

## MOLINA HEALTHCARE OF TEXAS, INC. HOSPITAL SERVICES AGREEMENT

### SIGNATURE PAGE

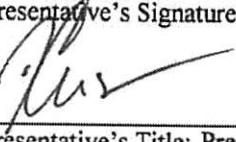
In consideration of the promises, covenants, and warranties stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement, and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

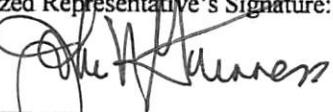
The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Effective Date of Agreement ("Effective Date"): <u>5/1/18</u>
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#### Provider Signature and Information:

Provider's Legal Name ("Provider") – as listed on applicable tax form (i.e. W-9): Dallas County Hospital District dba Canton Oaks	
Authorized Representative's Signature: 	Authorized Representative's Name – Printed: Dr. Fredrick Cerise
Authorized Representative's Title: President and CEO	Authorized Representative's Signature Date: 2/22/2018
Telephone Number: 903-567-0444	Fax Number – Official Correspondence: 903-567-0445
Mailing Address – Official Correspondence: 1901 South Trade Days Boulevard, Canton, TX, 75103, USA	Payment Address – If different than Mailing Address: 1901 South Trade Days Boulevard, Canton, TX, 75103, USA
Email Address – Official Correspondence: sarah@cypresshcc.com	Tax ID Number – As listed on corresponding tax form: 75-6004221
NPI – That corresponds to the above Tax ID Number: 1417255233	

#### Health Plan Signature and Information:

Molina Healthcare of Texas, Inc., a Texas Corporation ("Health Plan")	
Authorized Representative's Signature: 	Authorized Representative's Name – Printed: John McGuinness
Authorized Representative's Title: COO	Authorized Representative's Countersignature Date: <u>5/18/18</u>
Mailing Address – Official Correspondence: 5605 N. MacArthur Blvd., Suite 400, Irving, TX, 75038- 2617,	Email Address – Official Correspondence: NFProviderServices@MolinaHealthCare.com

## HOSPITAL SERVICES AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

### RECITALS

- A. WHEREAS, Health Plan is a corporation licensed and approved by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care or other related services and enter into agreements with Participating Providers;
- B. WHEREAS, Provider is approved to render certain health care or other related services and desires to provide such services to eligible recipients; and
- C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or other related services available to eligible recipients enrolled in various Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, and warranties stated herein, the Parties agree as follows:

### ARTICLE ONE – DEFINITIONS

- 1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.
  - a. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.
  - b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.
  - c. **Agreement** means this Hospital Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.
  - d. **Centers for Medicare and Medicaid Services ("CMS")** means the agency responsible for Medicare, and certain parts of Medicaid, CHIP, MMP, and the Health Insurance Marketplace.
  - e. **Claim** means a bill for Covered Services provided by Provider.
  - f. **Claims Delegate** means an entity that agreed to administer Claims payment for certain Covered Services on behalf of Health Plan, as defined in the contract between Health Plan and the entity.
  - g. **Clean Claim** means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.
  - h. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.
  - i. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.
  - j. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.
  - k. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage Product, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
  - l. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

- m. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.
  - n. **Government Contracts** mean those contracts between Health Plan and state and federal agencies for the arrangement of health care services for Government Programs.
  - o. **Government Programs** mean various government sponsored health products in which Health Plan participates.
  - p. **Government Program Requirements** mean the requirements of governmental authorities for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contracts.
  - q. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
  - r. **Health and Human Services Commission (“HHSC”)** means the agency within the State of Texas that is responsible for the oversight and administration of the Medicaid and CHIP programs.
  - s. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.
  - t. **Health Plan** means Molina Healthcare of Texas, Inc., a Texas Corporation.
  - u. **Hospital Providers** mean hospital-based physicians and independent licensed non-physician health care professionals, who are employed by, contract with, or are on the medical staff of Hospital to provide Covered Services. For the avoidance of doubt, a Hospital Provider is not considered a Provider.
  - v. **Law** means all statutes and regulations applicable to this Agreement.
  - w. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.
  - x. **Medically Necessary or Medical Necessity** means health care services that a healthcare provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member’s condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.
  - y. **Medicare Advantage (“MA”)** means a program in which private health plans provide Covered Services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as “Medicare”). Medicare Advantage also includes Medicare Advantage Special Needs Plans (“MA-SNP”).
  - z. **Medicare-Medicaid Program (“MMP”)** means the managed care program established by CMS, through the capitated financial alignment demonstration, in which HHSC, CMS, and Health Plan have entered into a three-way contract that will allow the Health Plan to provide care to beneficiaries eligible for both Medicaid and Medicare.
- aa. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.
  - bb. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

- cc. **Overpayments** mean a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.
- dd. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.
- ee. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.
- ff. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".
- gg. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.
- hh. **Quality Improvement Program ("QI Program")** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.
- ii. **State Children's Health Insurance Program ("SCHIP" or "CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.
- jj. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement, including delegation activities. For the avoidance of doubt, a Subcontractor does not include Individual Providers.
- kk. **Utilization Review and Management Program ("UM Program")** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

## ARTICLE TWO – PROVIDER OBLIGATIONS

### 2.1 **Provider Standards.**

- a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws and Government Program Requirements.
- b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider's duties and responsibilities under this Agreement and to comply with Laws and Government Program Requirements.
- c. **Prior Authorization.** For Covered Services that require prior authorizations, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.
- d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.

- e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low cost alternative prescriptions for the prescribed medication.
- f. **Availability of Services.** Provider will ensure Emergency Services and Covered Services related to inpatient hospitalizations are available twenty-four (24) hours a day, seven (7) days a week. Provider will make necessary and appropriate arrangements to assure the availability of non-emergent Covered Services during Provider's normal business hours, unless otherwise required by Laws or Government Program Requirements.
- g. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.
- h. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.
- i. **Hospital Admission Notifications.** Provider will immediately notify Health Plan of Member hospital admissions, including inpatient admissions and Members referred to the emergency department.

## 2.2 Standards for Hospital Providers.

- a. **Hospital Providers.** Provider will have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members. Provider is responsible for the Covered Services provided by Hospital Providers and will ensure that Hospital Providers have appropriate liability coverage. Provider will establish policies and procedures to ensure Hospital Providers comply with applicable terms of this Agreement, Laws and Government Program Requirements.
- b. **Hospital Provider Information.** Upon request, Provider will give Health Plan a complete list of its Hospital Providers and any information required for administration of Products.
- c. **Restriction, Suspension, or Termination of Hospital Providers.** Provider will promptly restrict, suspend, or terminate Hospital Providers from providing Covered Services in the following circumstances: (i) the Hospital Provider ceases to meet credentialing, licensing/certification requirements, or other professional standards; or (ii) Health Plan or Provider reasonably determine there are serious deficiencies in the quality of care of the applicable Hospital Provider which affects or could adversely affect the health or safety of Members.
- d. **Notification.** Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be implemented against any Participating Provider or Hospital Provider which results in any suspension, reduction, or modification of hospital privileges. Provider's notification to Health Plan will state Provider's actions taken against the Hospital Provider or Participating Provider.
- e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Participating Providers, Health Plan's case management staff, and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules, and regulations of Provider.

## 2.3 Rights of Members.

Provider will observe, protect, and promote the rights of Members.

## 2.4 Use of Name.

Neither Provider nor Health Plan will use the other Party's name, including, but not limited to, trademarks, service marks, or logos, in advertisements without prior approval. However, Provider may refer to Health Plan in Provider's listings of participating health plans. Additionally, Health Plan may use Provider's name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.

## 2.5 Non-Discrimination in Enrollment.

Provider will not differentiate or discriminate in providing Covered Services because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation,

physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.6

**Recordkeeping.**

- a. **Maintaining Member Record.** Provider will maintain a medical and billing record ("Record") for each Member to whom Provider provides health care services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.
- b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality of Members' Record. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section will not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, authorized state or federal agency, or other providers of health care. This section will survive any termination.
- c. **Delivery of Member Record.** Provider will promptly deliver to Health Plan, upon request or as may be required by Law, Health Plan's policies and procedures, Government Program Requirements, or third party payers, any information, statistical data, Encounter Data, or Record pertaining to Members served by Provider. Provider is responsible for the fees associated with producing such records. Provider will further give direct access to said patient care information as requested by Health Plan or as required by any state or federal authority/agency with jurisdiction over Health Plan. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give such information to Health Plan promptly. This section will survive any termination.
- d. **Member Access to Member Record.** Provider will give Members access to Members' Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.7

**Program Participation.**

- a. **Participation in Grievance Program.** Provider will participate in and comply with Health Plan's Grievance Program, and will cooperate with Health Plan in identifying, processing, and promptly resolving Member grievances, complaints, or inquiries.
- b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program, and will cooperate in conducting peer review and audits of care provided by Provider.
- c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.
- d. **Participation in Credentialing.** Provider will participate in and satisfy credentialing criteria established by Health Plan before the Effective Date and throughout the term of this Agreement. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status. In accordance with Health Plan's policies and procedures, Provider must be credentialed by Health Plan or Health Plan's designee before providing Covered Services.
- e. **Health Education/Training.** Provider will participate in and comply with Health Plan's Provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

