HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
MEDICAL ASSISTANCE DIVISION
PROVISIONAL PROVIDER PARTICIPATION AGREEMENT

THIS AGREEMENT IS FOR GROUPS, ORGANIZATIONS, OR INDIVIDUAL APPLICANTS TO WHOM PAYMENTS WILL BE MADE. IF THE APPLICANT IS AN INDIVIDUAL APPLYING FOR A PROVIDER NUMBER ONLY FOR IDENTIFYING SERVICES BILLED THROUGH A GROUP PRACTICE OR OTHER ORGANIZATION AND PAYMENTS WILL BE MADE TO THAT GROUP OR ORGANIZATION, THIS FORM SHOULD NOT BE USED. USE FORM MAD 312 PROVISIONAL INSTEAD.

Return completed application to:
New Mexico Medicaid Project
Conduent
P.O. Box 27460
Albuquerque, NM 87125-7460

(1) NM Medicaid Number (if previously assigned) | **(2) National Provider Identifier (NPI)** | **(3) Primary Taxonomy** NOT REQUIRED

(4) Applicant Name (for individuals – must match license name)
First Name **Middle Initial** **Last Name** **Professional Title (MD, DDS, etc)**

(5) Business Name (DBA) | **(6) Federal Tax (Legal) Name**

(7) Physical Street Address where services are rendered (PO BOX NOT ACCEPTED) **City** **State** **Zip Code** **County**

(8) Billing Office Address (MAY BE PO BOX) **City** **State** **Zip Code**

(9) Mailing Address for official correspondence (MAY BE PO BOX) **City** **State** **Zip Code**

(10) Fax Number NOT REQUIRED | **(11) Billing Office Phone** | **(12) Location Phone (REQUIRED)**

(13) Mailing Email Address NOT REQUIRED | **(14) Billing Office Email Address** NOT REQUIRED | **(15) Location / Provider Email Address**

(16) Business Type ☐ Individual / sole proprietor ☐ Corporation ☐ Partnership / Professional Association ☐ Limited Liability Company ☐ Non-corporate Business Entity / Other ☐ Government Entity or Public School

(17) Provider Type (see attached list) | **(18) Provider Specialty (see attached list)** | **(19) License Information** Number: NOT REQUIRED; State: NOT REQUIRED; Expiration Date: NOT REQUIRED | **(20) (REQUIRED) Individual Provider's** Social Security Number; Date of Birth

(21) NM CRS (Tax & Revenue) Number (If services are provided in NM) | **(22) Are NM CRS tax payments current? If not, attach an explanation.** ☐ YES ☐ NO | **(23) Select one:** ☐ for profit ☐ not-for-profit (attach 501(c)3) | **(24) Federal Tax Number / FEIN (attach IRS letter)** | **(25) Are federal tax payments current? If not, attach an explanation.** ☐ YES ☐ NO

(26) DEA Number (attach copy) | **(27) CLIA Number (attach copy)** | **(28) NCPDP/NABP Number (pharmacies only)**

(29) IHS Certified or Tribal 638 Contracted Program? ☐ YES ☐ NO (If YES, attach copy of certification or contract)

(30) Title XVIII Medicare Certified? ☐ YES ☐ NO (If YES, attach copy of letter)

(31) Fiscal Year End Month

(32) JCAHO Certified? ☐ YES ☐ NO (If YES, attach copy of letter)

(33) Other Certification? YES ☐ NO ☐ (If YES, attach copy of letter) Certified by: _____

(34) To be completed by physicians (provider type 301 or 302) only: (If *Certified*, attach copy of certificate; if *Not Certified* or if *Eligible for Certification*, attach proof of residency completion / training in your specialty area)
Board certified in the provider specialty listed in box 18? ☐ Certified ☐ Eligible for certification ☐ Not certified

(35) Identify individuals who will be providing services for which payments will be made to your group or organization: (Please attach separate page if additional space is needed)

Individual's Name, Title	Prov. Type	Specialty	NM Medicaid Prov. No.	NPI

(36) If services have already been rendered to a NM Medicaid recipient, please enter Date of Service and attach copy of claim:
DOS: NOT REQUIRED

(37) To be completed by out-of-state providers only:
Home State Medicaid Provider Number: NOT REQUIRED

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

Name of Entity / Individual	EIN / SSN	NPI

Question 1 to be answered by all providers.

1. **Has the provider, or any person who has ownership or control interest in the provider, or any person who is an agent or managing employee of the provider, been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? If yes, give the name(s) of person(s) and description(s) of offense(s). Please use additional pages if necessary:**

YES ☐
NO ☐

Name	Social Security Number	Date of Birth	Description

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

Name of Entity / Individual	EIN / SSN	NPI

Question 2 is to be answered by all providers, including non-profit organizations and charities.

Definition: A managing employee is a "general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency." (42 CFR section 455.101) Managing employees are in a position to exert influence over the conduct of the provider's operations and includes officers, governing boards, or board of directors.

2. **Federal regulation requires the following information to be disclosed on all managing employees. Please use additional pages if necessary:**

NAME	ADDRESS	SOCIAL SECURITY NUMBER	DATE OF BIRTH

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

Name of Entity / Individual	EIN / SSN	NPI

Questions 3 – 5 to be answered by all providers EXCEPT individual practitioners.

3. Provide the name and address of each person (individual or corporation) with an ownership or control interest in the provider or in any subcontractor in which the provider has direct or indirect ownership of five percent or more. Please use additional pages if necessary:

NAME	ADDRESS	SOCIAL SECURITY NUMBER (IF INDIVIDUAL) OR TAX ID (IF NOT AN INDIVIDUAL)	DATE OF BIRTH (FOR INDIVIDUALS)
A.			
B.			
C.			
D.			
E.			

