MOLINA HEALTHCARE OF TEXAS, INC.

HOSPITAL, CLINIC AND HOSPITAL PROVIDER SERVICES AGREEMENT

This Hospital Services Agreement ("Agreement") is entered by and between **Molina Healthcare of Texas, Inc., a Texas corporation** ("Health Plan"), and **Dallas County Hospital District, dba Parkland Health & Hospital System, a political subdivision of the State of Texas and Hospital District of Dallas County, Texas** ("Provider"), effective on the date set forth on the signature page of this Agreement ("Effective Date"), with reference to the following facts:

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government-sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with physicians, IPAs, PAs, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Provider means the entity identified in Attachment A.

1.2 Capitalized words or phrases in this Agreement shall have the meanings set forth in Attachment B.

Provider or authorized representative's initials: _____

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall provide facility inpatient, outpatient and/or professional services to Members for the products specified in Attachment C. Provider agrees that its facility information will be used in Health Plan's provider directories, printed and online, made available to the public and Members. Provider information includes, name, address, telephone number, hours of operation, and services. Any other use of Provider's name, including but not limited to, promotional materials, advertising and other informational material by Health Plan shall require Provider's written approval. Provider shall timely notify Health Plan of any changes in this practice information.

2.2 **Standards for Provision of Care**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, not outside the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall use commercially reasonable efforts to provide Covered Services to Members at a level of care and competence that equals the generally accepted and professionally recognized standard of practice in the community at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements. 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. (UMCC Att. A, §4.07.)

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall use commercially reasonable efforts to verify eligibility of Members prior to rendering services. Notwithstanding anything to the contrary, within this Agreement or the Provider Manual, authorization for inpatient services shall be in accordance with Section 3.3, and outpatient services shall not require authorization by Health Plan for reimbursement to Provider.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use commercially reasonable efforts to use those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Subcontract Arrangements.** Provider shall use commercially reasonable efforts to ensure any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall inform Provider's subcontractors of their obligation under this Agreement.

g. **Availability of Services.** Provider shall make Covered Services available in accordance with the same standards, and within the same time availability, regardless of payor. Provider shall use commercially reasonable efforts to meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

2.3 Standards for Hospital Providers

a. **Hospital Providers.** Provider shall use commercially reasonable efforts to have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and in accordance with state and federal law.

b. **Contract Standards.** Any contract between Provider and a Hospital Provider shall be in writing and shall bind the Hospital Provider to the terms and conditions of this Agreement including terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** If in response to an HHSC audit, upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall, within the scope of its knowledge, promptly restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members if any Hospital Provider ceases to meet the licensing/certification requirements or other professional standards as specified in this Article.

e. **Notification**. Provider shall notify Health Plan in a timely matter after becoming aware of any of its employed Hospital Provider(s) who cease to meet the licensing/certification requirements as described in the Agreement. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 Nondiscrimination

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members 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. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability, regardless of payor.

b. **Employment.** In accordance with the law, Provider shall not differentiate or discriminate against any employee or applicant for employment.

2.5 Recordkeeping

a. **Maintaining Member Medical Records.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. The Member's medical record shall contain all information required by state and federal law, and applicable government sponsored health programs. Provider shall retain all such records in accordance with requirements of the law.

b. **Confidentiality.** Provider shall comply with all applicable state and federal laws regarding privacy and confidentiality of Members' health information and medical records, including mental health records.

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. (UMCC Att. A, §11.01(a).)

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. (UMCC Att. A, §11.01(c).)

Provider shall not transfer an identifiable Member record, including a patient record, to another entity or person without written consent from the Member or someone authorized to act or his or her behalf; however, Provider understands and agrees that HHSC may ask it to transfer a Member record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Member. (UMCC Att. A, §§7.02 and 7.07.)

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 HIPAA Privacy and Security Rule governing the use and disclosure of protected health information. (UMCC Att. A, §§7.02 and 7.07.)

c. **National Provider Identification ("NPI").** Provider shall comply with the Standard Unique Identifier for health care Provider regulations promulgated under HIPAA (45

CFR Section 162.402, et seq.). Provider shall include its NPI on all claims and encounters (both electronic and paper formats) submitted to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of becoming aware of the change.

d. **Health Plan Access to Records.** Provider shall promptly provide Health Plan and/or its designees upon request copies of any records pertaining to Members served by Provider. The purpose for such requests may include activities relating to utilization review and management, grievances, peer review, HEDIS studies, Quality Improvement Program, Consumer Assessment of Health Plans (CAHPS), or claims payment. The types of records covered by this section include all medical records and billing records. Health Plan shall also reimburse Hospital, as requested and invoiced by Hospital, in accordance with Health and Safety Code, §241.154(e) which may be updated from time to time.

e. **Member Access to Records.** Provider shall use commercially reasonable efforts to provide any Member and/or their authorized representative upon written request, in accordance with Provider's policies and procedures, a copy of health information about the Member, including but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs and in accordance with Health Plan's and Provider's policies and procedures.

f. **HHSC Access to Records**. Provider agrees to provide to the HHSC (i) all information required under the UMCC, 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. (UMCC Att. B-1, §8.1.20.)

g. **Audit or Investigation**. Provider agrees to provide the following entities or 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 the UMCC:

   i. HHSC and Health Plan Program personnel from HHSC;
   ii. U.S. Department of Health and Human Services;
   iii. Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;
   iv. an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
   v. state or federal law enforcement agency;
   vi. special or general investigation committee of the Texas Legislature;
   vii. the U.S. Comptroller General;
   viii. the Office of the State Auditor of Texas; and
   ix. any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

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. (UMCC Att. A, §9.02.)

Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor's Office, or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the State Auditor's Office or its successor in the conduct of the audit or investigation, including providing all records requested. (UMCC Att. A, §9.04.) 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. (UMCC Att. B-1, §§.8.2.5-8.2.7; 8.4.2-8.4.3.)

2.6 **Program Participation.**

a. **Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Quality Improvement Program.** Provider agrees to comply with Health Plan's Quality Improvement Program requirements. (UMCC Att. B-1, §8.1.7.)

c. **Utilization Review and Management Program.** Provider shall use commercially reasonable efforts to participate in and comply with Health Plan's Utilization Review and Management Program, and shall cooperate with Health Plan in audits to identify, confirm and/or assess utilization levels of Covered Services.

d. **Credentialing Program.** Provider shall participate in Health Plan's hospital and clinic credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, the credentialing and re-credentialing criteria established by the Health Plan for hospital and clinic credentialing. Provider shall timely notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another facility.

e. **Provider Manual.** Health Plan will furnish a copy of the Provider Manual to Provider prior to the execution of this Agreement. Except as otherwise provided herein,

Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual and any amendments thereto which are communicated to Provider in writing by Health Plan. Health Plan shall give a minimum of sixty (60) days prior written notification to Provider of any material changes to the Provider Manual. Provider shall have the right to reject any changes that have an adverse effect on Provider's operation or reimbursement. In the event such modification affects the material duty or responsibility, or have an adverse economic effect upon Provider, Provider shall provide Health Plan with written notification of such adverse effect. The parties shall seek to agree to a modification which satisfactorily addresses the effect on Provider's material duty or responsibility or addresses the material economic detriment caused to Provider. If the parties cannot agree, Provider shall not be bound by such a modification. Any new of revised policy or procedure shall not be discriminatory and shall apply to similarly situated health care providers. In the event of a conflict between the Provider Manual and this Agreement, this Agreement shall prevail.

f. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs. Provider shall comply with any term or condition of those government sponsored program contracts that are applicable to the services to be performed under this Agreement, provided that Health Plan has provided Provider all requirements that Provider is responsible to comply with.

g. **Health Education/Training.** Provider shall use commercial reasonable efforts to participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also use commercial reasonable efforts to comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with government agencies. Provider shall promptly deliver to medical staff, all educational or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

Provider or authorized representative's initials: _____

2.8 **Promotional Activities.** At the request of Health Plan, Provider shall (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) cooperate with and participate in all reasonable Health Plan marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan. Neither party shall use the other's name in any advertising or promotional materials without the prior written consent of the other party; this restriction does not apply to listing the Provider in the Health Plan's listing of contracted Providers.

2.9 **Licensure and Standing**

a. **Licensure.** Provider represents and warrants that it possesses any license/s that are required by law to deliver the services described herein. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give timely notice to Health Plan of: (i) any convictions of Provider for felonies.

d. **Liability Insurance.** Hospital is a governmental entity created pursuant to Article IX, Section 4 of the Texas Constitution and Chapter 281 of the Texas Health & Safety Code. As such, it maintains governmental immunity, except to the extent that immunity is waived by the Texas Tort Claims Act, Chapter 101 of the Texas Civil Practice & Remedies Code. Hospital is self-funded for professional liability to the limits of the Texas Tort Claims Act. The limits under the Act as they apply to Hospital are $100,000 per person and $300,000 per occurrence.

2.10 **Claims Payment**

a. **Submitting Claims.** Health Plan and Provider recognizing the need for standardization in the billing process agree that Provider shall promptly submit Clean Claims, for Covered Services rendered to Members, on either a standard CMS 1500 (or its successor) using the billing rules, codes, and modifiers set forth in the most current standard edition of the AMA CPT Code manual, or UB-04 (or its successor) claim form using Medicaid billing rules, codes and guidelines or ASC X 12N 837 electronic format in compliance with federal laws related to electronic claims. For all services, Provider shall use best efforts to file claims within ninety-five (95) days from the date of service. Health Plan shall have the right to deny Clean Claims received after three hundred sixty five (365) days from date of discharge. (UMCC Att. B-1, §8.1.18.5.)

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with

applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D. Provider shall accept such payment, applicable copayments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Health Plan shall adjudicate (finalize as paid or denied adjudicated) Clean Claims within thirty (30) days from the date the claim is received. For any Clean Claims that are not adjudicated within thirty (30) days, Health Plan shall pay eighteen percent (18%) interest calculated annually. 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.

c. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether 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, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other payers, not to exceed the amount specified in Attachment D. Any claims that are not submitted to Health Plan within three hundred sixty five (365) days from the date of disposition by the other payer shall not be eligible for payment, and Provider hereby waives any right to payment therefor. (UMCM §8.2.) The Provider should attach the explanation of benefit (EOB) or rejection letter issued by the other payer when resubmitting the claim to Health Plan. (UMCM §8.2.)

d. **Offset.** In the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid beyond or outside of what is provided for under this Agreement, Provider shall make repayment or dispute refund request to Health Plan within ninety (90) working days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. If Provider disagrees with the overpayment amount and notifies Health Plan within aforementioned ninety (90) working days of written notification by Health Plan, Provider and Health Plan agree to resolve the discrepancy.

e. **Member Billing**. Provider is prohibited from billing or collecting any amount from a Medicaid Member for Covered 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. (UMCC Att. A, §10.12(a).)