- 2.8 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.
- 2.9 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, and a physical copy is available upon request. Supplemental Materials will become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.
- 2.10 **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, Health Plan access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal. Such programs, registration, and use are contained in the Provider Manual or Supplemental Materials.
- 2.11 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete list of its health care providers, facilities, and business/practice locations it uses to provide Covered Services every thirty (30) days, together with specific information required for credentialing and administration. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another matter or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.
- 2.12 **Standing.**
- Requirements.** Provider warrants and represents it has the appropriate approvals, including, but not limited to, applicable licenses, certifications, registrations, and permits to provide health care services in accordance with Laws and Government Program Requirements. Provider will deliver evidence of any approvals to Health Plan upon request. Provider will maintain such approvals in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.
  - Unrestricted Status.** Provider warrants and represents it has not been and is not currently excluded from, and will promptly notify Health Plan if it becomes excluded from, participation in a federal or state health care program.
  - Malpractice and Other Actions.** Provider will give prompt notice to Health Plan of: (i) a malpractice claim asserted against it by a Member, a payment made by or on behalf of Provider in settlement or compromise of such a claim, or a payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction of Provider for crimes involving moral turpitude or felonies; and (iv) a civil claim asserted against Provider that may jeopardize Provider's financial soundness. This section will survive any termination.
  - Liability Insurance.** Provider will maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. This section will survive any termination.
- 2.13 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.
- 2.14 **Laws and Government Program Requirements.**

- a. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.
  - b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by state or federal agencies. This section will survive any termination.
  - c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.
  - d. **Ownership Disclosure Information.** If applicable, a Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to the Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.
- 2.15 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to assure reciprocity of health care services to Affiliate's enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate's enrollees.

### ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

- 3.1 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.
- 3.2 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.
- 3.3 **Medical Necessity Determination.** Health Plan's determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern. The primary concern with respect to Medical Necessity determinations is the interest of the Member.
- 3.4 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.
- 3.5 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.
- 3.6 **Corrective Action.** Health Plan, and state and federal regulators routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or regulator, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

## ARTICLE FOUR – CLAIMS PAYMENT

- 4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider will not be eligible for payment on Claims submitted beyond ninety-five (95) days from the Date of Service. When Health Plan is the secondary payer, if there is not a timeframe specified in Laws and Government Program Requirements, Provider will not be eligible for payment for Claims submitted more than ninety-five (95) days from the date the primary payer adjudicated the Claim. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.
- 4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.
- 4.3 **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances, and deductibles, if any.
- 4.4 **Member Hold Harmless.** Provider agrees that in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or co-payments as specifically provided in the Member's evidence of coverage, or fees for non-covered health care services provided to Member. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.
- 4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if Member has health insurance or health benefits other than from Health Plan, or is entitled to payment by a third party under any other insurance or plan of any type. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers, and payers, not to exceed the amount specified in the Compensation Schedule of this Agreement.
- 4.6 **Offset.** In the event of an Overpayment, Health Plan may recover the amount owed by: (i) recoupment; or (ii) by way of offset from current or future amounts due Provider. If required, such recoupment or offset will be done in a manner that is compliant with Laws and Government Program Requirements. As a material condition to Health Plan's obligations under this Agreement, Provider agrees the offset and recoupment rights set forth in this Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental authority that may now or hereafter have jurisdiction over Health Plan or Provider. This section will survive any termination.
- 4.7 **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. This section will survive any termination.
- 4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested

claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication and clinical practices, state and federal guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.

- 4.9 **Payments which are the Responsibility of a Claims Delegate.** If Provider provides Covered Services that are the responsibility of a Claims Delegate, Provider will look solely to the Claims Delegate for payment of such Covered Services. Pursuant to Health Plan's contract with Claims Delegate, Claims Delegate is to compensate Provider at the rate set forth in Provider's contract with Claims Delegate. If Claims Delegate and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Claims Delegate, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member's Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member's Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.
- 4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.
- 4.11 **Authorized Services.** Health Plan is responsible for the authorization of Covered Services. If Provider obtained prior or concurrent authorization for a Covered Service, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless: (i) Provider's claim or medical record for such services does not support the specific services or level of care authorized by Health Plan; (ii) Health Plan may do so pursuant to applicable Laws or Government Program Requirements; or (iii) Provider has been provided notice of policies through the Provider Manual or Supplemental Materials that Health Plan may do so. Health Plan will conduct medical management throughout the course of treatment.

## ARTICLE FIVE – TERM AND TERMINATION

- 5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.
- 5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party.
- 5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach may give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.
- 5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:
- Provider's license or any other approvals needed to provide Covered Services is limited, suspended, revoked, or disciplinary proceedings are commenced against Provider by applicable regulators and accrediting agencies;

- b. Either Party fails to maintain adequate levels of insurance;
- c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;
- d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;
- e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;
- f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to provide Covered Services;
- g. Either Party is excluded from participation in state or federal health care programs;
- h. Provider is terminated as a provider by any state or federal health care program;
- i. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party's obligations under this Agreement;
- j. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members' health and safety;
- k. Provider violates any state or federal law, statute, rule, regulation or executive order; or
- l. Provider fails to satisfy the terms of a corrective action plan.

**5.5 Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.

**5.6 Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

## ARTICLE SIX – GENERAL PROVISIONS

- 6.1 Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.
- 6.2 Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purpose of effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party to enforce this Agreement.
- 6.3 Governing Law.** The laws of the State of Texas will govern this Agreement.
- 6.4 Entire Agreement.** This Agreement, including attachments, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.
- 6.5 Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

- 6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.
- 6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.
- 6.8 **Amendments.**
- Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.
  - Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.
- 6.9 **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider's Subcontractors and a description of the Covered Services or administrative services that the Subcontractor provides. After the Effective Date, Provider will not subcontract with a Subcontractor without the prior written consent of Health Plan. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the terms required by Health Plan.
- 6.10 **Assignment.** Provider may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Parties and respective successors in interest and assignees.
- 6.11 **Dispute Resolution.**
- Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.
  - Binding Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services ("JAMS"), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution ("ADR") provider in accordance with that ADR provider's Commercial Arbitration Rules, in Dallas, Texas. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars (\$1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars (\$500,000.00), but less than one million dollars (\$1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings ("Selected Arbitrator"). Each Party can strike no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars (\$500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

The arbitrator will apply Texas substantive law and Federal substantive law where State law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars (\$1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars (\$500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act ("FAA"), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing pursuant to the FAA or applicable state arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the

Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

**6.12 Notice.**

- a. **Delivery.** All notices required or permitted by this Agreement will be in writing and will be delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by e-mail. Any notice sent with signature delivery confirmation or return receipt requested, is deemed given on the date of delivery. If no delivery date is shown, notice is deemed given two (2) business days after the postmark date. Notice delivered by USPS express mail, or by overnight courier that guarantees next day delivery is deemed given two (2) business days after delivery of the notice to USPS or the overnight courier. For delivery by facsimile transmission, the notice is deemed delivered upon confirmation of receipt of the transmission. For delivery by e-mail, the notice is deemed given on the date sent. All notices are deemed given if delivered as specified in this section.
- b. **Names & Addresses.** The name, mailing address, e-mail address, and facsimile number set forth under the Signature Page will be the particular Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement.

**6.13 Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

**6.14 Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, or signatures scanned and sent via e-mail will have the same effect as original signatures.

**6.15 Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member's Product. In the event of a conflict between this Agreement and any benefits, terms, or conditions of a Product, the benefits, terms, and conditions contained in the Member's Product will govern.

**6.16 Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

**6.17 Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

**ATTACHMENT A**

**Products**

- 1.1 **Medicaid** – including, but not limited to, STAR, STAR+PLUS, STAR Kids, and any other Medicaid programs Health Plan offers in the future.
- 1.2 **CHIP** – including, but not limited to, the CHIP MCO, CHIP Perinatal, CHIP RSA, and any other programs developed and implemented by Texas HHSC or its successor.
- 1.3 **Medicare Advantage** – including, but not limited to, Molina Medicare Options, Molina Medicare Options Plus and any other Medicare Advantage programs Health Plan offers in the future.
- 1.4 **Medicare-Medicaid Program** – including, but not limited to, the STAR+PLUS Medicare-Medicaid Program.
- 1.5 **Health Insurance Marketplace** – including, but not limited to, Molina Marketplace.

**ATTACHMENT B**  
**Compensation Schedule**

- 1.1 **Compensation for Medicaid and CHIP.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the Medicaid and CHIP Products, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) at an amount equivalent to the allowable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Texas, in effect on the Date of Service. In the event that there is no payment rate in the Texas Medicaid Fee-For-Service Program fee schedule as of the Date of Service, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date of Service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the Date of Service.