4. Is any person named in question #3 related to another as spouse, parent, child, or sibling? If yes, give the name(s) of person(s) and relationship(s). Please use additional pages if necessary. *NOTE: Designate relationship to each person listed in question #3 by using A., B., C., etc.*

YES ☐
NO ☐

NAME	RELATIONSHIP

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

Name of Entity / Individual	EIN / SSN	NPI

5. Does any person (individual or corporation) named in question #3 have an ownership or control interest in any other Medicaid provider or in [any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act?] (This includes participation in any federal, state, or jointly funded healthcare programs such as Medicaid; Medicare Part A; Medicare Part B; Medicare Part C; Medicare Part D; CHAMPUS; and programs established under parts XIX, XX, and XXI of the Social Security Act.) If yes, give the name(s), Medicaid provider identification number(s) and address(es) of the Medicaid provider or entity. Please use additional pages if necessary:	YES ☐ NO ☐

NAME	ADDRESS	MEDICAID PROVIDER NUMBER

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

This AGREEMENT, between the State of New Mexico (STATE), herein referred to as "the STATE," the New Mexico Human Services Department (HSD), herein referred to as "the DEPARTMENT" and the applicant as provider, herein referred to as "the PROVIDER", specifies the terms and conditions for providing health care services to eligible recipients of Medicaid, other medical assistance programs, and other health care programs administered by the Department and other departments of the State of New Mexico for which the Department is authorized to make payment to the PROVIDER. Administration of health care programs including, but not limited to, service authorizations, billing instructions and payment, may be performed by the DEPARTMENT and its agents including other departments and agencies of the State of New Mexico and their contractors, as authorized by joint power of agreements, contracts, or other binding agreements, herein referred to as its "AUTHORIZED AGENTS". This AGREEMENT shall be effective when completed in full with all required documentation attached and when signed by the PROVIDER and the Human Services Department Medical Assistance Division (HSD/MAD) or its designees and shall remain in effect until terminated pursuant to the terms set forth below.

ARTICLE 1 – OBLIGATIONS OF THE PROVIDER

The PROVIDER shall:

1.1. Abide by all federal, state, and local laws, rules and regulations, including but not limited to, those laws, regulations, and rules applicable to providers of services under Title XIX (Medicaid) and Title XXI (SCHIP) of the Social Security Act and other health care programs administered by the DEPARTMENT and its AUTHORIZED AGENTS.

1.2. Furnish services, bill for services, and receive payment for services only upon approval of this AGREEMENT by the HSD /MAD Director or his/her designees or its AUTHORIZED AGENTS.

1.3. Be responsible for the accuracy and validity of all claims for which reimbursement is sought by causing claims to be manually or electronically submitted to the DEPARTMENT or its AUTHORIZED AGENTS.

1.4. Comply with all instructions, directives, billing, reimbursement, audit, recoupment, and withholding provisions made available by the DEPARTMENT and its AUTHORIZED AGENTS.

1.5. Obtain, maintain, and keep updated program rules and instructions on billing and utilization review and other pertinent material made available by the DEPARTMENT and its AUTHORIZED AGENTS.

1.6. Not employ or enter into contract with excluded individuals or entities, as identified by the Health and Human Services Office of Inspector General's (HHS-OIG) List of Excluded Individuals/entities (LEIE), the Medicare Exclusion Database (MED), System for Award Management (SAM), Excluded Parties List System (EPLS) or a state's Employee Abuse Registry (EAR) or equivalent. EAR is available through the Department of Health's Consolidated Online Registry (COR) website at https://cor.health.state.nm.us/. All findings of placement of an employee on EAR should be forwarded to a law enforcement agency for possible prosecution. The HHS-OIG website can be searched by the name of any individual or entity, and must be searched on a monthly basis in order to capture exclusions and reinstatements that have occurred since the last search. Any exclusion information discovered must be immediately reported to the DEPARMENT or its AUTHORIZED AGENTS. A provider must ensure that every healthcare practitioner or other employee providing a service is appropriately licensed, registered, back-ground checked, and/or certified at the time the service is provided, as required by state law or regulation for the service or activity that is provided and is valid in the municipality. All payments made to PROVIDERS for services or items obtained from excluded parties or provided by insufficiently licensed, registered, back-ground checked, or certified individuals are overpayments subject to recoupment. These services or items extend to all methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system; payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and payments to cover an excluded individual's salary, expenses, or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program. In addition, civil monetary penalties may be imposed for noncompliance. 42 CFR 1003

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

.102(a)(2). The PROVIDER must also check New Mexico Courts (http://www.nmcourts.gov/) for records of any incidents involving any employee at the time of employment and annually thereafter. Documentation of the check must be maintained in the employee's personnel folder.

1.7. Comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B, including but not limited to disclosure upon request of information regarding ownership and control, business transactions and person convicted of crimes. This includes information about ownership of any subcontractor and any significant business transactions between the provider and subcontractor and/or provider and any wholly owned supplier. The provider agreement will be terminated if the PROVIDER fails to disclose ownership or control information as required by Federal law.

