NEW MEXICO CENTENNIAL CARE
REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

This New Mexico Centennial Care Regulatory Requirements Appendix (this "Appendix") supplements and is made a part of the provider agreement (the "Agreement") between Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including the State of New Mexico Centennial Care program (the "Centennial Care Program," as further defined below) as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "Centennial Care Contract" as defined herein). The Centennial Care Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the Centennial Care Program, the definitions shall have the meaning set forth under the Centennial Care Program.

2.1 Collaborative: The New Mexico Behavioral Health Purchasing Collaborative.

2.2 Centennial Care Contract: Health Plan's contract with the New Mexico Human Services Department and Collaborative for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the Centennial Care Program.

2.3 Centennial Care Program: The State of New Mexico's Medicaid program operated under section 1115(a) of the Social Security Act waiver authority, which is a Medicaid managed care program that is a joint initiative of HSD and Collaborative. For purposes of this Appendix,

Centennial Care Program may refer to the State agency(ies) responsible for administering the Centennial Care Program. The Centennial Care Program includes Centennial Care 2.0 and any successor program.

2.4 Covered Person: An individual who is currently enrolled with Health Plan and/or Subcontractor for the provision of Covered Services. A Covered Person may also be referred to as an Enrollee, Member, Customer or other similar term under the Agreement.

2.5 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan and/or Subcontractor to receive coverage under a contract with the State, including the Centennial Care Contract.

2.6 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare Insurance Company or one of its Affiliates.

2.7 Human Services Department ("HSD"): The administrative agency within the executive department of New Mexico State government established under Chapter 9, New Mexico Statutes Annotated 1978, or its designee, including but not limited to agencies of the New Mexico Human Services Department.

2.8 Provider: An individual provider, clinic, group, association or facility that is qualified and appropriately licensed to provide health care services to individuals enrolled in Medicaid or the Centennial Care Program and that has entered into an Agreement or is subject to and renders Covered Services under an Agreement for such services.

2.9 State: The State of New Mexico or its designated regulatory agencies, including specifically HSD and/or Collaborative, as applicable throughout this Appendix.

SECTION 3
PROVIDER REQUIREMENTS

The Centennial Care Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain requirements that Health Plan, Subcontractor, and Provider agree to undertake, which include the following:

3.1 Covered Service Definitions. Provider shall follow the Centennial Care Contract's provisions for the coverage of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or

her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any body organ or part; or (4) serious disfigurement to the individual.

(b) Emergency Services: Covered inpatient and outpatient services that are as follows: (1) furnished by a provider qualified to furnish these health services; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Services shall be provided to Covered Persons without the requirement of prior authorization of any kind pursuant to 42 CFR § 438.114.

(c) Medically Necessary Services: Clinical and rehabilitative physical, mental or behavioral health services that are: (1) essential to prevent, diagnose or treat medical conditions or are essential to enable the Covered Person to attain, maintain or regain optimal functional capacity; (2) delivered in the amount, duration, scope and setting that is both sufficient and effective to reasonably achieve their purposes and clinically appropriate to the specific physical, mental and behavioral health care needs of the Covered Person; (3) provided within professionally accepted standards of practice and national guidelines; and (4) required to meet the physical, mental and behavioral health needs of the Covered Person and (5) are not primarily for the convenience of the Covered Person, Provider, Health Plan, or Subcontractor.

3.2 Medicaid or CHIP Participation. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Health Plan's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor and Health Plan must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Subcontractor and Health Plan will exclude from its network any provider who has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.3 Appointment Access. Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the Centennial Care Contract, including without limitation, appointments for preventive care, urgent care, routine sick care, and well care.

3.4 Hours of Operation. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.5 Information to Covered Persons. Provider shall provide information to Covered Persons regarding treatment options, including the option of no treatment, in a culturally-competent manner and shall ensure that individuals with disabilities have effective communications in making decisions regarding treatment options, pursuant to the requirements of the Centennial Care Contract or as otherwise may be required by law.