Health Plan shall initiate and maintain any reasonable action necessary to stop a Network 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. (UMCC Att. A, §§4.05 and 10.12; TIC §843.361, and 28 TAC §11.901(a)(1).)

f. **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. (UMCC Att. A, §10.12(a).)

g. **HHSC Liability**. Provider understands and agrees that HHSC is not liable or responsible for payment for Outpatient Covered Services rendered pursuant to this Agreement. (UMCC Att. A, §§4.05 & 10.12.)

h. **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. (UMCC Att. B-1; §8.2.9.)

i. **Claims Processing Entities.** Non-electronic claims should be mailed to:

Molina Healthcare of Texas, Inc.
P.O. Box: 22719
Long Beach, CA 90801

Electronic claims can be sent to Health Plan via:

www.Molinahealthcare.com
Payor ID#20554

Providers may contact Molina Healthcare of Texas' Provider Services Department at 1-866-449-6849.

Health Plan shall notify Provider in writing of any changes in the claims processing or adjudication entity(ies) 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. (UMCC Att. B-1, §8.1.18.5.)

j. **Claims Processing Guidelines.** Health Plan shall provide in writing at least ninety (90) days notice prior to implementing a change in the claims guidelines (except any change in claims processing entities, see Section 2.10(i), unless the change is required by statute or regulation in a shorter timeframe. (UMCC Att. B-1, §8.1.18.5.) Provider shall have the right to object to any material changes and be allowed the opportunity to resolve any issues before the implementation of any such changes.

k. **Provider Information**. Health Plan shall disclose all information necessary to determine that Provider is being compensated in accordance with this Agreement. Provider, to the extent it requests and receives such information from Health Plan, shall use such information, pursuant to, and in accordance with, Health Plan's policies and procedures, and in conformity with Texas law. (28 TAC §11.901(a)(11).)

l. **Availability of Coding Guidelines.** Provider may request and Health Plan shall timely provide 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 the thirtieth (30th) day after Health Plan receives the request. Health Plan shall provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to Provider not later than the ninetieth (90th) day before the date the changes take effect and shall not make retroactive revisions to the coding guidelines and fee schedules. Provider may terminate this Agreement 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; (ii) disclose the information to a governmental agency involved in the regulation of health care or insurance and (iii) disclose as otherwise as may be required by law. 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. (UMCM §7.1; TIC §843.321.)

m. **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 eight (180) days of the date of the remittance advice.
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.

2.11 Claims Review

a. **One Day Stay Reviews.** Those admissions that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services

which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless the medical information available to the Provider at the time the services were rendered do not support the specific services and/or level of care authorized by Health Plan and the prior authorization was based upon a material misrepresentation by the Provider. Health Plan shall conduct medical management throughout the course of treatment.

c. **Reporting Requirements.** Both Parties shall work collaboratively to resolve any reporting requirements of the Health Plan.

d. **Claims Review and Audit.** Provider will use commercially reasonable efforts to accommodate Health Plan's right to review Provider's claims following payment for appropriateness in accordance with industry standard billing rules, contained within the current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level based on Plan benefits set forth by HHSC. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing reasonable access to requested claims information, all supporting medical records and billing records. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines to determine the appropriateness of the billing, coding and payment.

2.12 Reciprocity Agreements. Provider agrees to use reasonable efforts to provide Covered Services to Members who are enrolled in various government sponsored health products/programs offered by Health Plan's Affiliates. Provider agrees to cooperate with such Affiliate's participating providers in coordinating and scheduling such services, and agrees that all of the terms of this Agreement, including rates and prohibition on member billing, shall apply to Provider to the extent any services are provided to Members of Health Plan's Affiliates.

Provider or authorized representative's initials: JB

2.13 Compliance with Applicable Law

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to state laws and regulations that are set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the Medicaid and CHIP program are subject to the additional provisions set forth in Attachment F.

c. Provider acknowledges that all Covered Services rendered in conjunction with the Medicare program are subject to the additional provisions set forth in Attachment G.

d. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, 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 of UMCC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. (UMCC Att. A, §7.02.)

e. Provider understands and agrees that, to the extent applicable to Provider, 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 U.S.C. §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 U.S.C. §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 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §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, Executive Order 11246 (Public Law 88-352); Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112); Americans with Disabilities Act of 1990 (Public Law 101-336); and Title 40, Texas Administrative Code, Chapter 73.

   iii. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) and

the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.)* regarding employment verification and retention of verification forms.

iv. The Health Insurance Portability and Accountability Act of 1996 (HIPAA). (UMCC Att. A, §§7.04-7.07.)

2.14 **Provider Non-Solicitation**. Provider shall not solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities. Any transfers by Provider of a Member shall not be detrimental to Member's care.

2.15 **Fraud and Abuse**. Provider understands and agrees to the following:

a. HHSC Office of Inspector General ("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.
b. Requests for information from such entities shall be complied with, in the form and language requested.
c. 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 at Provider's own expense.
d. Compliance with these requirements will be at the Provider's own expense. (UMCC Att. B-1, §8.1.19.)

Provider also understands and agrees to the following:

a. Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable.
b. 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.
c. Provider shall provide originals and/or copies of any and all information, allow access to premises, and provide records to the OIG, HHSC, CMS, the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge.
d. 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.
e. 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. (UMCC Att. B-1, §8.1.19.)

2.16 **Gifts and Gratuities**. Neither party shall 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. Either Party may terminate this Agreement at any time for violation of this provision. (UMCC Att. A, §12.03(b)(5).)

2.17 **Advance Directives**. Provider shall comply with the requirements of state and federal laws, rules and regulations relating to advance directives, including the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws. (UMCC Att. B-1, §8.2.12.)

2.18 **Claims of Underpayment or Overpayment**. Notwithstanding anything to the contrary set forth herein, in no event shall either Party bring a claim of overpayment or underpayment for services after the expiration of 365 days following the date of service.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider within 30 days and in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D. For any Clean Claims that are not adjudicated within thirty (30) days, Health Plan shall pay eighteen percent (18%) interest calculated annually. 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.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data electronically on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider. Health Plan shall maintain online eligibility records in which Provider shall rely on for eligibility.