1.8. Furnish and update complete information on the PROVIDER's address, licensing, certification, board specialties, corporate names, and parties with direct or indirect ownership or controlling interest in the entity or in any subcontractor in which the entity has a direct or indirect ownership interest totaling five percent (5%) or more, and any relationship (spouse, parent, child, or sibling) of these persons to another; the name of any other entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest in; and information on the conviction of delineated criminal or civil offenses by the PROVIDER or parties with direct or indirect ownership or controlling interest at least sixty (60) calendar days prior to the contemplated change or within ten (10) calendar days after the conviction. Any payment made on the basis of erroneous or outdated information is the responsibility of the PROVIDER and is subject to recoupment, criminal investigative costs, and/or civil penalties.

1.9. Comply with all federal, state, and local laws and regulations regarding licensure, registration to pay applicable taxes, payment of applicable taxes, permit requirements, and employee tax filing requirements.

1.10. Assume sole responsibility for all applicable taxes, insurance, licensing, and other costs of doing business.

1.11. Verify that an individual is eligible for a specified health care program administered by the DEPARTMENT or its AUTHORIZED AGENTS.

1.12. Verify the identity of the eligible recipient on all occasions prior to rendering services.

1.13. Maintain the confidentiality of eligible recipient information and records in accordance with state and federal laws, including 42 CFR 431.305, 8.100.100.13 and .14 NMAC, and regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

1.14. Meet the Continuing Care Obligations of the PROVIDER. In the event of termination of this AGREEMENT for any reason, the PROVIDER shall continue to provide or arrange services to eligible recipients, including any recipients who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the termination or next renewal date of the recipient's eligibility, unless the DEPARTMENT arranges for the transfer of the eligible recipient to another Provider and provides written notice to the PROVIDER of such transfer prior to the termination or next renewal date of this AGREEMENT.

Notwithstanding the foregoing, at the direction of the DEPARTMENT, the PROVIDER may continue to provide or arrange services to any eligible recipient who cannot be transferred within the time period specified above in accordance with the legal and contractual obligations to: (1) provide services under the applicable health care program; (2) provide notice of termination to eligible recipients; and (3) ensure continuity of care for eligible recipients.

(A) In the event that the PROVIDER terminates this AGREEMENT on the basis of the DEPARTMENT'S failure to make timely payments, the PROVIDER shall continue to arrange for services to those eligible recipients who are hospitalized on an inpatient basis or otherwise residents of a facility at the time the PROVIDER terminates this AGREEMENT until eligible recipients are discharged from the hospital or other facility. The PROVIDER may file a claim with the DEPARTMENT or its AUTHORIZED AGENTS for such services.

(B) The DEPARTMENT or its AUTHORIZED AGENTS will pay the PROVIDER for services provided after the date of termination of this AGREEMENT at the current applicable reimbursement rate to eligible providers as of the dates of service when the services have been authorized by the DEPARTMENT or its AUTHORIZED AGENTS.

(C) The PROVIDER agrees that the provisions of this section and the obligations of the PROVIDER herein shall survive termination, and shall be construed to be for the benefit of eligible recipients.

1.15. Render covered services to eligible recipients in the same scope, quality, and manner as provided to the general public; comply with all federal and state civil rights laws; and not discriminate on the basis of race, color, national origin, sex, gender, age, ethnicity, religion, sexual orientation, sexual preference, health status, disability, political belief, or source of payment as per 45 CFR 80.3(a) and (b), 45 CFR 84.52, and 42 CFR 447.20 or other state and federal laws, rules, and regulations.

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

1.16. Assume all responsibility for any and all claims submitted on behalf of the PROVIDER under the PROVIDER'S identification number. Submission of false or miscoded claims or fraudulent representation may subject the PROVIDER to termination, criminal investigations and charges, and other sanctions specified in the HSD/MAD Program Policy Manual, and federal and state law and regulations.

1.17. Create, keep and maintain, and have readily retrievable, any and all original medical or business records as necessary to verify the treatment or care of any eligible recipient and to fully disclose the type and extent of all services, goods, and supplies provided to eligible recipients as set forth in 42 CFR 431.107 for at least six (6) years from the date of creation or until ongoing audits are settled, whichever is longer. The PROVIDER agrees that such records shall be made at or near the time at which the services, goods, and supplies are delivered or rendered. Services that have been billed to the DEPARTMENT or its AUTHORIZED AGENTS which are not substantiated in the PROVIDER'S record are subject to recoupment, sanction, and/or any other penalty provided for in this AGREEMENT.

1.18. Upon closure of office or facility, inform the DEPARTMENT or its AUTHORIZED AGENTS where records pertaining to eligible recipients will be located.

1.19. Furnish immediately to the DEPARTMENT or its AUTHORIZED AGENTS, the U.S. Secretary of Health and Human Services, or the Medicaid Fraud Control Unit, at no cost, access to records in any format requested and any information regarding payments claimed by the PROVIDER for furnishing services to eligible recipients.

1.20. Permit announced and unannounced inspection of facilities or the PROVIDER'S offices and other locations used in the provision of services for billing and to eligible recipients by the U.S. Secretary of Health and Human Services, the Medicaid Fraud Control Unit, and the DEPARTMENT and its AUTHORIZED AGENTS. Failure to comply with this provision constitutes a violation of federal and state law and may result in immediate withholding of any pending or future payments. If records are requested by mail, the PROVIDER shall furnish the records within two (2) to ten (10) business days of the receipt of the request or as provided in the request.

1.21. Assist and cooperate in any review, inspection or audit conducted in conformity with the terms of this AGREEMENT.

1.22. Accept as payment in full, the amount paid by the DEPARTMENT or its AUTHORIZED AGENTS for services furnished to eligible recipients in accordance with the reimbursement structure in effect for the period during which services were provided as per the DEPARTMENT'S or its AUTHORIZED AGENTS reimbursement rules. No exceptions to, or waiver of standard reimbursements will be permitted without the express written consent of the MAD Director or his/her designee.