3.6 Primary Care. If Provider is a primary care physicians ("PCP"), Provider shall comply with the PCP requirements set forth in the Centennial Care Contract.

3.7 Unique Identifier. Providers billing or rendering services to Covered Persons shall have a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act.

3.8 Records. Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered pursuant to the Centennial Care Contract. Provider shall also comply, with the following requirements related to maintenance and retention of records:

(a**)** Financial Records. 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 the Centennial Care Contract, including applicable federal and State requirements.

(i) Providers shall retain records for a period of ten (10) years after Centennial Care Contract is terminated or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to the Centennial Care Contract, whichever is longer.

(b) Retention and Access to Records:

(i) Provider shall retain records and reports relating to services provided to Covered Persons Contract, including records and reports of services provided to Covered Persons, for a minimum of ten (10) years after final payment. In cases involving incomplete audits or unresolved audit findings, administrative sanctions, or litigation, the minimum ten (10) year period shall begin on the date such actions are resolved.

(ii) Provider shall maintain appropriate records in accordance with federal and State statutes and regulations relating to Health Plan's performance under the Centennial Care Contract, including but not limited to records relating to services provided to Covered Persons, including a separate medical record for each Covered Person. 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.

(iii) Provider shall make all Covered Person medical records or other service records available for the purpose of quality review conducted by the State or its designated agents both during and after the Contract period.

3.9 Government Audit and Inspection. Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any

time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.10 Privacy. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard and maintain the confidentiality of information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 431, Subpart F, 42 CFR Part 434 and 42 CFR 438.3 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the Department and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Subcontractor, Health Plan and the Department of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide Subcontractor, Health Plan and the Department with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Subcontractor, Health Plan and the Department to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

3.11 Information. Provider shall release to Health Plan and/or Subcontractor any information necessary for Health Plan and/or Subcontractor to perform its obligations under the Centennial Care Contract.

3.12 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.13 Compliance with Law. Provider shall comply with all applicable State and federal statutes, rules and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act, and their implementing regulations, as may be amended from time to time.

(b) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(c) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency.

(d) All applicable statutes, regulations and rules implemented by the Federal Government, the State of New Mexico, and HSD, concerning Medicaid services, managed care organizations ("MCOs"), health maintenance organizations, fiscal and fiduciary responsibilities applicable under the New Mexico Insurance Code of New Mexico, NMSA 1978, §§59A-1-1, et seq., and any other applicable statutes and regulations, and;

(e) All applicable regulations pertaining to the Coordinated Long-Term Services, NMAC Title 8, Chapter 306; other Long-Term Care Services, NMAC, Title 8, Chapter 315; Letters of Direction issued (and not otherwise rescinded) by HSD to the Centennial Care MCOs; and any suspension of contract requirements as may be issued by HSD.

Moreover, Provider agrees and understands that a provider who furnishes services to a Medicaid eligible recipient agrees to comply with all federal and state laws, regulations, and executive

orders relevant to the provision of services. Provider must conform to State program rules and instructions, appendices, program directions and billing instructions, as updated. Provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. Provider must verify that individuals are eligible for a specific health care program administered by HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. Provider must determine if an eligible recipient has other health insurance. Provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

3.14 Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by Subcontractor, Health Plan or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor and/or Health Plan constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if the State, Subcontractor or Health Plan provides notice that a credible allegation of fraud exists and there is a pending investigation. Provider's payment of a claim may also be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Subcontractor and/or Health Plan performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor and/or Health Plan upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.15 Encounter Data. If Provider is paying its own claims, within thirty (30) days after the end of each calendar month, Provider shall submit encounter data to Health Plan and/or Subcontractor, in lieu of claims, for Covered Services provided during that month. When submitting data electronically, Provider shall comply with federal standards for electronic transmission of data, security and privacy, including standards regarding encryption of data transmitted via the internet. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets Subcontractor, Health Plan and State requirements. By submitting encounter data to Subcontractor and/or Health Plan, Provider represents to Subcontractor and/or Health Plan that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.16 Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, agents, employees, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act, or;

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider is obligated to screen its employees and contractors to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to Health Plan and/or Subcontractor any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Health Plan and/or Subcontractor will exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

Provider is also obligated to screen monthly all employees against, including those providing direct services to Covered Persons (e.g., home health, personal care), 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 databases. Provider shall further comply with 42 CFR § 438.08 regarding exclusion of entities, including all statutes and regulations referenced therin.