3.3 **Prior Authorization Review.** Notwithstanding anything to the contrary within this Agreement or the Provider Manual; Provider shall provide timely notification of inpatient admission, shall coordinate discharge planning efforts with Health Plan, and shall participate, at least weekly, in concurrent reviews. If Health Plan determines any financial risk due to the lack of concurrent reviews, Provider and Health Plan will work together to determine appropriateness of length of stay based on medical necessity. For outpatient services both parties shall work collaboratively in meeting Health Plan's needs for monthly utilization reports.

3.4 **Medical Necessity Determination**. Health Plan's determination with regard to Medically Necessary services and scope of Covered Services shall govern. This includes determinations of level of care and length of stay benefits available under the Member's

health program. The primary concern with respect to all medical determinations is the interest of the Member.

3.5 **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 the 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, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan's contracted providers.

3.6 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.7 **Provider Services**. Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures. Health Plan's Provider Services Department will coordinate provider complaints and appeals (provider grievances) in accordance with the UMCC, 42 CFR §438.114, and Chapter 843, Subchapter G of TIC. (UMCC Att. B-1 §8.4.2, and 8.2.5.)

3.8 **Medical Director**. Health Plan will employ a Texas Licensed physician as medical director who shall be responsible for the management of both the; (i) medical, and (ii) medically-related scientific and technical aspects of Health Plan.

3.9 **Monthly Joint Operating Committee.** Health Plan shall provide committed resources for Monthly Joint Operating Committee (JOC) meetings in which Provider may discuss detail issues related to any operational issues related but not limited to; Claims payment, Provider Manual changes, Policies and Procedures implemented by the Health Plan, billing questions or concerns or other issues. Resources from the Health Plan should include Network Management, Claims Management and, upon request by Provider, a Utilization Management representative.

3.10 **Health Plan Representations.** Health Plan represents and warrants that: (a) it is licensed to offer, issue and/or administer the Products and Programs listed in Attachment C in the service areas covered by this Agreement by the applicable regulatory authority ("License") except as noted; (b) such license shall be maintained during the course of this Agreement; (c) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder; including without limitation, any capital reserve requirements; (d) this Agreement has been executed by its duly authorized representative; and (e) executing this Agreement and performing its obligations hereunder shall not cause Health Plan to violate any law or any term or covenant of any other agreement or arrangement now existing or hereinafter executed. It is the Health Plan's intent to apply for and obtain licensure for the Medicare Program.

3.11 **Health Plan Insurance.** Health Plan at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Health Plan and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance or non-performance.

3.12 **Notice.** Health Plan shall provide notice to Provider of any restriction, suspension, revocation or termination of Health Plan's license, certification or accreditation, failure to meet statutory reserve requirements, or any action taken against Health Plan by a court, state agency or other governmental body.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** The term shall commence on the Effective Date and shall continue in effect for one year. Thereafter, the Agreement shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least ninety (90) days' written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached this Agreement. The party receiving the notice of termination shall have ninety (90) 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 ninety (90)-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 ninety (90)-day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Advisory Panel Review**. Before terminating this Agreement with cause, Health Plan shall provide a written explanation of the reasons for termination. On request, before the effective date of the termination and within a period not to exceed sixty (60) days, Provider is entitled to a review by an advisory review panel of Health Plan's proposed termination, except in a case involving: (a) imminent harm to patient health; (b) 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 physician's or provider's ability to practice medicine, dentistry, or another profession; or (c) fraud or malfeasance. (TIC §843.306; UMCC Att. B-1, §8.1.4.9.)

4.5 **Immediate Termination.** Notwithstanding the foregoing, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is revoked.

b. Provider loses credentialed status because of a failed credentialing element and not the lack of timely credentialing by the Health Plan.

c. Provider 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 is appointed by appropriate authority.

d. Provider is excluded from participation in Medicare and State health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any state or federal health care program.

4.6 Provider may immediately terminate this Agreement by giving notice to Health Plan in the event of any of the following:

a. The withdrawal, expiration, or non-renewal of any federal, state or local license, certificate, approval or authorization of Health Plan to offer, issue and/or administer the Products or Programs set forth in this Agreement.

b. Health Plan 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 Health Plan is appointed by appropriate authority.

c. Health Plan is excluded from participation in Medicare or State health care programs pursuant to Section 1128 of the Social Security Act or otherwise terminated as a provider by any state or federal health care program.

d. The revocation or suspension of accreditation of Health Plan by NCQA.

e. The loss or material limitation of Health Plan's insurance under Section 3.11.

4.7 **Member Notice**. Prior to the effective date of termination of this Agreement by either Provider or Health Plan, Health Plan alone shall provide reasonable advance notice to any Member who is assigned to Provider. (TIC §843.309.) Members may then be required to select another provider contracted with Health Plan prior to the effective date of termination.

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall 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 the provisions of this Agreement. This Agreement is not intended to create a relationship of

Provider or authorized representative's initials: _____

agency, representation, joint venture or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.2 **Entire Agreement.** This Agreement, together with attachments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. The UMCC shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement is of no force or effect. When there is a conflict between this Agreement and the Provider Manual, this document shall control.

5.3 **Severability.** If any 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 shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.4 **Non-exclusivity.** This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.5 **Amendment.** Any amendment to this Agreement shall be in writing and signed by both parties.

5.6 **Assignment.** Neither Health Plan or Provider may assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of the other party.