1.23. Electronic billing of claims is mandatory unless an exemption has been allowed by the DEPARTMENT or its AUTHORIZED AGENTS. Exemptions will be given on a case-by-case basis with consideration being given to any barriers the PROVIDER may face in billing electronically, including when volumes are so small that developing electronic submission capability is impractical. The requirement for electronic submission of claims does not apply to situations for which a paper attachment must accompany the claim form.

1.24. Not collect payments from the eligible recipient or any financially responsible relative or personal representative of the eligible recipient for services furnished to the eligible recipient, except as specifically allowed by the DEPARTMENT or its AUTHORIZED AGENTS. The PROVIDER may not bill or collect payments from the eligible recipient or their personal representative for any claim denied by the DEPARTMENT or its AUTHORIZED AGENTS for administrative or billing errors on the part of the PROVIDER except as specifically allowed by the DEPARTMENT'S regulations.

1.25. Seek payment from any other payer or insurer before seeking payment from the DEPARTMENT or its AUTHORIZED AGENTS in the event the eligible recipient is covered by an insurance policy or health plan including Medicare. Refund to the DEPARTMENT or its AUTHORIZED AGENTS the lesser of the payment received from the third party and the DEPARTMENT or its AUTHORIZED AGENTS. The PROVIDER shall not bill the DEPARTMENT or its AUTHORIZED AGENTS the difference between a "preferred patient care agreement" or "discount" arrangement and the PROVIDER'S billed charge.

1.26. Not refuse to furnish services to an eligible recipient because of a third party's potential liability for payment for the services, except in instances in which an eligible recipient is seeking services from a provider who does not participate in the HMO or other plan network and would not be paid for services by the HMO or other plan.

1.27. Inform the DEPARTMENT or its AUTHORIZED AGENTS immediately when an attorney or other party requests information related to the services rendered to an eligible recipient that were paid by the DEPARTMENT or its AUTHORIZED AGENTS and upon receipt of any knowledge of pending or active legal proceedings involving eligible recipients.

1.28. When furnishing services to eligible recipients who sustained injury in an accident or another action that may

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

be subject to a legal proceeding, agree to the following:

(A) The hospital PROVIDER must either file a claim with the DEPARTMENT or its AUTHORIZED AGENTS within the time period specified in 8.302.14 NMAC of the date of hospital discharge or impose a hospital lien on the potential recovery from the liable third party. If the hospital PROVIDER elects to impose a lien, the PROVIDER is prohibited from filing a claim with the DEPARTMENT or its AUTHORIZED AGENTS for payment of any unpaid balance resulting from the third party recovery or from seeking payment from the eligible recipient or their personal representative.

(B) The non-hospital PROVIDER must accept the payment made by the DEPARTMENT or its AUTHORIZED AGENTS as payment in full. The non-hospital PROVIDER may not seek additional payment for those services from the eligible recipient or their personal representative even if the eligible recipient or their personal representative subsequently received a monetary award or settlement from the liable party.

1.29. When entering into contracts with the Medicaid managed care organization (MCOs) contracting with the DEPARTMENT for the provision of managed care services to the Medicaid population, agree to be paid by the MCO at any amount mutually-agreed between the provider or provider group and the MCOs. If the provider or provider group and MCO are unable to agree to terms or fail to execute an agreement for any reason, the provider or provider group shall be obligated to accept the percent of the applicable reimbursement rate as stated in the MAD Program Policy Manual based on the provider type. The "applicable reimbursement rate" is defined as the rate paid by the DEPARTMENT to the PROVIDER participating in Medicaid or other medical assistance programs administered by the DEPARTMENT or its AUTHORIZED AGENTS and excludes disproportionate share hospital and medical education payments.

1.30. When a Medicaid managed care organization (MCO) recoups payment from the provider because the DEPARTMENT retroactively disenrolls a recipient from the MCO, the PROVIDER agrees to bill the DEPARTMENT or its AUTHORIZED AGENTS and accept the applicable reimbursement rate as stated in the MAD program policy manual, according to the provider type.

1.31. For those caregivers whose employment or contractual service with a care provider includes direct care or routine and unsupervised physical or financial access to any care recipient served by that provider, the caregiver and care provider must adhere to provisions in the Caregivers Criminal History Screening Act (CCHS).

1.32. Understand and agree to meet the requirements concerning enrollment and screening, criminal background checks, fingerprinting, use of the National Provider Identifier, federal database checks, site visits, verification of provider licenses, and application fees as found at 42 CFR 455.400 – 455.470.

1.33. To understand the appeal rights that are given to the PROVIDER as provided for in MAD 8.353.2, PROVIDER HEARING, MAD 8.349.2, APPEALS and GRIEVANCE PROCESS, MAD 8.350.2, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS, MAD 8.350.3, ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS, MAD 8.350.4, RECONSIDERATION OF AUDIT SETTLEMENTS, MAD 8.351.2, SANCTIONS AND REMEDIES, MAD 8.352.2, RECIPIENT HEARINGS, MAD 8.353.2, PROVIDER HEARINGS, MAD 8.354.2, PASRR AND PATIENT STATUS HEARING POLICIES, or as amended or their successors, of the Medical Assistance Division Program Policy Manual.

