PRESBYTERIAN NETWORK, INC.
PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (this "Agreement") is dated as of the date specified below and is by and between Presbyterian Network, Inc., a New Mexico corporation ("PNI"), acting as agent for and on behalf of Payors, specifically including but not limited to, Presbyterian Health Plan, Inc. ("PHP"), a duly licensed health maintenance organization, and Presbyterian Insurance Company, Inc. ("PIC"), a duly licensed health insurance company, (referred to collectively as "Health Plan"), and Provider (as defined below):

#LEGALENTITYNAME#
("Provider").

organized under the laws of #Provider_Add_State# and lawfully operating in New Mexico pursuant to licensure or certification from <Insert New Mexico Agency>.

Health Plan and Provider are referred to herein individually as a "Party" and collectively as the "Parties".

RECITALS:

WHEREAS, PNI acts as agent for Health Plan and other Payors, as hereinafter defined, and

WHEREAS, PNI desires to engage Provider to provide certain services in support of the Health Benefit Programs that Health Plan and other Payors offer and which are designated in this Agreement, and

WHEREAS, PNI and Provider desire to set forth the arrangements between them concerning the responsibilities of each Party to this Agreement.

NOW, THEREFORE, in consideration of the premises, the mutual covenants, promises and conditions herein contained, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree to the Agreement that follows.

Presbyterian Network, Inc.

By: {{Sig_es_:signer2:signature}}
Amor Brannin, CFO

PO Box 27489
Albuquerque NM 87125-7489

Facsimile No.: (505) 923-5440

Execution Date: {{Dte2_es_:date}}

Effective Date: _____

#LEGALENTITYNAME#

By: {{Sig_es_:signer1:signature}}
Authorized Representative

#Billing_Add_Line1# #Billing_Add_Line2#
#Billing_Add_City# #Billing_Add_State#
#Billing_Add_Zip#

Execution Date: {{Dte1_es_:date}}

EIN: #Tax_ID_Number#

GENERAL PROVISIONS

1. Definitions

Any term used in this Agreement which is defined in the New Mexico Insurance Code ("Code") or in the regulations adopted by the New Mexico Office of Superintendent of Insurance ("OSI"), or in the regulations adopted by HCA, will have the same meaning as defined therein. Subject to the foregoing limitation, each of the following terms will have the specified meaning when used in this Agreement:

1.1. **Capitation Payment**: A predetermined periodic payment based on the estimated cost of providing defined Covered Services to one Member in a defined age/sex group with payment made to a Provider based on the number of Members for which the Provider assumes responsibility.

1.2. **Turquoise Care Agreement**: The contract between Health Plan and HCA for Medicaid managed care referred to as "Turquoise Care" which may be located on New Mexico HCA's website by searching for Turquoise Care MCO contracts.

1.3. **Clean Claim**: A manually or electronically submitted claim that contains all of the required data elements, as determined by Health Plan, necessary for accurate adjudication without the need for additional information from outside of the Health Plan's system and contains no deficiency or impropriety, including the lack of substantiating documentation currently required by the Health Plan, or particular circumstances requiring special treatment that prevents timely payment from being made by the Health Plan. Clean Claim does not include a Claim if the Provider is ineligible for governmental funds, or under investigation for Fraud or Abuse, or a Claim under review for Medical Necessity.

1.4. **CMS**: Refers to the Centers for Medicare and Medicaid Services.

1.5. **Copayment Charges**: The amount required to be paid by the Member to Providers for Covered Services, which includes specified coinsurance, copayments and applicable deductibles.

1.6. **Covered Services**: Those Medically Necessary health care services and supplies which a Member is entitled to receive as benefits under such Member's Health Benefit Program, including Turquoise Care, and are provided within Provider's license and scope of practice, routinely provided by Provider, and provided in accordance with the terms of this Agreement; it being acknowledged that Provider is not the exclusive provider of Covered Services and Health Plan may contract with other providers for the same services for which Provider is contracted.

1.7. **Days:** Unless otherwise noted herein, days shall refer to calendar days.

1.8. **Health Benefit Program**: A program which defines and limits the medical and Facility Services for which a Member is eligible, includes the conditions and circumstances under which the Health Plan is obligated to pay participating providers for Covered Services on behalf of Members and defines the Copayment Charges for which a Member is responsible. The Health Benefit Programs are described in the Product Attachments.

1.9. **Health Plan Policies:** The policies and procedures regarding the administration of the Health Benefit Program which can be accessed through Health Plan's website, as updated from time to time in accordance with this Agreement, including the following: (i) the Provider Manual, and (ii) if not expressly included in the Provider Manual, policies and procedures regarding: (a) the quality management program, (b) utilization management program, (c) credentialing program, (d) care management and medical management programs, (e) Member services, (f) preventative

health guidelines, (g) medical record review, (h) claims processing guidelines, and (i) provider sanctions program.

1.10. **HCA**: Refers to the New Mexico Health Care Authority.

1.11. **Major Subcontractor:** An entity with which Health Plan has, or intends to have, an executed agreement to deliver or arrange for the delivery of any of the Covered Services under the Turquoise Care Agreement.

1.12. **Medicaid Contract:** The written contract entered into between Health Plan and HCA pursuant to which Health Plan arranges for the provision of health care services to Members on a capitated basis.

1.13. **Medically Necessary:** Those clinical and rehabilitative physical, mental or Behavioral Health services that are: (i) provided for the preventative diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under New Mexico law for coverage of clinical trials, not for experimental, investigational, or cosmetic purposes; (ii) necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; (iii) delivered in the amount, duration, scope, and setting that are both sufficient and effective to reasonably achieve their purposes and clinically appropriate, (iv) within generally accepted standards of medical care in the community; and (v) not solely for the convenience of the insured, the insured's family, or the provider. For Medically Necessary services, nothing in this Agreement precludes Health Plan from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

1.14. **Member**: A person enrolled in a Health Plan's or Payor's Health Benefit Program and who is eligible under the Health Benefit Program, including Turquoise Care, to receive Covered Services and for whom the applicable premium has been received.

1.15. **Out-of-Plan Medical Services**: All Covered Services provided to a Member by any and all provider types that are not contracted with a particular Health Plan, Payor or its agent.

1.16. **Payor**: An entity, such as a self-insured employer group, insurer, third-party administrator, health maintenance organization, preferred provider organization, governmental entity or other third-party payor which provides financial incentives through a Health Benefit Program for Members to use Covered Services provided by participating providers and which agrees to allow participating providers to provide Covered Services to Members. Health Plan and PIC are Payors.

1.17. **Product Attachments**: The attachments to this Agreement which set forth additional terms and conditions under which Provider shall provide Covered Services to Members pursuant to the Health Benefit Programs. Each Product Attachment will identify the Health Plan or Payors. All Product Attachments that are executed by the parties shall be attached to this Agreement as part of **Exhibit 1**, shall become a part of this Agreement and are incorporated herein by reference.

1.18. **Provider Manual**: Health Plan's or the Payor's participating provider Policies and Procedures Manual and related written materials, which shall be available to Provider by Health Plan or the Payor and which may be updated from time to time by Health Plan or the Payor as provided in this Agreement. The Provider Manual is part of this Agreement and is incorporated herein as if fully set forth.

1.19. **Service Area**: #Provider_Add_City#, #Provider_Add_County# county, #Provider_Add_State#.

1.20. **Value-Based Purchasing (VBP):** Payment arrangements with providers that move away from fee-for-service reimbursement or payments based on volume of services, and toward payment methodologies that compensate for value or outcomes, such as primary care incentives, performance-based contracts, risk contracts, bundled/episode payments, shared savings and shared risk, global capitation payments or any other payment arrangement that HSD approves as VBP.

1.21. **Covered Specialty**: #Speciality#.

2. Legal Relationship

2.1. Relationship. None of the provisions of this Agreement are intended to create nor shall they be deemed or construed to create an agency, partnership, joint venture, or any other relationship between the parties other than that of independent parties, contracting hereunder solely for the purpose of implementing the provisions of this Agreement. Provider acknowledges and agrees that it is not a third party beneficiary to the Turquoise Care Agreement.

2.2. Provider. If Provider is an individual, this Agreement binds Provider. If Provider is a partnership, corporation, Limited Liability Company or other form of legal entity, this Agreement binds the Provider, each Health Care Provider employee of the Provider that has been credentialed by the Health Plan and each Health Care Provider that subcontracts with Provider to provide Covered Services to Members and that have been credentialed by the Health Plan. As of the Effective Date, Provider has provided to the Health Plan the name of all Health Care Provider employees of the Provider. Provider will provide to the Health Plan an update with the name of each new Health Care Provider employee or departing employee, prior to or contemporaneous with any change in employment.

2.3. Continuing Care Rights. If this Agreement terminates for any reason other than quality of care concerns, medical competence or professional behavior of Provider, the Health Plan shall permit the Member to continue an ongoing course of treatment with Provider for a transition period. Unless the Health Plan otherwise agrees, the transition period will be as follows:

2.3.1. If the Member has entered the third trimester of pregnancy at the time of termination, the transition period will include the provision of post-partum care directly related to the delivery.

2.3.2. In all other cases, the transition period will continue for a time sufficient to permit coordinated transition planning, consistent with the patient's condition and needs relating to continuity of care and, in any event, Provider shall use best efforts to complete within thirty (30) days but not longer than ninety (90) days.

2.3.3. The Health Plan or Payor shall pay Provider for services provided pursuant to this Agreement after the date of termination at the rates specified in the applicable Product Attachments.

The provision of continued care contained in this Section will be subject to the conditions specified in the Managed Health Care Rule, NMAC 13.10.23.14

In the event of termination of the Agreement for any reason, Provider shall continue to provide or arrange Covered Services to Members, including any Members who become eligible during

the termination notice period, beginning on the effective date of termination and continuing until the termination or next renewal date of the Member's Evidence of Coverage, unless the Health Plan arranges for the transfer of the Member to another participating provider and provides written notice to Provider of such transfer prior to the termination or next renewal date of the Evidence of Coverage. Notwithstanding the foregoing, Provider will continue to provide or arrange Covered Services to any Members who cannot be transferred within the time period specified above in accordance with the Health Plan's obligations to:

i. provide Covered Services under the Health Benefit Program and Evidence of Coverages;

ii. provide notice of termination to Members and;

iii. ensure continuity of care for its Members.

The Health Plan or Payor shall pay Provider for services provided pursuant to this Agreement after the date of termination at the rates specified in the applicable Product Attachments.

