services Entity must notify Corporation of such dispute within 90 calendar days after the initial date of payment or denial. Medical Services Entity waives any right to dispute the amount of payment or any other action taken by Corporation on a claim subject to this Agreement unless notification is received within the times specified in this paragraph. In such event, Medical Services Entity shall be prohibited from collecting any payment from the Member.

4. Payment Adjustments. Corporation or its designated contractor may request, and Medical Services Entity shall provide, medical records and other information related to claims previously submitted by Medical Services Entity to Corporation. Review and evaluation of such claims may result in retrospective payment adjustments. Corporation shall be limited in making such retroactive adjustments to a period that is two years from the date of service, except this limitation shall not apply in the event that for any claim(s) Corporation has evidence of misrepresentation or fraud.

5. Advance Deposits. Medical Services Entity shall not require advance deposits for Covered Services from any Member who provides proof of identity and coverage under Medicaid managed care plan administered by BCBSNM. However, Members may be required to pay a MAD-allowed Deductible, Coinsurance, or Copayment for certain Covered Services at the time Covered Services are rendered. The collection of Member's Deductible, Coinsurance, or Copayment shall be the responsibility of the Medical Services Entity.

6. Overpayments. Medical Services Entity is required to report Overpayments to Corporation by the later of: (i) the date which is 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.

   a. An Overpayment shall be deemed to have been “identified” when Medical Services Entity:

      (i) reviews billing or payment records and learns that it incorrectly coded certain services, resulting in increased reimbursement;

      (ii) learns that a patient death occurred prior to the service date on which a claim that has been submitted for payment;

      (iii) learns that services were provided by unlicensed or excluded individual on its behalf;

      (iv) performs an internal audit and discovers that an Overpayment exists;

      (v) is informed by a government agency of an audit that discovered a potential Overpayment;

      (vi) is informed by Corporation of an audit that discovered a potential Overpayment;

(vii) 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) has been notified that the CONTRACTOR or a government agency has received a hotline call for email;

(ix) has been notified that the CONTRACTOR or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the Medical Services Entity submitted a claim for payment.

b. Within sixty (60) calendar days from the date on which the Medical Services Entity identifies an Overpayment, Medical Services Entity shall send an "Overpayment Report" to the CONTRACTOR and HSD which shall include the:

(i) Medical Services Entity's name;

(ii) tax identification number and National Provider Number;

(iii) how the Overpayment was discovered;

(iv) reason for the Overpayment;

(v) 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 Medical Services Entity 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) 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.

c. All self-reported refunds for Overpayments shall be made by Medical Services Entity to Corporation as an Intermediary and are property of the Corporation unless (i) HSD, the Recovery Audit Contractor (RAC) or MFEAD independently notified Medical Services Entity that an Overpayment existed; (ii) Corporation fails to initiate recovery within 12 months from the date Corporation first paid the Claim; or (iii) Corporation fails to complete recovery within 15 months from the date Corporation first paid the Claim. Medical

Services Entity may: (1) request that Corporation permit installment payments of the refund, such request may be agreed to by Corporation and the Medical Services Entity; or (2) 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.

d. Overpayments that have been identified by Medical Services Entity and not self-reported within the 60-day timeframe may be considered false claims and may be subject to referrals as Credible Allegations of Fraud and subject to reporting by Corporation to HSD in accordance with Section 4.17.2 of the MMCSA.

e. If Medical Services Entity receives payment from another insurer or source (for example, Workers' Compensation company) and determines that Corporation is due a refund, the Medical Services Entity shall within 30 calendar days of receiving the other payment contact Corporation's Customer Services Department and provide the necessary information. Medical Services Entity shall not issue Corporation a refund check but shall give Corporation timely notice of all such overpayments.

7. Noncovered Services. Medical Services Entity is prohibited from billing the Member for a Noncovered Services and the Member is not responsible therefor unless, prior to rendering the service, Medical Services Entity (i) informed the Member or their personal representative that the specific service is not a Covered Service, and (ii) obtained a signed statement from the Member or their personal representative acknowledging such.

8. Cost Sharing. Medical Services Entity shall administer Member cost sharing (e.g., copayments) as may be required by HSD from time-to-time and set forth in the Provider Reference Manual. For non-emergency use of the emergency room and for legend drugs when a generic drug is available, the following provisions regarding copayments apply, as applicable. Medical Services Entity shall not impose any cost sharing on Native Americans.

9. Patient Liability for Members in Residential Facilities. Members residing in residential facilities are required to pay their applicable patient liability. Patient liability amounts are determined by the State of New Mexico. Corporation delegates collection of patient liability for Members in a Nursing Facility or community-based residential alternative facility. Corporation shall pay the facility net of the applicable patient liability amount.

10. Responsibilities Regarding Third Party Liability. For coordinating benefits in Medicaid managed care as a component of third party liability (TPL), Medical Services Entity acknowledges that Corporation is the payer of last resort. Accordingly, if a Member has coverage with another plan that is primary to the Medicaid managed care plan administered by BCSBNM, Medical Services Entity must submit a claim for payment to that plan first and then to Corporation within 180 days from the other insurance paid date. The amount payable by Corporation will be governed by the amount paid by the primary plan and the Medicaid secondary payer regulations at Sections 8.302.3.1, *et seq.*, NMAC.

    a. Medical Services Entity shall establish procedures for identification of Members with work-related injuries or illnesses. As with other primary carriers, Medical Services Entity is obligated to file claims with a workers' compensation carrier before filing with Corporation.

11. Reimbursement of a Community Benefit Provider. If Medical Services Entity is a Community Benefit provider, reimbursement shall 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 Corporation.

C. Other Obligations

1. Insurance and Liability. Throughout the term of this Agreement, Medical Services Entity shall maintain at its sole cost and expense policies of insurance or funded self-insurance programs providing general and professional liability coverage as shall be necessary to insure Medical Services Entity and its agents, servants, and employees acting within the scope of their duties against any claim or death occasioned directly or indirectly in connection with the performance of any Covered Services pursuant to this Agreement. Such policy(s) shall provide at least minimum coverage appropriate to the licensure. Medical Services Entity shall provide a certificate of insurance or self-insurance evidencing such coverage upon request, and shall notify Corporation not more than 10 days after Medical Services Entity's receipt of notice of cancellation, modification or termination of such insurance. If any insurance coverage is written on a claims-made basis, Medical Services Entity shall continue to maintain insurance coverage for claims occurring during the term of this Agreement (tail coverage) for a period of at least two (2) years beyond the expiration or termination of this Agreement.