1.34. All work associated with the Agreements contained herein must be performed in the United States of America.

ARTICLE II – OBLIGATION OF THE HUMAN SERVICES DEPARTMENT

The DEPARTMENT shall:

2.1. Make available on the HSD/MAD website, other DEPARTMENT websites, or in hard copy format information necessary to participate in health care programs administered by the DEPARTMENT or its AUTHORIZED AGENTS, including program rules, billing instructions, and other pertinent materials. The PROVIDER must contact the DEPARTMENT or its AUTHORIZED AGENTS to request hard copies of any program rules, manuals, billing and utilization review instructions, and other pertinent materials.

2.2. Process payments in a manner delineated by federal guidelines either internally or through a designated fiscal agent contractor. Please refer to 8.302.2.9 NMAC.

2.3 Reimburse the PROVIDER for furnishing covered services or procedures to eligible recipients when all program rules have been followed by the PROVIDER. Reimbursement is based on the fee schedule, reimbursement rate, or reimbursement methodology in place at the time service is furnished by the PROVIDER. No exception to, or waiver of, standard reimbursement will be permitted without the express written consent of the MAD Director or his/her designee.

2.4. Conduct administrative investigations and administrative proceedings to ensure that the PROVIDER complies with the terms of

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

this AGREEMENT and federal and state law, and regulations pertaining to the administration of the health care programs administered by the DEPARTMENT or its AUTHORIZED AGENTS, including the Medicaid Provider Act.

ARTICLE III - PATIENT SELF-DETERMINATION ACT

The nursing facility, intermediate care facility, hospital, home health agency, and hospice PROVIDER shall:

3.1. Furnish written information to all adult eligible recipients or their personal representatives receiving medical care concerning their right to make decisions about medical care; accept or refuse medical or surgical treatment; and formulate arrangements for a living will or durable power of attorney.

3.2 Document in the eligible recipient's medical record whether he/she has executed an advance directive which complies with New Mexico law on advance directives. The provision of care shall not be based on whether the eligible recipient has executed an advance directive.

3.3. Inform each adult eligible recipient or personal representative, orally and in writing, at the time of facility admission or initiation of treatment, of the eligible recipient's legal rights during his or her facility stay or course of treatment.

ARTICLE IV - SUBMISSION OF COST REPORTS

4.1. The PROVIDER, when delineated by the DEPARTMENT shall furnish the DEPARTMENT or its AUTHORIZED AGENTS with such financial reports, audited or certified cost statements, and other substantiating data as necessary to establish a basis for reimbursement or as required by regulation.

4.2. Cost statements or other data are to be furnished no later than 150 (one hundred- fifty) calendar days following the closure of the PROVIDER'S fiscal accounting period. Failure to comply with this provision will result in suspension of payment until the required statements and other data are provided.

ARTICLE V - STATUS OF PROVIDER

The PROVIDER, its agents, and employees are independent contractors who perform professional services for eligible recipients served through health care programs administered by the DEPARTMENT or its AUTHORIZED AGENTS are not employees of the DEPARTMENT or its AUTHORIZED AGENTS. The PROVIDER shall not purport to bind the DEPARTMENT nor the State of New Mexico to any obligation not expressly authorized herein unless the DEPARTMENT has given the PROVIDER express written permission to do so.

ARTICLE VI - CHANGE IN OWNERSHIP

6.1. As soon as possible, but at least sixty (60) calendar days prior to a change in ownership or status, the PROVIDER must notify the DEPARTMENT or its AUTHORIZED AGENTS of the proposed change in ownership. Upon completion of the transfer of ownership, this initial AGREEMENT is terminated. The new owner must complete and receive approval of a new AGREEMENT before submitting any claims to the DEPARTMENT or its AUTHORIZED AGENTS. Any payment made on the basis of erroneous or outdated information due to the lack of notice is the responsibility of the PROVIDER and is subject to recoupment.

6.2. The previous owner shall be responsible for any overpayments and is entitled to receive payments up to the date of ownership transfer, unless otherwise specified in the contract for transfer of ownership.

6.3. The new owner shall furnish to the DEPARTMENT or its AUTHORIZED AGENTS upon receipt of a written request, the contract or other applicable documents specifying the terms of the change in ownership and responsibilities delineated in this AGREEMENT.

6.4. The DEPARTMENT and its AUTHORIZED AGENTS reserve the right to withhold all pending and other claims until the right to payments and/or recoupment is determined, unless the new owner agrees in writing to be liable for any recoupment or overpayment amounts.

6.5. For the PROVIDER who is reimbursed on a cost basis and subject to cost settlements, the DEPARTMENT or its AUTHORIZED AGENTS shall impose a lien and/or penalty of up to ten percent (10%) of the purchase price against the previous owner until such time as the final cost settlement is completed and amounts owed, if applicable, are remitted to the DEPARTMENT, or its AUTHORIZED AGENTS.

ARTICLE VII - TERMINATION OF PROVIDER AGREEMENT

7.1. The PROVIDER status may be terminated without cause if the PROVIDER or the DEPARTMENT or its AUTHORIZED AGENTS give the other written notice of termination at least sixty (60) calendar days prior to the effective date of the termination.

7.2. The DEPARTMENT or its AUTHORIZED AGENTS may terminate this AGREEMENT for cause, with thirty (30) calendar days notice if the PROVIDER, his or her agent, a managing employee, or any person having an ownership interest equal to five percent (5%) or greater in the health care PROVIDER entity:

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

(A) Misrepresents, by commission or omission, any information on the AGREEMENT enrollment form.

(B) Has previous or current exclusion, suspension, termination from, or the involuntary withdrawal from participation in a health care program administered by the DEPARTMENT, any other state's Medicaid program, Medicare, or any other public or private health insurance program.

