NEW MEXICO MEDICAID MANAGED CARE AMENDMENT

PARTIES

This New Mexico Medicaid Managed Care Amendment ("Amendment"), to the Medical Services Entity Agreement dated _____ ("Agreement") is made and entered by and among Blue Cross and Blue Shield of New Mexico (BCBSNM), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company organized under the laws of, and domiciled in, the State of Illinois and lawfully operating in New Mexico pursuant to certification from the New Mexico Office of the Superintendent of Insurance (sometimes referred to herein as "Corporation"), and _____, organized under the laws of _____ {STATE} and lawfully operating in New Mexico pursuant to licensure or certification from _____ _____ {NEW MEXICO AGENCY} and if required by law, registration, in good standing, with the New Mexico Secretary of State ("Medical Services Entity" or "MSE"), and supplements and amends the terms of the Agreement as set forth herein.

PURPOSE

BCBSNM administers a New Mexico Medicaid managed care plan pursuant to the Medicaid Managed Care Services Agreement ("MMCSA")with the State of New Mexico Health Care Authority (HCA), New Mexico Children, Youth and Families Department, New Mexico Early Childhood Education and Care Department, HCSCHCA and New Mexico Behavioral Health Purchasing Collaborative ("Collaborative") for the New Mexico Medicaid Program that is operated under federal waiver and/or demonstration projects; and

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

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

ARTICLES

i. DEFINITIONS

A. For purposes of this Amendment the following definitions apply:

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

ii. BCBSNM's Medicaid Managed Care Provider Reference Manual or Medicaid PRM means the policy and procedure manual prepared by Corporation, which may be amended at Corporation's option from time to time, setting forth the basic policies and procedures to be followed by Medical Services Entity in carrying out the terms and conditions of this Amendment. The Medicaid PRM, as amended from time to time, is incorporated herein by reference.

iii. Behavioral Health is the umbrella term for mental health (including psychiatric illnesses and emotional disorders) and substance abuse (involving addictive and

chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health and substance abuse disorders.

iv. CMS means the Centers for Medicare and Medicaid Services.

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

vi. Community Benefit means both the Agency-Based Community Benefit and the Self-Directed Community Benefit subject to the annual allotment as determined by HCA on an annual basis.

vii. Covered Services means those physical, Behavioral Health and Long-Term Care services covered by the New Mexico Medicaid managed care programs as set forth in BCBSNM's Medicaid Member Handbook and PRM, the applicable Medical Assistance Division Rules in Title 8 NMAC, and the MMCSA, as the foregoing may be amended or succeeded, or other applicable rules, regulations or guidelines.

viii. Copayment means that portion of a claim or medical expense that Members must pay out of their pocket for the services.

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

x. HCA means the New Mexico Health Care Authority or its designee responsible for the administration of New Mexico Medicaid Program.

xi. HIPAA means the Health Insurance Portability and Accountability Act and its implementing regulations, as amended.

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

xiii. MAD means the Medical Assistance Division of HCA which directly administers the New Mexico Medicaid program.

xiv. Managed Care Organization (MCO) means an entity that participates under contract with HCA to assist the State in meeting the requirements established under Public Assistance Act, §27-2-12, NMSA 1978, as amended.

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

xvi. Medicaid Program means the State of New Mexico's Medicaid managed care program operated under section 1115(a) of the Social Security Act waiver authority as of the Effective Date hereof that is administered by HCA/MAD.

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

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

xix. Nursing Facility (NF) means a licensed Medicare/Medicaid facility certified in accordance with 42 CFR Part 483 to provide inpatient room, board and nursing services to Members who require these services on a continuous basis, but who do not require hospital care or direct daily care from a physician.

xx. Participating Provider means a professional, institutional, or any other provider who or that has entered into a written agreement with Corporation to provide certain Covered Services to Members, and if applicable, upon appropriate referral by the Member's Primary Care Provider and/or Corporation. A nonparticipating provider is a provider who has not entered into any written agreement with Corporation. To be eligible for reimbursement for furnishing Covered Services to Members, all providers must enroll with HCA through a Provider Participation Agreement as Medicaid Providers.

xxi. Primary Care means all health care and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the HCA, to the extent the furnishing of those services is legally authorized in the state in which the services are furnished.