2. Program Integrity. Medical Services Entity shall comply with the following program integrity requirements.

    a. Medical Services Entity shall have a comprehensive internal Fraud, Waste and Abuse program in accordance with 42 CFR Section 438.608(a)(1).

    b. Medical Services Entity shall conduct screening of all employees, including those providing direct services to Members (e.g., home health, personal care), in accordance with the Employee Abuse Registry Act, §27-7A-3, NMSA 1978, as amended, the New Mexico Caregivers Criminal History Screening Act, §29-17-2 et seq., NMSA 1978, as amended, and ensure that all employees are screened against the Office of Inspector General's "List of Excluded Individuals/Entities" and the Medicare exclusion databases; unless otherwise granted by the OIG or other applicable federal authority, Medical Services Entity will neither employ nor contract with any person or entity licensed or otherwise authorized to provide any Covered Services who or which are excluded from participation in federal health care programs under either Section 1128 or Section 1128 of the Social Security Act.

    c. Medical Services Entity represents and warrants that it is not an individual provider, an entity, or an entity with an individual who is an officer, director, agent, manager or person with more than 5% of beneficial ownership of an entity's equity, that has been convicted of crimes specified in the sections 1128 and 1128A of the Social Security Act or who has a contractual relationship with an entity convicted of a crime specified in such section.

    d. Medical Services Entity shall assure, to the extent of its authority that services or items ordered or provided by Medical Services Entity or its providers to Members: (i) will be provided economically and only when, and to the extent, medically necessary; (ii) will be of a quality which meets professionally recognized standards of health care; and (iii) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities.

e. If Medical Services Entity receives at least $5,000,000 in the aggregate in Medicaid payments annually, it shall establish written policies and procedures for all employees, agents, or contractors that provide detailed information regarding (i) the New Mexico False Claims Act, §27-14-1 et seq., NMSA 1978, as amended, (ii) the New Mexico Fraud Against the Taxpayers Act, §44-9-1 et seq., NMSA 1978, as amended , (iii) the New Mexico Medicaid Fraud Act, §30-44-1 et seq., NMSA 1978, as amended, and (iv) the Federal False Claims Act established under 31 U.S.C §§ 3729-3733, administrative remedies for false claims established under 31 U.S.C. 3801 et seq., and preventing and detecting Fraud, waste, and Abuse in federal health care programs (as defined in Social Security Act §1128B(f)) and 42 CFR § 438.608. Such policies and procedures shall articulate Medical Services Entity's commitment to compliance with federal and State standards. Medical Services Entity shall include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as "whistleblowers," and the Medical Services Entity's policies and procedures for detecting and preventing fraud, waste and abuse.

(i) Medical Services Entity acknowledges and agrees that as part of its compliance with applicable State and federal statutes, rules and regulations, it shall, regardless of the amount of Medicaid payments received annually, comply with the Federal False Claims Act and any State laws, including those identified hereinabove, pertaining to civil or criminal penalties for false claims and statements, including whistleblower protections thereunder.

f. Before entering into or renewing this Agreement with Corporation, within 35 days after a change in ownership in Medical Services Entity, or at any time on request, Medical Services Entity is required to complete, sign, and return a "Provider Disclosure of Ownership and Control Interest Form," available at www.bcbsnm.com and in the Medicaid PRM, regarding certain criminal convictions, ownership and control information. Additionally, within 35 days of request by Corporation, Medical Services Entity is required to submit full and complete information about: the ownership of any subcontractor with whom Medical Services Entity has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request, and any significant business transactions between Medical Services Entity and any wholly owned supplier, or between Medical Services Entity and any subcontractor, during the 5-year period ending on the date of the request. Medical Services Entity is required to collect and maintain disclosure information regarding certain criminal convictions, ownership and control information as described in this Article III.C.2.f.

g. Medical Services Entity shall, upon request, make available to HSD, MFEAD, the Medicaid Recovery Audit Contractor (RAC), CMS, or Medicaid Integrity Contractor (MIC) the any and all administrative, financial and medical records relating to the delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, Medical Services Entity shall provide the HSD, MFEAD, RAC, CMS or MIC with access during normal business hours to its respective place of business and records and shall further cooperate with the retrospective claim review activities of the RAC, complying with all requirements and expectations set forth in Section 6411 of the Affordable Care Act, Expansion of recovery Audit Contractor Program, and in accordance with guidance from CMS and state rules.

h. Medical Services Entity acknowledges and agrees that Corporation must and will comply with any written notice of participation or payment suspension issued by HSD per HSD's determination of a credible allegation of fraud against Medical Services Entity and

Medical Services Entity therefore shall have no recourse whatsoever against Corporation for such compliance, including but in no way limited to interest if it is later determined that payment may be made on a previously suspended Claim. Consistent with NMSA 1978, Sections 27-11-13 and -14 (2019) as interpreted by HSD, Medical Services Entity further acknowledges and agrees that suspension of participation or payment may be avoided or lifted if so directed by HSD because to HSD's satisfaction, Medical Services Entity (1) submits to BCBSNM's prepayment review of claims for ongoing services; (2) demonstrates to BCBSNM completion of related training or education required by HSD to prevent the submission of claims for payment to which Medical Services Entity is not entitled; and (3) engages an independent third party reasonably approved by BCBSNM to temporarily manage or provide related technical assistance to Medical Services Entity during the pendency of the dispute. If HSD-OIG determines Medical Services Entity compliance with the foregoing, Clean Claims for ongoing services during the HSD-referral or dispute shall be reimbursed within 10 and 30 days of receipt for electronic and paper claims respectively, provided, however, that prompt pay interest shall not be applied based on those accelerated timeframes.

i. Medical Services Entity shall notify Corporation within five business days of the issuance of any formal charges against the Medical Services Entity by any government agencies, or any other licensing or accreditation organization, which would, if sustained, materially impair its ability to comply with its duties and obligations pursuant to this Agreement.

3. Records, Information and Audits. Medical Services Entity shall: (i) maintain all records relating to services provided under this Agreement for at least a 10-year period from the date of creation as further described herein; (ii) make all Member medical records or other service records available for the purpose of quality review conducted by HSD/MAD or their designated agents both during and after the term of the Agreement; (iii) provide reasonable access to facilities and records to authorized representatives of HSD, the Collaborative or other State and federal agencies for financial and medical audit purposes both during and after the term of the Agreement; (iv) provide to Corporation any information necessary for Corporation to perform its obligations under the MMCSA. In addition to the foregoing, Medical Services Entity shall:

   a. Abide by all federal and State statutes and regulations regarding the confidentiality, privacy and security of medical records or other Member information, including but not limited to, HIPAA.

   b. Acknowledge Corporation's right and intent to monitor Medical Services Entity's performance on an ongoing basis and subject Medical Services Entity to formal periodic review.

   c. In the event of termination of the MMCSA, immediately make available to HSD or its designated representative in a usable form any or all records whether medical or financial related to Medical Services Entity's activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to HSD.

   d. Timely submit all reports, clinical information, and Encounter Data required by Corporation.

   e. Maintain appropriate records in accordance with federal and State statutes and regulations relating to Medical Services Entity'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. Each medical record shall be maintained on paper and/or in electronic format in a manner that is timely, legible, current and organized, and that permits effective and confidential patient care and quality review.