(C) Is convicted under federal or state law of a criminal offense relating to the delivery of the goods, services, or supplies, under a health care program administered by the DEPARTMENT, any other state's Medicaid Program, Medicare, or any other public or private health insurance program.

(D) Is convicted under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(E) Is convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

(F) Is convicted under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(G) Is convicted under federal or state law of a criminal offense punishable by imprisonment of a year or more which involved moral turpitude or acts against the elderly, children, or infirm.

(H) Is sanctioned pursuant to a violation of federal or state laws or rules relative to a health care program administered by the DEPARTMENT, any other state's Medicaid Program, Medicare, or any other public health insurance program.

(I) Is convicted under federal or state law of a criminal offense in connection with the interference or obstruction of any
investigations into any criminal offense listed in Paragraphs (C) through (H) of this subsection.

(J) Violates licensing or certification conditions or professional standards relating to the licensure or certification of the PROVIDER or the required quality of goods, services, or supplies provided.

(K) Fails to pay recovery properly assessed or pursuant to an approved repayment schedule under a health care program administered by the DEPARTMENT or its AUTHORIZED AGENTS.

7.3. The PROVIDER's status may be terminated immediately, without notice, in instances in which the health and safety of eligible recipients in institutions are deemed
to be in immediate jeopardy; are subject to an immediate or serious threat; or when it has been demonstrated, on the basis of reliable evidence, that the PROVIDER has committed fraud, abuse, or other illegal or sanctionable action. For purposes of this provision, institutional providers include nursing facilities, intermediate care facilities for the mentally retarded, all residential psychiatric treatment facilities, group homes, and other facility-based residential treatment programs.

7.4. The DEPARTMENT or its AUTHORIZED AGENTS reserve the right to terminate this AGREEMENT for cause as summarized in this AGREEMENT and as delineated in Section MAD-8.351.2, SANCTIONS AND REMEDIES of the Medical Assistance Division Program Policy Manual, or as amended and/or its successor.

7.5. Immediately upon termination for any reason, the PROVIDER shall:

(A) Comply with all directives issued by the DEPARTMENT or its AUTHORIZED AGENTS; and

(B) Take such action as the DEPARTMENT or its AUTHORIZED AGENTS shall direct for the protection, preservation, retention or transfer of all property, included but not limited to all recipient records.

ARTICLE VIII - IMPOSITION OF SANCTIONS FOR FRAUD OR MISCONDUCT

8.1. If the PROVIDER obtains an excess payment or benefit willfully, by means of false statement, representation, concealment of any material fact, or other fraudulent scheme or devise with intent to defraud, criminal sentences and fines and/or civil monetary penalties shall be imposed pursuant to, but not limited to, the Medicaid Fraud Act, NMSA 1978, 30-44-1 et seq., 42 USC 1320a-7b, and 42 CFR 455.23.

8.2 In addition to the above criminal and civil penalties, the DEPARTMENT or its AUTHORIZED AGENTS may impose monetary or non-monetary sanctions, including civil monetary penalties for PROVIDER misconduct or breach of any of the terms of this AGREEMENT.

8.3 Upon written notice to the PROVIDER, the DEPARTMENT or its AUTHORIZED AGENTS may sanction non-performance under this AGREEMENT consistent with the DEPARTMENT's rules through one or more following actions:

(A) Compensation Reduction. As a sanction, the DEPARTMENT or its AUTHORIZED AGENTS may recover past payments to the PROVIDER and/or reduce the compensation of the PROVIDER for past failure to fully and satisfactorily perform, and for any ongoing failure to fully and satisfactorily perform this AGREEMENT's obligations. Imposition of such a penalty does not preclude the DEPARTMENT or its AUTHORIZED AGENTS from recouping or recovering payments as specifically provided in any other law, regulation or this AGREEMENT.

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

(B) The amount of the compensation paid to the PROVIDER by the DEPARTMENT or its AUTHORIZED AGENTS for services that the PROVIDER did not fully and satisfactorily perform in accordance with the terms of this AGREEMENT.

8.4. The DEPARTMENT or its AUTHORIZED AGENTS may recover funds by reducing future compensation payable by the DEPARTMENT or its AUTHORIZED AGENTS to the PROVIDER.

ARTICLE IX – EMPLOYEE EDUCATION CONCERNING FALSE CLAIMS

9.1. In accordance with Section 1902(a) of the Social Security Act, the PROVIDER must:

(A) Establish written policies and rules for all employees, agents, or contractors, that provide detailed information regarding the New Mexico of 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 statement established under chapter 38 of title 31, United States Code, including but not limited to, 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 the entity'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 subparagraph (A), the rights of employees to be protected as whistleblowers, and the PROVIDER's rules and procedures for detecting and preventing fraud, waste, and abuse.

9.2. The DEPARTMENT may, at its sole discretion, exempt the PROVIDER from the requirements set forth in 9.1 herein; however, the DEPARTMENT shall not exclude the PROVIDER, if the PROVIDER receives at least $5,000,000 in annual payments from the DEPARTMENT.

9.3 For the purposes of this Article, the following definitions apply:

(A) An "employee" includes any officer or employee of the PROVIDER.

(B) A "contractor" or "agent" includes any contractor, subcontractor, agent or other person which or who, on behalf of the PROVIDER, furnishes, or otherwise authorizes the furnishing of Medicaid or other health care program items or services, performs billing or coding functions or is involved in monitoring of health care provided by the PROVIDER.