5.7 **Dispute Resolution Process**

a. **Non-Claims Payment Related Disputes**

i. Provider shall use commercially reasonable efforts to submit any dispute (other than any dispute relating to payment or non-payment of a claim, which is subject to Section 2.10(m) 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, which is subject to Section 2.10.m) within seven (7) business days.

ii. Health Plan shall investigate and resolve disputes within 30 days of Health Plan's receipt of Provider's written correspondence. (UMCC Att. B-1, §§8.2.5.1; 8.2.5.2; 8.4.2.)

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. (UMCC Att. B-1, §8.4.2.)

5.8 **Silent PPO**. Health Plan acknowledges that no third party payor (meaning an entity that is not an Affiliate of Health Plan) shall access the rates and services set forth in this Agreement.

5.9 **TPIA.** Health Plan acknowledges and agrees that Provider is a governmental entity subject to the Texas Public Information Act (the "Act") and that notwithstanding anything else to the contrary contained herein, no disclosure made by Provider pursuant to the Act shall be a violation of this Agreement.

5.10 **Confidentiality and Proprietary Information.** The parties acknowledge that as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party and except as may be required to fulfill the rights and obligations set forth in this Agreement or as may be required by law.

5.11 **Arbitration**. Provider will not participate in any Binding Arbitration process. Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. All claims shall be considered final within three hundred sixty five (365) days unless agreed upon by both parties.

5.12 **Notice.** All notices required or permitted by this Agreement shall be in writing and sent by registered or certified mail and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:	If to Provider:
Molina Healthcare of Texas, Inc.	Legal Name Parkland Health & Hospital System
84 NE Loop 410, Suite 200	Street 5201 Harry Hines Blvd
San Antonio, TX 78216	City, state, zip Dallas, TX 75235
Fax: (972) 352-6564	Fax: _____
Attn.: President	Attn.: Director of Managed Care Contracting
	Copy To:
	Parkland Health & Hospital System
	Attn: Legal Department
	5201 Harry Hines Blvd
	Dallas, TX 75235

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card.

5.13 **Attachments.** Each of the attachments identified below is hereby made a part of this Agreement:

Attachment A - Provider Identification Sheet
Attachment B - Definitions
Attachment C - Products/Programs
Attachment D - Compensation Schedule
Attachment E - State Laws & Regulations
Attachment F – Medicaid & CHIP Program Requirements
Attachment G – Medicare Program Requirements
Attachment G-1 – Medicare Program Requirements – Delegated Services

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider, and does so freely with the intent to fully bind Provider to the provisions of this Agreement.

Parkland Health & Hospital System		**Molina Healthcare of Texas, Inc.**	
Provider Signature:		Health Plan Signature:	
Signatory Name (Printed):	John Dragovitz	Signatory Name (Printed):	Don Hairston
Signatory Title (Printed):	SVP + CFO	Signatory Title (Printed):	President

Provider or authorized representative's initials: JD

Signature Date: 1-27-11

Signature Date: 2-9-2011

Effective Date:

(To be completed by Health Plan)

Provider or authorized representative's initials:

ATTACHMENT A
Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple facilities, clinics and Hospital Providers, please check all the categories that apply.

__X____ Hospital

__X____ Clinic

__X____ Ambulatory Surgery Center

_____ Rural Health Center

___X___ Other: type _____ Hospital Providers (available upon request) _____

Please enter "N/A" for the following if not applicable or not available:

Provider Name	Parkland Health & Hospital System	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-590-8000	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.	000474	Physical Address (if different than above): 5201 Harry Hines Dallas Texas 75235
Texas Provider Identification Number (TPIN)	127295703	
NPI (or UPIN if NPI not yet designated)	NPI:1932123247 UPIN:	
DEA No.	AP2247799	

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

Provider Signature:	James Blackburn
Signatory Name (Printed):	James Blackburn
Signatory Title (Printed):	Dir of Mgd Care
Signature Date:	1-27-11

Provider or authorized representative's initials: JB

ATTACHMENT A
Provider Identification Sheet Continuation Page

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN.

Provider Name	Simmons Ambulatory Surgery Center – Parkland	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-590-8000	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.	00474	Physical Address (if different than above): 4900 Harry Hines Blvd Dallas Texas 75235
Texas Provider Identification Number (TPIN)	022477601	
NPI (or UPIN if NPI not yet designated)	NPI:1932123247 UPIN:	
DEA No.		

Provider Name	Parkland Urgent Care Clinic	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-590-5512	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.	00474	Physical Address (if different than above): 5201 Harry Hines Dallas Texas 75235
Texas Provider Identification Number (TPIN)	080038501	
NPI (or UPIN if NPI not yet designated)	NPI: 1417985979 UPIN:	
DEA No.		

Provider Name	Parkland Comprehensive Breast Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-3300	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 5701 Maple Ave, Suite 300 Dallas Texas 75235
Texas Provider Identification Number (TPIN)	018360002	
NPI (or UPIN if NPI not yet designated)	NPI:1144408253 UPIN:	
DEA No.		

Provider Name	Parkland Geriatrics Center	Billing Address:

Provider or authorized representative's initials: _____

Telephone No.	214-590-8369	P.O. Box 660599 Dallas Texas 75266-0599
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1936 Amelia Court , 2nd floor Dallas Texas 75235
Texas Provider Identification Number (TPIN)	146794602	
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
DEA No.		

Provider Name	Amelia Court (HIV/AIDS clinic)	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-590-5632	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1936 Amelia Court , 1st floor Dallas Texas 75235
Texas Provider Identification Number (TPIN)	080022901	
NPI (or UPIN if NPI not yet designated)	NPI: 1184788978 UPIN:	
DEA No.		