In the event the Health Plan or Payor ceases operations or Provider terminates this Agreement on the basis of the Health Plan's or Payor's failure to make timely payments, Provider shall continue to arrange for Covered Services to those Members who are hospitalized on an inpatient basis at the time the Health Plan or Payor ceases operations or Provider terminates this Agreement until such Members are discharged from the hospital. Provider may file a claim with the Health Plan or Payor for such services.

Provider agrees that the provisions of this Section and the obligations of Provider herein shall survive termination and shall be construed to be for the benefit of Members.

2.4. Dispute Resolution. If a dispute arises out of this Agreement which is not resolved by the Health Plan hearing provided pursuant to Section 10.2.5. then:

2.4.1. *Informal Conflict Resolution*. As an initial step in any effort to resolve any dispute regarding this Agreement, and after the exhaustion of any dispute resolution procedures provided by Health Plan as part of its claims or grievance process, Health Plan and Provider will attempt in good faith to negotiate a resolution of the dispute for a period of time appropriate for the nature of the dispute.

2.4.2. *Arbitration.* If the informal procedure described above does not resolve the dispute, any controversy or claim arising out of or relating to this Agreement or the breach hereof will be settled by arbitration in accordance with the New Mexico Arbitration Act or such other rules on which the parties may agree (the "Arbitration Rules"). Any arbitration shall be conducted in Bernalillo County, New Mexico. Judgment on any award may be entered in any court in Bernalillo County having jurisdiction thereof. The results of the arbitration will be final and binding on both parties. In any arbitration, the non-prevailing party will pay all reasonable attorneys' fees incurred by the prevailing party in connection with such arbitration. If there is no prevailing party, the issue of payment of attorneys' fees will be decided by the arbitrator. Costs of any arbitration, including any fees of the arbitrator, will be shared by the parties.

2.4.3. *Venue*. Any litigation arising under or relating to this Agreement shall be brought only in Bernalillo County, New Mexico.

2.4.4. *Governing law*. Any controversy or claim arising under or relating to this Agreement shall be governed only by the law of the State of New Mexico.

2.5. Notice. Any notices or other communications required by or contemplated under the provisions of this Agreement shall be in writing and delivered;

i. in person, evidenced by a signed receipt,

ii. mailed by certified mail, return receipt requested, postage prepaid, or

iii. by overnight delivery service such as UPS or FedEx, or

iv. by facsimile transmission with receipt acknowledged to the addresses indicated on the signature page or to such other persons or addresses as the Health Plan or Provider may provide by notice to the other.

The date of the notice shall be the date of delivery if the notice is personally delivered, delivered by facsimile transmission or by overnight delivery service, or the third day following the date of mailing if the notice is mailed by certified mail.

2.6. Responsibility for Own Acts. Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

2.7. Amendments.

2.7.1. Except as otherwise provided in this Section 2.7, all amendments or modifications to this Agreement shall be effective only upon mutual written agreement of the parties.

2.7.2. Health Plan or the Payor may amend this Agreement, the Provider Manual or any fee schedule by providing thirty (30) days' prior written notice to Provider. Such amendments shall be binding upon Provider at the end of the thirty (30)-day period unless;

i. Provider provides Health Plan or the Payor with notice of objection within the thirty (30)-day period, **and**

ii. the change has a material adverse economic effect upon Provider as reasonably determined by Provider, **and**

iii. such change is not made in order to comply with state or federal law, **and**

iv. Provider delivers written notice to Health Plan during such thirty (30)-day period terminating this Agreement pursuant to Section 10.3, **or**

v. Provider delivers written notice to Health Plan during such thirty (30)-day period terminating this Agreement as of the last day of the one hundred and twenty (120)-day period specified in this Section pursuant to Section 10.3.

2.8. Confidential and Proprietary Information. During the term of this Agreement and thereafter, Health Plan and Provider shall ensure that Health Plan and Provider, and their directors, officers, employees, contractors and agents hold Confidential Information in the strictest confidence and in accordance with state and federal law. "Confidential Information" shall include without limitation all information and records whether oral or written or disclosed prior to or subsequent to the execution of this Agreement regarding the following: patients,

utilization review, quality assurance, finances, volume of business, contracts, and prices. Each party shall return or destroy all Confidential Information received from the other party within thirty (30) days following termination of this Agreement for any reason.

Notwithstanding anything contained in this Agreement to the contrary, Health Plan or the Payor may retain copies of the Confidential Information submitted by the Provider for the purpose of complying with requirements of all state and federal laws and with the requirements of accreditation organizations. Both Health Plan and the Provider may disclose Confidential Information to the extent that such disclosure is required by law or is required by an accreditation organization.

Notwithstanding the foregoing, the parties hereby expressly agree that nothing in this Agreement, including this Section, shall restrict or otherwise prohibit Health Plan or any Payor from making any information regarding this Agreement available to consumers, members or other government or regulatory agencies to allow for the use of comparison tools, such as Health Plan's Treatment Cost Calculator Program or Medicare's comparison website, or any other state or federal regulations regarding transparency of health care costs. In addition, Health Plan or Payor may make certain claim cost and utilization information available for medical groups or entities providing services under a risk-based arrangement for the sole purpose of allowing the risk-based group or entity to manage the quality, quantity and cost of services provided to members assigned to them. Health Plan or Payor will use commercially reasonable efforts to provide only the minimum necessary information to enable such management.

2.9. Confidentiality of this Agreement. To the extent reasonably possible, each party agrees to maintain this Agreement as a confidential document and not to disclose the Agreement or any of its terms without the approval of the other party.

2.10. Applicable Laws. Both parties agree that this agreement shall be executed in accordance with all applicable federal and State statutes, regulations, policies, procedures and rules. The compensation payable to Provider pursuant to this Agreement consists in part of federal funds; accordingly, Provider acknowledges that it will be required to comply with certain laws applicable to entities and individuals receiving federal funds.

3. Provider Duties

3.1. Participation in Health Plan Program. Provider shall provide Covered Services to Members under the Health Benefit program. Provider shall provide all Covered Services to Members within the scope of Provider's qualifications, consistent with accepted standards of medical practice, in accordance with all applicable state or federal statutes and regulations, and in accordance with this Agreement.

3.2. Member Billing. (i) Covered Services. Provider agrees that in no event, including but not limited to nonpayment by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit or gross receipts tax from, seek remuneration or reimbursement from, or have any recourse against, Member, person to whom health care services have been provided, or person acting on behalf of the Member, or HCA, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting coinsurance, deductibles, or Copayment Charges as specifically provided in the Health Benefit Program, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the Health Plan or its successor. (ii) Non-Covered Services. The Provider may bill a Member for non-Covered Services that the Provider provides. For non-Covered Services Provider shall notify Member

in advance that the services are not covered by Health Plan and obtain such acknowledgement in writing, on an HCA-approved form provided by the Health Plan, prior to rendering the service.

The provisions of this Section 3.2. shall survive the termination of this Agreement.

3.3. Claims Submission. Within ninety (90) days of the date of service for outpatient services or ninety (90) days of the date of discharge for inpatient services, Provider will submit to the Health Plan or Payor pursuant to all Product Attachments, complete encounter or CMS 1500 claim forms or an equivalent or substitute approved by the Health Plan and will identify services rendered to Members by using appropriate diagnosis and procedure codes as defined by the then current CPT-4 and/or ICD-10-CM or subsequent editions. If the claim is not filed within such time limits, at the discretion of the Health Plan, the claim may be denied. Provider may resubmit previously denied claims to the extent permitted by the Provider Manual, which will address appeals process.

3.4. Provider Qualifications. Provider agrees to maintain a current license to practice in the Service Area, will maintain a current narcotics license issued by the Federal Drug Enforcement Administration if a current narcotics license is necessary for the Provider's practice, and, unless waived in writing by the Health Plan, will maintain medical staff membership and clinical privileges in good standing at a Plan Facility. Provider represents that the Provider has not been excluded from participation in any governmental health care program, including the Medicare and Medicaid Programs. Provider will notify the Health Plan within seven (7) days of any suspension, revocation or restriction of the Provider's license to practice or prescribe or administer controlled substances, and of any exclusion from participation in governmental healthcare programs. Provider's failure to notify the Health Plan of any such action within seven (7) days of the action shall constitute breach of a material term of this Agreement. Provider has legal basis of operation in the State of New Mexico.

3.5. Insurance. Provider will maintain at Provider's expense comprehensive general liability insurance with minimum limits of two hundred thousand (200,000) dollars per occurrence and six hundred thousand (600,000) dollars aggregate for all occurrences. In addition, Provider will either;

i. qualify as a health care provider entitled to the protection of the New Mexico Medical Malpractice Act, as such Act may be amended or revised, or;

ii. carry professional liability insurance in amounts and containing such provisions from time to time deemed adequate by Health Plan or the Payor.

Provider will provide to Health Plan or the Payor upon request certificates evidencing that the insurance required by this Section is in effect and proof of qualification under the New Mexico Medical Malpractice Act, if applicable. Provider hereby authorizes the Provider's insurance carrier to notify Health Plan or the Payor upon cancellation or termination of the Provider's insurance coverage. Provider will notify Health Plan or the Payor promptly whenever a Member files a claim or notice of intent to commence action against the Provider. Provider will notify Health Plan or the Payor not more than ten (10) days after the Provider's receipt of notice of any reduction or cancellation of the insurance coverage required by this Section.

3.6. Utilization Management. Provider will comply with the Health Plan's utilization management program, as outlined in the Provider Manual. If Provider fails to comply with Health Plan's

Utilization Management Program, Provider acknowledges that Health Plan may deny payment for any charges arising from such services.

3.7. Complaints and Grievances. Complaints and grievances of Provider, including those relating to quality of care, shall be resolved in accordance with Health Plan's complaint or grievance procedure set forth in the Provider Manual. Member complaints and grievances shall be resolved in accordance with the Health Plan's procedure provided to Members, and Provider shall cooperate with Members and Health Plan in such Member complaint and grievance procedures and in implementing any final decision rendered, including any corrective action plans, through the internal grievance procedure.

3.8. Publicity. Provider agrees that the Health Plan may list each participating provider's name, specialty, address, phone number and other relevant information in a directory of participating providers. Except for such use, the Health Plan will not use the Provider's name without the Provider's prior written consent. Provider will not use the Health Plan's trademarks, service marks, and related symbols without the prior written consent of the Health Plan.