3.17 False Claims. If Provider receives annual Medicaid payments of at least Five million dollars ($5,000,000.00), or as otherwise required by the State, Provider shall comply with the following:

(a) Establish written policies for all employees, agents, or contractors; provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, §§27-14-1, et seq. and the Federal False Claims Act established under sections 3729 through 3733 of title 31, United States Code; administrative remedies for false claims and statements established under chapter 38 of Title 31, United States Code; and preventing and detecting

fraud, waste, and abuse in federal health care programs (as defined in Section 1128B(f) of the Social Security Act);

(b) Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse, and;

(c) Include in any employee handbook a specific discussion of the laws described in 4.9(a), the rights of employees to be protected as whistleblowers, and Provider's policies for detecting and preventing fraud, waste, and abuse.

3.18 Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by Health Plan and/or Subcontractor, insolvency of Health Plan and/or Subcontractor, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Covered Person or a person (other than Health Plan and/or Subcontractor) acting on a Covered Person's behalf for services provided pursuant to the Centennial Care Contract, except for any Medicaid population required to make co-payments under HSD policy. In no event shall the State and/or any Covered Person be liable for any debts of Health Plan and/or Subcontractor. Provider shall hold harmless the State and Covered Persons in the event Health Plan and/or Subcontractor cannot or will not pay for services performed by Provider pursuant to an Agreement. This hold harmless provision shall survive termination of the Agreement for authorized services rendered prior to termination of the Agreement, regardless of the reason for the termination, and shall be construed for the benefit of Covered Persons.

Pursuant to New Mexico Administrative Code 8.200.430.16, if the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If Health Plan and/or Subcontractor determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.19 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold HSD and Collaborative and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. HSD and Collaborative may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.20 Cultural Competency and Access. Provider shall participate in Health Plan's, Subcontractor's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.21 Employee Health Coverage Requirements. If Provider has or anticipates having six (6) or more employees who reside in New Mexico and who work, or who worked, are working or are expected to work, an average of at least twenty (20) hours per week over a six (6) month period with said six-month period beginning at any time during the year prior to entering into the Agreement or at anytime during the term of the Agreement, Provider certifies by signing the Agreement to:

(a) 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, 2008 if the expected annual value in the aggregate of the Agreement and any contracts between Provider and the State exceeds One million dollars ($1,000,000.00), or;

(b) 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 the Agreement and any contracts between Provider and the State exceeds Five hundred thousand dollars ($500,000.00), or;

(c) 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 the Agreement and any contracts between Provider and the State exceeds Two hundred fifty thousand dollars ($250,000.00).

(d) Provider agrees to maintain a record of the number of employees who have:

(i) Accepted health insurance;

(ii) Declined health insurance due to other health insurance coverage already in place, or;

(iii) Declined health insurance for other reasons.

Such records are subject to review and audit by the State or its representative.

(e) Provider further agrees to advise all New Mexico employees in writing of the availability of State publicly financed health coverage programs by providing each employee with, at a minimum, the following web site link for additional information http://insurenewmexico.state.nm.us/ .

(f) Failure to comply with the requirements of this section may result in immediate termination of the Agreement, or as may be mandated by the State.