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

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

xxiv. State means the State of New Mexico.

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

ii. OBLIGATIONS OF MEDICAL SERVICES ENTITY

A. **Services**

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

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

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

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

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

ii. *Members' Access to Covered Services*. Medical Services Entity acknowledges that a Member may choose to access Covered Services through his or her PCP or by self-direction without a referral. Medical Services Entity agrees to participate in and otherwise foster and facilitate such access by, without limitation, (1) informing the Member about BCSBNM's website and customer service, case management and/or care coordination departments, as applicable, (2) providing to the Member available BCBSNM health education and other resource materials tailored to the Member's unique needs; and (3) actively participating in the provision and coordination of the overall health care of Members, including, without limitation, issuing and accepting appropriate referrals to/from other participating providers, as the foregoing are more fully described in the Medicaid PRM.

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

a. Medical Services Entity must also conform to MAD program rules and instructions as specified in MAD's "Program Policy Manual," its appendices, and program directions and billing instructions, as updated and applicable to Medicaid managed care. Medical Services Entity will (1) follow coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services, (2) verify that individuals are eligible for a specific health care program administered by the Corporation, (3) verify the eligible recipient's enrollment status at the time services are furnished, (4) determine if an eligible recipient has other health insurance, and (5) maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

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

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

a. Primary Care Providers shall meet and fulfill all PCP requirements and responsibilities pursuant to the MMCSA as set forth in the Medicaid PRM, including but in no way limited to: (1) providing 24-hour, seven-day-a-week access to care, (2) ensuring the coordination and continuity of care with providers within and outside of Corporation's network (including Behavioral Health and Long-Term Care providers) according to Corporation's policy, and (3) ensuring that the Member receives appropriate prevention services for the Member's age group.

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

c. Nursing Facility providers shall promptly notify Corporation of (1) a Member's admission or request for admission to the Nursing Facility regardless of payer source for the Nursing Facility stay, (2) a change in a Member's known circumstances and (3) a Member's pending discharge.

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

e. Agency-Based Community Benefit providers shall provide at least 30 calendar days' advance notice to Corporation when the provider is no longer willing or able to provide services to a Member, including the reason for the decision, and to cooperate with the Member's care coordinator to facilitate a seamless transition to alternate providers.

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

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

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

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

j. Behavioral Health Providers who utilize Comprehensive Community Support Services (CCSS) and High-Fidelity Wraparound (HFW) services, for Members who are Child(ren) in State Custody ("CISC") agree to "no reject" and "no eject" for CISC Members. 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 discrimination against an individual on the basis of health status or need for services. No Eject means that the Provider must continue to coordinate services and assist Members in accessing appropriate services and supports.

k. Behavioral Health providers for Members who are CISC must deliver staff training on the following topics: Trauma-responsive training as approved by HCA; and No reject and no eject provision for Members who are CISC;

l. In the event that HSD 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 alternate payment methodology in compliance with Section 1905(a)(2)(C) of the Social Security Act.

B. **Compensation and Billing**

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

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

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

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

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

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

a. Medical Services Entity is expected to submit Claims within 90 days from the date of service and must submit Claims no later than 180 calendar days from the date

of service or the Claims will be ineligible for reimbursement by Corporation and Medical Services Entity may not seek payment from the Member, HCA or the State.

b. Unless expressly waived by Corporation in accordance with applicable law and HCA requirements, Medical Services Entity shall bill Corporation electronically.