3.9. Medical Records. Provider agrees to maintain medical records, and records pertaining to Covered Services, for Members and preserve them for a minimum of ten (10) years or as are required by applicable law, regulations and practices. Provider shall exercise Provider's best efforts to safeguard the privacy of Member medical records and to maintain the confidentiality of all medical records so as to comply with all state and federal laws and regulations regarding the confidentiality of medical records. Subject to such confidentiality requirements, with the express written consent of the Member, which may be obtained from the Member at the time of enrollment, within two (2) to ten (10) Business days of the request date, the Provider shall release such records to the Health Plan, in accordance with NMSA 1978, § 27-11- 4(B).

In addition to the foregoing general provisions, the following provisions apply to medical records generated by the Provider:

3.9.1. Medical records shall be available to health care practitioners for each clinical encounter and each plan specialty care provider shall forward a record of referral services provided to the Member's Plan Primary Care Provider.

3.9.2. Provider shall make any and all Member medical records available to the Health Plan, OSI, CMS, HCA, the New Mexico Behavioral Health Purchasing Collaborative or other state or federal regulatory agencies or their agents for the purpose of quality review, for the purpose of annual HEDIS audits, or for the purpose of investigating the grievances or complaints of Members. In addition, the Health Plan, OSI, CMS, HCA, the New Mexico Behavioral Health Purchasing Collaborative and other state or federal regulatory agencies or their agents shall have reasonable access to Provider's facilities and records for purposes of financial and medical audits performed in connection with services provided to Members and/or to the Health Plan in connection with the Agreement. OSI, CMS, HCA, the New Mexico Behavioral Health Purchasing Collaborative and other state or federal regulatory agencies shall also have access to those financial records of Provider that relate to the Health Plan's capacity to bear potential financial loss.

3.9.3. Provider agrees to maintain all Member medical records in an accurate, logically organized and timely manner as defined in the Provider Manual.

3.9.4. The provisions in this Section and other provisions in the Agreement relating to medical records and record retention shall survive termination of the Agreement for the time required by state or federal law.

3.9.5. The Health Plan or Payor will reimburse the Provider up to reasonable and customary charges for the copying of medical records relating to utilization management. Provider will not be reimbursed for the copying of records required for claims payment.

3.9.6. Failure to adhere to the medical record standards established in this Section shall constitute breach of a material term of this Agreement.

3.10. Access. Provider will maintain reasonable accessibility through the maintenance of regular office hours and through reasonable provision for after-hours services. The provisions of this Section are subject to procedures and standards of accessibility adopted from time to time by the Health Plan and outlined in the Provider Manual.

3.11. Non-Discrimination. Provider will provide services to Members without discrimination based upon Members participation in the Health Benefit Program, race, color, national origin, limited English proficiency (LEP), sex, gender, gender identity, age, ethnicity, religion, marital status, sexual orientation, sexual preference, health status, physical or mental impairment, and without regard to the source of payments for health care services rendered to the Member. This requirement will not apply to circumstances where the Provider appropriately does not render services due to limitations arising from the Provider's lack of training, experience, or skill or due to licensing restrictions. Provider will provide services to Members in a manner sensitive to Members' cultural background and to Members' beliefs, values and traditions. If the Member is enrolled in a Health Plan Health Benefit Program, Health Plan shall assist Provider in the provision of translation services upon request of the Provider. Payor will provide interpreters for LEP individuals and interpretative services to accommodate patients with disabilities. Such interpretive services will be made available to Provider at no cost to the Provider.

3.12. Member Acceptance and Practice Closure. Provider will accept as Members all currently treated patients who convert to a Health Benefit Program regardless of the patient's relative health status and in compliance with the requirements of CMS, HCA, MAD and any other governmental agency. Unless otherwise provided in the Product Attachments, Provider may close the Provider's practice to new Members by providing thirty (30) days advance written notice to Health Plan and the Payor. Until the Provider closes the Provider's practice, the Provider will accept new Members without regard to Members' health status. If Provider closes the Provider's practice to any Health Benefit Program, Provider shall be deemed to have closed the Provider's practice to all Health Benefit Programs.

3.13. Quality Improvement. The Health Plan conducts and in the future will initiate quality improvement and health management programs designed to improve the quality and value of Covered Services provided to Members. The success of each such quality improvement program and health management program will require the active cooperation of participating providers. Provider will participate in and cooperate with all quality improvement programs and health management programs conducted by the Health Plan which apply to Provider.

3.14. Office Inspection. Provider will allow the Health Plan reasonable access to the Provider's office or other location to make an on-site review of the books, records, and papers of the Provider relating to the health care services provided to Members, the cost thereof, and to payments received by the Provider from Members. Such visits may be announced or unannounced. If

announced, Health Plan shall notify Provider with ten (10) days' advance written notice, or such shorter notice period that is required to comply with the demands of accrediting bodies or regulatory agencies. Provider will assist and cooperate with the Health Plan in any review, inspection or audit conducted in conformity with the terms of this Agreement or conducted by any governmental or accreditation agency.

3.15. Non-Exclusive. Nothing in this Agreement restricts Provider from entering into other contracts or agreements to provide health care services to other health care delivery plans, patients, another Medicaid managed care organization, or employer groups. Nothing in this Agreement restricts the Health Plan from entering into other contracts or agreements with health care providers for the provision of Covered Services. Health Plan may not enter into a preferred or exclusive Medicaid contractual arrangement without the consent of HCA for the services represented in Exhibit III-B in order to monitor potential consequences of narrowed networks or reduced Member access.

3.16. Patient Protection. Provider will observe, protect and promote the rights of Members as patients. Nothing in this Agreement prevents or discourages the provider from discussing concerns and disagreements with a Member. Provider will discuss appropriate treatment alternatives with Members.

3.17. No Inducement. Nothing in the Agreement or in any Health Benefit Program is intended to offer any inducement, financial or otherwise, to provide less than Medically Necessary services to Members.

3.18. Managed Care Program Services. Provider agrees to abide by the Health Plan's or Payor's policies and procedures pertaining to the administration of Health Benefit Program services and to abide by all Provider Manuals issued by the Health Plan or Payor. The applicable policies and procedures may include, but not be limited to, policies and procedures pertaining to the Health Plan's or Payor's Utilization Management ("UM") Program, Quality Management ("QM") Program, Credentialing Program, and Claims Processing Guidelines. Such policies and procedures will outline the non-delegated requirements for claims submission, subcontract rate information, utilization management, and credentialing.

3.19. Employee Screening. Provider shall conduct screening of all employees, including those providing direct services to Members in accordance with the Employee Abuse Registry Act, NMSA 1978 § 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978 § 29-17-2 et seq., and ensure that all employees are screened against the New Mexico "List of Excluded Individuals/Entities and the Medicare exclusion database. Provider shall not employ or contract with providers excluded from participating in federal healthcare programs under either section 1128 or Section 1128A of the Social Security Act, unless otherwise granted by federal authority.

3.20. Solicitation of Health Plan Members or Subscriber Groups. During the term of this Agreement and for one (1) year thereafter, Provider agrees that neither Provider, its officers, agents or employees, will directly solicit any Member to enroll in any other managed care organization, preferred provider organization, or similar healthcare service plan or insurance program in which the Provider has any monetary interest or with which the Provider contracts. Notwithstanding any other provision of this Agreement, Provider agrees that Health Plan shall, in addition to any other remedies provided for under this Agreement, have the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Provider to enforce its rights under this Section.

3.21. The Provider must ensure that each Member is free to exercise his or her rights and that the exercise of these rights does not adversely affect the way the Provider or the State treat the Member. The Provider agrees to abide by the Member Rights & Responsibilities.

3.22. The Provider shall accept payment or appropriate denial made by the Health Plan (or, if applicable, payment by the Health Plan that is supplementary to the Member's third party payer) 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.

4. Subcontracts

4.1. Provider Subcontracts. With Health Plan's prior written consent, Provider may subcontract with other Health Care Providers to provide those Plan Covered Services that Provider has agreed to provide pursuant to Section 3.1. of this Agreement. The Health Plan may impose any conditions to its consent that the Health Plan deems appropriate. Each Health Care Provider with whom the Provider contracts pursuant to this Section shall be deemed to be a participating provider.

4.1.1. Subcontractual relationships and delegation.

(a) Applicability. The requirements of this section apply to any contract or written arrangement that an MCO, PIHP, PAHP, or PCCM entity has with any subcontractor.

(b) General rule. The State must ensure, through its contracts with MCOs, PIHPs, PAHPs, and PCCM entities that –

(1) Notwithstanding any relationship(s) that the MCO, PIHP, PAHP, or PCCM entity may have with any subcontractor, the MCO, PIHP, PAHP, or PCCM entity maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State; and

(2) All contracts or written arrangements between the MCO, PIHP, PAHP, or PCCM entity and any subcontractor must meet the requirements of paragraph (c) of this section.

(c) Each contract or written arrangement described in paragraph (b)(2) of this section must specify that:

(1) If any of the MCO's, PIHP's, PAHP's, or PCCM entity's activities or obligations under its contract with the State are delegated to a subcontractor - (i) The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. (ii) The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCO's, PIHP's, PAHP's, or PCCM entity's contract obligations. (iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the MCO, PIHP, PAHP, or PCCM entity determine that the subcontractor has not performed satisfactorily.

(2) The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions;

(3) The subcontractor agrees that - (i) The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's, PIHP's, or PAHP's contract with the State. (ii) The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. (iii) The right to audit under paragraph (c)(3)(i) of this section will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. (iv) If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

4.2. Provider Subcontract Provisions. Upon Health Plan's or the Payor's written request at any time during the term of this Agreement, Provider shall certify that its subcontracts with participating providers comply with the requirements of this Agreement. Provider shall amend any and all of its existing subcontracts with participating providers which do not comply with this Agreement within thirty (30) days following the earlier of the execution of this Agreement or the written request of Health Plan or Payor and shall provide Health Plan or Payor with written certification thereof.

4.2.1. Provider's subcontracts with participating providers shall be in writing. All such subcontracts shall be consistent with the terms and conditions of this Agreement. If this Agreement is amended or modified, all such subcontracts shall be amended or modified within thirty (30) days to be consistent with such amendments or modifications.

4.2.2. Provider's subcontracts with participating providers shall comply with the standards of accreditation organizations and requirements of state and federal law. If there are changes in such standards and/or requirements, Provider shall amend its subcontracts with participating providers to comply with such changes within thirty (30) days following notice thereof from Health Plan or Payor.