3.22 Marketing. As required under the Centennial Care Contract, any marketing materials developed and distributed by Provider as related to performance of the Agreement must be submitted to Health Plan and/or Subcontractor to submit to the Centennial Care Program for prior approval. Provider agrees not to engage in the following marketing and outreach activities, which are prohibited under the Centennial Care Contract:

(a) Asserting or implying that a Covered Person shall lose Medicaid benefits if he/she does not enroll with Health Plan and/or Subcontractor or inaccurately depicting the consequences of choosing a different managed care organization;

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

(c) Initiating an enrollment request on behalf of a Centennial Care recipient;

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

(e) Asserting or implying that Health Plan and/or Subcontractor offers unique covered services when another managed care organization provides the same or similar service;

(f) Using gifts or other incentives to entice people to join a specific health plan;

(g) Directly or indirectly conducting door-to-door, telephonic or other "cold call" marketing. "Cold call" marketing means any unsolicited personal contact by Health Plan and/or Subcontractor, either directly or through subcontractors or providers, with a potential Covered Person for the purpose of marketing. Marketing includes any communication from Health Plan and/or Subcontractor or Provider to an individual who is not enrolled with Health Plan and/or Subcontractor that can reasonably be interpreted as intended to influence the individual to enroll in Health Plan's and/or Subcontractor's Centennial Care product and not to enroll in, or to disenroll, from another managed care organization's Centennial Care product;

(h) Conducting any other marketing activity prohibited by the State during the course of the Agreement;

(i) Including statements that Provider is endorsed by CMS, the federal or state government, or a similar entity, and;

(j) Provider shall comply with all federal rules regarding Medicare – Medicaid Marketing (Chapter 42 of the CFR, Parts 422 and 423) and the CMS Medicare – Medicaid Marketing Guidelines found at:

https://www.cms.gov/ManagedCareMarketing/03_FinalPartCMarketingGuidelines.asp.

3.23 Services. Provider shall perform those services set forth in the Agreement, which shall also describe how the services performed by Provider are accessed by Covered Persons.

3.24 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination. If Health Plan and/or Subcontractor has delegated credentialing to Provider, Health Plan and/or Subcontractor will provide monitoring and oversight and Provider shall ensure all licensed medical professionals are credentialed in accordance with Health Plan's and/or Subcontractor's and the Centennial Care Contract's credentialing requirements. Indian Health Service (IHS) health care professionals employed by an Indian tribe or tribally operated health program are exempt from the state licensing requirements of the state in which the tribe or organization performs services, if the health care professional is licensed in any state or its territories, pursuant to the Indian Health Care Improvement Act (IHCIA).

3.25 Lobbying. Provider certifies in accordance with the Byrd Anti-Lobbying Amendment, to the best of its knowledge and belief that:

(a) No federally appropriated funds have been paid or will be paid, by or on behalf of Provider, to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than federally appropriated funds have been paid or shall be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the Agreement or Centennial Care Contract, Provider shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying" in accordance with its instructions.

3.26 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Health Plan's and/or Subcontractor's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the Centennial Care Contract. Provider shall cooperate and assist the Centennial Care Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and

federal health care programs. This shall include, but not be limited to, cooperating fully in any investigation by the New Mexico State Medicaid Fraud Control Unit of the Attorney General's Office ("MFCU") or subsequent legal action that may result from such investigation. Provider shall, upon request, make available to MFCU any and all administrative, financial and medical records relating to delivery of items or services for which State monies are expended, unless otherwise provided by law. In addition, MFCU shall be allowed to have access during normal business hours to the place of business and all records of Provider, except under special circumstances when after hours access shall be allowed. Special circumstances shall be determined by MFCU. Provider also agrees to cooperate with the retrospective claim review activities of the Medicaid Recovery Audit Contractor (RAC), complying with all requirements and expectations set forth in Section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor Program, and in accordance with guidance from CMS and State rules.

In accordance with Health Plan's and/or Subcontractor's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.27 Data; Reports. Provider shall cooperate with and release to Health Plan and/or Subcontractor any information necessary for Health Plan and/or Subcontractor to perform its obligations under the Centennial Care Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Health Plan and/or Subcontractor, in the format specified by Health Plan, Subcontractor or the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Health Plan, Subcontractor, and the State. Data must be provided at the frequency and level of detail specified by Subcontractor, Health Plan or the State. By submitting data to Subcontractor and/or Health Plan, Provider represents and attests to Subcontractor, Health Plan and the State that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.28 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement.