**Provider agrees to the above reimbursement and participation in Medicaid and CHIP:**

**Provider Signature:** not applicable      **Date:** \_\_\_\_\_

- 1.2 **Compensation for Medicare Advantage.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the Medicare Advantage Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the Date of Service. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

**Provider agrees to the above reimbursement and participation in Medicare Advantage:**

**Provider Signature:** MHS      **Date:** 2/22/2018

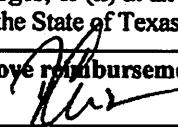
- 1.3 **Compensation for Medicare-Medicaid Program.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the MMP Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, at the lesser of: (i) Provider's billed charges; or (ii) pursuant to the methodology described below.

Provider will receive an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography) as of the Date of Service, and any portion, if any, that the Medicaid agency or Medicaid managed care plan would have been responsible for paying if the Member was enrolled in the Medicare Fee-For-Service Program. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

In the event the Provider bills for Services covered by Medicaid or that are primary to Medicaid, but not Medicare, Health Plan agrees to compensate Provider on a fee-for-service basis for such Covered Services provided that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser

of: (i) Provider's billed charges; or (ii) at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rates set forth by the State of Texas in effect on the Date of Service.

**Provider agrees to the above reimbursement and participation in Medicare-Medicaid (MMP) Program:**

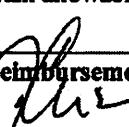
Provider Signature: 

Date: 2/22/2018

- 1.4 **Compensation for Health Insurance Marketplace.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the Health Insurance Marketplace Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate (adjusted for place of locality or geography), as of the Date of Service. In the event that there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the Date of Service, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) an amount equivalent to the allowable rate under the applicable Medicaid Fee-For-Service Program fee schedule set forth by the State of Texas, in effect on the Date of Service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography), as of the Date of Service.

**Provider agrees to the above reimbursement and participation in Health Insurance Marketplace:**

Provider Signature: 

Date: 2/22/2018

**ATTACHMENT C**  
**State of Texas Required Provisions**  
**State Laws**

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

- 1.1 **Retaliation.** Health Plan may not engage in retaliatory action, including refusal to renew or termination of a contract, against Provider because Provider has, on behalf of a Member, reasonably filed a complaint against Health Plan or appealed a decision of Health Plan.
- 1.2 **Continuity of Care.** Unless termination of this Agreement is based upon reasons of medical competence or professional behavior, Health Plan shall have a continuing obligation to reimburse Provider for the treatment of a member with special circumstances, as defined in and in accordance with applicable Texas law.
- 1.3 **Member Notice.** Provider shall post in Provider's office a notice to Members on the process for resolving complaints with Health Plan. Such notice shall include the Texas Department of Insurance's toll-free telephone number for filing complaints.
- 1.4 **Podiatry.** The following provisions apply to providers credentialed by Health Plan, or Health Plan's designee, as podiatrists.
  - a. Podiatrists may request, and Health Plan will provide not later than the thirtieth (30th) day after the date of the request, a copy of coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the Agreement.
  - b. Health Plan may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the Agreement.
  - c. Podiatrists may, while practicing within the scope of the law regulating podiatry, provide x-rays and non-prefabricated orthotics covered by a Member's health benefits plan.
- 1.5 **Capitation.** In the event Provider receives capitation, the language required by 28 TAC §11.901(a)(9), and (10) is incorporated into this Agreement.
- 1.6 **Availability of Coding Guidelines.** Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that Provider will receive under the Agreement, and Health Plan or its agent shall provide the coding guidelines and fee schedules not later than thirty (30) days after Health Plan receives the request. Health Plan shall provide notice of changes to the coding guidelines and fee schedules to Provider not later than ninety (90) days before the date the changes take effect, unless the change is required by statute or regulation in a shorter timeframe, and shall not make retroactive revisions to the coding guidelines and fee schedules. Provider may terminate participation in the product(s)/program(s) that the change in coding guidelines applies to, on or before the thirtieth (30th) day after the date Provider receives information requested under this section without penalty or discrimination in participation in other Health Plan products. Any Provider who receives information under this section may only: (i) use or disclose the information for the purpose of practice management, billing activities, and other business operations; and (ii) disclose the information to a governmental agency involved in the regulation of health care or insurance. On Provider's request, Health Plan shall provide the name, edition, and model version of the software that Health Plan uses to determine bundling and unbundling of claims.

**ATTACHMENT D**  
**Medicaid and CHIP**  
**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid and CHIP Products. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid and CHIP Products. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid and CHIP Products.

**1.1 Definitions.**

- a. **Clean Claim** means a claim submitted by a Provider for health care services rendered to a Member, with the data necessary for the Health Plan to adjudicate and accurately report the claim. A Clean Claim other than a nursing facility services Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate claim type encounter guides as follows: (i) 837 Professional Combined Implementation Guide; (ii) 837 Institutional Combined Implementation Guide; (iii) 837 Professional Companion Guide; (iv) 837 Institutional Companion Guide; or (v) National Council for Prescription Drug Programs (“NCPDP”) Companion Guide.
- b. **Emergency Behavioral Health Condition** means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (i) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others; or (ii) renders Members incapable of controlling, knowing, or understanding the consequences of their actions.
- c. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious disfigurement; or (v) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.
- d. **Emergency Services** means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Agreement and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-Stabilization Care Services.
- e. **Medically Necessary or Medical Necessity (for Medicaid product/program)** has the meaning defined in 1 TAC §353.2.
- f. **Medically Necessary or Medical Necessity (for CHIP product/program)** has the meaning defined in 1 TAC §370.4.
- g. **Post Stabilization Care Services** means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, for a Medicaid Member, under the circumstances described in 42 §§CFR 438.114(b)&(e) and 42 CFR §422.113(c)(iii) to improve or resolve the Medicaid Member's condition.

- 1.2 Behavioral Health.** If Providers provides inpatient psychiatric services to Members, Provider shall schedule Members for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must

occur within seven (7) days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within twenty-four (24) hours to reschedule appointments.

- 1.3 **Early Childhood Intervention.** Providers must cooperate and coordinate with local Early Childhood Intervention (“ECI”) programs to comply with federal and state requirements relating to the development, review, and evaluation of Individual Family Service Plans (“IFSP”). Provider understands and agrees that any Medically Necessary health and behavioral health services contained in an IFSP must be provided to the Member in the amount, duration, scope, and setting established in the IFSP.
- 1.4 **Liability.** Provider understand and agrees that: (i) in the event Health Plan becomes insolvent or ceases operations, Provider sole recourse against Health Plan will be through the Health Plan’s bankruptcy, conservatorship, or receivership estate; (ii) Members may not be held liable for Health Plan’s debts in the event of Health Plan insolvency; and (iii) Texas Health and Human Services Commission (“HHSC”) does not assume liability for the actions of, or judgments rendered against, Health Plan, its employees, agents, or subcontractors. Further, there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by the Health Plan or any judgment rendered against the Health Plan. HHSC’s liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code 101.001 et seq.).
- 1.5 **Marketing.** Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, the Provider agrees to comply with HHSC’s marketing policies and procedures, as set forth in HHSC’s Uniform Managed Care Manual (“UMCM”). Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- 1.6 **Medicaid Provider Agreement.** Acute care providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid program, and must have a Texas Provider Identification Number (“TPIN”). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (“NPI”) in accordance with the timelines established in 45 CFR Part 162, Subpart D.
- 1.7 **Member Communications.** Health Plan is prohibited from imposing restrictions upon Provider’s free communication with a Member about the Member’s medical conditions, treatment options, Health Plan referral policies, and other Health Plan policies, including financial incentives or arrangements and all managed care plans with whom Provider contracts.
- 1.8 **Primary Care Providers.** The following provisions apply to providers credentialed by Health Plan, or Health Plan’s designee, as Primary Care Providers (“PCP”).
  - a. PCP shall have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
  - b. PCP shall be accessible to Members twenty-four (24) hours per day, seven (7) days per week.
  - c. PCP shall provide preventive care: (i) to children under age twenty-one (21) in accordance with American Academy of Pediatrics recommendations for Members and CHIP perinatal newborns, and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members; and (ii) to adults in accordance with the U.S. Preventative Task Force requirements.
  - d. PCP shall assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed.
  - e. PCP must coordinate Members’ care with specialty care providers after referral.
  - f. PCP will serve as a medical home for Members.
- 1.9 **Tuberculosis.** Provider shall coordinate with the local tuberculosis (“TB”) control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy. Provider shall report to the Texas Department of State Health Services (“DSHS”) or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat.