f. Maintain records, books, documents, and information that are adequate to ensure that services are provided and payments are made in accordance with the requirements of the MMCSA, including Encounter Data and audited financial reports, information relating to adequate provision against the risk of insolvency, the medical loss ratio report required in Section 7.2 of the MMCSA and the annual report on overpayments, and including applicable federal and state requirements (e.g., 45 C.F.R. § 74.53), the foregoing to be retained for a period of ten (10) years after this Agreement is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

g. Maintain records, books, documents and information on ownership and control as required in 42 CFR Section 455.104 and prohibited affiliations as specified in 42 CFR Section 438.610. Such shall be maintained for a period of ten (10) years after termination of this Addendum or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement whichever is longer.

h. To the extent in Medical Services Entity's possession, if at all, maintain records, books, documents and information related to the adequacy of BCBSNM's network as specified in 42 CFR Sections 438.68 and 438.207, as applicable. Such shall be maintained for a period of ten (10) years after termination of this Agreement or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Agreement, whichever is longer.

i. In addition to cooperating with MFEAD and other investigatory agencies in accordance with the provisions of NMSA 1978, Sections 27-11-1, *et seq*., upon reasonable notice and for the purposes of, but not limited to, examination, audit, investigation, MMCSA administration, or the making of copies, excerpts or transcripts, provide the following officials and entities with prompt, reasonable and adequate access to any personnel and records that are related to the scope of work performed under this Agreement within two business days after the date of the request or within 10 business days if the records are held by a subcontractor, agent or satellite office per NMSA 1978, Sections 27-11-3(A) and 27-11-4(B) and 42 CFR 438.3(h): (i) the United States Department of Health and Human Services or its designee; (ii) the Comptroller General of the United States or its designee; (iii) HSD personnel or its designee; (iv) HSD's Office of Inspector General; (v) the Collaborative's personnel or designee; (vi) MFEAD or its designee; (vii) any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of HSD; (viii) the Office of the State Auditor or its designee; (ix) a State or federal law enforcement agency; (x) a special or general investigating committee of the New Mexico Legislature or its designee; and (xi) any other State or federal entity identified by HSD, or any other entity engaged by HSD ("Access").

j. Medical Services Entity agrees to provide the Access described above: (1) for ten (10) years from the termination of this Agreement or from the date of completion of any audit, whichever is later, in accordance with 42 CFR 438.3(h), 42 CFR 438.230(c)(3)(iii), and 42 CFR 438.3(k); and (2) wherever the Medical Services Entity maintains such books, records and supporting documentation and further agrees to provide such Access in reasonable comfort and to provide any furnishings, equipment or other conveniences deemed necessary to fulfill the purposes described in this Article.

k. Upon request, Medical Services Entity must provide copies of the information described in this Article II.C free of charge to HSD and the entities described herein.

l. The requirements of maintaining records, books, documents, and information will include all medical, business, and financial records. All other records, books, documentation, and information resulting from this Agreement maintained by Medical Services Entity must be retained for a period of at least ten (10) years from the date of creation.

4. Participation and Cooperation in Quality (and Related) Programs. Without limitation, Medical Services Entity shall participate and cooperate in any internal and external Quality Management/Quality Improvement monitoring, utilization review, peer review and/or Appeal procedures established by Corporation and/or HSD.

   a. Medical Services Entity acknowledges and agrees that Corporation will be monitoring the quality of services delivered under this Agreement and that initial corrective action will be taken where necessary to improve quality of care, in accordance with that level of medical, Behavioral Health or Long-Term Care that is recognized as acceptable professional practices and/or the standards established by HSD.

   b. Medical Services Entity will comply with corrective action plans initiated by Corporation.

   c. The Utilization Management Program at BCBSNM evaluates, promotes, and coordinates quality and cost-effective health services. Medical Services Entity will work with Corporation to obtain the necessary information to ensure that Members obtain medically necessary care in a timely way as outlined in the Medicaid PRM. Utilization management decisions shall be based on appropriateness of care and service.

   d. Medical Services Entity shall cooperate with, participate in, and abide by the Corporation's "internal peer review programs," including credentialing and recredentialing, member-specific quality of care review, programs designed to evaluate and/or improve the quality of clinical and/or preventive services, external audits, and other quality management and improvement activities as described in the Medicaid PRM and its updates.

   e. Failure by Medical Services Entity to comply with the agreed upon Corporation UMP/QMI Programs may result in the denial and non-payment of claims. In accordance with the provisions of Article II.B, Medical Services Entity shall not seek to collect payment from any Member for claims denied under this paragraph.

   f. Medical Services Entity agrees to abide by Corporation's process for resolving Member grievances and appeals, as described in the Medicaid PRM.

   g. Without limitation, Medical Services Entity shall display notices of the Member's right to Appeal adverse action affecting services in public areas of the Medical Services Entity's facility(s) in accordance with HSD rules and regulations, as amended.

   h. *Disaster Behavioral Health Planning*. Medical Services Entity shall participate in disaster Behavioral Health planning efforts at their local area level.

i. *Care Coordinator Notification*. Medical Services Entity shall notify the Member's care coordinator of any change in a Member's medical or functional condition that could impact the Member's level of care determination.

j. *Medical Services Entity Status*. In accordance with 45 CFR Part 76, Medical Services Entity certifies that neither the Medical Services Entity nor its Principals or subcontractors have been: (i) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract, (ii) listed by a federal governmental agency as debarred or suspended, (iii) proposed for debarment or suspension or otherwise excluded from federal program participation, (iv) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (v) within a three-year period preceding the date of this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default. Medical Services Entity acknowledges and agrees that it has a continuing obligation to notify Corporation in writing within seven business days if any of the above-referenced representations change. Medical Services Entity further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of this Agreement, may be grounds for immediate termination of this Agreement, at the sole discretion of Corporation.

III. OBLIGATIONS OF CORPORATION

A. Services

1. Laws and Regulations. Corporation shall adhere to all applicable federal and state laws and regulations in effect during the term of this Agreement.

2. Monitor Performance. Corporation shall monitor Medical Services Entity's performance on an ongoing basis and subject Medical Services Entity to formal periodic review.

3. Benefits to Members. Corporation shall provide benefits for Members in accordance with the BCBSNM's Medicaid Managed Care plan.

4. Online Access to Medicaid PRM. Corporation shall provide Medical Services Entity with on-line access to the Medicaid PRM. Corporation reserves the rights to amend, change or add to the provisions of the Medicaid PRM, and shall provide Medical Services Entity with notice of any such amendment, change or addition.

5. Emergency Services. Corporation shall not require prior authorization of any kind for the provision of Emergency Services.

B. Compensation and Billing

1. Payment. For all Covered Services provided by Medical Services Entity hereunder, Corporation shall pay to Medical Services Entity the compensation (including, if applicable, (i) risk-based compensation, (ii) physician incentive plan, or (iii) pay-for-performance programs), as set forth in the reimbursement attachments to this Agreement.