3.29 Physician Incentive Plans. In the event Provider participates in a physician incentive plans ("PIP") under the Agreement, Provider acknowledges and agrees that such PIP must comply with 42 CFR 417.479, 42 CFR 438.3(i), 42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210, as may be amended from time to time. Neither Health Plan, Subcontractor, nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary Services. Direct or indirect incentives must not serve as an inducement to reduce or limit Medically Necessary Services furnished to Covered Persons.

3.30 Disclosure. Provider shall cooperate with Health Plan and Subcontractor in disclosing information the State may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106. Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to the State or HSD on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the State or HSD for submission of fingerprints upon a request from the State, HSD or CMS in accordance with 42 CFR 455.434.

3.31 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Health Plan and Subcontractor any provider preventable conditions in accordance with 42 CFR §§ 434.6(a) (12), 438, including but not limited to § 438.3g, and § 447.26.

3.32 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Health Plan's and Subcontractor's quality assessment, performance improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Health Plan and Subcontractor or as required under the Centennial Care Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Health Plan and/or Subcontractor or Provider. Provider shall adhere to the quality assurance and utilization review standards of the applicable Centennial Care Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of

care. Furthermore, Provider agrees to participate and cooperate in any internal and external QM/QI monitoring, utilization review, peer review and/or Appeal procedures established by Health Plan, Subcontractor, and/or State.

3.33 Conflict of Interest. Provider shall cooperate with Health Plan's and Subcontractor's policies and procedures related to detection and preventing conflicts of interest at all levels. Moreover, Providers shall comply with, all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978.

3.34 National Provider ID (NPI). If applicable, Provider shall obtain a National Provider Identification Number (NPI).

3.35 Payment in Full. Provider shall accept payment or appropriate denial made by Health Plan and/or Subcontractor, as applicable, (or, if applicable, payment by Health Plan and/or Subcontractor that is supplementary to the Covered Person's third party payer) plus the amount of any applicable Customer 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 Customer in excess of the amount of applicable cost sharing responsibilities.

3.36 Behavioral Health Planning. Provider shall participate in disaster Behavioral Health planning efforts at their local area level.

3.37 Covered Person Rights:

(a) Provider shall ensure that each Covered Person is free to exercise his or her rights and that the exercise of these rights does not adversely affect the way Provider treats the Covered Person.

(b) Provider shall have written policies regarding the Covered Person's, and/or Representatives' rights including, but not limited to, the guaranteed right to:

(i) Be treated with respect and with due consideration for his or her dignity and privacy;

(ii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the his or her condition and ability to understand;

(iii) Make and have honored an Advance Directive consistent with State and federal laws;

(iv) Receive Covered Services in a nondiscriminatory fashion;

(v) Participate in decisions regarding his or her health care, including the right to refuse treatment;

(vi) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

(vii) Request and receive a copy of his or her medical records and to request that they be amended or corrected as specified in 45 C.F.R. Part 164;

(viii) Choose a Representative to be involved as appropriate in making care decisions;

(ix) Provide informed consent;

(x) Voice Grievances about the care provided by the Health Plan and/or Subcontractor and to make use of the Grievance, Appeal and Fair Hearing processes without fear of retaliation;

(xi) Choose from Providers in accordance with Health Plan's and Subcontractor's prior authorization requirements;

(xii) Receive information about Covered Services and how to access Covered Services, and Providers;

(xiii) Be free from harassment by the Providers in regard to contractual disputes between Health Plan, Subcontractor, and Providers, and;

(xiv) Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals.

(c) Provider shall ensure that each Covered Person (and/or as appropriate, Representative) is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the way Providers treat the Covered Person (and/or Representative).

3.38 Cost Sharing and Patient Liability. Provider agrees to comply with all responsibilities and prohibited activities regarding cost sharing and patient liability as provided in the Centennial Care Contract, including, but not limited to, the following:

(a) Provider shall impose the maximal nominal copayments for non-emergency use of the emergency room in accordance with federal regulations for individuals over 100% of the federal poverty level. Provider may not deny services for a Covered Person's failure to pay the copayment amount. Provider shall not impose any copayments on Native Americans. Provider shall not reduce payments to hospitals or emergency rooms for any Covered Person non-emergent visits to the emergency room.