- 1.10 **Women, Infants and Children.** Provider shall coordinate with the Women, Infants, and Children (“WIC”) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin.
- 1.11 **Standard of Care.** While performing the services described in this Agreement, Provider agrees to: (i) comply with applicable state laws, rules, and regulations, and HHSC’s requests regarding personal and professional conduct generally applicable to the service locations; and (ii) otherwise conduct his or her self in a businesslike and professional manner.
- 1.12 **Confidentiality.** Provider shall treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement. Provider shall protect the confidentiality of Member Protected Health Information (“PHI”), including patient records. Provider must comply with all applicable federal and state laws, including the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy and Security Rule governing the use and disclosure of protected health information.
- 1.13 **Access to Records.**
- a. Provider agrees to provide at no cost to HHSC: (i) all information required under Health Plan’s contract with HHSC, including but not limited to, the reporting requirements and other information related to the Provider’s performance of its obligations under the contract; and (ii) any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.
  - b. Upon receipt of a record review request from the HHSC Office of Inspector General (“OIG”) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than twenty-four (24) hours, the provider must provide the records requested at the time of the request or in less than twenty-four (24) hours. The request for record review includes, but is not limited to: (i) clinical medical or dental Member records; (ii) other records pertaining to the Member; (iii) any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; (iv) documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; (v) radiographs and study models related to orthodontia services; (vi) business and accounting records with backup support documentation; (vii) statistical documentation; (viii) computer records and data; and/or (ix) contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the provider as described in 1 Tex. Admin. Code, Chapter 371, Subchapter G.
- 1.14 **Audit or Investigation.**
- a. Provider agrees to provide, at no cost to the following entities and their designees, prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or Provider’s performance of its responsibilities under this Agreement: (i) the United States Department of Health and Human Services; (ii) the Comptroller General of the United States; (iii) Health Plan program personnel from HHS; (iv) the Office of Inspector General; (v) the Medicaid Fraud Control Unit of the Texas Attorney General’s Office; (vi) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC; (vii) the Office of the State Auditor of Texas; (viii) state or federal law enforcement agencies; (ix) special or general investigating committee of the Texas Legislature; and (x) any other state or federal entity identified by HHSC or any other entity engaged by HHSC.

- b. Provider shall provide access wherever it maintains such records, books, documents, and papers. Provider shall provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes: (i) examination; (ii) audit; (iii) investigation; (iv) contract administration; (v) the making of copies, excerpts, or transcripts; or (vi) any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.
  - c. Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.
- 1.15 Complaints and Appeals.** Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.
- 1.16 Member Billing.**
- a. Provider is prohibited from billing or collecting any amount from a Medicaid or CHIP Member for health care services provided pursuant to this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.
  - b. Health Plan shall initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP provider from collecting allowable copayment and deductible amounts from CHIP Members. Additionally, this provision does not restrict a CHIP dental provider from collecting payment for services that exceed a CHIP Member's benefit cap.
- 1.17 Costs of Non-Covered Services.** Providers shall inform Members of the costs for non-Covered Services prior to rendering such services and shall obtain a signed private pay form from such a Member.
- 1.18 HHSC Liability.** Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.
- 1.19 Third Party Recovery.** Provider shall not interfere with or place any liens upon the State's right or Health Plan's right, acting as the State's agent, to recovery from third party resources.
- 1.20 Clean Claims Payment.** Health Plan shall adjudicate (finalize as paid or denied adjudicated) Clean Claims for: (i) Covered Service within thirty (30) days from the date the Claim is received by Health Plan; or (ii) pharmacy Covered Services, no later than eighteen (18) days from receipt if the Claim submitted electronically, or twenty-one (21) days of receipt if the Claim is submitted non-electronically. Health Plan shall pay Provider interest at a rate of eighteen (18) percent interest, per annum, on all Clean Claims that are not adjudicated within thirty (30) days. However, duplicate Claims filed prior to the expiration of thirty-one (31) days are not subject to any interest payment if not processed within thirty (30) days.
- 1.21 Claims Processing.**
- a. Health Plan shall compensate Provider pursuant to the terms of this Agreement. Provider may access the State of Texas Medicaid Fee-For-Service Program fee schedule at: [www.Molinahealthcare.com](http://www.Molinahealthcare.com).
  - b. Providers may:
    - i. Contact Molina Healthcare of Texas' Provider Services Department at 1-866-449-6849.
    - ii. Non-electronic claims should be mailed to:
- Molina Healthcare of Texas, Inc.  
P.O. Box: 22719  
Long Beach, CA 90801

iii. Electronic claims can be sent to Health Plan via:

[www.Molinahealthcare.com](http://www.Molinahealthcare.com)

- c. Health Plan shall notify Provider in writing of any changes in the claims processing or adjudication entity at least thirty (30) days prior to the effective date of change. If Health Plan is unable to provide thirty (30) days' notice, Health Plan shall allow Provider a thirty (30) day extension on the claims filing deadline to ensure claims are routed to the correct processing center.
- d. Provider must comply with the requirements of Texas Government Code 531.024161, regarding the submission of claims involving supervised providers.
- e. Program violations arising out of performance of this Agreement are subject to administrative enforcement by the OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

**1.22 Appeals of Claims Payment Decisions.** The timeframes for appeals of claims payment decisions shall be as follows: (i) In the event that Health Plan denies a Provider claim, Provider must submit a request for review of the denied claim within one hundred twenty (120) days of the initial denial; (ii) in the event that Provider believes Health Plan incorrectly paid a Provider claim, Provider must submit a request for correction or adjustment within one hundred twenty (120) days of the date of the remittance advice; and (iii) Health Plan will use its best efforts to resolve all disputed claims within thirty (30) days of receipt. The format for appeals of claims payment decisions shall be as follows: (i) the request must specify why the Provider believes Health Plan owes the payment; (ii) in the case of coordination of benefits, the request must include the name and mailing address of any entity that has disclaimed responsibility for payment; (iii) the request must be addressed to the attention of Health Plan's Provider Services Department; (iv) the request must clearly indicate "Denied Claims Review Request" or "Adjustment Request;" and (v) the request must include all pertinent information, including, but not limited to, claim number, Member identifier, denial letter, supporting medical records, and any new information pertinent to the request.

**1.23 Compliance with Applicable Law.**

- a. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement, the UMCC, Health Plan's health benefits programs, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by Provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation Health Plan's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
- b. In addition, Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to this Agreement:
  - i. Environmental Protection Laws: Pro-Children Act of 1994 (20 USC 6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products; National Environmental Policy Act of 1969 (42 USC 4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures; Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans"); State Clean Air Implementation Plan (42 USC 740 et seq.) regarding conformity of federal actions to State Implementation Plans under Sec.176(c) of the Clean Air Act; and Safe Drinking Water Act of 1974 (21 USC 349; 42 USC 300f to 300j-9) relating to the protection of underground sources of drinking water.
  - ii. State and Federal Anti-Discrimination Laws: Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.) and as applicable 45 CFR Part 80 or 7 CFR Part 15; Section 504 of the Rehabilitation Act of 1973 (29 USC 794); Americans with Disabilities Act of 1990 (42 USC 12101 et seq.); Age Discrimination Act of 1975 (42 USC 6101-6107); Title IX of the Education Amendments of 1972 (20 USC 1681-1688); Food Stamp Act of 1977 (7 USC 200 et seq.); Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16 and Title 40; and the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement;

- iii. The Immigration and Nationality Act (8 USC 1101 et seq.) and all subsequent immigration laws and amendments;
- iv. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); and
- v. The Health Information Technology for Economic and Clinical Health Act at 42 USC 17931 et. seq.

**1.24 Fraud and Abuse.**

- a. Provider understands and agrees to the following: (i) the OIG and/or the Texas Medicaid Fraud Control Unit shall be allowed to conduct private interviews of Provider and its employees, agents, contractors, and patients; (ii) requests for information from such entities shall be complied with, in the form and language requested; (iii) Provider and its employees, agents, and contractors shall cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations; and (iv) compliance with these requirements will be at the Provider's own expense.
- b. Provider further understands and agrees to the following: (i) Provider is subject to all state and federal laws and regulations relating to fraud, abuse, or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable; (ii) Provider shall cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, abuse, or waste; (iii) Provider shall provide originals and/or copies of any and all information as requested by HHSC or the state or federal agency, allow access to premises, and provide records to the OIG, HHSC, CMS, the U.S. Department of Health and Human Services, Federal Bureau of Investigation, Texas Department of Insurance, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge; (iv) if Provider places required records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and (v) Provider shall report any suspected fraud or abuse including any suspected fraud and abuse committed by the Health Plan or a Member to the OIG.
- c. If the Provider receives annual Medicaid payments of at least five (5) million (cumulative, from all sources), Provider must:
  - i. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.
  - ii. Include as part of such written policies, detailed provisions regarding the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
  - iii. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.

**1.25 Gifts and Gratuities.** Provider shall not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than fifty dollars (\$50.00) and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Health Plan may terminate this Agreement at any time for violation of this provision.

**1.26 Termination.** Health Plan shall provide a written explanation of the reasons for Provider's termination at least ninety (90) days before the effective date of the proposed termination. Health Plan may immediately terminate a Provider in cases involving: (i) imminent harm to patient health; (ii) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession; or (iii) fraud or malfeasance. Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of Health Plan's

proposed termination by an advisory review panel. A provider whose participation is being terminated is entitled to an expedited review by Health Plan upon request. Within sixty (60) days following receipt of Provider's request and before the termination effective date, the advisory review panel will make its formal recommendation. Health Plan will communicate the advisory review panel decision to Provider and, upon Provider's request, Health Plan will provide a copy of the recommendation. The advisory review panel decision is not binding upon Health Plan.