4.2.3. Provider and its subcontracted participating providers shall be required to make available at all reasonable times for inspection, examination and copying by Health Plan, Payor, accreditation organizations and government agencies copies of all participating provider subcontracts, and all books and records pertaining to Covered Services provided to Members under this Agreement. Within thirty (30) days after execution of any subcontract, Provider shall submit a duplicate copy of the subcontract to Health Plan or Payor. Provider and its participating providers shall retain such books and records for a term of at least ten (10) years from the close of the fiscal year in which the Covered Services were provided.

4.2.4. Notwithstanding the existence of Provider's subcontracts with its participating providers, Provider shall remain responsible for satisfying the obligations of Provider set forth in this Agreement. If any of Provider's subcontracts with participating providers are terminated, Provider shall remain responsible for providing or arranging Covered Services through its remaining participating providers and shall remain

financially responsible for Covered Services provided to Members to the extent that it has accepted financial responsibility under this Agreement.

4.2.5. Provider's subcontracts shall require its participating providers who are independent contractors to agree to be bound, at Health Plan's or the Payor's option, to the terms and conditions of this Agreement in the event of dissolution or insolvency of Provider or in the event of termination of this Agreement by Health Plan for any reason.

4.3. Health Plan Subcontracts. The Health Plan's subcontracts shall include the following:

4.3.1. The relationship between the Health Plan and the Subcontractor or Major Subcontractor including if the Subcontractor or Major Subcontractor is a subsidiary of the Health Plan or within the Health Plan's corporate organization;

4.3.2. The responsibilities of the Health Plan and the Subcontractor or Major Subcontractor;

4.3.3. The frequency of reporting (if applicable) to the Health Plan;

4.3.4. The process by which the Health Plan evaluates the Subcontractor or Major Subcontractor;

4.3.5. Subcontracts in excess of one hundred thousand dollars ($100,000) shall require compliance with all applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 1857 (h)), Section 508 of the Clean Water Act (33 U.S. C. 1368), Executive Order 11738 and Environmental Protection Agency regulations (40 C.P.R. Part 15);

4.3.6. The requirements for submission of Encounter Data, as applicable;

4.3.7. The remedies, including the revocation of the delegation, available to the Health Plan if the delegate does not fulfill its obligations; and

4.3.8. That Major Subcontractors and Subcontractors agree to hold harmless the State and the Health Plan's Members in the event that the Health Plan cannot or shall not pay for services performed by the Major Subcontractor or Subcontractor pursuant to the subcontract. The hold harmless provision shall survive the effective termination of the Health Plan and Major Subcontractor or Subcontractor agreement for authorized services rendered prior to the termination of the agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members.

5. Health Plan Duties

5.1. Professional Relationships. Except as provided by the terms of this Agreement, the Health Plan shall not intervene with the provision of medical care by Provider, it being agreed that Provider shall have the sole responsibility for the provision of medical care and that nothing herein contained shall interfere with the professional relationship between a Member and Provider or with Provider's ability to advise Members about their health status or medical care or treatment as provided in Section 1932(b)(3) or the Social Security Act, 42 CFR § 438.102, or in contravention of NMSA 1978 §§ 59A-57-1 to 59A-57-11.Provider understands that Medical Necessity determinations, if any, to deny authorizations for payment or payments for services that were not provided in accordance with the requirements of this Agreement are administrative decisions only. Such a denial does not absolve Provider of its responsibility to exercise independent judgement in Member treatment decisions.

5.2. Administrative Services. The Health Plan or Payor shall perform, provide or arrange for the provision of all legal services, audit services, utilization management, provider relations, quality management, administrative services, claims processing services, data processing services, accounting services, marketing services and enrollment services reasonably necessary for the administration of the Health Benefit Programs. The accounting services performed by the Health Plan or Payor in connection with its operations and the operation of the Health Benefit Programs shall be on a calendar year basis.

5.3. Records Maintenance. The Health Plan or Payor shall maintain such records and establish and adhere to such procedures as shall be reasonably required to ascertain the number and identity of Members. Provider shall cooperate with the Health Plan or Payor regarding such records and procedures to enable the Health Plan or Payor to determine eligibility for coverage by the Health Plan or Payor and the amount of compensation payable to Provider.

5.4. Payments. The Health Plan shall pay the Provider for the provision of Covered Services in accordance with provisions of Section 6 of this Agreement.

5.5. Policies and Procedures. The Health Plan has adopted and in the future will adopt policies and procedures relating to the administration of the Health Benefit Programs and the provision of Covered Services to Members. The policies and procedures applicable to this Agreement are contained in the Provider Manual. While the Provider will have the opportunity to participate in the formulation of future policies or procedures or the amendment of existing policies or procedures, the Health Plan may amend the Provider Manual without the consent of Provider in accordance with Section 2.7 of this Agreement.

5.6. Out-of-Plan Medical Services. The Health Plan shall manage and coordinate Out-of-Plan Medical Services. Provider shall cooperate fully with the Health Plan in providing information that may be required for transferring Members back to participating providers, including promptly notifying the Health Plan of known or suspected Out-of-Plan Medical Services, and shall accept the prompt transfer of Members to the care of Provider following the receipt of Out-of-Plan Medical Services.

5.7. Out of State/Border Providers. To the extent possible, the Health Plan is encouraged to utilize in-state and border providers, which are defined as those providers located within one hundred (100) miles of the New Mexico border, Mexico excluded. The Health Plan may include out-of-state providers in its network.

5.8. Benefit Interpretation; Coverage Decisions. The Health Plan shall be solely responsible for interpreting the terms of and making final coverage determinations under the Health Benefit Programs.

5.9. Managed Care Program Services. Consistent with the requirements of state and federal law and the standards of accreditation organization, Health Plan or the Payor shall be accountable for the performance of the following services for all Health Benefit Programs:

i. quality management and improvement,

ii. utilization management,

iii. credentialing,

iv. Member rights and responsibilities,

v. preventive health services,

vi. medical record review and

vii. payment and processing of claims (collectively, "Managed Care Program Services").

Provider shall cooperate with any independent quality review and improvement organization designated by the Health Plan and with the Health Plan in the performance of all Managed Care Program Services and conduct their activities in a manner consistent with the provisions of this Section 5.9 including specifically, but without limitation, the Health Plan's quality management and improvement program, utilization management program, credentialing program, member services activities, and claims processing guidelines.

5.9.1. Health Plan or the Payor shall maintain an ongoing quality management and improvement program ("QM Program") to assess and improve the quality of clinical care and the quality of service provided to Members under the Health Benefit Programs. The QM Program shall be maintained in accordance with the requirements of Health Plan's or Payor's policies and procedures, state and federal law and the standards of accreditation organizations.

5.9.2. Health Plan or the Payor shall maintain an ongoing utilization management program ("UM Program") to address pre-authorization, concurrent and retrospective review of the quality, appropriateness, level of care and utilization of all Covered Services provided or to be provided to Members under the Health Benefit Programs. The UM Program shall be maintained in accordance with the requirements of Health Plan's or Payor's policies and procedures, of state and federal law and the standards of accreditation organizations.

5.9.3. Health Plan or the Payor shall maintain standards, policies and procedures for credentialing and re-credentialing physicians, hospitals, and other health care professionals and facilities that provide Covered Services to Members under the Health Benefit Programs ("Credentialing Program"). The Credentialing Program shall be maintained in accordance with the requirements of Health Plan or Payor's policies and procedures, state and federal law and the standards of accreditation organizations.

5.9.4. The Health Plan must ensure that each Member is free to exercise his or her rights and that the exercise of these rights does not adversely affect the way the Provider and its Contract Providers or the State treat the Member.

5.9.5. Health Plan or the Payor shall inform Members of their rights and responsibilities under each Health Benefit Program provide Members with membership cards and member handbooks, distribute periodic communications to Members, process Member complaints and grievances and respond to inquiries and requests from Members regarding Health Benefit Programs (collectively "Member Services").

5.9.6. The Health Plan must have written policies regarding the Member's, and/or Representatives' rights that are in line with the requirements of state and federal law and standards.

5.9.7. Health Plan or the Payor shall develop preventive health guidelines for the prevention and early detection of illness and disease ("Preventive Health Guidelines") and shall encourage Members to use preventive health services. The Preventive Health Guidelines shall be maintained in accordance with the standards of accreditation

organizations and shall be distributed to participating providers. Participating providers shall provide preventive health services required pursuant to the applicable Evidence of Coverages to the Provider's Members in accordance with the Preventive Health Guidelines.

5.9.8. Health Plan or the Payor shall periodically review medical records maintained by the participating provider to assess compliance with the requirements of state and federal law and the standards of accreditation organizations. Provider shall maintain medical records in accordance with the provisions of this Agreement regarding medical records and in accordance with Health Plan's or the Payor's guidelines regarding medical records.

5.9.9. Health Plan or the Payor shall establish and maintain standards, policies and procedures for the timely and accurate processing and payment of claims for Covered Services provided to Members ("Claims Processing Guidelines"). The Claims Processing Guidelines shall be maintained in accordance with the requirements of Health Plan's policies and procedures, state and federal law and the Health Benefit Programs.

5.9.10. Any delegation by the Health Plan of the credentialing, utilization management or other such function for the Health Benefit Programs shall be subject to a separate written Agreement which shall detail the parties' responsibilities, the Health Plan's obligation to oversee the performance of these functions, and the ongoing right and obligation of the Health Plan to monitor and evaluate the performance of these services.

5.10. Fee Schedule. Health Plan or the Payor shall maintain all fee schedules used in computing payments on a Fee-for-Service basis. Periodic fee schedule updates shall not be deemed to be amendments to the fee schedule and shall automatically become effective on the date designated by Health Plan or the Payor. Health Plan or the Payor may amend the fee schedule in accordance with Section 2.7 of the Agreement.

5.11. Grievance and Appeals system education. The Health Plan must provide the information specified in 42 C.F.R. § 438.10(g)(2)(xi) about its Grievance and Appeals system to all Providers at the time they enter into contract with the Provider.

6. Compensation

6.1. Compensation. The Health Plan shall pay Provider for providing Medically Necessary Covered Services to Members in accordance with the compensation specified in the Product Attachments attached to this Agreement. PNI shall not be liable for the payment of any compensation to the Provider.

6.2. Submission of Claims/Claims Payment. Provider shall submit all claims for reimbursement under this Agreement to the Health Plan or Payor no later than ninety (90) days from the date Covered Services are provided pursuant to Product Attachments as applicable to this Agreement. Provider shall submit such claims in accordance with the procedures and standards established by the Health Plan or Payor and outlined in the Provider Manual. Provider acknowledges and agrees that if Provider fails to submit claims as specified by this Section, the Health Plan or Payor reserves the right to deny payment for such claims. If the Provider cannot submit a Clean Claim within such period for reasons beyond the reasonable control of the Provider, the Provider may request an extension of the filing limit and the Health Plan or Payor will address such request in good faith. In submitting claims, encounters, and other

information to Health Plan, Provider shall certify the accuracy, completeness and truthfulness of records as required by Health Plan of applicable law.