(b) Provider shall impose the maximal nominal copayment in accordance with federal regulations for individuals over 100% of the federal poverty level on any prescription filled for a Covered Person with a legend drug when a therapeutically equivalent generic drug is

available. This copayment shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of Behavioral Health conditions. Provider shall develop a copayment exception process to be prior approved by State for other legend drugs where such drugs are not tolerated by the Covered Person. Provider may not deny services for a Covered Person's failure to pay the copayment amounts. Provider shall not impose any copayments on Native Americans.

(c) Provider shall have policies and procedures to ensure that, where applicable, Covered Persons residing in residential facilities pay their patient liability. State will notify Provider of any applicable patient liability amounts for Covered Persons via the eligibility/enrollment file. Provider shall delegate collection of patient liability to the Nursing Facility or community-based residential alternative facility and shall pay the facility net of the applicable patient liability amount. Provider shall submit patient liability information associated with Claim payments to providers in its Encounter Data submission.

3.39 Prohibition of Bribes, Gratuities and Kickbacks. Pursuant to the State of New Mexico statutes and regulations, Provider shall not accept or solicit bribes, gratuities and kickbacks. No elected or appointed officer or other employee of the State of New Mexico shall benefit financially or materially from this Agreement. No individual employed by the State of New Mexico shall be admitted to any share or part of the Agreement or to any benefit that may arise there from.

3.40 Notice. Provider shall display notices of the Covered Person's right to Appeal adverse action affecting services in public areas of Provider's facility(s) in accordance with HSD rules and regulations, subsequent amendments.

3.41 Care Coordination. If applicable, Provider must notify the care coordinator of any change in a Covered Person's medical or functional condition that could impact the Covered Person's level of care determination.

3.42 Overpayments. Provider shall comply with the following:

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

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

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

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

(iv) A Provider performs an internal audit and discovers that an overpayment exists;

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

(vi) A Provider is informed by Health Plan of an audit that discovered a potential overpayment;

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

(viii) A Provider has been notified that Subcontractor, Health Plan or a government agency has received a hotline call for email, and;

(ix) A Provider has been notified that Subcontractor, Health Plan, or a government agency has received information alleging that a recipient had not received services or been supplied goods for which the Provider submitted a claim for payment.

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

(i) Provider's name;

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

(iii) How the overpayment was discovered;

(iv) The reason for the overpayment;

(v) The health insurance claim number, as appropriate;

(vi) Date(s) of service;

(vii) Medicaid claim control number, as appropriate;

(viii) Description of a corrective action plan to ensure the overpayment does not occur again;

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

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

(xi) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment, and;

(xii) The refund amount.

(c) Provider shall pay all self-reported refunds for overpayments to Health Plan as an intermediary and are property of Health Plan unless HSD, the RAC or MFEAD independently notified the Provider that an overpayment existed. The Provider may:

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

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

(d) Provider acknowledges that overpayments that have been identified by the Provider and not self-reported within the sixty (60)-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud.

3.43 Electronic Visit Verification (EVV). Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.44 Non-Discrimination Against Covered Persons. Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

3.45 Transition of Covered Persons. In the event of transitioning Covered Persons from other Medicaid managed care contractors and their provider, Provider shall work with Subcontractor and Health Plan to ensure quality-driven health outcomes for such Covered Persons to the extent required by the State Contract or otherwise required by law.

3.46 Continuity of Care. Provider shall cooperate with Subcontractor and Health Plan and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's

participation with Health Plan terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider.

3.47 Health Records. Provider agrees to cooperate with Subcontractor and/or Health Plan to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.48 Advance Directives. When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i).