2. Payment of Clean Claims. Corporation's goal and intention is to pay Clean Claims within time frames specified by HSD for the New Mexico Medicaid managed care program. For Claims from I/T/Us, day activity Providers, assisted living Providers, Nursing Facilities and home care agencies, including Community Benefit Providers, HSD's specified time frame for paying Clean Claims is 15 calendar days after receipt; for claims from other provider types, HSD's specified time frame for paying Clean Claims is 30 calendar days after receipt. Corporation shall pay interest at the rate established by HSD for each month or portion of any month on a prorated basis on the amount of a Clean Claim electronically submitted by Medical Services Entity and not adjudicated within 30 Calendar Days of the date of receipt and on the amount of a Clean Claim manually submitted by Medical Services Entity and not adjudicated within 45 Calendar Days of the date of receipt. Interest shall accrue from the 31st day for electronic claims and from the 46th day for manual claims.

    a. In the event additional information is required to appropriately process a claim, payments shall be made within 30 calendar days following Corporation's receipt of the additional information.

3. Third Party Liability. If Corporation has determined that TPL exists for part or all of the services provided to a Member by Medical Services Entity, and the third party is reasonably expected to make payment within 120 Calendar Days, Corporation may pay Medical Services Entity only the amount, if any, by which Medical Services Entity's allowable Claim exceeds the amount of the anticipated third- party payment; or, Corporation may pay Medical Services Entity only the amount, if any, by which Medical Services Entity's allowable Claim exceeds the amount of TPL.

a. Corporation may not withhold payment for services provided to a Member if third-party liability or the amount of liability cannot be determined, or if payment shall not be available within a reasonable time, beyond 120 Calendar Days from the date of receipt.

b. If the probable existence of TPL has been established at the time the Claim is filed, Corporation must reject the Claim and return it to Medical Services Entity for a determination of the amount of any TPL.

C. Other Obligations

1. Insurance and Liability. Corporation, at its sole cost and expense, shall procure and maintain for the term of this Agreement policies of insurance or funded self-insurance programs providing comprehensive general liability, professional liability, malpractice and other insurance as shall be necessary to insure Corporation and its agents and employees acting within the scope of their duties, against any claim or claims for damages arising in connection with the performance by Corporation of services pursuant to this Agreement. Corporation shall provide a certificate of insurance or self-insurance evidencing such coverage upon request.

2. Records. Any data or information pertaining to the diagnosis, treatment, or health of any Member or applicant obtained from such person or from any Medical Services Entity by Corporation shall be held in confidence and shall not be disclosed to any third person except in connection with utilization review or unless an appropriate release has been obtained or to the extent required or permitted by law.

3. Utilization Management (UM) and Quality Management and Improvement Program (QMI). Corporation shall provide comprehensive information regarding the UM and QMI Programs in the Medicaid PRM, its updates, and Provider newsletters. Corporation shall provide opportunity for Participating Providers to have formal input into the UM and QMI programs as described in the Medicaid PRM.

   a. Corporation shall not offer incentives for denials of coverage and service or for discouraging utilization of health care services.

4. Member Identification. Corporation shall provide each Member with a suitable identification card. Corporation will supply eligibility and benefit information upon request.

5. Administration. Corporation shall provide Medical Services Entity with a Medicaid PRM. Corporation reserves the rights to amend, change or add to the provisions of the Medicaid PRM, and shall provide Medical Services Entity with notice of any such amendment, change or addition.

   a. Corporation may also provide information on changes to its policies and procedures or new policies and procedures in provider newsletters or other mailings to providers. If Medical Services Entity fails to follow the procedures set forth in the Medicaid PRM, Corporation may not cover the services rendered and the provisions of Article II.B shall apply. Failure to follow the procedures set forth in the Medicaid PRM may also result in termination of this Agreement.

6. Provider Selection. Corporation will comply with the provider selection requirements specified in 42 CFR Section 438.214 and maintain policies and procedures that reflect these requirements.

7. Grievance and Appeals Information. Corporation will provide to Medical Services Entity on-line or other access to the information specified in 42 CFR Section 438.10(g)(2)(xi) about its Member Grievance and Appeals system upon complete execution of this Agreement.

IV. TERM AND TERMINATION

A. Term of Agreement

Term of Agreement. The term of this Agreement shall commence on the Effective Date stated on the signature page of this Agreement and shall continue until Corporation no longer administers a New Mexico Medicaid managed care plan for Members by whatever name(s) then known or is otherwise terminated as provided herein.

B. Termination of Agreement

1. Unilateral. This Agreement may be terminated by either Party at any time, upon giving a minimum of 90 days' advance written notice of termination to the other Party. Termination shall be effective at the end of the calendar month in which the 90-day notice requirement expires, or at the end of any subsequent calendar month specified in the notice. When such notice is given, both Parties may endeavor to reach a mutually satisfactory basis for continuing their contractual relationship. If, during the course of such negotiations, either Party determines that there is not a mutually satisfactory basis for continuing the contractual relationship, then such Party shall give the other Party written notice of final termination by certified mail, and this Agreement shall terminate as of the date specified in such notice, or 90 days from the date of the initial notice, whichever is later.

    a. Corporation may suspend, deny, refuse to renew or terminate this Agreement in accordance with the terms of the MMCSA and applicable statutes and regulations.

    b. HSD reserves the right to direct Corporation to terminate or modify this Agreement when HSD determines it to be in the best interest of the State.

2. Default. If either Party defaults in the performance of its obligations under this Agreement, then the non-defaulting Party shall give the defaulting Party 45 days' prior written notice to cure the default or 15 days' prior written notice if a financial default. If the default is not cured within the 45-day or 15-day period to the satisfaction of the non-defaulting Party, then such Party shall give the defaulting Party an additional 45 days' prior written notice of termination of this Agreement, or 15 days' prior written notice if a financial default and the Agreement shall terminate at the expiration of the final notice period.

3. Immediate Termination. This Agreement shall terminate immediately upon written notice in the event Medical Services Entity, in Corporation's sole and exclusive determination, is no longer able to provide services hereunder at the level or of the quality required as a result of: (i) the suspension or revocation of, or the imposition of restrictions on, Medical Services Entity's license; or (ii) loss of liability insurance coverage; or (iii) loss of Medicare certification, or addition to the Medicare sanctions list and/or inclusion on the Office of the Inspector General's Cumulative Sanction Listing, General Services Administration Excluded Party List System, or a listing of debarred providers published by the Office of Personnel Management; or (iv) in the event Corporation determines that continuation of services hereunder presents

an imminent risk of danger to the health of any Member. In addition, this Agreement shall terminate immediately upon written notice in the event of final revocation of Corporation's certificate of authority.

4. For Cause Termination. This Agreement shall terminate for cause as determined by the Corporation for reasons including, but not limited to:

    a. Violation of applicable State or federal statues, rules, and regulations, including but not limited to applicable HSD requirements. Such termination shall be effective upon thirty (30) days' written notice by Corporation to Medical Services Entity; or

    b. Data and information obtained from the Credentialing and Recredentialing Program, and/or Utilization Management Program, and/or Quality Management and Improvement Program with 30 days' written notice unless the reason is included in Article IV.B.3, above.