6.3. Prompt Payment. Should the Health Plan fail to pay the amount due to the Provider under a Clean Claim received from the Provider within the time limits established by state or federal law or regulation, the Health Plan shall pay the amount of any interest or penalty required by state or federal law or regulation.

6.4. Collection of Copayments. Provider shall be responsible for the collection of Copayment Charges in accordance with the applicable Health Benefit Program upon providing Covered Services to Members. Copayment Charges stated as a percentage shall be based on the payments for Covered Services specified in the applicable Product Attachment. Provider shall not routinely waive Copayment Charges unless otherwise allowed under applicable law.

6.5. Collection of Charges from Third Parties. If a Member is entitled to payment from a third party, Provider shall provide Covered Services to the Member pursuant to the provisions of this Agreement. Provider shall not routinely waive Copayment Charges. In submitting claims for Covered Services provided, the Provider shall comply with the provisions of Section 6.2 of this Agreement.

6.6. Adequacy of Compensation and Coordination of Benefits. Provider shall accept the compensation described in this Agreement including any applicable Copayment Charges as payment in full for providing the Covered Services, whether that amount is paid in whole or in part by a Member or Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by law or regulatory requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Copayment Charges. Provider shall not be entitled to challenge any payment or payment determination made by or on behalf of Health Plan unless such challenge is made in writing to Health Plan within twelve (12) months from the date such payment or payment determination is made.

6.7. Overpayments and Recoupment. Health Plan may recover overpayments made to Provider by Health Plan by offsetting such amounts from later payments to Provider, including, without limitation, making retroactive adjustments to payments to Provider for errors and omissions relating to data entry errors, incorrectly submitted claims, incorrectly applied discounts, moneys Provider recovers from third parties under subrogation, or services that Health Plan determines are not Medically Necessary even if such items or services were authorized by Health Plan. In addition, since Members' eligibility status is subject to retroactive disenrollment, Health Plan may, unless prohibited by law or the New Mexico Medicaid managed care program, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items or services were authorized by Health Plan. If a provider has incorrectly overcharged co-payments to a member, then the provider must refund any amount incorrectly collected to the member. The provider has ten (10) working days after receiving a notice of overcharged co-payments from the MCO to refund the co-payment to the member.

6.8. Payments Following Termination of Agreement. Following termination of this Agreement and until the expiration of the continuity of care period provided in Sections 2.3 and 5.9 of this Agreement, the Health Plan shall compensate Provider for Covered Services provided to Members in accordance with the applicable Product Attachment.

6.9. Fee-for-Service Reimbursement. In accordance with the applicable Product Attachment, Provider may be paid on a Fee-for-Service basis. If payment is based on Fee-for-Service, Provider will be paid the lesser of Provider's billed charges or the fee payable under the fee schedule identified in the appropriate Product Attachment.

6.10. Physician Incentive Plans. Health Plan may operate a physician incentive plan, which may include VBP payment methods to compensate Provider.

6.10.1. Value-Based Purchasing

6.10.1.1. Providers will be rewarded based on achieving quality and improved outcomes, rather than volume of services delivered.

6.10.1.2. The Health Plan shall develop a VBP plan that encompasses all HCA requirements, while meeting the general expectation to reward the Provider based on achieving quality and outcomes.

6.10.1.3. The VBP plan, at a minimum, shall include the following:

6.10.1.3.1. The Health Plan's overall approach to VBP;

6.10.1.3.2. Initiatives, goals, targets and strategies;

6.10.1.3.3. Barriers and actions to overcome barriers; and

6.10.1.3.4. Data sharing arrangements established with participating Providers.

6.10.1.4. The Health Plan shall submit narrative updates to the evaluation plan to HCA quarterly that include barriers, solutions, successes, status, supportive data and other pertinent information to the delivery system improvement.

6.10.1.5. The Health Plan shall share performance and Claims data and lists of attributed Members with the Provider on a quarterly basis for the membership that is attributed to the provider in VBP arrangements.

6.10.2. Health Plan and Provider agree that upon decision to explore opportunities for VBP models that they agree to amend this Agreement to include such arrangements at the appropriate time for both Parties.

6.11. Special Reimbursement. In the event that HCA assigns the Provider a Federally Qualified Health Clinic (FQHC) and Rural Health Clinic (RHC) Provider Type, the Health Plan acknowledges that payment to provider will utilize the Prospective Payment System (PPS) or alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act.

6.12. Gross Receipts Tax. The payments to the Provider shall be all inclusive. Health Plan shall be under no obligation to reimburse Provider for gross receipts tax due from Provider as a result of payments received under this Section 6.

7. Grievance/Complaints

7.1. Between the Health Plan and Provider. Should Provider feel aggrieved by any decision of the Health Plan relative to this Agreement, Provider shall submit the grievance to Health Plan or the Payor for resolution in accordance with the Provider Manual. The Health Plan or Payor and Provider shall cooperate in resolving any such grievance.

7.2. Between Member and the Health Plan or Provider. Grievances between a Member and either the Health Plan or the Provider shall be resolved in accordance with Health Plan's or the Payor's internal Member grievance procedure. As a condition for payment under this Agreement, Provider shall fully cooperate with Health Plan or the Payor in implementing any final decision rendered through the internal grievance procedure and not appealed to a duly authorized official or agency of the state of New Mexico, which may from time to time have jurisdiction to hear, consider and rule upon complaints of the Members against the Health Plan, Payor or the Provider. In a similar manner, the Health Plan or Payor shall fully cooperate with Provider in implementing any final decision rendered by the internal grievance procedure regarding health service use behaviors of Members.

8. Medicare Provisions

The provisions of this Section 8 supplement the other provisions of the Agreement and apply to the Medicare Program and Covered Services provided to Medicare Members.

8.1. General Data and Information Requirements. Provider shall maintain and provide to Health Plan, upon written request, any and all information required by Health Plan, state and federal law, government agencies or accreditation organizations for administration of Health Benefit Programs. Provider shall submit such information and data to Health Plan in the format and within the time periods specified by Health Plan. Provider shall accurately and completely maintain all encounter data, all other information and data required by this Agreement, including medical records, necessary to characterize the scope and purpose of Covered Services provided to Members. Provider shall provide to Health Plan and to CMS any required certification as to Provider's compliance with the foregoing.

8.2. Member Acceptance. Provider shall accept Medicare Members in accordance with the Health plan policies on accepting Medicare Members and closing practices.

8.3. Excluded and Precluded Providers. Provider is not, and shall not contract for the provision of services under this Agreement with, an individual provider, entity, or an entity with an individual who is an officer, director, agent or manager who owns or has a controlling interest in the entity, that has been convicted of crimes specified in Section 1128 or Section 1128A of the Social Security Act, excluded from participation in the Medicare and Medicaid Program, assessed a civil penalty under the provisions of Section 1128, or that has a contractual relationship with an entity convicted of a crime specified in Section 1128.

8.3.1. Provider will be ineligible for payment from Health Plan for Covered Services provided to Members and will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed more than sixty (60) days after Health Plan provides notice pursuant to 42 C.F.R. § 422.222(a)(1)(ii)(A) relating to individuals or entities included on CMS' preclusion list. All such denied payments are subject to the prohibitions on member billing described in Section 3.2 herein.

8.4. Accounting. Provider shall maintain a system of accounting in accordance with standard accounting methodologies for provider/physician offices. Such system shall clearly document

all financial transactions between Health Plan and Provider. These transactions shall include but are not limited to claim payments, refunds, and adjustments of payments.

8.5. Advance Directives. Provider shall comply with the provisions of the federal Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws. Provider shall discuss and review with Medicare Members issues related to advance directives and shall document in each Member's medical record whether or not the Medicare Member has executed an advance directive.

8.6. Disclosure of Information under Physician Incentive Plan Regulations. If this Agreement is with an entity other than an individual provider, the Provider hereby represents to Health Plan that it does not put individual physician members at substantial financial risk for services they do not furnish, as defined by 42 C.F.R. § 417.479(c). The Provider agrees to notify Health Plan prior to adopting any plan that has such effect so that Health Plan may comply with applicable requirements under 42 C.F.R. § 417.479(i).

8.7. Compliance with Law. Provider shall comply with Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, other laws applicable to recipients of federal funds and all other applicable laws and rules, including applicable Medicare laws, regulations and CMS instructions. Provider acknowledges that payments received with respect to Medicare Members are, in whole or in part, from federal funds.

8.8. Accountability and Policy Development.

8.8.1. Any provision of the Agreement to the contrary notwithstanding, Health Plan oversees and is accountable to CMS for services provided to Medicare Members and for compliance with regulations regarding such services. Such accountability shall not prevent Health Plan's recourse to Provider for the Provider's failure to fulfill the Provider's obligations hereunder.

8.8.2. In addition to policies and procedures currently in effect, and as amended pursuant to the Agreement, Health Plan may adopt policies and procedures specific to the operation of the Medicare Program. Provider agrees to comply with all Medicare Program policies and procedures. Changes to Medicare Program policies and procedures shall be effected in accordance with the provisions set forth in this Agreement.

8.9. Supplemental Medical Record Provisions. In addition to the obligations contained in Section 3.9, the following provisions apply to medical records generated by Provider relating to Medicare Members:

8.9.1. Provider agrees to establish and maintain procedures and controls so that no information contained in its records relating to Medicare Members or obtained from CMS or from others in carrying out the terms of this Agreement shall be used by or disclosed by it, its agents, officers, or employees except as provided under section 1106 of the Social Security Act and regulations prescribed hereunder.

8.9.2. Medical records and other records relating to Medicare Members shall be maintained by Provider for a period of ten (10) years following the provision of Covered Services as required by state and federal law. In cases involving incomplete audits and/or unresolved audit findings, administrative sanctions or litigation relating to services

provided under this Agreement to Medicare Members, the maximum ten (10)-year period shall begin when such actions are resolved.