Provider Name	Bluitt-Flowers Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-4200	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 303 E. Overton Rd Dallas Tx 75216
Texas Provider Identification Number (TPIN)	119781602	
NPI (or UPIN if NPI not yet designated)	NPI: 1679515639 UPIN:	
DEA No.		

(Add additional Att. A continuation pages as needed).

Provider Name	DeHaro-Saldivar Health Center – COPC	Billing Address: P.O. Box 660599

Telephone No.	214-266-0500	Dallas Texas 75266-0599
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1400 N. Westmoreland Rd Dallas Texas 75211
Texas Provider Identification Number (TPIN)	121547701	
NPI (or UPIN if NPI not yet designated)	NPI:1477597300 UPIN:	
DEA No.		

Provider Name	East Dallas Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1000	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 3320 Live Oak Dallas Texas 75204
Texas Provider Identification Number (TPIN)	109335301	
NPI (or UPIN if NPI not yet designated)	NPI: 1891738050 UPIN:	
DEA No.		

Provider Name	Garland Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0700	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 802 Hopkins Garland Texas 75040
Texas Provider Identification Number (TPIN)	112176601	
NPI (or UPIN if NPI not yet designated)	NPI:1811939994 UPIN:	
DEA No.		

Provider Name	Irving Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-3000	
Facsimile No.		

Provider or authorized representative's initials: _____

Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1800 N. Britain Road Irving Texas 75061
Texas Provider Identification Number (TPIN)	187092501	
NPI (or UPIN if NPI not yet designated)	NPI: 1699973735 UPIN:	
DEA No.		

Provider Name	Oak West Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1450	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 4201 Brook Spring Drive Dallas Texas 75224
Texas Provider Identification Number (TPIN)	079741703	
NPI (or UPIN if NPI not yet designated)	NPI:1952345613 UPIN:	
DEA No.		

Provider Name	Southeast Dallas Health Center – COPC	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1600	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 9202 Elam Road Dallas Texas 75217
Texas Provider Identification Number (TPIN)	080011201	
NPI (or UPIN if NPI not yet designated)	NPI: 1447288907 UPIN:	
DEA No.		

Provider Name	Vickery Health Center - COPC	Billing Address: P.O. Box 660599
Telephone No.	214-266-0350	

Facsimile No.		Dallas Texas 75266-0599
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 8224 Park Lane Suite 130 Dallas Texas 75231
Texas Provider Identification Number (TPIN)	112177402	
NPI (or UPIN if NPI not yet designated)	NPI: 1821026386 UPIN:	
DEA No.		

Provider Name	DeHaro-Saldivar – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0580	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1400 N. Westmoreland Rd Dallas Tx 75211
Texas Provider Identification Number (TPIN)	121547706	
NPI (or UPIN if NPI not yet designated)	NPI:1043468333 UPIN:	
DEA No.		

Provider Name	East Dallas – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1203	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 3320 Live Oak, 5th floor Dallas TX 75204
Texas Provider Identification Number (TPIN)	195779701	
NPI (or UPIN if NPI not yet designated)	NPI: 1134377427 UPIN:	
DEA No.		

Provider Name	Garland – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0784	
Facsimile No.		
Email Address		

Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 802 Hopkins, 2nd floor Garland, Texas 75040
Texas Provider Identification Number (TPIN)	193024001	
NPI (or UPIN if NPI not yet designated)	NPI: 1407034515 UPIN:	
DEA No.		

Provider Name	Irving – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-3050	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 1800 N. Britain Rd Irving Texas 75061
Texas Provider Identification Number (TPIN)	195489301	
NPI (or UPIN if NPI not yet designated)	NPI: 1326296617 UPIN:	
DEA No.		

Provider Name	Southeast – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1505	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 9202 Elam Road Dallas Texas 75217
Texas Provider Identification Number (TPIN)	176925910	
NPI (or UPIN if NPI not yet designated)	NPI: 1316125420 UPIN:	
DEA No.		

Provider Name	Lakewest – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0922	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	

Provider or authorized representative's initials: _____

License No.		Physical Address (if different than above): 3737 Goldman Ave Dallas Texas 75212
Texas Provider Identification Number (TPIN)	196202901	
NPI (or UPIN if NPI not yet designated)	NPI: 1780832071 UPIN:	
DEA No.		

Provider Name	Maple – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0144	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 6303 Harry Hines Blvd, Suite 101 Dallas Texas 75235
Texas Provider Identification Number (TPIN)	018360002	
NPI (or UPIN if NPI not yet designated)	NPI: 1144408253 UPIN:	
DEA No.		

Provider Name	Oakwest – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-1403	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above): 4201 Brook Spring Drive Dallas Texas 75224
Texas Provider Identification Number (TPIN)	195120401	
NPI (or UPIN if NPI not yet designated)	NPI: 1871741165 UPIN:	
DEA No.		

Provider Name	Vickery – Women's Health Center	Billing Address: P.O. Box 660599 Dallas Texas 75266-0599
Telephone No.	214-266-0281	
Facsimile No.		
Email Address		
Tax I.D. No.	756004221	
License No.		Physical Address (if different than above):

Provider or authorized representative's initials

Texas Provider Identification Number (TPIN)	018361802	8224 Park Lane, Suite 130 Dallas Texas 75231
NPI (or UPIN if NPI not yet designated)	NPI: 1538316120 UPIN:	
DEA No.		

Provider Name		Billing Address:
Telephone No.		
Facsimile No.		
Email Address		
Tax I.D. No.		
License No.		Physical Address (if different than above):
Texas Provider Identification Number (TPIN)		
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
DEA No.		

Provider Name		Billing Address:
Telephone No.		
Facsimile No.		
Email Address		
Tax I.D. No.		
License No.		Physical Address (if different than above):
Texas Provider Identification Number (TPIN)		
NPI (or UPIN if NPI not yet designated)	NPI: UPIN:	
DEA No.		