5. Termination upon Cessation of Administration of Medicaid managed care plan(s). This Agreement shall terminate upon the complete cessation of Corporation's administration of any and all New Mexico Medicaid managed care plans by whatever name(s) then known.

6. New Mexico Medicaid Managed Care Program Updates. Until this Agreement's termination in accordance with this Article IV, any modifications or updates required to comply with, or conform to, modifications or updates to regulations or the MMCSA (including related communications, such as letters of direction) made by HSD or any federal or State regulatory authority applicable to Medical Services Entity's provision of services to Members, whether for Centennial Care 2.0 or successor New Mexico Medicaid managed care program by whatever name called, shall be deemed agreed to and incorporated herein by reference upon written notice of such modifications or updates to Medical Service Entity by Corporation.

C. Rights and Responsibilities Upon Termination

1. Termination of Rights and Responsibilities. Upon termination as described in Article IV.B, the rights of each Party hereunder shall terminate, provided, however, that such action shall not release Medical Services Entity or Corporation from their obligations with respect to:

    a. Payments and/or settlements accrued to either Party prior to termination;

    b. Completion of treatment of Members then receiving care until Corporation can arrange continuation of Member's care, unless termination occurs for reasons stated in Article IV.B.3 above;

    c. Holding the Member and State harmless for payment of services;

    d. Any other provision of this Agreement identified as surviving termination or as may be required by applicable statutes, rules and regulations, the MMCSA, and/or HSD pronouncements.

2. Continuing Obligations of Care. Even though this Agreement may be terminated, Medical Services Entity and Corporation agree that the Agreement's provisions shall continue to apply with respect to the provision of and payment for Covered Services for Members who are currently undergoing an acute course of treatment. Corporation will make every effort to transfer the Member's care to a contracted Medical Services Entity, as the Member's care needs reasonably permit.

3. Notice of Termination. Any notice of termination shall be sent by certified mail, postage prepaid to the receiving Party's then current address of record.

V. GRIEVANCES, APPEALS, AND DISPUTE RESOLUTION

A. Right to File

The Medical Services Entity shall have the right, in accordance with Section 8.305.12 NMAC, to file with Corporation Grievances and Appeals on its own behalf and, upon a Member's written designation of Medical Services Entity as the Member's representative, on behalf of the Member. Information about Grievance and Appeal rights and processes, including Fair Hearings, is set forth in the Medicaid PRM.

B. Initial Mediation of Dispute

In the event any dispute should arise with regard to performance or interpretation of any of the terms of this Agreement and the Parties are unable to resolve such dispute through the Grievance and Appeals process, the Parties may choose to submit the dispute to mediation prior to either Party pursuing arbitration. Notification to the other Party must be made prior to any Demand for Arbitration having been filed. The Party choosing mediation shall designate an organization or a company specializing in providing neutral, third-party mediators. The mediation process shall be coordinated by the requesting Party with the mediator and be subject to the following agreed-upon conditions: the Parties shall participate in the mediation in good faith; Both Parties will be represented at the mediation meeting by individuals with full decision-making authority regarding the matters in dispute; the mediation meeting will be held within 60 days of the initial request, unless the Parties mutually agree on a later date; the Parties shall each bear their own costs and shall each pay one-half of the mediator's fees.

C. Binding Arbitration

Either Party may submit any dispute arising out of this Agreement that is not resolved through mediation to final and binding arbitration. The Parties shall submit their dispute to arbitration in accordance with commercial arbitration rules as established by the American Arbitration Association. Such arbitration shall be held in Albuquerque, New Mexico. Any decision rendered in arbitration shall be binding and may be enforced in any court of competent jurisdiction. Each Party shall be responsible for its own costs and expenses related to the arbitration, including attorneys' fees, and shall bear its proportionate share of the arbitrator's fees. The arbitrator shall be selected on the mutual agreement of both Parties.

VI. MISCELLANEOUS PROVISIONS

A. Entire Agreement

1. This Agreement, as of its Effective Date set forth in the signature block, including all exhibits and attachments hereto and documents incorporated by reference, contains all the terms and conditions agreed upon by the Parties regarding Medical Services Entity's participation in Corporation's network supporting its New Mexico Medicaid managed care plan for Members on and after the Effective Date. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to Medical Services Entity's participation in Corporation's New Mexico Medicaid network as of or after the Effective Date that are not expressly set forth in this Agreement, are null and void.

a. Notwithstanding this Article VI.A.1, the Parties continue to have and be bound by any rights and obligations under any prior Medicaid agreement between them that continue beyond the Effective Date of this Agreement, including but not limited to those rights and obligations attendant Medical Services Entity's provision of services to Members (as defined in such prior agreement) before this Agreement's Effective Date and claims to Corporation therefor.

b. Medical Services Entity agrees that by executing this Agreement, it waives the notice requirements, if any, for termination of any prior Medicaid agreement with Corporation which shall occur as of this Agreement's Effective Date.

2. Masculine, Feminine, Singular and Plural. In this Agreement references to the masculine include the feminine and references to the singular include the plural.

3. Capitalized Terms. All capitalized terms not defined in this Agreement shall have the meaning as set forth in the MMCSA or the Medicaid regulations.

B. Modification and Amendment

This Agreement shall be modified by Corporation upon 30 days' prior written notice when the change or additions are required by the provisions of the New Mexico Insurance Code or regulations thereunder applicable to Medicaid, if any, or other State or federal laws, rules or regulations, or regulatory authority (including HSD) applicable to Medicaid, or as otherwise expressly provided in this Agreement. Accordingly, if any requirement in this Agreement is determined by HSD to conflict with the MMCSA, such requirement shall be null and void and all other provisions shall remain in full force and effect.

1. Changes or Modifications. No other changes or modifications of this Agreement shall be valid or binding upon the Parties, nor shall any waiver of any term or condition be deemed a waiver of such term or condition in the future, unless such modification, change, or waiver shall be in writing signed by the Parties.

2. Notice of Changes. Notwithstanding the above provisions, the Corporation may at any time modify or amend one or more of the Reimbursement Schedules attached to this Agreement. Corporation shall provide at least 30 days' prior written notice of such changes. The changes will become effective on the date stated by Corporation unless Medical Services Entity prior to the effective date has given notice to Corporation of Medical Services Entity's intent to terminate the Agreement, in which case the reimbursement terms then in effect will continue until termination.

C. Assignment

Neither Party may assign, directly or indirectly, all or part of its rights or obligations under this Agreement without the prior written consent of the other Party, which consent shall not be unreasonably withheld or delayed; provided, however that Corporation may transfer, assign, delegate or extend, all or part of its rights or obligations under this Agreement to any entity that directly or indirectly controls, is controlled by, or is under common control with, or is a successor organization of, Corporation ("Corporation's Affiliates").