**1.27 Complaint Process.**

a. **Complaints.**

- i. Provider shall submit any dispute, other than any dispute relating to payment or non-payment of a claim, to Health Plan in writing within sixty (60) days of when the issue arises.
- ii. Provider shall submit such disputes to the attention of Health Plan's Provider Services Department.

b. **Health Plan Response.**

- i. Health Plan shall use best efforts to acknowledge by phone, e-mail, or other writing, receipt of a dispute, other than any dispute relating to payment or non-payment of a claim, within five (5) business days.
- ii. Health Plan shall investigate and resolve disputes within thirty (30) days of Health Plan's receipt of Provider's written correspondence.
- iii. Health Plan's decision regarding disputes shall be communicated within thirty (30) days of Health Plan's receipt of Provider's written correspondence requesting review. If additional time is required, Health Plan shall communicate this information to Provider within thirty (30) days.

**1.28 Administrative Requirements.** Providers must inform both Health Plan and HHSC's administrative services contractor of any changes to Provider's address, telephone number, and group affiliation.

**1.29 Product Orders.** If Provider offers delivery services for covered products, such as durable medical equipment ("DME"), limited home health supplies ("LHHS"), or outpatient drugs or biological products, Provider must reduce, cancel, or stop delivery if Member or the Member's authorized representative submits an oral or written request. Provider must maintain records documenting the request.

**1.30 Insurance.** Provider shall maintain, during the term of this Agreement, Professional Liability Insurance of one hundred thousand dollars (\$100,000.00) per occurrence and three hundred thousand dollars (\$300,000.00) in the aggregate, or the limits required by the hospital at which Provider has admitting privileges.

**1.31 Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and activities, including peer review and audits of care rendered by Provider.

**1.32 Service Coordination.** In addition to the requirements stated herein, the following provisions are specific to and apply to STAR+PLUS Members.

- a. Home and Community Support Services Agency ("HCSSA") providers, adult day care providers, and residential care facility providers must notify Health Plan if a Member experiences any of the following: (i) a significant change in the Member's physical or mental condition or environment; (ii) hospitalization; (iii) an emergency room visit; or (iv) two or more missed appointments.
- b. Providers using the Electronic Visit Verification system must maintain compliance with HHSC minimum standards detailed in UMCM, Chapter 8.7, Section IX.

**1.33 Waiting Times.** Providers must provide services within the timeframes that are noted within Health Plan's Provider Manual.

**1.34 STAR and STAR+PLUS.** In addition to the requirements stated herein, the following provisions are specific to and apply to STAR and STAR+PLUS Members.

a. **Family Planning.**

- i. If a Member requests contraceptive services or family planning services, Provider must also provide the Member counseling and education about family planning and available family planning services.

- ii. Provider shall not require parental consent for Members who are minors to receive family planning services.
    - iii. Provider shall comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.
  - b. **THSteps.** Provider shall send all THSteps newborn screens to DSHS, formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Provider shall include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.
  - c. **Mental Health.** Providers must comply with 25 Tex. Admin. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing Mental Health Rehabilitative Services and Mental Health Targeted Case Management.
  - d. **Advance Directives.** Provider shall comply with the requirements of state and federal laws, rules, and regulations relating to advance directives, including but not limited to, the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended.
  - e. **Lead Screening.** In accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, Providers must: (i) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory); and (ii) follow-up on suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located at [www.dshs.state.tx.us/lead/pdf\\_files/pb\\_109\\_physician\\_reference.pdf](http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf).
- 1.35 **CHIP.** In addition to the requirements stated herein, the following provisions are specific to and apply to CHIP Members.
- a. Provider is responsible for collecting at the time of service any applicable CHIP copayments or deductibles in accordance with CHIP cost-sharing limitations.
  - b. Providers shall not charge: (i) cost-sharing or deductibles to CHIP Members of Native American Tribes or Alaskan Natives; (ii) copayments or deductibles to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; (iii) copayments for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA); or (iv) copayments for routine preventive and diagnostic dental services (CHIP Dental).
  - c. Copayments are the only amounts that Network Providers may collect from CHIP Members, except for costs associated with unauthorized nonemergency services provided to a Member by out-of-network providers for non-covered services.

**ATTACHMENT E**  
**Medicare Advantage**  
**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product.

Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicare Advantage Product.

- 1.1 **Downstream Compliance.** Provider agrees to require its Downstream Entities that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein.
- 1.2 **Right to Audit.** The United States Department of Health and Human Services ("HHS"), the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later.
- 1.3 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118.
- 1.4 **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstances, including non-payment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a MA-SNP will not be held liable for Medicare Part A and B cost sharing when the State or another payer such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of co-payments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.
- 1.5 **Accountability.** Health Plan may only delegate activities or functions to a Downstream Entity in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement.
- 1.6 **Delegation.** Any services or other activity performed by a Downstream Entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS.
- 1.7 **Prompt Payment.** For the avoidance of doubt, prompt payment will be governed by Section 4.2, Compensation, in the Agreement. Health Plan reserves the right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing.

- 1.8 **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.
- 1.9 **Compliance with Medicare Laws and Regulations.** Provider will comply with all applicable Medicare laws, regulations, and CMS instructions.
- 1.10 **Benefit Continuation.** Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge.
- 1.11 **Cultural Considerations.** Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

**ATTACHMENT E-1**  
**Medicare Advantage**  
**Laws and Government Program Requirements**  
**Delegated Services**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicare Advantage Product.

- 1.1 **Downstream Compliance.** Provider agrees to require all of its Downstream Entities that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein.
- 1.2 **Medicare Compliance.** Provider agrees to require all of its Downstream Entities to comply with all applicable Medicare laws, regulations, and CMS instructions.
- 1.3 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118.
- 1.4 **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later.
- 1.5 **Responsibilities and Reporting Arrangements.** The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 422.310 by providing relevant data.
- 1.6 **Revocation of Delegated Activities.** In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked.
- 1.7 **Accountability.** Notwithstanding any relationship Health Plan may have with Downstream Entity, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms of its contract with CMS. Any services or other activity performed by a Downstream Entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS.
- 1.8 **Credentialing.** If Provider is delegated for credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement.
- 1.9 **Monitoring.** Notwithstanding any relationship Health Plan may have with Downstream Entity, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms of its contract with CMS. Any services or other activity performed by a Downstream Entity in accordance with a contract or written

agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of Downstream Entity.

- 1.10 **Further Requirements.** Any services or other activity performed by a Downstream Entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement.

**ATTACHMENT F**  
**Medicare-Medicaid Program**  
**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control MMP Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the MMP Product.

**1.1 Definitions.**

- a. **Clean Claim** means a claim submitted by a Provider for health care services rendered to a Member, with the data necessary for the Health Plan to adjudicate and accurately report the claim. A Clean Claim other than a nursing facility services Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate claim type encounter guides as follows: (i) 837 Professional Combined Implementation Guide; (ii) 837 Institutional Combined Implementation Guide; (iii) 837 Professional Companion Guide; (iv) 837 Institutional Companion Guide; or (v) National Council for Prescription Drug Programs (NCPDP) Companion Guide.
  - b. **Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including but not limited to severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, (i) that there is inadequate time to effect a safe Transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.
  - c. **Emergency Services** means covered inpatient and outpatient services that are as follows: (i) furnished by a provider that is qualified to furnish these services under this title; and (ii) needed to evaluate or stabilize an emergency medical condition.
  - d. **Medically Necessary or Medical Necessity** means Covered Services must be provided in a way that provides all protections to covered individuals provided by Medicare and Texas Medicaid. Services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC §1395 (per Medicare); and has meaning assigned in Texas Administrative Code (TAC) Section 353.2 (per HHSC).
  - e. **Post Stabilization Care Services** means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, for a Member, under the circumstances described in 42 §§ CFR 438.114(b)&(e) and 42 CFR § 422.113(c)(iii) to improve or resolve the Member's condition.
- 1.2 **Downstream Compliance.** Provider and its Downstream Entity(s) agree that any functions being performed on behalf of Health Plans related to the operation of the Medicare-Medicaid plan are in compliance with 42 CFR 422.504, 42 CFR 423.505, and 42 CFR 438.6(1).
- 1.3 **Right to Audit.** CMS, HHSC, HHS, Comptroller General, and other state and federal department/agencies, as well as their agents and designees, have the right to audit, evaluate, and inspect any pertinent information, including but not limited to, books, contracts, records, medical records, and documentation that pertain to any aspect of services

performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS and HHSC, or as the appropriate regulatory department/agency may deem necessary to enforce Health Plan's contract with CMS and HHSC. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, as well as pertinent information relating to its Members, and any additional relevant information that CMS, HHSC, HHS, Comptroller General, and other state and federal department/agencies, as well as their agents and designees, may require. These rights to inspect evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS and HHSC or completion of audit, whichever is later.