8.10. First Tier or Downstream Entity. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with PNI, PHP or PIC, through ten (10) years from the final date of the final contract period of the contract entered into between CMS and the Health Plan or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

8.10.1. First Tier or Downstream Entity will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

8.10.2. Enrollees will not be held liable for payment of any fees that are the legal obligation of Health Plan. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

8.10.3. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. First Tier or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the Medicare Advantage plan payment as payment in full, or (2) bill the appropriate state source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

8.10.4. Any services or other activity performed in accordance with a contract or written agreement by First Tier or Downstream Entity are consistent and comply with Health Plan's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

8.10.5. Contracts or other written agreements between Health Plan and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. Health Plan is obligated to pay contracted providers under the terms of the Service Agreement. [42 C.F.R. §§ 422.520(b)(1) and (2)]

8.10.6. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

8.10.7. If any activities or responsibilities are delegated to any first tier, downstream and related entity then Provider agrees that:

i. The delegated activities and reporting responsibilities will be appropriately agreed upon in writing:

ii. CMS and Health Plan reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or Health Plan determine that such parties have not performed satisfactorily.

iii. Health Plan will monitor the performance of the parties on an ongoing basis.

iv. The credentials of medical professionals affiliated with the party or parties will be either reviewed by Health Plan or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

v. If Health Plan delegates the selection of providers, contractors, or subcontractor, Health Plan retains the right to approve, suspend, or terminate any such arrangement.

9. Medicaid Provisions

9.1. Exhibit III-B provides a list of Turquoise Care Covered Services, activities and reporting responsibilities to be performed by the Provider. Providers will be responsible to perform Turquoise Care Covered Services within the scope of practice for which they are credentialed HCA and CMS require that specific terms and conditions be included in this Agreement to comply with the Medicaid managed care laws, regulations, HCA and CMS instructions. Provider expressly acknowledges that it shall be bound by and comply with these provisions when providing Covered Services to Turquoise Care Members.

9.2. Provider will be cognizant of the Covered Services provided under the terms of this Agreement. Provider will also assist and educate Members about self-referrals, linkages and how to access Care Coordinators in support of the Presbyterian Turquoise Care Program;

9.3. The Primary Care Provider (PCP), if applicable:

9.3.1. With the exception of Dual Eligibles, Health Plan will ensure that each Member is assigned a PCP. For Dual Eligibles, Health Plan will be responsible for coordinating the primary, acute, Behavioral Health and Long-Term Care services with the Member's Medicare PCP. For all other Members, the PCP shall be a medical or Behavioral Health provider participating with Health Plan who has the responsibility for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of the Member's care. Health Plan is prohibited from excluding providers as primary care providers based on the proportion of high-risk patients in their caseloads.

9.3.2. Provider acknowledges that the Health Plan shall submit a PCP Report as required by HCA. Provider understands that the monthly PCP Report submitted to HCA will include, at a minimum, the following information:

9.3.2.1. the names of newly enrolled Members and the name of the PCP to which they are assigned or selected;

9.3.2.2. the PCP to Member ratio per one thousand five hundred (1,500) Members;

9.3.2.3. the percent of PCP panel slots open;

9.3.2.4. the number of providers serving as PCPs stratified by type (nurse practitioners, internists, pediatricians, etc.);

9.3.2.5. the number of PCP visits per one thousand five hundred (1,500) Members;

9.3.2.6. the percent of new Members who did not select a PCP and were assigned to one; and

9.3.2.7. the number of PCP change requests received and processed.

9.4. If Provider acts as a PCP, Provider shall comply with the following:

9.4.1. The PCP shall ensure that the following responsibilities are met:

9.4.1.1. the PCP shall ensure coordination and continuity of care with providers, including all Behavioral Health and Long-Term Care providers, according to the Health Plan's policy; and

9.4.1.2. the PCP shall ensure that the Member receives appropriate prevention services for the Member's age group.

9.4.2. The PCP shall refer a Member for Behavioral Services based on the following indicators:

9.4.2.1. Suicidal/homicidal ideation or behavior;

9.4.2.2. At-risk of hospitalization due to a Behavioral Health condition;

9.4.2.3. Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;

9.4.2.4. Trauma victims;

9.4.2.5. Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

9.4.2.6. Request by Member or Representative for Behavioral Health services;

9.4.2.7. Clinical status that suggests the need for Behavioral Health services;

9.4.2.8. Identified psychosocial stressors and precipitants;

9.4.2.9. Treatment compliance complicated by behavioral characteristics;

9.4.2.10. Behavioral and psychiatric factors influencing medical condition;

9.4.2.11. Victims or perpetrators of Abuse and/or neglect and Members suspected of being subject to Abuse and/or neglect;

9.4.2.12. Non-medical management of substance abuse;

9.4.2.13. Follow-up to medical detoxification;

9.4.2.14. An initial PCP contact or routine physical examination indicates a substance abuse problem;

9.4.2.15. A prenatal visit indicates substance abuse problems;

9.4.2.16. Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

9.4.2.17. A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or

9.4.2.18. The persistence of serious functional impairment.

9.5. In regards to Member Cost Sharing the Health Plan:

9.5.1. Is responsible for implementation of copayments as directed by HCA.

9.5.2. Shall implement processes to bill and collect premium payments from Members as directed by HCA. Members must be able to make premium payments using a Member portal. Payment options shall include debit card, credit card, check and other methods of payment approved by HCA.

9.5.3. Shall not impose any enrollment fee, premium or similar charge and shall not impose any deductible, copayment, cost sharing or similar charge to Members who are Native American, who were furnished an item or service directly by the Indian Health Service, and Indian Tribe, Tribal Organization, or Urban Indian Organization (collectively, "IHS Providers") or by a health provider through referral under contract health services for which Medicaid payment may be made. In addition, payment to IHS Providers may not be reduced by any such charges.

9.6. In regards to Patient Liability:

9.6.1. Provider shall follow the Health Plan's policies and procedures to ensure that, where applicable, Members residing in residential facilities pay their patient liability.

9.6.2. Provider shall follow the Health Plan's policies regarding collection of patient liability from Nursing Facility or community-based residential alternative facility and agrees the Health Plan shall pay such facilities net of the applicable patient liability amount.

9.6.3. HCA will notify the Health Plan of any applicable patient liability amounts for Members via the eligibility/enrollment file.

9.6.4. The Health Plan shall submit patient liability information associated with Claim payments to providers in its Encounter Data submission.

9.7. Provider acknowledges that HCA has directed Health Plan to move provider payments to VBP value-based methods. Health Plan and Provider agree to explore opportunities for VBP models and agree to amend this Agreement to include such arrangements at the appropriate time for both Parties.

9.8. Provider agrees to release to Health Plan any information necessary to perform its obligations to HCA and the Health Plan shall monitor the Provider's performance on an ongoing basis and subject the Provider to formal periodic review.

9.9. Health Plan shall monitor the quality of services delivered under this Agreement and specify initial corrective action that 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 HCA.

9.10. Emergency Services shall be rendered without the requirement of prior authorization of any kind.

9.11. Provider shall comply with corrective action plans initiated by Health Plan.

9.12. Provider shall submit all reports, clinical information, and Encounter Data as required by Health Plan, in a timely fashion or as required by Health Plan or other regulatory agencies.

9.13. Provider's responsibilities regarding Third Party Liability (TPL):

9.13.1. Health Plan shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to Members and notify the agency's third-party liability vendor of any third-party creditable coverage discovered. Provider shall make every effort to coordinate with primary Payor for services rendered to Members involved where TPL may exist;

9.13.2. Medicaid shall be the payer of last resort for Covered Services in accordance with federal regulations. Health Plan has the same rights to recovery of the full value of services as HCA and shall make every reasonable effort to determine the legal liability of third parties to pay for services rendered to enrollees under this Agreement and cost avoid and/or recover any such liability from the third party; and

9.13.3. Health Plan shall provide TPL data to any provider having a Claim denied by Health Plan based upon TPL.

9.14. Health Plan has the right to suspend, deny, refuse to renew or terminate any Provider agreement in accordance with the terms of this Agreement and applicable statutes and regulations.

9.15. Both parties recognize that in the event of termination of the Health Plan and HCA Agreement, the Provider shall immediately make available, to HCA or its designated representative in a usable form any or all records whether medical or financial related to the Provider's activities undertaken pursuant to this agreement. The provision of such records shall be at no expense to HCA.

9.16. If any requirement in this Agreement is determined by HCA to conflict with Turquoise Care Agreement., such requirement shall be null and void and all other provisions shall remain in full force and effect.

9.17. Provider acknowledges and agrees that HCA reserves the right to direct Health Plan to terminate or modify this Agreement when HCA determines it to be in the best interest of the state.

9.18. If a laboratory service provider, Provider will meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

9.19. Provider acknowledges and agrees that 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.

9.20. Provider acknowledges and agrees that to the best of its knowledge and belief, federal funds have not been used for lobbying in accordance with 45 CRF Part 93 and 31 USC §1352. Provider agrees to disclose any lobbying activities using non-federal funds in accordance with 45 CFR Part 93.

9.21. Provider acknowledges and agrees that it has complied with, and during the Agreement, will continue to comply with all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978 and 42 CFR §438.58.

9.22. Provider agrees to indemnify and hold HCA harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Agreement. Health Plan is solely responsible for fulfillment of this agreement. HCA shall make payments only to the Health Plan.

9.23. As a condition of receiving any amount of payment pursuant to this Agreement, Provider agrees to comply with the applicable provisions of Health Plan's Fraud, Waste and Abuse Program.

9.24. Provider agrees to comply with Health Plan's Cultural and Linguistic Competence/Sensitivity Plan.

9.25. In accordance with the terms and conditions of this Agreement, as amended, between the Provider and Health Plan, Provider hereby agrees to all terms and conditions of the Agreement, as amended, related to New Mexico Employee Coverage regulations and hereby attest to one of the following outlined below:

By signing this document, Provider hereby attests that they are eligible to participate in Medicaid, by meeting one of the minimum necessary requirements as represented below. Provider also agrees that the information submitted in this document is true and accurate as of the date of signature. Any misrepresentation or falsification of this information may result in termination of Provider's participation in the Medicaid Turquoise Care program or any other state funded health care program subject to Executive Order 2007-049 issued on November 30, 2007.

9.25.1. Provider hereby attests that they have had or anticipates having six (6) or more employees who work, worked, are working, or are expected to work, an average of at least twenty (20) hours per week over a six (6) month period with said six (6) month period being at any time during the year prior to the effective date of the attached Amendment or at any time during the term of the Agreement. As such, Provider agrees to:

9.25.1.1. Have in place and maintain for the term of the Agreement health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2008, if the expected annual value in the aggregate of any and all contracts or subcontracts between the Provider and the State or its contracted entities exceeds one million dollars ($1,000,000); or

9.25.1.2. Have in place, and agree to maintain for the term of the Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2009, if

the expected annual value in the aggregate of any and all contracts or subcontracts between the Provider and the State or its contracted entities exceeds five hundred thousand dollars ($500,000); or

9.25.1.3. Have in place, and agree to maintain for the term of the Agreement, health insurance for those New Mexico employees and offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts or subcontracts between the Provider and the State or its contracted entities exceeds two hundred fifty thousand dollars ($250,000).