ARTICLE X - REFUSAL TO EXECUTE AN AGREEMENT

The DEPARTMENT will not execute an AGREEMENT with the PROVIDER if the PROVIDER, his/her agent, managing employee, or any person having an ownership interest equal to five percent (5%) or greater in the health care PROVIDER commits or has committed any of the violations listed in Article 7.2. of this AGREEMENT or other provisions delineated in Section 8.351.2 or as amended and/or its successor, REMEDIES AND SANCTIONS of the Medical Assistance Division Program Policy Manual, when such exclusions are mandatory under federal or state law.

ARTICLE XI - RECIPIENT FUND ACCOUNT

Nursing facilities, swing bed hospitals, and intermediate care facilities for the mentally retarded shall establish and maintain an acceptable system of accounting for eligible recipients' personal funds, in the manner prescribed by the DEPARTMENT or its AUTHORIZED AGENTS, in those cases in which eligible recipients entrust their personal funds to the facility.

ARTICLE XII - PRECONDITION FOR PARTICIPATION

The PROVIDER understands that signing this AGREEMENT is a precondition for participating in health care programs administered by the DEPARTMENT or its AUTHORIZED AGENTS. The PROVIDER understands that the provision of services, billing of services, and receipt of payments for services cannot occur until this AGREEMENT is completed by the PROVIDER and approved for execution by the DEPARTMENT.

ARTICLE XIII – INSURANCE

13.1 During the term of this AGREEMENT, the PROVIDER shall, at its sole cost and expense, carry comprehensive general liability insurance and professional liability insurance in amounts and containing such provisions from time to time deemed adequate by the DEPARTMENT or its AUTHORIZED AGENTS. Upon request, the PROVIDER will provide to the DEPARTMENT and its AUTHORIZED AGENTS certificates evidencing that the insurance required by this Section is in effect. The PROVIDER hereby authorizes the PROVIDER's insurance carrier to notify the DEPARTMENT and its AUTHORIZED AGENTS upon cancellation or termination of the PROVIDER's insurance coverage. The PROVIDER will notify the DEPARTMENT or its AUTHORIZED AGENTS promptly whenever an eligible recipient files a claim or notice of intent to commence action against the PROVIDER. The PROVIDER will notify the DEPARTMENT or its AUTHORIZED AGENTS not more than ten (10) business days after the

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

PROVIDER's receipt of notice of any reduction or cancellation of the insurance coverage required by this Section.

13.2 The DEPARTMENT may, at its sole discretion, exempt the PROVIDER from the requirements of 13.1 for any reason, including but not limited to, the inability of the PROVIDER to procure such insurance.

ARTICLE XIV – HEALTH INSURANCE

14.1 If the PROVIDER has, or grows to have, six (6) or more employees who work or who are expected to work, an average of at least twenty (20) hours per week over a six (6) month period during the term of this AGREEMENT and by signing it, agree to comply with these provisions.

(A) Have in place, and agree to maintain for the term of this AGREEMENT, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2008, if the expected annual value in the aggregate of any and all contracts between the PROVIDER and the STATE exceeds one million ($1,000,000) dollars; or

(B) Have in place, and agree to maintain for the term of this AGREEMENT, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2009, if the expected annual value in the aggregate of any and all contracts between the PROVIDER and the STATE exceeds five-hundred thousand ($500,000) dollars; or

(C) Have in place and agree to maintain for the term of this AGREEMENT, health insurance for those employees and offer that health insurance to those employees no later than July 1, 2010, if the expected annual value in the aggregate of any and all contracts between the PROVIDER and the STATE exceeds two-hundred and fifty thousand ($250,000) dollars

14.2 The PROVIDER must agree to maintain a record of the number of employees who have:

(A) accepted health insurance

(B) declined health insurance due to other health insurance coverage already in place; or

(C) declined health insurance for other reasons.

These records are subject to review and audit by the STATE or its representative(s).

14.3 The PROVIDER must agree to advise all employees of the availability of STATE publicly financed health care coverage programs by providing each employee with, at a minimum, the following web site link (or its successor) for additional information http://www.insurenewmexico.state.nm.us/

ARTICLE XV - NO WAIVERS

No terms or provision of this AGREEMENT shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and executed by the party claiming to have waived or consented.

ARTICLE XVI - APPLICABLE LAW

This AGREEMENT shall be governed by the laws of the State of New Mexico. All legal proceedings arising from unresolved disputes under this AGREEMENT are subject to administrative and judicial review as provided for in MAD 8.353.2, PROVIDER HEARING, MAD 8.349.2, APPEALS and GRIEVANCE PROCESS, MAD 8.350.2, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS, MAD 8.350.3, ABSTRACT SUBMISSION FOR LEVEL OF CARE DETERMINATIONS, MAD 8.350.4, RECONSIDERATION OF AUDIT SETTLEMENTS, MAD 8.351.2, SANCTIONS AND REMEDIES, MAD 8.352.2, RECIPIENT HEARINGS, MAD 8.353.2, PROVIDER HEARINGS, MAD 8.354.2, PASRR AND PATIENT STATUS HEARING POLICIES, or as amended or their successors, of the Medical Assistance Division Program Policy Manual.

ARTICLE XVII - ASSIGNMENT

The PROVIDER shall not assign or transfer any obligation, duty, or other interest in this AGREEMENT, nor assign any claim for monies due under this AGREEMENT without authorization of the DEPARTMENT or its AUTHORIZED AGENTS. Any assignment or transfer which is not authorized by the DEPARTMENT or its AUTHORIZED AGENTS shall be void.