Provider or authorized representative's initials: JB

ATTACHMENT B
Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

2. **Affiliate** is any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company

3. **Agreement** means this Provider Services Agreement, all attachments and incorporated documents or materials.

4. **Claim** means an invoice for services rendered to a Member by Provider, UB04 for Facility Claims and CMS 1500 for Professional Claims, or successor forms.

5. **Clean Claim** means a completed UB04 or CMS 1500 or successor format including electronic equivalent submitted by Provider for health care services rendered to a Member that contains all of the applicable elements listed in the Provider Manual. (28 TAC §21.2803.)

6. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

7. **CMS Agreement** means the Medicare Advantage contract between Health Plan and CMS.

8. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product or a Health Plan Affiliate's product which covers the Member.

9. **Emergency Services** means inpatient and/or outpatient medical care furnished by a provider who is qualified to furnish such services that are needed to evaluate and stabilize 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 might result in:

    a. placing the patient's health in jeopardy;
    b. impairment to bodily functions;
    c. dysfunction of any bodily organ or part;
    d. disfigurement; or
    e. in the case of a pregnant woman, jeopardy to the health of the woman or her unborn child. (UMCC Att. A, §2.)

10. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances. Provider shall use commercially reasonable efforts to comply with the Grievance Program.

Provider or authorized representative's initials: _____

11. **Health Plan** means Molina Healthcare of Texas, Inc.

12. **HEDIS Studies** means Health Employer Data and Information Set.

13. **HHSC** means the Texas Health and Human Services Commission.

14. **Hospital Providers** are hospital-based physicians and independent licensed non-physician healthcare professionals who are employed by Provider.

15. **IPA** means Independent Practice Association.

16. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

17. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

18. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

19. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to received Covered Services.

20. **Medically Necessary** means health care services that are:

    a. reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member or endanger life;
    b. provided at the appropriate levels of care for the treatment of a Member's health condition;
    c. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies within USA;
    d. consistent with the diagnoses of the conditions;
    e. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    f. are not experimental or investigative; and
    g. are not primarily for the convenience of the Member or Provider. (UMCC Att. A, §2.)
    h. Provider has the right to appeal Medical Necessity in accordance with TIC 1301.055 & .053

21. **PA** means a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes).

22. **Provider** means the entity or entities on Attachment A, including all employed or contracted physicians, allied health professionals and staff persons who provide health care services to

Members. All of said persons are bound by the terms of this Agreement. The definition of provider is shall not include any such provider employed by or under contract with The University of Texas Southwestern Medical Center at Dallas.

23. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must use commercially reasonable efforts to adhere.

24. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

25. **TIC, TAC** means the Texas Insurance Code and Texas Administrative Code, respectively.

26. **Uniform Managed Care Contract Terms & Conditions ("UMCC")** means the contract that sets forth the terms and conditions for Health Plan's participation as a managed care organization in one or more of the programs administered by the Texas Health & Human Services Commission. The UMCC mandates that Health Plan include certain contract terms and conditions in all of its contracts with providers, including this Agreement.

27. **Uniform Managed Care Manual ("UMCM")** means the HHSC manual that defines procedures that STAR, CHIP and STAR+PLUS managed care organizations must follow in order to meet certain requirements in the UMCC and that provides interpretation on provisions in the UMCC that need clarification.

28. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

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Provider or authorized representative's initials: _____

ATTACHMENT C
Products/Programs

Provider hereby elects to participate as a panel provider for each of the Health Plan products indicated below.

____ STAR+PLUS - **STAR+PLUS Program** means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, acute and long term care Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the Medical Assistance Only Program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program. (UMCC Att. A, Article 2. Definitions)

____ Medicare Advantage (Molina Medicare Options)

____ Medicare Advantage-Special Needs Plan (Molina Medicare Options Plus)

Provider or authorized representative's initials: _____

ATTACHMENT D
Compensation Schedule

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs as specified in Attachment C, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

STAR+PLUS:

Inpatient Services:
Covered Services shall be paid by HHSC via TMHP (and not Health Plan) at one hundred percent (100%) of the State of Texas Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Outpatient Services:
Covered Services shall be paid at one hundred ten percent (110%) of the payable rate under the State of Texas Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Texas Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not 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.

Professional Services: (110%)
Covered Services shall be paid at one hundred ten percent (110%) of the payable rate under the State of Texas Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Network Access Assurance Payment:
In the event that HHSC allocates Network Access Assurance Payment or other similar payments to the Health Plan that have historically been paid or that are derived from amounts intended for payment to Provider for either hospital or professional services, the Health Plan will assure one hundred percent (100%) of those funds are paid to the Provider within thirty (30) days of the Health Plan receiving such funds.

Medicare Advantage (Molina Medicare Options) and MA-SNP (Molina Medicare Options Plus): Inpatient, Outpatient and Hospital Provider Covered Services shall be paid at one hundred five percent (105%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

ATTACHMENT E

Provider or authorized representative's initials: _____

State Laws & Regulations

The following provisions are required by the Texas HMO Act and the regulations promulgated thereunder. The Agreement shall be automatically modified to conform to subsequent amendments to applicable statutes and regulations. Any purported modification to the Agreement that is inconsistent with applicable statutes and regulations is not effective.

1) Retaliation

Pursuant to Texas state law, 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. (28 TAC §11.901(a)(2).)

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. (28 TAC §11.901(a)(3).)

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. (28 TAC §11.901(a)(6).)