D. Indemnification

1. Medical Services Entity shall indemnify and hold Corporation free and harmless against any and all claims, demands, and expenses of all kinds made against or incurred by Corporation which may result or arise out of any negligent act of Medical Services Entity or any agent, employee, or representative of Medical Services Entity in the performance or omission of any act or responsibility assumed by Medical Services Entity pursuant to this Agreement.

2. Corporation shall indemnify and hold Medical Services Entity free and harmless against any and all claims, demands, and expenses of all kinds made against or incurred by Medical Services Entity which result or arise out of any negligent act of Corporation or any agent, employee or representative of Corporation in the performance or omission of any act or responsibility assumed by Corporation pursuant to this Agreement.

3. Medical Services Entity shall indemnify and hold HSD harmless from all claims, losses, or suits relating to activities undertaken by Medical Services Entity pursuant to this Agreement.

E. Gratuities, Lobbying, and Conflict of Interest

1. Pursuant to the State of New Mexico statutes and regulations, the receipt or solicitation of bribes, gratuities and kickbacks is strictly prohibited. No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual employed by the State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise there from. HSD may, as more particularly described in the MMCSA, terminate the MMCSA if it is duly found that Corporation or any agent or representative of Corporation gave impermissible gratuities to any officer or employee of the State of New Mexico to secure the MMCSA or for favorable treatment under the MMCSA.

2. Medical Services Entity 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 shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure. Medical Services Entity shall disclose any lobbying activities using non-federal funds in accordance with 45 C.F.R. Part 93.

3. Medical Services Entity represents and warrants that it has complied with, and during the term of this Agreement, will continue to comply with, and that this Agreement complies with all applicable provisions of the New Mexico Government Conduct Act, §§ 10-16-1 et seq., NMSA 1978, as amended, and 42 C.F.R. § 438.58.

F. Marketing and Outreach**.** Medical Services Entity shall not engage in any marketing or outreach activities relating to Covered Services provided under this Agreement without prior approval from Corporation. All such marketing or outreach activities must comply with state and federal guidelines. Accordingly, the following marketing activities are prohibited, regardless of the method of communication (oral, written) or whether the activity is performed by Corporation directly (or by its Contract Providers, including Medical Services Entity), subcontractors, agents, consultants, or another other Party affiliated with Corporation:

1. Asserting or implying that a Recipient shall lose Medicaid benefits if he or she does not enroll with HISC, or inaccurately depicting the consequences of choosing a different MCO;

2. Designing a Marketing plan that discourages or encourages MCO selection based on health status or risk;

3. Initiating an enrollment request on behalf of a Recipient;

4. Making inaccurate, false, materially misleading or exaggerated statements;

5. Asserting or implying that HISC offers unique Covered Services when another MCO provides the same or similar services. Such provision does not apply to Value Added Services offered in accordance with this Agreement;

6. Using gifts or other incentives to entice people to join a specific MCO;

7. Directly or indirectly conducting door-to-door, telephonic, electronic or other Cold Call Marketing. (Corporation may, however, send informational material regarding its benefit package to Recipients and potential Members);

8. Conducting any other Marketing activity prohibited by HSD during the term of this Agreement; and

9. Including statements that HISC or Corporation is endorsed by CMS, the federal or State government, or a similar entity.

G. Exclusivity. Corporation retains the right to contract with other providers within the same service area and will not be a Party to an exclusive relationship.

H. Independent Contractors. Corporation and Medical Services Entity are separate and independent entities. The relationship between Corporation and Medical Services Entity is purely contractual. Neither Corporation nor any employee thereof shall be deemed to be the agent, employee, or other representative of Medical Services Entity, nor shall Medical Services Entity or any employee thereof be deemed to be an agent, employee, or other representative of Corporation. In the performance of this Agreement and in rendering medical services as provided herein, Medical Services Entity shall at all times be and act as an independent contractor.

I. Association Service Mark. Medical Services Entity hereby expressly acknowledges its understanding that this Agreement constitutes a contract between Medical Services Entity and Corporation, that Corporation is an independent Corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, permitting Corporation to use the Blue Cross and Blue Shield Service Marks in the State of New Mexico, and the Corporation is not contracting as the agent of the Association. Medical Services Entity further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Corporation and that no person, entity, or organization other than Corporation shall be held accountable or liable to Medical Services Entity for any of Corporation's obligations to Medical Services Entity created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Corporation other than those obligations created under other provisions of this Agreement.

J. Excuse of Nonperformance (Force Majeure). Medical Services Entity or Corporation shall be excused from performance under this Agreement if for any period either is prevented from

performing any obligations pursuant hereto, in whole or in part, as a result of any Act of God, unanticipated electronic system failure, war, civil disturbance, court order, third party labor dispute or other cause beyond its reasonable control, including shortages or fluctuations in electrical power, heat, light, or air conditioning, and such nonperformance shall not be a ground for default.

K. Use of Names. Corporation may include Medical Services Entity's name in lists or other notifications of Participating Providers. Medical Services Entity may identify itself as a Corporation Participating Provider. Except as provided in this paragraph, neither Corporation nor Medical Services Entity shall use the other Party's name, symbols, trademarks, or service marks in promotional material or otherwise without the prior written consent of the other Party.

L. Notice. Any notice relating to this Agreement, other than notice of termination, shall be deemed sufficiently given and served for all purposes if and when sent in writing by regular mail, postage prepaid, addressed to each Party at its address of record.

M. Required Notice. Medical Services Entity shall notify Corporation immediately upon loss of licensure, insolvency, loss of Medicare certification, and/or appropriate accreditation, and/or upon the sale or transfer to a third party of all or substantially all of its assets that are utilized for the performance of this Agreement (such notice to include names and contact information of the acquirer, purchaser, or transferee and effective date of the sale, acquisition, or transfer. Corporation shall notify Medical Services Entity immediately upon revocation of state certification of authority or insolvency.

N. Severability. In the event any portion of this Agreement is found to be void, illegal or unenforceable, the validity or enforceability of any other portion shall not be affected.

O. Waiver. The waiver by either Party of a breach or violation of any provision of this Agreement shall not be construed as a waiver of any subsequent breach thereof.

P. Paragraph Headings. The article and sub-article headings used in this Agreement are for reference only. They are not to be used by themselves for the purpose of interpreting provisions of this Agreement.

Q. Governing Law. The laws of the State of New Mexico shall apply to any matter or dispute arising out of this Agreement.

R. Third Party Beneficiaries. Unless otherwise expressly set forth in this Agreement, it shall not create any rights or cause of action in or on behalf of any person other than Medical Services Entity and Corporation (including Corporation's Affiliates). Furthermore, Medical Services Entity acknowledges and agrees that it is not a third-party beneficiary to the MMCSA and Medical Services Entity is an independent contractor performing services as outlined in this Agreement.