9.25.2. Provider hereby attests that they do not have, nor anticipates having six (6) or more employees who work, worked, are working, or expect to work an average of at least twenty (20) hours per week over a six (6) month period with said six (6) month period being at any time during the year prior to the effective date of the attached Amendment or at any time during the term of the Agreement.

Provider agrees that this attestation will remain in effect until such time that Provider notifies Health Plan of a material change to Provider's practice that would amend this Attestation. Provider will immediately notify Health Plan of such change.

9.26. Family Planning Providers, if applicable

9.26.1. Provider acknowledges that a Member, including each adolescent or Adult Member, has the right to use his or her own PCP or go to any family planning provider for family planning services without a referral. Members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to HIV and other sexually transmitted diseases and risk reduction practices; birth control pills and devices (including Plan B); and Members can self-refer to non-contracted family planning Providers.

9.26.2. Pursuant to State law and regulation, Providers are responsible for keeping family planning information confidential in favor of the individual Member even if the Member is a minor.

9.27. Shared Responsibility Between Health Plan and Public Health Offices. Provider acknowledges and shall, at Health Plan's option, assist Health Plan when applicable, and cooperate with Health Plan in complying with the following requirements:

9.27.1. Coordinating with public health offices operated by the New Mexico Department of Health regarding the following services:

9.27.1.1. Sexually transmitted disease services, including screening, diagnosis, treatment, follow-up and contact investigations;

9.27.1.2. HIV prevention counseling, testing, and early intervention, birth control pills and devices (including Medicaid Cover Plan B).

9.27.1.3. Tuberculosis screening, diagnosis, and treatment;

9.27.1.4. Disease outbreak prevention and management, including reporting according to State law and regulatory requirements, responding to

epidemiology requests for information, and coordination with epidemiology investigations and studies;

9.27.1.5. Referral and coordination to ensure maximum participation in the Supplemental Food Program for Women, Infants, and Children (WIC);

9.27.1.6. Health education services for individuals and families with a particular focus on injury prevention including car seat use, domestic violence, and lifestyle issues, including tobacco use, exercise, nutrition, and substance use;

9.27.1.7. Home visiting programs for families of newborns and other at-risk families; and

9.27.1.8. Participation and support for local health councils to create healthier and safer communities with a focus on coordination of efforts, such as driving while intoxicated (DWI) councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others.

9.28. Emergency Planning and Response. Provider acknowledges and shall, at Health Plan's option, assist Health Plan when applicable, and cooperate with Health Plan in complying with the following requirements:

9.28.1. Behavioral Health

9.28.1.1. Participating in Behavioral Health emergency planning and response in collaboration with the New Mexico Behavioral Health Purchasing Collaborative. The participation of Health Plan in these activities is intended to ensure that the disaster-related emotional needs of individuals with chronic Behavioral Health disorders, other special populations, the general public, and emergency responders will be addressed in a systemic and systematic fashion.

9.28.1.2. Participating in planning and training activities for statewide disaster Behavioral Health preparedness and response.

9.28.1.3. Coordinating with the New Mexico Behavioral Health Purchasing Collaborative to implement Behavioral Health response activities in the event of a local, State or federally declared disaster.

9.28.1.4. In the event of a federally declared disaster, Coordinating with the New Mexico Behavioral Health Purchasing Collaborative to locate providers to participate the FEMA- and SAMHSA-funded Immediate and Regular Service Program Crisis Counseling Services grants. Health Plan shall also serve as a flow-through entity for funding of these grants. The grants will be managed by HCA.

9.28.1.5. Participating in disaster Behavioral Health planning efforts at their local area level.

9.28.2. Participating in any and all other emergency planning and response as directed by HCA.

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

9.30. 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.

9.31. Agency-Based Community Benefit providers shall provide at least thirty (30) Calendar Days advance notice to Health Plan 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.

9.32. Reimbursement of a Community Benefit provider 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 Health Plan.

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

9.34. Community Benefit providers will comply with all applicable, federal requirements for HCBS settings requirements.

9.35. Require Providers to 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.

9.36. Complying with the requirements specified in 42 C.F.R. §438.214 and all applicable State requirements regarding provider networks and Health Plan's policies and procedures that reflect these requirements:

9.36.1. Establish and maintain a comprehensive network of providers capable of serving all Members who enroll with Health Plan;

9.36.2. Pursuant to section 1932(b)(7) of the Social Security Act, not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment;

9.36.3. Not discriminate with respect to participation, reimbursement, or indemnification of any provider acting within the scope of that provider's license or certification under applicable State law solely on the basis of the provider's license or certification;

9.36.4. Upon declining to include individual or groups of providers in its network, give the affected providers written notice of the reason for its decision;

9.36.5. Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to Members; and

9.36.6. Not make payment to any provider who has been barred from participation based on existing Medicare, Medicaid or SCHIP sanctions, except for Emergency Services.

9.37. Provider shall display notices of the Member's right to Appeal adverse action affecting services in public areas of the Provider's facility(s) in accordance with HCA rules and regulations, subsequent amendments;

9.38. Provider acknowledges and shall, at Health Plan's option, assist and cooperate with Health Plan in complying with the following requirements:

9.38.1. Marketing Requirements

All federal rules regarding Medicare Advantage marketing (42 C.F.R. Part 422) and the CMS Medicare Marketing Guidelines found at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.html.

All federal rules regarding Medicaid marketing found at 42 C.F.R. Part 438, including 42 C.F.R. Part 438.104.

Health Plan shall maintain written policies and procedures governing the development and distribution of marketing materials that, among other things, include methods for quality control to ensure that marketing materials are accurate and do not mislead, confuse, or defraud recipients, potential Members, or HCA.

Health Plan marketing materials shall be reviewed for content, comprehension level, and language(s) by HCA, and approved before use by Health Plan.

Health Plan shall distribute marketing materials statewide.

9.38.2. Marketing Activities Not Permitted Under This Agreement

The following Marketing activities are prohibited, regardless of the method of communication (oral, written) or whether the activity is performed by Health Plan directly, or by its Providers, subcontractors, agents, consultants, or any other party affiliated with Presbyterian Inc.:

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

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

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

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

9.38.2.5. Asserting or implying that Health Plan 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;

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

9.38.2.7. Directly or indirectly conducting door-to-door, telephonic, electronic or other Cold Call Marketing. Health Plan may send informational material regarding its benefit package to Recipients and potential Members;

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

9.38.2.9. Including statements that Health Plan is endorsed by CMS, the federal or State government, or a similar entity.

9.39. Provider acknowledges and shall, at the Health Plan's option, assist the Health Plan when applicable, and cooperate with the Health Plan in complying with the following requirements:

9.39.1. Maintenance of Medical Records

Provider shall maintain and shall require its subcontractors to maintain appropriate records in accordance with federal and State statutes and regulations relating to Provider'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.

9.39.2. Financial Records

9.39.2.1. Provider shall 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 this Agreement, including applicable federal and State requirements (e.g., 45 C.F.R. § 74.53).

9.39.2.2. Provider shall retain records identified in this Agreement 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.

9.39.3. Grievance and/or Appeal Files

9.39.3.1. All Grievance and/or Appeal files shall be maintained in a secure, designated area and be accessible to HCA upon request, for review. Grievance and/or Appeal files shall be retained for ten (10) years following the final decision by the Health Plan, HCA, judicial appeal or closure of a file, whichever occurs later.

9.39.3.2. The Provider will have procedures for ensuring that files contain sufficient information to identify the Grievance and/or Appeal, the date it was received, the nature of the Grievance and/or Appeal, notice to the Member of receipt of the Grievance and/or Appeal, all correspondence between the Provider and the Member, the Member's Representative(s) and/or the provider, the date the Grievance and/or Appeal is resolved, the resolution and notices of

final decision to the Member, the Member's Representative(s) and/or provider and all other pertinent information.

9.39.3.3. Documentation regarding the Grievance and/or Appeal shall be made available to the Member, if requested.

9.39.4. Program Integrity Related Records. Books and Documents

9.39.4.1. The Provider agrees to maintain and require its Subcontractors and to maintain, records, books, documents and information on ownership and control, as required in 42 C.F.R. § 455.104 and prohibited affiliations, as specified in 42 C.F.R. § 438.610.

9.39.4.2. The records, books, documents and information in Section 9.39.4.1 shall be maintained 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.

9.39.5. Provider Network Records, Books and Documents

9.39.5.1. The Providers agrees to maintain, records, books, documents and information related to the adequacy of the provider network as specified in Section 9.36 of this Agreement and 42 C.F.R. § 438.207.

9.39.5.2. The records, books, documents and information in Section 9.39.5.1. shall be maintained 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.

9.39.6. Access to Records, Books and Documents

9.39.6.1. Upon reasonable notice, Provider will provide the officials and entities identified in this Section with prompt, reasonable and adequate access to any records that are related to the scope of work performed under this Agreement.

9.39.6.2. Provider and its subcontractors must provide the access described in this Section upon HCA's request through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, in accordance with 42 C.F.R. § 438.3(h); 42 C.F.R. § 438.230(c)(3)(iii); and 42 C.F.R. § 438.3(k). This request may be for, but is not limited to, the following purposes:

9.39.6.2.1. Examination;

9.39.6.2.2. Audit;

9.39.6.2.3. Investigation;

9.39.6.2.4. Agreement administration; or

9.39.6.2.5. The making of copies, excerpts, or transcripts.

9.39.6.3. Access required must be provided to the following officials and/or entities:

9.39.6.3.1. The United States Department of Health and Human Services or its designee;

9.39.6.3.2. The Comptroller General of the United States or its designee;

9.39.6.3.3. HCA personnel or its designee;

9.39.6.3.4. HCA's Office of Inspector General;

9.39.6.3.5. The New Mexico Behavioral Health Purchasing Collaborative's personnel or designee;

9.39.6.3.6. MFEAD or its designee;

9.39.6.3.7. Any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of HCA;

9.39.6.3.8. The Office of the State Auditor or its designee;

9.39.6.3.9. A State or federal law enforcement agency;

9.39.6.3.10. A special or general investigating committee of the New Mexico Legislature or its designee; and

9.39.6.3.11. Any other State or federal entity identified by HCA, or any other entity engaged by HCA.

9.39.7. Provider agrees to provide the access described herein wherever Provider maintains such books, records and supporting documentation. Provider 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 Section. Provider will require its subcontractors to provide comparable access and accommodations.