- 1.4 **Confidentiality.** Provider agrees to safeguard Member privacy and the confidentiality of Member health records. Provider will abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, and other health and enrollment information. Provider must ensure that medical information is released in accordance with applicable federal or state laws, and pursuant to court orders and subpoenas. Providers must maintain Member medical records and information in an accurate and timely manner. Providers must ensure timely access by Members to the records and information that pertain to them.
- 1.5 **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstance, including but not limited to, nonpayment of moneys due to Provider by Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. This Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition:
  - a. Members will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Member.
  - b. Notwithstanding the foregoing, Provider may bill Members for Part D pharmacy co-payments, if applicable.
- 1.6 **Accountability.** Health Plan may only delegate activities or functions to a Downstream Entity(s) in a manner that is consistent with the provisions set forth in Attachment E-1 of this Agreement.
- 1.7 **Delegation.** Any service or other activity performed by a Downstream Entity(s), which is performed pursuant to a contract or written agreement between Provider and the Downstream Entity(s), will be consistent and comply with the Health Plan's contract with CMS and HHSC, and the terms of this Agreement.
- 1.8 **Claims Payment.**
  - a. Notwithstanding any other provision of this Agreement, Health Plan shall not make any payment or pay any Claim, nor does Health Plan have any obligation to make any payment or pay any Claim, to a Provider:
    - i. Excluded, terminated, or suspended from the Medicare program, Medicaid program, or other state or federally funded health care programs. This includes, but is not limited to, Providers excluded for fraud, abuse, or waste;
    - ii. For a provider preventable condition as defined in 42 CFR 447.26(b);
    - iii. That has not complied with reporting requirements on provider preventable conditions as described at 42 CFR 447.26(d), or by Health Plan or HHSC;
    - iv. On payment hold under the authority of HHSC, CMS, or its authorized agent(s);
    - v. With pending accounts receivable with HHSC or CMS; or
    - vi. For nursing facility services that do not comply with the Texas Department of Aging and Disability Services ("DADS") criteria for clean claim.
  - b. Providers must comply with the requirements of Texas Government Code §531.024161, regarding reimbursement of claims based on orders or referrals by supervising providers to be eligible for payment.

- c. Health Plan may suspend payments to Provider if the OIG, HHSC, or CMS determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid or Medicare program against Provider.
- 1.9 **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in Health Plan's contract with CMS and HHSC. When applicable, Provider must provide all information that CMS and HHSC require:
- a. Under Health Plan's contract with CMS and HHSC related to the performance of the responsibilities under the MMP Program, including non-medical information for the purposes of research and evaluation;
  - b. To comply with applicable federal or state laws and regulations; or
  - c. For external rapid cycle evaluation, including but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Member satisfaction, Member complaints and appeals, and enrollment/disenrollment rates.
- 1.10 **Compliance with Laws and Regulations.** Provider will comply with all federal and state laws, regulations, and CMS and HHSC instructions. This includes, but is not limited to, laws, regulations, and instructions that pertain to the Medicare and Medicaid programs.
- 1.11 **Benefit Continuation.** Provider agrees to provide for the continuation of Member health care benefits: (i) for all Members for the duration of the period for which CMS or HHSC has made payments to Health Plan for MMP services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS and HHSC terminates, or, in the event of insolvency, through discharge.
- 1.12 **Cultural Considerations.** Provider agrees that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.
- 1.13 **Corrective Action.** Health Plan monitors Provider performance under this Agreement on an ongoing basis and Health Plan may impose corrective action as necessary to address instances of noncompliance.
- 1.14 **Federal Emergency Medical Treatment and Labor Act.** As applicable to Provider, Provider must comply with the Federal Emergency Medical Treatment and Labor Act ("EMTALA") and all requirements outlined in 42 USC 1395dd. Health Plan will not create any policies that conflict with the Provider's obligations under EMTALA.
- 1.15 **Physician Incentive Plans.** Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to, 42 CFR 417, 42 CFR 422, 42 CFR 434, 42 CFR 438.6(h), and 42 CFR 1003.
- 1.16 **Indemnification.** Provider is not required to indemnify Health Plan for any expenses and liabilities, including without limitation, judgments, settlements, attorney's fees, court costs, and any associated charges, incurred in connection with any claim or action brought against Health Plan based on Health Plan's management decisions, utilization review provisions or other policies, guidelines or actions. For the avoidance of doubt, nothing in this section creates any conflict with the Section 6.1, Indemnification, in the Agreement.
- 1.17 **Provider Participation.**
- a. Provider may not close or otherwise limit its acceptance of Members as patients unless the same limitations apply to all commercially insured individuals.
  - b. Providers will comply with Health Plan's requirements for the delivery of preventive health services.
  - c. Provider shall provide to Health Plan all state and federally required disclosures and comply with state and federal requirements for disclosure of ownership and control, business transactions, and information of persons convicted of crimes against federal and state health care programs as described in 42 CFR 455, 42 CFR 1002.3, and as specified by HHSC and CMS.
  - d. Provider shall offer hours of operation that are no less than the hours of operation offered to individuals who are not MMP Members.
  - e. Provider must notify the Member's PCP of a Member's screening and treatment.

- f. If a Member files a grievance with Provider, Provider must promptly forward it to Health Plan. Provider will be bound by the terms and conditions of the Health Plan's contract with CMS and HHSC that are appropriate to the service or activity Provider is performing pursuant to this Agreement.
- g. Provider is required to meet the same federal and state financial and program reporting requirements as Health Plan. Provider is required to attend annual fraud detection training as provided by HHSC.

**1.18 Provider Protection.**

- a. Health Plan may not refuse to contract or pay a Provider for the provision of Covered Services solely because such Provider has in good faith:
  - i. Communicated with or advocated on behalf of one (1) or more of his or her prospective, current, or former patients regarding the provisions, terms, or requirements of Health Plan's benefit plans as they relate to the needs of such Provider's patients; or
  - ii. Communicated with one (1) or more of his or her prospective, current, or former patients with respect to the method by which such Provider is compensated by Health Plan for services provided to the patient.
- b. Health Plan shall notify Providers in writing of modifications in payments, modifications in Covered Services, or modifications in Health Plan's procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided thirty (30) days before the effective date of such modification unless such other date for notice is mutually agreed upon between Health Plan and the Provider or unless such change is mandated by CMS or HHSC without thirty (30) days prior notice.
- c. Health Plan may not impose a financial risk on medical Providers for the costs of medical care, services, or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:
  - i. Stop-loss protection;
  - ii. Minimum patient population size for the physician or physician group; and
  - iii. Identification of the health care services for which the physician or physician group is at risk.

**1.19 Laboratory Providers.** Laboratory testing sites must have either a Clinical Laboratory Improvement Amendment ("CLIA") certificate or waiver of a certificate of registration along with a CLIA identification number.

**1.20 Primary Care Providers.** The following provisions apply to Providers credentialed by Health Plan, or Health Plan's designee, as Primary Care Providers ("PCP").

- a. PCPs shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate behavioral health services within the scope of their practice.
- b. Provider must attend trainings on how to screen for and identify behavioral health disorders, on Health Plan's referral process for behavioral health services, and on clinical coordination requirements for such services.
- c. Provider must attend trainings on coordination and quality of care such as behavioral health screening techniques and models of behavioral health interventions.
- d. Health Plan will develop and disseminate policies regarding clinical coordination between behavioral health service providers and PCPs.

**1.21 Behavioral Health Services Providers.** The following provisions apply to Providers providing behavioral health services to Members.

- a. Provider must refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's Legally Authorized

Representative's ("LAR") consent. Behavioral health Providers may only provide physical health care services if they are licensed to do so.

- b. Providers shall send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's LAR's consent.
- c. Members receiving inpatient psychiatric services must be scheduled for outpatient follow-up or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge.
- d. Providers must contact Members who have missed appointments within one (1) business day to reschedule appointments.
- e. Providers shall make available behavioral health clinical assessment and outcomes data for quality management and network management purposes to Health Plan.

**1.22 Nursing Facilities.** The following provisions apply to nursing facilities.

- a. Nursing facility must use state and federally-required assessment instruments, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations.
- b. Nursing facility will promptly supply these assessments to Health Plan.

**1.23 Agreement Review.** HHSC and CMS retain the right to reject or require changes to this Agreement if it does not comply with STAR+PLUS MMP requirements or Health Plan's contract with CMS and HHSC. Health Plan may amend this Agreement to ensure compliance with this requirement.

**1.24 Program Violations.** Violations arising out of performance of this Agreement are subject to administrative enforcement by the OIG as specified in 1 TAC, Chapter 371, Subchapter G.

## Article II

In the event of any inconsistency or conflict between Article I and Article II of this attachment, Article I shall control.