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

d. As a condition of receiving any amount of payment from Corporation for Covered Services furnished under this Amendment, Medical Services Entity must comply with Section 4.18 of the MMCSA, including, but not necessarily limited to, all program integrity requirements described in Article ii.C.i of this Amendment and as may be set forth in the Medicaid PRM. Consistent with its contractual requirements, BCBSNM must have methods for identifying, investigating, auditing, or reviewing, that include in-person, both announced and unannounced, site visits, audits, or reviews for some providers of covered services to ensure services are being rendered and billed correctly. Unannounced means no advanced notice made prior to arrival.

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

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

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

vi. *Reimbursement of a Community Benefit Provider*. If Medical Services Entity is a Community Benefit provider, reimbursement shall be contingent upon the provision of services to an eligible Member in accordance with applicable federal and State requirements and the Member's care plan as authorized by Corporation.

vii. *Overpayments*. Medical Services Entity is required to report Overpayments to the Corporation by the later of: (1) the date which is 60 calendar days after the date on which the Overpayment was identified; or (2) the date any corresponding cost report is due, if applicable. A person has identified an Overpayment if the person has

actual knowledge of the existence of an Overpayment or acts in reckless disregard or with deliberate indifference of the Overpayment.

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

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

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

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

   iv. performs an internal audit and discovers that an overpayment exists;

   v. is informed by a government agency of an audit that discovered a potential overpayment;

   vi. is informed by Corporation of an audit that discovered a potential overpayment;

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

   viii. has been notified that Corporation or a government agency has received a hotline call for email;

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

b. Within 60 calendar days from the date on which the Medical Services Entity identifies an Overpayment, Medical Services Entity shall send an "Overpayment Report" to Corporation and HCA which shall include the:
   i. Medical Services Entity's name;

   ii. tax identification number and National Provider Number;

   iii. how the Overpayment was discovered;

   iv. reason for the Overpayment;

   v. health insurance claim number, as appropriate;

   vi. date(s) of service;

   vii. Medicaid claim control number, as appropriate;

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

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

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

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

xii. the Refund amount.

c. All self-reported Refunds for Overpayments shall be made by Medical Services Entity to Corporation as an Intermediary and are property of the Corporation unless (1) HCA, the Recovery Audit Contractor (RAC) or MFEAD independently notified Medical Services Entity that an Overpayment existed; (2) Corporation fails to initiate recovery within 12 months from the date Corporation first paid the Claim; or (3) Corporation fails to complete recovery within 15 months from the date Corporation first paid the Claim. Medical Services Entity may: (i) request that Corporation permit installment payments of the Refund, such request may be agreed to by Corporation and the Medical Services Entity; or (ii) in cases where HCA, the RAC, or MFEAD identify the Overpayment, HCA shall seek recovery of the Overpayment in accordance with Section 8.351.2.13 NMAC.

d. Overpayments that have been identified by Medical Services Entity and not self-reported within the 60-day timeframe may be considered false claims and may be subject to referrals as Credible Allegations of Fraud and subject to reporting by Corporation to HCA in accordance with Section 4.18.2 of the MMCSA.

C. **Other Obligations**

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

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

b. Medical Services Entity shall conduct screening of all employees, including those providing direct services to Members (e.g., home health, personal care), in accordance with the Employee Abuse Registry Act, §27-7A-3, NMSA 1978, as amended, the New Mexico Caregivers Criminal History Screening Act, §29-17-2 et seq., NMSA 1978, as amended, and NMAC 7.1.9, and the New Mexico Children and Juvenile Facility and Program Criminal Records Screening Act, NMSA 1978, § 32A-15-1 to 32A-15- 4, and ensure that all employees are screened against the Office of Inspector General's "List of Excluded Individuals/Entities" and the Medicare exclusion databases; unless otherwise granted by the OIG or other applicable federal authority, Medical Services Entity will neither employ nor contract with any person or entity licensed or otherwise authorized to provide any Covered Services who or which are excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act.