S. Confidentiality. To the extent permissible by law, this Agreement is confidential as between Medical Services Entity and Corporation (including Corporation's Affiliates) and shall not be disclosed to third parties other than HSD (and other government agencies per this Agreement) and the Parties' respective financial, accounting, and legal advisors absent (i) prior written consent of the non-disclosing Party, or (ii) valid, compulsory legal process, including by a court or government agency of competent jurisdiction, of which the recipient shall promptly give notice to the other Party before complying therewith. Furthermore, the Parties shall not use any information obtained through performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement.

T. Absence of Prohibited Terms. The Parties stipulate and acknowledge that this Agreement does not: (i) prohibit Medical Services Entity from entering into a contractual relationship with another MCO; (ii) include any incentive or disincentive that encourages Medical Services Entity not to enter into a contractual relationship with another MCO; or (iii) contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in section 1932(b)(3) of the Social Security Act, 42 C.F.R. § 438.102 or in contravention of Patient Protection Act §§ 59A-57-1 to 59A-57- 11, NMSA 1978, as amended.

In Witness Whereof, the Parties have caused this Agreement to be executed by their duly authorized officers as of the date(s) set forth below.

<<Provider Name>>

SIGNATURE: _____

PRINT: _____

TITLE: _____

DATE: _____

ADDRESS: _____

_____

TAX ID: _____

EMAIL: _____

Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company

BY: _____
John C. Cook

TITLE: Vice President, NM Programs and Network Management

DATE: _____

ADDRESS:
P. O. Box 27630
Albuquerque, New Mexico 87125-7630

Effective Date:[1] _____

[1] Medical Services Entity agrees that BCBSNM may insert the date at the time of BCBSNM's execution.

BLUE CROSS AND BLUE SHIELD OF NEW MEXICO

MEDICAL SERVICES ENTITY AGREEMENT

TABLE OF CONTENTS

Exhibit I

Scope of Service
Medical Services Entity

The Parties agree as follows:

I. Services

A. Specialty Services. Medical Services Entity agrees to provide covered health specialty services to Covered Members within the scope of licensure and to obtain referrals and prior authorizations when mandated by the Member Certificate.

II. Member Dispute/Resolution

A. Medical Services Entity agrees that at the request of Corporation, it will cooperate and participate in Corporation's complaint and grievance procedure, and to make a good faith effort to comply with the decisions of Corporation's Member complaint and grievance committee. If Medical Services Entity determines that it cannot in good faith comply with a decision of this committee, Medical Services Entity shall notify Corporation and Corporation shall make alternative arrangements for effectuating the decision. The Member Complaint and Grievance Procedure is set forth in the *Provider Reference Manual.*

Exhibit II

LISTING OF LOCATIONS AND/OR SUBSIDIARIES

The locations (including locations of separately organized wholly or majority owned or controlled subsidiaries of Medical Services Entity, if any) listed below are included under the Agreement until sold or permanently closed. Medical Services Entity is required to inform Corporation in writing of such location-sales and closures. If sold or closed, the location is no longer included under this Agreement even if not removed from this Exhibit by amendment. If Medical Services Entity now has or later opens one or more additional locations, they shall not be included under this Agreement unless and until they are added to this Exhibit II by amendment or other written agreement of the parties.

Location	**Billing/Participation Information**
[Location Name or Legal Entity Name (if different from contracting legal entity)] [Address] [City, Zip Code]	Tax ID: Medicare Number: Medicaid Number: NPI Number:
[Location Name or Legal Entity Name (if different from contracting legal entity)] [Address] [City, Zip Code]	Tax ID: Medicare Number: Medicaid Number: NPI Number:

Attachment A
General Acute Hospital Reimbursement
New Mexico Medicaid Managed Care

Corporation shall pay, and Medical Services Entity shall accept as full and final payment, inclusive of all taxes and fees, the reimbursement set forth in this Attachment for Covered Services furnished to Members by and at Medical Services Entity's facility.

A. DEFINITIONS.

In addition to the definitions set forth in the New Mexico Medicaid Managed Care Amendment and, where applicable, the Agreement, the following definitions apply:

1. Base Rate. The standard dollar amount for the applicable DRG as set by HSD that is multiplied by the DRG Weight in the DRG Reimbursement calculation.

2. Billed Charge(s). The amount reasonably billed by Medical Services Entity for Covered Services provided to a Member. Included in this amount are any adjustments made by Corporation or Medical Services Entity as a result of late charges, late credits, or other adjustments to the Billed Charges such as, but not limited to, those for Hospital Acquired Conditions, Never Events, lack of Medical Necessity, unauthorized or unsupported level of care, unauthorized services, and charges disallowed by HSD.

3. Diagnosis Related Group (DRG). A statistical system of classifying any inpatient stay into groups for the purposes of reimbursement.

4. DRG Weight. The value assigned by HSD to each DRG that reflects the relative intensity of resource utilization for that DRG.

5. DRG Reimbursement. Inpatient reimbursement methodology whereby each admission is categorized into a DRG, assigned to each of which is a DRG Weight. The calculation for DRG Reimbursement is set forth in Section C of this Attachment.

6. MOPPS Reimbursement. Outpatient reimbursement methodology whereby Covered Services furnished on an outpatient basis by or at Medical Services Entity's facility are priced according to Corporation's Modified Outpatient Prospective Payment System (MOPPS), which is based on HSD's Outpatient Prospective Payment System (OPPS) methodology. The calculation for MOPPS Reimbursement is set forth in Section E of this Attachment.

7. Pass Through. A reimbursement adjustment determined and funded by HSD, including, but not limited to, Interim Capital Rates (ICR).

8. Stop Loss Reimbursement. Inpatient reimbursement methodology utilized in lieu of DRG Reimbursement if the Stop Loss Threshold for the admission has been exceeded and any other preconditions are met whereby the Billed Charges are multiplied by a predetermined percentage (as determined by HSD). The calculation for Stop Loss Reimbursement is set forth in Section C of this Attachment.

9. Stop Loss Threshold. The Billed Charge dollar amount (as determined by HSD) above which the reimbursement methodology for an inpatient admission may change from DRG Reimbursement to Stop Loss Reimbursement.

10. Transfer Case. Transfer of an admitted Member from one acute care facility to another acute care facility, regardless of the reimbursement method(s) applicable to those facilities.

B. REIMBURSEMENT FOR INPATIENT SERVICES

1. DRG Reimbursement shall apply to each admission of a Member to Medical Services Entity's facility unless another reimbursement methodology, such as, but not limited to, Stop Loss Reimbursement or Transfer Reimbursement (defined below), applies according to the terms of this Attachment.

2. DRG reimbursement is inclusive of all Covered Services furnished by Medical Services Entity and by non-physician providers while the Member is admitted to Medical Services Entity's facility. The Covered Services furnished to the Member while admitted to Medical Services Entity's facility shall be billed only by Medical Services Entity and not by any non-physician provider. Inpatient professional services furnished by physician providers (*i.e.*, MDs, DOs), shall be billed separately.