- 2.1 Behavioral Health.** If Provider provides inpatient psychiatric services to Members, Provider shall schedule Members for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within twenty-four (24) hours to reschedule appointments.
- 2.2 Early Childhood Intervention.** Provider must cooperate and coordinate with local Early Childhood Intervention ("ECI") programs to comply with federal and state requirements relating to the development, review, and evaluation of Individual Family Service Plans ("IFSP"). Provider understands and agrees that any Medically Necessary health and behavioral health services contained in an IFSP must be provided to the Member in the amount, duration, scope, and setting established in the IFSP.
- 2.3 Liability.** Provider understand and agrees that: (i) in the event Health Plan becomes insolvent or ceases operations, Provider sole recourse against Health Plan will be through the Health Plan's bankruptcy, conservatorship, or receivership estate; (ii) Members may not be held liable for Health Plan's debts in the event of Health Plan insolvency; and (iii) Texas Health and Human Services Commission ("HHSC") does not assume liability for the actions of, or judgments rendered against, Health Plan, its employees, agents, or subcontractors. Further, there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by the Health Plan or any judgment rendered against the Health Plan. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code 101.001 et seq.).
- 2.4 Marketing.** Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, the Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in HHSC's Uniform Managed Care Manual ("UMCM"). Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

- 2.5 **Medicaid Provider Agreement.** Acute care providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid program, and must have a Texas Provider Identification Number (“TPIN”). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (“NPI”) in accordance with the timelines established in 45 CFR Part 162, Subpart D.
- 2.6 **Member Communications.** Health Plan is prohibited from imposing restrictions upon Provider’s free communication with a Member about the Member’s medical conditions, treatment options, Health Plan referral policies, and other Health Plan policies, including financial incentives or arrangements and all managed care plans with whom Provider contracts.
- 2.7 **Primary Care Providers.** The following provisions apply to Providers credentialed by Health Plan, or Health Plan’s designee, as Primary Care Providers (“PCP”).
- a. Provider shall have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.
  - b. Provider shall be accessible to Members twenty-four (24) hours per day, seven (7) days per week.
  - c. Provider shall provide preventative care: (i) to children under age twenty-one (21) in accordance with American Academy of Pediatrics recommendations for CHIP Members and CHIP perinatal newborns, and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members; and (ii) to adults in accordance with the U.S. Preventative Task Force requirements.
  - d. Provider shall assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed.
  - e. PCPs must coordinate Members’ care with specialty care providers after referral.
  - f. PCP will serve as a medical home for Members, as that term is defined in Texas Government Code § 533.0029(a).
- 2.8 **Tuberculosis.** Provider shall coordinate with the local tuberculosis (“TB”) control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy. Provider shall report to the Texas Department of State Health Services (“DSHS”) or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat.
- 2.9 **Women, Infants and Children.** Provider shall coordinate with the Women, Infants, and Children (“WIC”) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit, or hemoglobin.
- 2.10 **Standard of Care.** While performing the services described in this Agreement, Provider agrees to: (i) comply with applicable state laws, rules, and regulations, and HHSC’s requests regarding personal and professional conduct generally applicable to the service locations; and (ii) otherwise conduct his or her self in a businesslike and professional manner.
- 2.11 **Confidentiality.** Provider shall treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement. Provider shall protect the confidentiality of Member Protected Health Information (“PHI”), including patient records. Provider must comply with all applicable federal and state laws, including the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy and Security Rule governing the use and disclosure of protected health information.
- 2.12 **Access to Records.**
- a. Provider agrees to provide at no cost to HHSC: (i) all information required under Health Plan’s contract with HHSC, including but not limited to, the reporting requirements and other information related to the Provider’s performance of its obligations under the contract; and (ii) any information in its possession sufficient to permit

HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

- b. Upon receipt of a record review request from the HHSC Office of Inspector General (“OIG”) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than twenty-four (24) hours, the provider must provide the records requested at the time of the request or in less than twenty-four (24) hours. The request for record review includes, but is not limited to: (i) clinical medical or dental Member records; (ii) other records pertaining to the Member; (iii) any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; (iv) documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; (v) radiographs and study models related to orthodontia services; (vi) business and accounting records with backup support documentation; (vii) statistical documentation; (viii) computer records and data; and/or (ix) contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against the provider as described in 1 Tex. Admin. Code, Chapter 371, Subchapter G.

#### **2.13 Audit or Investigation.**

- a. Provider agrees to provide at no cost to the following entities and their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or Provider’s performance of its responsibilities under this Agreement: (i) the United States Department of Health and Human Services; (ii) the Comptroller General of the United States; (iii) Health Plan program personnel from HHS; (iv) the Office of Inspector General; (v) the Medicaid Fraud Control Unit of the Texas Attorney General’s Office; (vi) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC; (vii) the Office of the State Auditor of Texas; (viii) state or federal law enforcement agencies; (ix) special or general investigating committee of the Texas Legislature; and (x) any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.
- b. Provider shall provide access wherever it maintains such records, books, documents, and papers. Provider shall provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes: (i) examination; (ii) audit; (iii) investigation; (iv) contract administration; (v) the making of copies, excerpts, or transcripts; or (vi) any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.
- c. Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor’s Office (“SAO”), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

#### **2.14 Complaints and Appeals.** Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

#### **2.15 Member Billing.**

- a. Provider is prohibited from billing or collecting any amount from a Medicaid or CHIP Member for health care services provided pursuant to this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.
- b. Health Plan shall initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP provider from collecting allowable copayment and deductible amounts

from CHIP Members. Additionally, this provision does not restrict a CHIP dental provider from collecting payment for services that exceed a CHIP Member's benefit cap.

- 2.16 **Costs of Non-Covered Services.** Providers shall inform Members of the costs for non-Covered Services prior to rendering such services and shall obtain a signed private pay form from such a Member.
  - 2.17 **HHSC Liability.** Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.
  - 2.18 **Third Party Recovery.** Provider shall not interfere with or place any liens upon the State's right or Health Plan's right, acting as the State's agent, to recovery from third party resources.
  - 2.19 **Clean Claims Payment.** Health Plan shall adjudicate (finalize as paid or denied adjudicated) Clean Claims for: (i) Covered Service within thirty (30) days from the date the claim is received by Health Plan; or (ii) pharmacy Covered Services, no later than eighteen (18) days from receipt if the Claim submitted electronically, or twenty-one (21) days of receipt if the Claim is submitted non-electronically. Health Plan shall pay Provider interest at a rate of eighteen (18) percent interest, per annum, on all Clean Claims that are not adjudicated within thirty (30) days. However, duplicate Claims filed prior to the expiration of thirty-one (31) days are not subject to any interest payment if not processed within thirty (30) days.
  - 2.20 **Claims Processing.**
    - a. Health Plan shall compensate Provider pursuant to the terms of this Agreement. Provider may access the State of Texas Medicaid Fee-For-Service Program fee schedule at: [www.Molinahealthcare.com](http://www.Molinahealthcare.com).
    - b. Providers may:
      - i. Contact Molina Healthcare of Texas' Provider Services Department at 1-866-449-6849.
      - ii. Non-electronic claims should be mailed to:

Molina Healthcare of Texas, Inc.  
P.O. Box: 22719  
Long Beach, CA 90801
      - iii. Electronic claims can be sent to Health Plan via:

[www.Molinahealthcare.com](http://www.Molinahealthcare.com)
  - c. Health Plan shall notify Provider in writing of any changes in the claims processing or adjudication entity at least thirty (30) days prior to the effective date of change. If Health Plan is unable to provide thirty (30) days' notice, Health Plan shall allow Provider a thirty (30) day extension on the claims filing deadline to ensure claims are routed to the correct processing center.
  - d. Provider must comply with the requirements of Texas Government Code 531.024161, regarding the submission of claims involving supervised providers.
  - e. Program violations arising out of performance of this Agreement are subject to administrative enforcement by the OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G.
- 2.21 **Appeals of Claims Payment Decisions.** The timeframes for appeals of claims payment decisions shall be as follows: (i) in the event that Health Plan requests repayment for a claim that was overpaid or paid in duplicate, or repayment of funds that were paid which were not provided for under this Agreement, Provider must contest Health Plan's request for repayment in writing within thirty (30) days of its receipt, (ii) In the event that Health Plan denies a Provider claim, Provider must submit a request for review of the denied claim within one hundred twenty (120) days of the initial denial, (iii) In the event that Provider believes Health Plan incorrectly paid a Provider claim, Provider must submit a request for correction or adjustment within one hundred twenty (120) days of the date of the remittance advice, and (iv) Health Plan will use its best efforts to resolve all disputed claims within thirty (30) days of receipt. The format for appeals of claims payment decisions shall be as follows: (i) The request must specify why the Provider believes Health Plan owes the payment; (ii) In the case of coordination of benefits, the request must

include the name and mailing address of any entity that has disclaimed responsibility for payment; (iii) The request must be addressed to the attention of Health Plan's Provider Services Department; (iv) The request must clearly indicate "Denied Claims Review Request" or "Adjustment Request;" and (v) The request must include all pertinent information, including, but not limited to, claim number, Member identifier, denial letter, supporting medical records, and any new information pertinent to the request.