ARTICLE XVIII - INDEMNIFICATION

The PROVIDER shall indemnify, defend, and hold harmless the STATE, the DEPARTMENT, its AUTHORIZED AGENTS , and employees from any and all actions, proceedings, claims, demands, costs, damages, and attorney's fees, from all liabilities or expenses of any kind from any sources accruing to or resulting from the PROVIDER or its employees in connection with the performance of this AGREEMENT and from all claims of any person or entity that may be directly or indirectly injured or damaged by the PROVIDER or its employees in the performance of this AGREEMENT.

ARTICLE IXX - ENTIRE AGREEMENT

This AGREEMENT incorporates all the agreements, covenants, and under-standings between the parties hereto concerning the subject matter contained in this AGREEMENT, and all such

Name of Entity / Individual	EIN / SSN	NPI	*APPLICANT INITAL HERE _____ CERTIFYING YOU HAVE READ AND UNDERSTAND THE INFORMATION ON THIS PAGE*

covenants, agreements, and understandings have been merged into this AGREEMENT. No prior agreement, covenants, or understandings, either verbal or otherwise, of the parties or their agents shall be valid or enforceable unless contained in this AGREEMENT.

This AGREEMENT shall not be altered, changed, revised, or amended except by written instrument executed by the parties in the same manner as in this AGREEMENT. Amendments shall contain an effective date. Any amendments to this AGREEMENT shall not be binding upon either party until approved in writing by the DEPARTMENT or its AUTHORIZED AGENTS.

Name of Entity / Individual	EIN / SSN	NPI

A) Have you ever had a license revoked, suspended or denied in any state? ____YES ____NO **Initial** _____

B) Have you or any owners or principals ever been convicted of any criminal offense? ____YES ____NO **Initial** _____

C) Have you or any owners or principals ever been excluded or suspended from participation in Title XVIII (Medicare), Title XIX (Medicaid) or any other health care program ____YES ____NO **Initial** _____

If YES to any of the above three questions, attach a brief statement of situation; date; city, county and professional association or court which handled the matter; any precinct case identification, and the adjudication or other result.

All Providers Initial to Confirm the following:

_____ The provider is covered by malpractice, professional, medical, or other liability insurance. Coverage will remain in place for all dates of service

This section to be completed if Provider/Applicant is an individual to whom payments will be made under SSN

Initial One:

_____ I am licensed in NM and do not otherwise participate as a NM Medicaid provider. I will provide and bill NM Medicaid only for COVID19 testing and related service.

_____ In accordance with the NM licensure authority for my professional license, I am authorized to practice in NM based on my federal, temporary, emergency, or other license (copies attached). My practice also meets requirements for conducting business in NM.

Initial and Complete All That Apply:

_____ I am currently enrolled and receive direct reimbursement as a Medicare provider. My Medicare provider ID is _____

_____ I am currently enrolled and receive direct reimbursement as a Medicaid provider in another state. State(s) of enrollment is/are _____ and Medicaid provider ID(s) is/are _____

This section to be completed if Provider/Applicant is a group or organization to which payments will be made under FEIN and selected provider type is not 211 or 212 (Nursing Facility)

Initial and Confirm the Following:

_____ This business complies with all federal, state, and local requirements to receive NM Medicaid reimbursement for covered services provided during the emergency declaration period.

Initial and Complete All That Apply:

_____ This business entity/billing provider is enrolled as a Medicare provider. Medicare provider ID is _____

_____ This business entity/billing provider is enrolled in another state's Medicaid program. State(s) of enrollment is/are _____and Medicaid provider ID(s) is/are _____

This section to be completed if Provider/Applicant selected provider type is 211 or 212 (Nursing Facility)

Initial All That Apply:

_____ This facility is licensed in NM and does not otherwise participate as a NM Medicaid provider. This facility will provide and bill NM Medicaid for NF services only during the public health emergency, and NM Medicaid provider status will terminate after the public health emergency.

_____ This facility has been identified as a COVID facility and has been granted a temporary waiver from DOH for Medicaid certification (copy attached).

_____ This facility is currently enrolled as a Medicare provider. Medicare provider ID is_____

_____ This facility is currently undergoing a Change of Ownership (CHOW) and has received from NM DOH a temporary waiver for Medicaid certification (copy attached).

HUMAN SERVICES DEPARTMENT

STATE OF NEW MEXICO
MEDICAL ASSISTANCE DIVISION
PROVISIONAL PROVIDER PARTICIPATION AGREEMENT

Name of Entity / Individual	EIN / SSN	NPI

New Mexico Medicaid project staff may need to contact you regarding the completion of this form. Please list contact person and telephone number.

Contact Person: _____ ***Telephone Number:*** _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or State laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or, where the entity already participates, a termination of its agreement or contract with the State agency.

Original signature required. Please use blue ink only.

INDIVIDUAL PROVIDER:

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Individual Practitioner: _____

Signature of Individual Practitioner: _____ **Date:** _____

FACILITIES AND NON-PRACTITIONER ORGANIZATIONS:

I understand that payment of claims will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state law.

Printed Name of Authorized Representative: _____

Title / Position: _____

Address: _____

Telephone Number: _____

Signature of Authorized Representative: _____ **Date:**_____

FOR STATE PURPOSES ONLY:	
HUMAN SERVICES DEPARTMENT APPROVAL ☐ APPROVED ☐ NOT APPROVED	
Reasons Not Approved:	
Dates of Agreement: From: _____	
Authorized Signature	**Date**

APPLICANT INITIAL HERE _____
CERTIFYING THE INFORMATION ON THIS PAGE IS TRUE AND CORRECT