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

d. Medical Services Entity shall assure, to the extent of its authority that services or items ordered or provided by Medical Services Entity or its providers to Members: (1) will be provided economically and only when, and to the extent, medically necessary; (2) will be of a quality which meets professionally recognized standards of health care; and (3) will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing quality improvement organization in the exercise of its duties and responsibilities.

e. To the extent applicable to Medical Services Entity's activities related its performance of this Amendment and contemplated by federal law or otherwise required by HCA, Medical Services Entity shall cooperate and comply with all program integrity provisions in the Patient Protection and Affordable Care Act (PPACA) including: (1) enhanced provider screening and enrollment, Section 6401(b) of PPACA, amending Section 1902(a) of the Social Security Act (SSA) by adding paragraph (77) and subsection (kk), codified at 42 USC Sections 1396a(a)(77) and 1396a(kk), and the rules promulgated thereunder, codified in 42 CFR Part 455, Subpart E (Sections 455.400, ***et seq.***); (2) termination of provider participation, Section 6501 of PPACA, amending Section 1902(a)(39) of the SSA, codified at 42 USC Section 1396a(a)(39), and the rules promulgated thereunder, codified in Part 455, Subpart E (Sections 455.400, ***et seq.***); and (3) upon establishment of disclosure requirements by CMS, if any, or as may be otherwise required by HCA, disclosure of current or previous affiliation with excluded providers, Section 6401(b)(1)(B) of PPACA, amending Section 1902(a) of the Social Security Act (SSA) by adding subsection (kk)(3), codified at 42 USC Section 1396a(kk)(3).

f. If Medical Services Entity receives at least $5,000,000 in the aggregate in Medicaid payments annually, it shall establish written policies and procedures for all employees, agents, or contractors that provide detailed information regarding (1) the New Mexico False Claims Act, 27-14-1 et seq., NMSA 1978, as amended, (2) the New Mexico Fraud Against the Taxpayers Act, §44-9-1 et seq., NMSA 1978, as amended, (3) the New Mexico Medicaid Fraud Act, §30-44-1 et seq., NMSA 1978, as amended, and (4) the Federal False Claims Act established under 31 U.S.C §§3729-3733, administrative remedies for false claims established under 31 U.S.C. §§3801 et seq., and preventing and detecting Fraud, waste, and Abuse in federal health care programs (as defined in Social Security Act 42 CFR §1128B(f) and 42 CFR §438.608. Such policies and procedures shall articulate Medical Services Entity's commitment to compliance with federal and State standards. Medical Services Entity shall include in any employee handbook a specific discussion of the foregoing laws, the rights of employees to be protected as "whistleblowers," and the Medical Services Entity's policies and procedures for detecting and preventing fraud, waste and abuse.

    i. Medical Services Entity acknowledges and agrees that as part of its compliance with applicable State and federal statutes, rules and

regulations, it shall, regardless of the amount of Medicaid payments received annually, comply with the Federal False Claims Act and any State laws, including those identified hereinabove, pertaining to civil or criminal penalties for false claims and statements, including whistleblower protections thereunder.

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

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

i. Medical Services Entity acknowledges and agrees that Corporation must and will comply with any written notice of participation or payment suspension issued by HCA per HCA's determination of a credible allegation of fraud against Medical Services Entity and Medical Services Entity therefore shall have no recourse whatsoever against Corporation for such compliance, including but in no way limited to interest if it is later determined that payment may be made on a previously suspended Claim. Consistent with NMSA 1978, Sections 27-11-13 and -14 (2019) as interpreted by HCA, Medical Services Entity further acknowledges and agrees that suspension of participation or payment may be avoided or lifted if so directed by HCA because to HCA's satisfaction, Medical Services Entity (1) submits to BCBSNM's prepayment review of claims for ongoing services; (2) demonstrates to BCBSNM completion of related training or education required by HCA to prevent the submission of claims for payment to which Medical Services Entity is not entitled; and (3) engages an independent third party reasonably approved by BCBSNM to temporarily manage or provide related technical assistance to Medical Services Entity during the pendency of the dispute. If HCA-OIG determines Medical Services Entity compliance with the foregoing, Clean Claims for ongoing services during the HCA-referral or

dispute shall be reimbursed within 10 and 30 days of receipt for electronic and paper claims respectively, provided, however, that prompt pay interest shall not be applied based on those accelerated timeframes.