3. Stop Loss Reimbursement shall apply to any admission of a Member to Medical Services Entity's facility if the Stop Loss Threshold and any other preconditions to Stop Loss Reimbursement are met, such as, but not necessarily limited to, Medical Services Entity's facility's disproportionate share hospital status and the age of the Member.

    a. If Medical Services Entity is a disproportionate share hospital, Stop Loss Reimbursement under this Attachment shall apply only to admissions of children under six years old at the time of admission (or such other age threshold determined by HSD) and when the Stop Loss Threshold has been met.

    b. If Medical Services Entity is not a disproportionate share hospital, Stop Loss Reimbursement under this Attachment shall apply only to admission of children under one year old (or such other age threshold determined by HSD) at the time of admission and when the Stop Loss Threshold has been met.

    c. For the avoidance of any doubt, when, pursuant to the foregoing, Stop Loss Reimbursement under this Attachment does not apply, Medical Services Entity's reimbursement for inpatient services shall be determined by DRG Reimbursement, regardless of the amount of Billed Charges.

4. If the Member's admission constitutes a Transfer Case, Corporation may review and reimburse the admission to Medical Services Entity's facility according to HSD's transfer payment methodology ("Transfer Reimbursement") in lieu of DRG Reimbursement or Stop Loss Reimbursement.

5. Readmissions occurring within 15 calendar days of a prior acute care admission for a related condition may be reviewed to determine Medical Necessity and appropriateness of care. Corporation may review the appropriateness of the readmission and payment. If it is determined that either or both admissions were unnecessary or inappropriate, payment for either or both admissions may be denied, combined or considered a Transfer Case.

6. Medical Services Entity agrees to accept pre-admission testing performed in other appropriately licensed facilities, provided such tests were performed within 48 hours of the Member's admission to Medical Services Entity's facility. Medical Services Entity shall neither bill nor be compensated for performing such pre-admission testing. By way of illustration, but

not limitation, Corporation reserves the right to exclude charges for such pre-admission testing for purposes of determining whether Stop Loss Reimbursement applies, and if so, calculating the resulting reimbursement to Medical Services Entity therefor.

7. Medical Services Entity shall neither bill nor be compensated for routine admissions testing that is not specifically ordered by the admitting physician.

C. CALCULATIONS FOR INPATIENT SERVICES REIMBURSEMENT

DRG Reimbursement calculation:

(100% Base Rate x DRG Weight) + ICR

Stop Loss Reimbursement calculation:

Billed Charge x cost-to-charge ratio (determined by HSD) x percentage (determined by HSD)

D. REIMBURSEMENT FOR OUTPATIENT SERVICES

1. MOPPS Reimbursement is inclusive of all Covered Services furnished by Medical Services Entity and by non-physician providers while the Member is receiving outpatient services at Medical Services Entity's facility. Such Covered Services shall be billed only by Medical Services Entity and not by any non-physician provider. Outpatient professional services furnished by physician providers (*i.e.*, MDs, DOs), shall be billed separately.

2. Medical Services Entity agrees to accept laboratory and radiological testing performed in other appropriately licensed facilities that was performed within 48 hours of the outpatient services furnished to Member by or at Medical Services Entity's facility. Medical Services Entity shall not be compensated for performing such laboratory and radiological testing.

3. Medical Services Entity agrees not to perform routine testing that is not specifically ordered by an attending physician.

E. CALCULATIONS FOR OUTPATIENT SERVICES REIMBURSEMENT

MOPPS Reimbursement calculation:

100% MOPPS rate x applicable HSD OPPS percentage

F. MISCELLANEOUS REIMBURSEMENT PROVISIONS

1. Reimbursement shall be made according to Corporation's medical/reimbursement policies for services including, but not limited to, multiple surgical procedures, surgical assistance, global surgical services, coding and unbundling, and other billing and reimbursement practices, which are available at bcbsnm.com.

2. References in this Attachment to actions by, or information from, HSD include, but are not necessarily limited to, Chapter 27 of the New Mexico Statutes, Title 8 (Social Services) of the New Mexico Administrative Code, HSD Supplements to MAD NMAC Program Rules (aka, Provider Supplements), HSD Letters of Direction, New Mexico Medicaid Managed Care Services Agreement, and other applicable documented communications from HSD to Managed Care Organizations.

3. Within sixty (60) days of notification from HSD, Corporation shall implement changes to numerical elements of reimbursement calculations described in this Attachment that are based on actions by, or information from, HSD. Corporation reserves the right to determine the effective date of the such changes, subject to specific direction by HSD.

4. Notwithstanding any other provision of this Attachment, Corporation may apply to Medical Services Entity's reimbursement any HSD-directed reimbursement adjustments (whether decreases or increases), including, but in no way limited to, Pass Throughs.

5. Member financial responsibility, if any, shall be determined in accordance with the terms of the Member's Membership Certificate. The amount of the Member's financial responsibility, if any, shall be calculated using the lesser of Billed Charges or the reimbursement amount determined by operation of the calculations set forth in this Attachment.

6. This paragraph shall only apply to Medical Services Entity if its application will not cause inpatient reimbursement to be less than the minimum amount allowed by the New Mexico Medicaid Managed Care Services Agreement, if any. For Covered Services reimbursed based on a percent of the Billed Charge ("Percent of Billed Charge"), Medical Services Entity agrees that no force or effect under this Attachment will be given to any annual increase to its prior year's charge master ("CM") by more than the lesser of three percent (3%) or the current year Producer Price Index for acute care hospitals ("Allowable Increase"). Medical Services Entity will make best efforts to provide Corporation with notice of any increase to the CM at least sixty (60) days prior to its implementation. If Corporation determines that the increase to the charge master for Covered Services actually received by Members and reimbursed by Corporation is greater than the Allowable Increase, then Corporation may elect to adjust the Percent of Billed Charge in accordance with the sample calculation below. The Stop Loss Threshold may be increased by the same percentage as any estimated charge master increase announced by Medical Services Entity or by the actual increase if it is later determined to be greater than the announced increase, if any. Corporation will adjust the Percent of Billed Charges on claims for Covered Services consistent with the following example:

Baseline Charge	$ 100.00
Current Percent of Billed Charge	x 50%
Payment	$ 50.00
Allowed Increase (CM-3%; PPI-2.0%)	$ 102.00
Current Percent of Billed Charge	x 50%
Maximum Allowed Payment	$ 51.00
Actual charge master Increase (10%)	$ 110.00
Current Percent of Billed Charge	x 50%
Disallowed Payment	$ 55.00
Revised Percent of Billed Charge	46.36% (51.00/110)

7. Medical Services Entity shall bill Corporation electronically.

8. Corporation shall "zero pay" ($0.00) any Covered Service furnished to a Member by or at Medical Services Entity's facility that is not addressed by operation of the reimbursement provisions of this or any other reimbursement attachment to the New Mexico Medicaid Managed Care Amendment.

9. With regard to all reimbursement methodologies described in this Attachment and unless precluded by HSD, Corporation shall pay the lessor of the amount resulting from the applicable reimbursement methodology or billed charges.