4) Podiatry

Providers who are podiatrists (i) may request Health Plan to provide, not later than the 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; (ii) 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; and (iii) may, while practicing within the scope of the law regulating podiatry, is/are permitted to furnish x-rays and nonprefabricated orthotics covered by a Member's health benefits plan. (TIC §843.311; 28 TAC §11.901(a)(13).)

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ATTACHMENT F
Medicaid & CHIP Program Requirements

The following provisions are required by the Texas Medicaid and/or CHIP programs. The Agreement shall be automatically modified to conform to subsequent amendments to such program requirements. Any purported modification to the Agreement inconsistent with such program requirements is not effective.

1) Behavioral Health

To the extent Provider is a primary care physician:

> Provider shall have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. (UMCC Att. B-1, §8.1.15.4.)

To the extent Provider provides inpatient psychiatric services:

> Provider shall schedule Members for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments. (UMCC Att. B-1, §8.1.15.5.)

2) 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. (UMCC Att. B-1, §8.1.9.)

3) Family Planning

To the extent this Agreement includes STAR:

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. (UMCC Att. B-1, §8.2.2.2.)

Provider or authorized representative's initials: JB

4) ***Liability***

In the event Health Plan becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against Health Plan will be through the Health Plan's bankruptcy, conservatorship, or receivership estate. (UMCC Att. A, §4.05(f).)

Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Health Plan, its employees, agents or subcontractors. Further, Provider understands and agrees that 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.). (UMCC Att. A, §4.05(f).)

5) ***Marketing***

Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the UMCC (which includes UMCM). (UMCC Att. B-1, §8.1.6, UMCM, Ch. 4.)

Provider is prohibited from engaging in direct marketing to enrollees 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. (UMCC Att. B-1, §8.1.6, UMCM Ch. 4.)

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 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.) (UMCC Att. B-1, §8.1.4.)

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. (UMCC Att. A, §7.02, and BBA §438.102.)

Provider or authorized representative's initials: _____

8) ***Primary Care Physicians (PCPs)***

To the extent Provider is a primary care physician:

a) Provider shall be accessible to Members 24 hours per day, 7 days per week. (UMCC Att. B-1, §8.1.4.)
b) Provider shall provide preventative care (i) to children under age 21 in accordance with AAP recommendations for CHIP Members 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. (UMCC Att. B-1, §8.1.4.2.)
c) Provider shall assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. (UMCC Att. B-1, §8.1.4.2.)

9) ***THSteps***

Provider shall send all THSteps newborn screens to the Texas Department of State Health Services (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. (UMCC Att. B-1, §8.2.2.3.)

10) ***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 (DOT). 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. (UMCC Att. B-1, §8.2.2.6.)

11) ***Women, Infants and Children***

Provider shall coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. (UMCC Att. B-1, §8.1.10.)

This Attachment G sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements with Providers covering the provision of health care services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

1. Downstream Compliance.

Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. 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 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 enrollees, 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. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii).)

3. Confidentiality.

Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

4. Hold Harmless/Cost Sharing.

Provider agrees that under no circumstance shall a Member be liable to the Provider for any sums owed by Health Plan to the Provider. Members who are dually eligible for Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate responsible party, for any Medicare Part A and B cost sharing that is covered by Medicaid. (42 CFR 422.504(g)(1)(i).)

5. Delegation.

Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment G-1. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or

Provider or authorized representative's initials:

written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4).)

6. Prompt Payment.

Health Plan and Provider agree that Health Plan shall pay all clean claims for services that are covered by Medicare within sixty (60)~~6~~ days of the date such claim is delivered by Provider to Health Plan and Health Plan determines such claim is complete/clean. Any claims for services that are covered by Medicare that are not submitted to Health Plan within six (6)~~6~~ months of providing the services that are subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefore. 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. (42 CFR 422.520(b).)

7. 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. (42 CFR 504(a)(8).)

8. Accountability.

Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment G-1. (42 CFR 422.504(i)(3)(ii).)

9. Compliance with Medicare Laws and Regulations.

Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

10. Benefit Continuation.

Provider agrees to provide for continuation of enrollee 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 an insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 422.504(g)(2)(ii) and 422.504(g)(3).)

ATTACHMENT G-1
MEDICARE PROGRAM REQUIREMENTS--DELEGATED SERVICES

This Attachment G-1 sets forth Medicare program requirements that are hereby incorporated into contracts and/or agreements that delegate to Provider responsibility for any management or administrative services. The Agreement and this attachment shall be automatically modified to conform to subsequent amendments to Medicare program requirements. In the event of any inconsistency between the terms of this attachment and the Agreement, the terms of this attachment shall control.

Provider or authorized representative's initials: _____

1. **Downstream Compliance.**

Provider agrees to require all of its downstream, related entity(s), and transferees that provide any services benefiting Health Plan's Medicare enrollees to agree in writing to all of the terms provided herein.

2. **Medicare Compliance.**

Provider shall comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)

3. **Confidentiality.**

Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)

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 enrollees, 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. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4) and 422.504(i)(2)(ii).)

5. **Responsibilities and Reporting Arrangements.**

The Agreement specifies the delegated activities and reporting responsibilities. To the extent applicable, Provider shall support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data . (42 CFR 504(a)(8).)

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 shall be revoked upon not less than five (5) days prior written notice. (42 CFR 422.504(i)(4)(ii).)

7. **Accountability.**

Provider or authorized representative's initials: 

Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii).)

8. Credentialing.

If Provider is delegated 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. (422.504(i)(4) and 422.504(i)(5).)

9. Monitoring.

Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall be consistent and comply with the Health Plan's contractual obligations. Health Plan shall monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 422.504(i)(4).)

10. Further Requirements.

Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement shall 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. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).)

Provider or authorized representative's initials: JB