j. *Records, Information and Audits.* Medical Services Entity shall: (1) maintain all records relating to services provided under this Amendment for at least a 10 year period from the date of creation as further described herein; (2) make all Member medical records or other service records available for the purpose of quality review conducted by HCA/MAD or their designated agents both during and after the term of the Amendment; (3) provide reasonable access to facilities and records to authorized representatives of HCA, the Collaborative or other state and federal agencies for financial and medical audit purposes both during and after the term of the Amendment; (4) provide to Corporation any information necessary for Corporation to perform its obligations under the MMCSA. In addition to the foregoing, Medical Services Entity shall:

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

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

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

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

m. Maintain appropriate records in accordance with federal and state statutes and regulations relating to Medical Services Entity's performance under this Amendment, 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.

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

o. Maintain records, books, documents and information on ownership and control as required in 42 CFR Section 455.104 and prohibited affiliations as specified in 42

CFR Section 438.610. Such shall be maintained for a period of ten (10) years after termination of this Addendum or until the resolution of all litigation, Claims, financial management reviews or audits pertaining to this Amendment whichever is longer.

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

q. In addition to cooperating with MFEAD and other investigatory agencies in accordance with the provisions of NMSA 1978, Sections 27-11-1, *et seq.,* upon reasonable notice and for the purposes of, but not limited to, examination, audit, investigation, MMCSA administration, or the making of copies, excerpts or transcripts, provide the following officials and entities with prompt, reasonable and adequate access to any personnel and records that are related to the scope of work performed under this Amendment within two business days after the date of the request or within 10 business days if the records are held by a subcontractor, agent or satellite office per NMSA 1978, Sections 27-11-3(A) and 27-11-4 (B) and 42 CFR 438.3(h): (1) the United States Department of Health and Human Services or its designee; (2) the Comptroller General of the United States or its designee; (3) HCA personnel or its designee; (4) HCA's Office of Inspector General; (5) the Collaborative's personnel or designee; (6) MFEAD or its designee; (7) any independent verification and validation contractor, audit firm or quality assurance contractor acting on behalf of HCA; (8) the Office of the State Auditor or its designee; (9) a State or federal law enforcement agency; (10) a special or general investigating committee of the New Mexico Legislature or its designee; and (11) any other State or federal entity identified by HCA, or any other entity engaged by HCA ("Access").

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

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

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

ii. *Participation and Cooperation in Quality (and Related) Programs*. Without limitation, Medical Services Entity shall participate and cooperate in any internal and external Quality Management/Management/Quality Improvement monitoring, utilization

review, peer review and/or Appeal procedures established by Corporation and/or HCA.

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

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

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

iii. *Notices of Member's Right to Appeal*. Medical Services Entity shall display notices of the Member's right to Appeal adverse action affecting services in public areas of the Medical Services Entity's facility(s) in accordance with HCA rules and regulations, as amended.