3.49 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and/or Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Pharmacy Providers. Payment for pharmacy providers shall be consistent with NMSA 1978, § 27-2-16B unless there is a change in statute or regulation;

4.2 Laboratory Providers. Laboratory service providers shall meet all applicable requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988;

4.3 Nursing Facility Requirements. Provider shall:

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

(b) notify the Covered Person and/or the Covered Person's Representative in writing prior to discharge in accordance with State and federal requirements.

4.4 Agency-Based Community Benefit Provider. Provider shall provide at least thirty (30) Calendar Days advance notice to Health Plan and Subcontractor when Provider is no longer willing or able to provide services to a Covered Person, including the reason for the decision, and to cooperate with the Covered Person's care coordinator to facilitate a seamless transition to alternate providers.

Reimbursement of Provider shall be contingent upon the provision of services to an eligible Covered Person in accordance with applicable federal and State requirements and the Covered Person's care plan as authorized by Health Plan and/or Subcontractor.

Additionally, Provider shall immediately report any deviations from a Covered Person's service schedule to Health Plan and/or Subcontractor.

4.5 Home and Community Based (HCB) Providers. HCB Providers shall comply with all applicable federal requirements for HCB settings requirements including, but not limited to, 42 CFR § 441.301(c)(4).

4.6 Mental Health and Substance Use Providers. Providers who provide Mental Health and Substance Use services to Covered Persons must provide for services to be delivered in compliance with the requirements of 42 CFR 438.3 subpart K insofar as those requirements are applicable.

SECTION 5
HEALTH PLAN AND/OR SUBCONTRACTOR'S OBLIGATIONS

5.1 Delegated Activities. Any activities delegated to Provider by Health Plan and/or Subcontractor shall be set forth in the Agreement or such other written delegation agreement between the parties. The Agreement or delegation agreement shall specify the activities and reporting responsibilities delegated to Provider and provide for revoking delegation or imposing other sanctions if Provider's performance is inadequate.

5.2 Termination, Revocation, and Sanctions. In addition to Health Plan's and Subcontractor's termination rights under the Agreement, Health Plan and Subcontractor may terminate, rescind or cancel the Agreement in the event Provider violates any applicable HSD or Collaborative requirements or State or federal statutes, rules or regulations. Health Plan and Subcontractor also have the right to revoke any functions or activities delegated to Provider or impose other sanctions consistent with the Centennial Care Contract if in Health Plan's and/or Subcontractor's reasonable judgment Provider's performance under the Agreement is inadequate. Health Plan and Subcontractor shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the Centennial Care Contract and applicable law and regulation. Additionally, any program violations arising out of performance of the Agreement are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG). Health Plan shall notify HSD within 5 business days, via e-mail, when a formal written action is taken by Health against a provider. Such action being defined for purposes of this provision as: (i) denial of credentialing or enrollment, or contract termination, when the denial or termination is "for cause", as such term is defined in the provider's agreement with Health Plan; or (ii) due to concerns other than fraud, such as integrity or quality.

5.3 Prompt Payment. Health Plan and/or Subcontractor, as applicable, shall pay Provider pursuant to the Centennial Care Contract, applicable State law and regulations, and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. In regard to Centennial Care Contract obligations, Subcontractor will pay Provider upon approval of a clean claim properly submitted by the Provider within the required time frames (See Section 4.19.1.6 of the Centennial Care Contract.). If Provider is an Indian Health Service (IHS) or Tribal 638 provider, reimbursement will follow federal and State regulations for Covered Services provided to Covered Persons entitled to receive Covered Services through Indian Health Services (IHS) and Tribal 638 providers. If a third party liability exists, payment of claims shall be determined in accordance with federal

and/or State third party liability law and the terms of the Centennial Care Contract. Unless Health Plan and/or Subcontractor otherwise requests assistance from Provider, Health Plan and/or Subcontractor will be responsible for third party collections in accordance with the terms of the Centennial Care Contract.