9.39.8. Upon request, Provider must provide copies of the information described in this Section free of charge to HCA and the entities described in this Section.

9.40. For Comprehensive Community Support Services (CCSS) and High-Fidelity Wraparound (HFW) provider types and services treating members who are Children in State Custody (CISC), the following "no reject" and "no eject" provisions are applicable:

9.40.1. "No reject" means that the provider must accept the referral for eligibility and medical necessity determination. If the member is Medicaid eligible, meets the Serious Emotional Disturbance (SED) criteria, and meets medical necessity, the provider must coordinate all needed services through CCSS and HFW service providers for CISC. A provider will not discriminate against nor use any policy or practice that has the effect of discriminating against an individual on the basis of health status or need for services.

9.40.2. "No eject" means that the provider must continue to coordinate services and assist members in accessing appropriate services and supports.

9.41. In order to evaluate the efficacy of the no reject, no eject provision, the Provider is directed to include a provision for in-state accredited residential treatment centers (ARTCs), residential treatment centers (RTCs), group homes, and treatment foster care (TFC) provider contracts that requires these providers to inform the Provider if a child in state custody who is enrolled with the Provider is not accepted into service(s) or if a child in state custody is prematurely discharged. The Provider, with state oversight, will review all cases to determine the validity of each action and will evaluate the efficacy of the provision quarterly. In all cases, the Provider will provide training, education, and/or take other appropriate measures if it is determined providers are not accepting, or are prematurely discharging, members for reasons other than medical necessity or other exclusionary criteria, such as age, gender, provider specialty, and bed availability. The Health Plan shall capture and report data to HCA and CYFD on a quarterly basis regarding denial of services for CISC Members.

9.42. Provider shall accept payment from the Health Plan as payment for any services performed, and cannot request payment from HCA or the Member, unless the Member is required to pay a copayment.

9.43. As a condition of payment under this Agreement, Provider shall participate and cooperate in any internal and external QM/QI monitoring, utilization review, peer review, and/or appeal procedures established by the Health Plan and/or HCA.

9.44. In applicable Behavioral Health Provider agreements for Members who are CISC that requires Contract Providers to deliver staff training on the following topics:

9.44.1. Trauma-responsive training as approved by HCA; and

9.44.2. No reject and no eject provision for Members who are CISC.

10. Term and Termination

10.1. Term. The term of this Agreement shall commence on the Effective Date and shall automatically end on the Termination Date.

10.2. Termination of Agreement with Cause. Either Health Plan, Payor or Provider may terminate this Agreement for cause as set forth below, subject to the notice requirement and cure period set forth below.

10.2.1. The following shall constitute cause for termination of this Agreement by Provider:

i. A Health Plan's insolvency. Health Plan shall have the opportunity to dispute such determination by Provider by providing reasonable evidence and assurances of financial stability and capacity to perform within the cure period specified in Section 10.2.3.

ii. A Health Plan's failure to comply with the timely and accurate payment provisions contained in this Agreement and subsequent failure to cure such breach as provided below in Section 10.2.3.

iii. or Health Plan's breach of any material term, covenant or condition of this Agreement and subsequent failure to cure such breach as provided below in Section 10.2.3.

10.2.2. The following shall constitute cause for termination of this Agreement by Health Plan:

i. Provider's insolvency. Provider shall have the opportunity to dispute such determination by Health Plan by providing reasonable evidence and assurances of financial stability and capacity to perform within the cure period specified in Section 10.2.3.

ii. Provider's failure to provide Covered Services in accordance with the standards set forth in this Agreement and the applicable QM Program and UM Program. Notwithstanding the foregoing, Health Plan or the Payor reserves the right to immediately withdraw from Provider's care any or all Members in the event it determines in its sole discretion that the health or safety of Members is endangered by the actions of Provider or as a result of continuation of this Agreement.

iii. Such time as Provider files an affidavit with CMS promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under Section 1802 (b) of the Social Security Act.

iv. Provider's breach of any material term, covenant or condition of this Agreement, or violation of applicable state or federal statues, rules and regulations, and subsequent failure to cure such breach as provided below in Section 10.2.3.

v. Upon an asset purchase, merger, partnership, affiliation or other transaction that results in an independent third party acquiring majority control of Provider. If the third party already has a then-existing agreement with Health Plan, Health Plan may, in its sole discretion choose to (a) terminate this Agreement and elect for Provider to be covered by the then-existing contract with the third party, (b) terminate this Agreement, or (c) continue this Agreement.

10.2.3. *Notice of Termination and Effective Date of Termination*. The party asserting cause for termination of this Agreement (the "Terminating Party") shall provide written notice of termination (the "Termination Notice") to the other party. The Termination Notice shall specify the breach or deficiency underlying the cause for termination. The party receiving the Termination Notice shall have thirty (30) days from the receipt of such notice to cure the breach or deficiency to the satisfaction of the Terminating Party (the "Cure Period"). If such party fails to cure the breach or deficiency to the satisfaction of the Terminating Party within the Cure Period or if the breach or deficiency is not curable, the Terminating Party shall provide written notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period. This Agreement shall terminate upon receipt of the written notice of failure to cure or at such other date as may be specified in such notice. During the Cure Period, the Health Plan may cease referrals to Provider and begin transferring Members to other participating providers.

10.2.4. *Termination Notice – Medicare Provider*. If Health Plan elects to terminate the Agreement for cause and the Provider is providing services under the Medicare Program, in addition to any other requirements of the Agreement, the notice of termination shall contain the following information:

i. Health Plan's reasons for terminating the Agreement;

ii. The standards and the profiling data Health Plan used to evaluate the Provider;

iii. The number and mix of healthcare professionals Health Plan needs; and

iv. The Provider's right to appeal the action and the process and timing for requesting the Health Plan hearing.

10.2.5. *Health Plan Hearing*. If Provider disputes the existence of adequate cause to terminate this Agreement pursuant to the provisions of this Section 10.2.5, or otherwise desires a Health Plan hearing in connection with any termination pursuant to this Section 10.2.5, the Provider is entitled to a Health Plan hearing prior to termination of this Agreement in accordance with the Health Plan's hearing plan then in effect. In order to have a Health Plan hearing, the Provider must deliver a written request for a Health Plan hearing to Health Plan or the Payor within thirty (30) days after the Provider's receipt of the Termination Notice required by Section 10.2.3. During the pendency of the procedures required by the Health Plan hearing plan, Health Plan may suspend Provider's services under this Agreement;

i. for a period of less than fourteen (14) days if such action is necessary to permit the conduct of an investigation or

ii. until completion of the Health Plan hearing procedure if Health Plan concludes that the failure to suspend the Provider may result in an imminent danger to the health of any individual.

10.3. Termination without Cause. This Agreement may be terminated by either party with or without cause at any time upon one hundred twenty (120) days written notice to the other party, or with such shorter advance notice as may be specified in Section 2.7 of this Agreement. The provisions of this Section 10.3 will be superseded by any inconsistent provision of a Product Attachment. The Health Plan hearing procedure specified in Section 10.2.5 shall not apply to any termination pursuant to this Section.

10.4. Automatic Termination upon Revocation of License or Certificate, or Loss of Insurance. This Agreement shall automatically terminate upon the loss or insurance, or revocation, suspension or restriction of any license, certificate, accreditation or other authority required to be maintained by Provider or the Health Plan in order to perform the services required under this Agreement or upon the Provider's or the Health Plan's failure to obtain such license, certificate, accreditation or authority. The Health Plan hearing procedure specified in Section 10.2.5 shall not apply to any termination pursuant to this Section.

10.5. Transfer of Medical Records. Following termination of this Agreement, the Provider shall comply with the provisions of the Provider Manual regarding the transfer of Medical Records, including making records available to HCA or its designated representative.

10.6. Effect of Termination. No termination of this Agreement will impair any right or obligation arising prior to the date of termination or any obligation which, by the terms of this Agreement, is to be performed following termination.

10.7. Termination Not an Exclusive Remedy. Any termination by either party pursuant to this Article is not meant as an exclusive remedy and such terminating party may seek whatever action in law or equity as may be necessary to enforce its rights under this Agreement.

11. Miscellaneous

11.1. Assignment and Subcontract. This Agreement and the rights, interests and benefits hereunder shall not, without the prior written consent of the other party, be assigned, transferred or pledged in any way by Provider or Health Plan and shall not be subject to execution, attachment or similar process, and such consent shall not be unreasonably withheld. Provider may not subcontract with a third party to fulfill any of the Provider's obligations under this Agreement without the prior written consent of Health Plan. Health Plan shall not unreasonably withhold its consent to any such subcontract.

11.2. Invalidity of Sections of Agreement. The unenforceability or invalidity of any paragraph or subparagraph of any section or subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

11.3. Waiver of Breach. The waiver by either party to this Agreement of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

11.4. No Third Party Beneficiaries. This Agreement shall not create any rights in any third parties other than Health Plan's or Payors identified in a Product Attachment who have not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

11.5. Entire Agreement. This Agreement, including all exhibits, attachments and amendments hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

EXHIBIT 1
PRODUCT ATTACHMENTS
(This Exhibit 1 is an integral part of this Agreement.)

PROVIDER NAME: #LEGALENTITYNAME#

The Provider Manual and sample form Evidence of Coverage for each Health Benefit Program specified below can be viewed by Provider on line at https://www.phs.org/ProviderManual:

PRODUCT ATTACHMENTS

The following Commercial Product Attachments are an integral part of this Agreement:

☐ PHP Commercial Plan

☐ PHP Commercial Point of Service (POS) Plan

☐ PHP Administrative Services Only (ASO) Plan

☐ PIC Commercial Preferred Provider Organization (PPO) Plan

☐ Employer Direct Network Plan

☐ Select Provider Network (SPN)

☐ Engage Commercial Plan

The following Medicare Product Attachments are an integral part of this Agreement:

☐ Medicare Health Maintenance Organization (HMO) Plan

☐ Medicare Preferred Provider Organization (MPPO) Plan

☐ Medicare Point of Service (POS) Plan

☐ Medicare Dual Eligible Special Needs (DSNP) Plan

The following Medicaid Product Attachments are an integral part of this Agreement:

☐ Turquoise Care Plan

The following Exchange Product Attachments are an integral part of this Agreement:

☐ PHP Individual Select Plan