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

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

vi. *Medical Services Entity Status.* In accordance with 45 CFR Part 76, Medical Services Entity certifies that neither the Medical Services Entity nor its Principals or subcontractors have been: (1) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract, (2) listed by a federal governmental agency as debarred or suspended, (3) proposed for debarment or suspension or otherwise excluded from federal program participation, (4) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (5) within a three year period preceding the date of this Amendment, had one or more public transactions (federal, state or local) terminated for cause or default. Medical Services Entity acknowledges and agrees that it has a continuing obligation to notify Corporation in writing within seven business days if any of the above-referenced representations change. Medical Services Entity further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of this Amendment may be grounds for immediate termination of this Amendment, at the sole discretion of Corporation.

iii. OBLIGATIONS OF CORPORATION

A. Services

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

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

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

B. **Compensation and Billing**

i. For all Covered Services provided by Medical Services Entity hereunder, Corporation shall pay to Medical Services Entity the compensation (including, if applicable, (1) risk-based compensation, (2) physician incentive plan, or (3) pay-for-performance programs), as set forth in the reimbursement attachments to this Amendment.

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

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

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

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

C. **Other Obligations**

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

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

iv. TERM AND TERMINATION

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

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

C. HCA reserves the right to direct Corporation to terminate or modify this Amendment when HCA determines it to be in the best interest of the State.

D. This Amendment shall terminate for cause as determined by the Corporation for violation of applicable State or federal statues, rules, and regulations, including but not limited to applicable HCA requirements. Such termination shall be effective upon 30 days' written notice by Corporation to Medical Services Entity.

E. In the event that Medical Services Entity or Corporation seeks to terminate the Agreement or this Amendment without cause, such party seeking to terminate shall provide the other party with advance written notice of termination in accordance with the Agreement, but in no event less than 90 days prior to the effective date of such termination.

F. This Amendment shall terminate upon the complete cessation of Corporation's administration of any and all New Mexico Medicaid managed care plans for Members by whatever name(s) then known.

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

v. MISCELLANEOUS PROVISIONS

A. Medical Services Entity shall indemnify and hold HCA harmless from all claims, losses, or suits relating to activities undertaken by Medical Services Entity pursuant to this Amendment.

B. Unless otherwise expressly set forth in this Amendment, it shall not create any rights or cause of action in or on behalf of any person other than Medical Services

Entity and Corporation (including Corporation's Affiliates). Furthermore, Medical Services Entity acknowledges and agrees that it is not a third-party beneficiary to the MMCSA and Medical Services Entity is an independent contractor performing services as outlined in this Amendment.

C. If any requirement in this Amendment is determined by HCA to conflict with the MMCSA, such requirement shall be null and void and all other provisions shall remain in full force and effect.

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

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

F. Medical Services Entity represents and warrants that it has complied with, and during the term of this Amendment, will continue to comply with, and that this Amendment complies with all applicable provisions of the New Mexico Government Conduct Act, Chapter 10, Article 16 NMSA 1978, and with 42 C.F.R. §438.58.

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

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

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

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

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

v. Asserting or implying that BCBSNM 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 Amendment;

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

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

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

ix. Including statements that BCBSNMis endorsed by CMS, the federal or State government, or a similar entity.

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

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

i. Notwithstanding this Article vi.i, the parties continue to have and be bound by any rights and obligations under the Medicaid Amendment by and between them, if any, some of which may continue beyond the effective date of this Amendment, including but not limited to those rights and obligations attendant Medical Services Entity's provision of services to Members (as defined in such prior amendment) before this Amendment's Effective Date and claims to Corporation therefor.

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

J. To the extent permissible by law, this Amendment is confidential as between Medical Services Entity and Corporation (including Corporation's Affiliates) and

shall not be disclosed to third parties other than HCA (and other government agencies per this Amendment) and the parties' respective financial, accounting, and legal advisors absent (1) prior written consent of the non-disclosing party, or (2) valid, compulsory legal process, including by a court or government agency of competent jurisdiction, of which the recipient shall promptly give notice to the other party before complying therewith. Furthermore, the parties shall not use any information obtained through performance of this Amendment in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Amendment.