5.4 Communication with Covered Persons. Health Plan and/or Subcontractor shall not:

(a) prohibit or restrict Provider from assisting or advocating on behalf of a Covered Person in any appeals and grievance process or otherwise acting to protect a Covered Person's interests;

(b) prohibit or otherwise restrict Provider from advising Covered Persons about their health status or medical care or treatment as provided in Section 1932(b)(3) of the Social Security Act, 42 CFR § 438.102 or in contravention of the New Mexico Patient Protection Act, NMSA 1978, §59A-57-1 to 57-11, as may be amended from time to time;

(c) prohibit the Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, or;

(d) sanction Provider for any actions described above.

5.5 No Incentives to Limit Medically Necessary Services. Health Plan and/or Subcontractor shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.6 Non-Discrimination Against Providers. Health Plan and Subcontractor shall not discriminate with respect to participation, reimbursement, or indemnification of Provider when acting within the scope of Provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision does not prohibit Health Plan and Subcontractor from limiting Provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Health Plan and Subcontractor that are designed to maintain quality of care practice standards and control costs. Pursuant to section 1932(b)(7) of the Social Security Act, and consistent with 42 CFR 438.12, Health Plan and Subcontractor also shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.

5.7 Grievance System. Health Plan and/or Subcontractor shall provide Provider information specified in 42 CFR 438.10(g)(2)(xi) about Health Plan's and/or Subcontractor's grievance system at the time Health Plan, Subcontractor, and Provider enter into the Agreement.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with the Centennial Care Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the Centennial Care Contract, as set forth in this Appendix, applicable manuals and protocols, policies and procedures that Health Plan and Subcontractor have provided or made available to Provider. The applicable provisions of the Centennial Care Contract are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves Health Plan and/or Subcontractor of their responsibility under the Centennial Care Contract. If any provision of the Agreement or this Appendix is in conflict with provisions of the Centennial Care Contract, the terms of the Centennial Care Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the Centennial Care Contract will be considered waived. Provider acknowledges that in order to meet the Centennial Care contract requirements, Health Plan and/or Subcontractor may offset overpayments against future payments when notifying Provider of the same.

6.2 State Approval. Health Plan, Subcontractor, and Provider acknowledge that the State reserves the right to review and disapprove the Agreement and/or any significant subsequent modifications to the Agreement.

6.3 Monitoring. Health Plan and/or Subcontractor shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the Centennial Care Contract. As a result of such monitoring activities, Health Plan and/or Subcontractor shall identify to Provider any deficiencies or areas for improvement mandated under the Centennial Care Contract and Provider and Health Plan and/or Subcontractor shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Health Plan and/or Subcontractor, and/or required by the Centennial Care Program action 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 State. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Health Plan and/or Subcontractor, and Provider practice and/or the performance standards established under the Centennial Care Contract.

6.4 Reimbursement Rates. The reimbursement rates for Provider's performance of services under the Agreement and any risk assumption, if applicable, shall be as set forth in the Agreement. Provider shall comply with all requirements of the Fair and Equal Pay for All New Mexicans as set forth in Executive Order 2009-049 or any other applicable fair and equal pay law.

6.5 No Restrictions on Other Contracts. Nothing in the Agreement or this Appendix shall be construed to prohibit or restrict Provider from entering into a contract with another managed care organization. Health Plan and/or Subcontractor shall not provide incentives or disincentives

to Provider that discourage Provider from entering into a contractual relationship with another managed care organization.

6.6 Regulatory Amendment. Subcontractor may amend this Appendix to comply with the requirements of State and federal regulatory authorities and shall give written notice to Provider of such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.

6.7 Termination of Agreement by State. The State reserves the right to direct Health Plan and/or Subcontractor to terminate or modify the Agreement when the State determines it to be in the best interest of the State. Provider recognizes that in the event of termination of the Agreement, Provider shall immediately make available, to State 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 the Agreement. The provision of such records shall be at no expense to State.

6.8 Provider Relationship. Provider is not a third party beneficiary to the Centennial Care Contract and that Provider is an independent contractor performing services as outlined in the Centennial Care Contract.

6.9 Operation in New Mexico. Health Plan, Subcontractor, and Provider represent and warrant that they have a legal basis for operating in the State of New Mexico.