## **2.22 Compliance with Law.**

- a. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement, the UMCC, Health Plan's health benefits programs, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by Provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation Health Plan's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
- b. In addition, Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to this Agreement:
  - i. Environmental Protection Laws: Pro-Children Act of 1994 (20 USC 6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products; National Environmental Policy Act of 1969 (42 USC 4321 et seq.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures; Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans"); State Clean Air Implementation Plan (42 USC 740 et seq.) regarding conformity of federal actions to State Implementation Plans under Sec.176(c) of the Clean Air Act; and Safe Drinking Water Act of 1974 (21 USC 349; 42 USC 300f to 300j-9) relating to the protection of underground sources of drinking water.
  - ii. State and Federal Anti-Discrimination Laws: Title VI of the Civil Rights Act of 1964 (42 USC 2000d et seq.) and as applicable 45 CFR Part 80 or 7 CFR Part 15; Section 504 of the Rehabilitation Act of 1973 (29 USC 794); Americans with Disabilities Act of 1990 (42 USC 12101 et seq.); Age Discrimination Act of 1975 (42 USC 6101-6107); Title IX of the Education Amendments of 1972 (20 USC 1681-1688); Food Stamp Act of 1977 (7 USC 200 et seq.); Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16 and Title 40; and the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement;
  - iii. The Immigration and Nationality Act (8 USC 1101 et seq.) and all subsequent immigration laws and amendments;
  - iv. The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); and
  - v. The Health Information Technology for Economic and Clinical Health Act at 42 USC 17931 et. seq.

## **2.23 Fraud and Abuse.**

- a. Provider understands and agrees to the following: (i) the OIG and/or the Texas Medicaid Fraud Control Unit shall be allowed to conduct private interviews of Provider and its employees, agents, contractors, and patients; (ii) requests for information from such entities shall be complied with, in the form and language requested; (iii) Provider and its employees, agents, and contractors shall cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations; and (iv) Compliance with these requirements will be at the Provider's own expense.
- b. Provider further understands and agrees to the following: (i) Provider is subject to all state and federal laws and regulations relating to fraud, abuse, or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable; (ii) Provider shall cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, abuse, or waste;

- (iii) Provider shall provide originals and/or copies of any and all information as requested by HHSC or the state or federal agency, allow access to premises, and provide records to the OIG, HHSC, CMS, the U.S. Department of Health and Human Services, Federal Bureau of Investigation, Texas Department of Insurance, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge; (iv) if Provider places required records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and (v) Provider shall report any suspected fraud or abuse including any suspected fraud and abuse committed by the Health Plan or a Member to the OIG.
- c. If the Provider receives annual Medicaid payments of at least five (5) million (cumulative, from all sources), Provider must:
- i. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.
  - ii. Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
  - iii. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste, and abuse.
- 2.24 **Gifts and Gratuities.** Provider shall not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than fifty dollars (\$50.00) and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Health Plan may terminate this Agreement at any time for violation of this provision.
- 2.25 **Termination.** Health Plan shall provide a written explanation of the reasons for Provider's termination at least ninety (90) days before the effective date of the proposed termination. Health Plan may immediately terminate a Provider in cases involving: (i) imminent harm to patient health; (ii) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the Provider's ability to practice medicine, dentistry, or another profession; or (iii) fraud or malfeasance. Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of Health Plan's proposed termination by an advisory review panel. A Provider whose participation is being terminated is entitled to an expedited review by Health Plan upon request. Within sixty (60) days following receipt of Provider's request and before the termination effective date, the advisory review panel will make its formal recommendation. Health Plan will communicate the advisory review panel decision to Provider and, upon Provider's request, Health Plan will provide a copy of the recommendation. The advisory review panel decision is not binding upon Health Plan.
- 2.26 **Complaint Process.**
- a. **Complaints.**
    - i. Provider shall submit any dispute, other than any dispute relating to payment or non-payment of a claim, to Health Plan in writing within sixty (60) days of when the issue arises.
    - ii. Provider shall submit such disputes to the attention of Health Plan's Provider Services Department.
  - b. **Health Plan Response.**
    - i. Health Plan shall use best efforts to acknowledge by phone, e-mail or other writing, receipt of a dispute, other than any dispute relating to payment or non-payment of a claim, within five (5) business days.
    - ii. Health Plan shall investigate and resolve disputes within thirty (30) days of Health Plan's receipt of Provider's written correspondence.

- iii. Health Plan's decision regarding disputes shall be communicated within thirty (30) days of Health Plan's receipt of Provider's written correspondence requesting review. If additional time is required, Health Plan shall communicate this information to Provider within thirty (30) days.
- 2.27 **Administrative Requirements.** Providers must inform both Health Plan and HHSC's administrative services contractor of any changes to Provider's address, telephone number, and group affiliation.
- 2.28 **Product Orders.** If Provider offers delivery services for covered products, such as durable medical equipment ("DME"), limited home health supplies ("LHHS"), or outpatient drugs or biological products, Provider must reduce, cancel, or stop delivery if Member or the Member's authorized representative submits an oral or written request. Provider must maintain records documenting the request.
- 2.29 **Insurance.** Provider shall maintain, during the term of this Agreement, Professional Liability Insurance of one hundred thousand dollars (\$100,000.00) per occurrence and three hundred thousand dollars (\$300,000.00) in the aggregate, or the limits required by the hospital at which Provider has admitting privileges.
- 2.30 **Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and activities, including peer review and audits of care rendered by Provider.
- 2.31 **Service Coordination.** In addition to the requirements stated herein, the following provisions are specific to and apply to STAR+PLUS MCO Members.
  - a. Home and Community Support Services Agency ("HCSSA") providers, adult day care providers, and residential care facility providers must notify Health Plan if a Member experiences any of the following: (i) a significant change in the Member's physical or mental condition or environment; (ii) hospitalization; (iii) an emergency room visit; or (iv) two or more missed appointments.
  - b. Providers using the Electronic Visit Verification system must maintain compliance with HHSC minimum standards detailed in UMCM, Chapter 8.7, Section IX.
- 2.32 **Family Planning.**
  - a. If a Member requests contraceptive services or family planning services, Provider must also provide the Member counseling and education about family planning and available family planning services.
  - b. Provider shall not require parental consent for Members who are minors to receive family planning services.
  - c. Provider shall comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.
- 2.33 **THSteps.** Provider shall send all THSteps newborn screens to DSHS, formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Provider shall include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.
- 2.34 **Mental Health.** Providers must comply with 25 Tex. Admin. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing Mental Health Rehabilitative Services and Mental Health Targeted Case Management.
- 2.35 **Advance Directives.** Provider shall comply with the requirements of state and federal laws, rules and regulations relating to advance directives, including but not limited to, the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended.
- 2.36 **Lead Screening.** In accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, Providers must: (i) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory); and (ii) follow-up on suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located at [www.dshs.state.tx.us/lead/pdf\\_files/pb\\_109\\_physician\\_reference.pdf](http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf).
- 2.37 **Waiting Times.** Providers must provide services within the timeframes that are noted within Health Plan's Provider Manual.

**ATTACHMENT G**  
**Molina Marketplace**  
**Laws and Government Program Requirements**

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Molina Marketplace Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law or Government Program Requirement. This attachment only applies to Molina Marketplace Product.

**1.1 Definitions.**

- a. Emergency Care means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could: (i) place the individual's health in serious jeopardy; (ii) result in serious impairment to bodily functions; (iii) result in serious dysfunction of a bodily organ or part; (iv) result in serious disfigurement; or (v) for a pregnant woman, result in serious jeopardy to the health of the fetus.

**1.2 Duplicate Claim Submission.** A Provider may not submit a duplicate claim for payment before the forty-sixth (46th) day after the original claim was submitted.

**1.3 Determination of Claim and Penalties for Late Payment of Claims.** Health Plan shall make determinations of claims and follow the penalties associated for late payment of Clean Claims pursuant to Texas Insurance Code, Chapter 843, and/or federal law, as applicable.

**1.4 Coordination of Benefits.** Provider and Health Plan shall follow the requirements related to coordination of benefits pursuant to Texas Insurance Code, Chapter 843, and/or federal law, as applicable.

**1.5 Member Hold Harmless.** Provider hereby agrees that in no event, including, but not limited to non-payment by the Health Plan, Health Plan insolvency, or breach of this agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than Health Plan acting on their behalf for services provided pursuant to this agreement. This provision will not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Agreement between Health Plan and Member. Provider further agrees that:

- a. this provision will survive the termination of this agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of the Health Plan Member; and
- b. this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than fifteen (15) days after the commissioner has received written notice of such proposed changes.

**1.6 Deductibles and Copayments.** Provider may bill a Member for any co-payment, deductible or co-insurance obligation applicable to Member's Health Plan product. Provider may not waive a deductible or copayment by the acceptance of an assignment.