K. The parties stipulate and acknowledge that this Amendment does not: (1) prohibit Medical Services Entity from entering into a contractual relationship with another MCO; (2) include any incentive or disincentive that encourages Medical Services Entity not to enter into a contractual relationship with another MCO; or (3) contain any provisions that prohibit or otherwise restrict health professionals from advising patients about their health status or medical care or treatment as provided in section 1932(b)(3) of the Social Security Act, 42 C.F.R. §438.102 or in contravention of the Patient Protection Act, §§59A-57-1 to 59A-57- 11, NMSA 1978, as amended.

L. Where there is direct conflict between the terms and conditions of the Agreement and those of this Amendment, the terms and conditions of this Amendment shall prevail. All other terms and conditions of the Agreement between Medical Services Entity and Corporation remain in full force and are unchanged by this Amendment.

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

<<Provider Name>>

Signature: _____

Print: _____

Title: _____

Date: _____

Address: _____

_____

Tax ID: _____

Email: _____

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

By: _____
John C. Cook

Title: Vice President, NM Programs and Network Management

Date: _____

Address:
5701 Balloon Fiesta Pkwy
Albuquerque, New Mexico 87113

Effective Date:[1] _____

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

Exhibit I

[Intentionally Left Blank]

Exhibit II

LISTING OF LOCATIONS AND/OR SUBSIDIARIES

For avoidance of any doubt, the terms and conditions for, and identification of, locations / subsidiaries as set forth in the Agreement, and as may be updated from time to time, shall also apply to this Amendment.

Attachment A
Reimbursement
New Mexico Medicaid Managed Care

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

A. DEFINITIONS.

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

1. Billed Charge(s). The amount reasonably billed by Medical Services Entity for Covered Services provided to a Member. Included in this amount are any adjustments made by Corporation or Medical Services Entity as a result of late charges, late credits, or other adjustments to the Billed Charges such as, but not limited to, those for Provider Preventable Conditions, lack of Medical Necessity, unauthorized or unsupported level of care, unauthorized services, and charges disallowed by HCA.

2. Medicaid Fee Schedule. Corporation's listing of fees for Covered Services furnished by Medical Services Entity that is based on HCA's fee schedules using HCPCS/CPT codes. Corporation's Medicaid Fee Schedule is available upon request.

B. REIMBURSEMENT PROVISIONS.

1. The Medicaid Fee Schedule shall apply to all Covered Services provided to Members by Medical Services Entity. As reimbursement for Covered Services provided to Members by Medical Services Entity, Corporation shall allow 100% of the applicable fee set forth on the Medicaid Fee Schedule, and, subject to the Member's financial responsibility, if any, calculate payment accordingly. Covered Services billed with HCPCS/CPT codes that are not on the Medicaid Fee Schedule will be allowed using the Corporation's hierarchical pricing logic for such Covered Services which may include various references as determined by Corporation from time-to-time, such as Medicare.

C. MISCELLANEOUS REIMBURSEMENT PROVISIONS

1. Medical Services Entity must submit claims for reimbursement on a CMS-1500 claim form or its successor.

2. Reimbursement shall be made according to Corporation's reimbursement policies for services including, but not limited to, coding and unbundling, and other billing and reimbursement practices, which are available at bcbsnm.com.

3. Notwithstanding any other provision of this Attachment, Corporation may apply to Medical Services Entity's reimbursement any HCA-directed reimbursement adjustments (whether decreases or increases), including, but in no way limited to, pass throughs, if applicable.

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

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

6. Corporation may at any time modify the, HCPCS/CPT codes or schedules on which the reimbursement is based to accommodate for new or updated codes.

7. With regard to all reimbursement methodologies described in this Attachment and unless precluded by HCA, Corporation shall pay the lesser of the amount resulting from the applicable reimbursement methodology described in this Attachment or Billed Charges.

8. Member financial responsibility, if any, shall be determined in accordance with the terms of the Member's Coverage Certificate. The amount of the Member's financial responsibility, if any, shall be calculated using the lesser of the amount resulting from the applicable reimbursement methodology described in this Attachment or Billed Charges.

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

10. Medical Services Entity shall bill Corporation electronically.