MOLINA HEALTHCARE OF TEXAS, INC.

PROVIDER SERVICES AGREEMENT

This Provider Services Agreement ("Agreement") is entered by and between **Molina Healthcare of Texas, Inc., a Texas corporation** ("Health Plan"), and **Sumana Ketha MD, PA** ("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 health care professional(s), IPA or PA identified in Attachment A to this Agreement.

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

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall serve on Health Plan's panel of providers for the products specified in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Practice Information includes, but is not limited to, name, address, telephone number, hours of operation, type of practice, and ability to accept new patients. Provider shall promptly notify Health Plan of any changes in this practice information.

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2.2 Standards for Provision of Care.

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's business and practice, 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 provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice 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.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider shall obtain prior authorization of Health Plan in accordance with the Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care.

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

f. **Member Eligibility Verification.** Provider shall verify eligibility of Members prior to rendering services.

g. **Admissions.** Provider shall cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

h. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider shall provide notification to Health Plan within 24 hours of the referral.

i. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and

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prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

j. **Subcontract Arrangements.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.

k. **Availability of Services.** Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Members on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of Member patient visits after hours. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

l. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of Covered Services limitations. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **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.

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.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

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2.5 **Recordkeeping.**

a. **Maintaining Member Medical Records.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

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 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

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covered by this section include all medical records, billing records, statistical data, encounter data, and any other patient treatment information pertaining to Members served by Provider. Health Plan shall have the right to withhold compensation from Provider in the event Provider fails or refuses to comply with this provision.

e. **Member Access to Records.** Provider shall promptly provide any Member and/or their authorized representative upon request 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 Health Plan'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

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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 shall participate in Health Plan's Quality Improvement Program and activities, including peer review and audits of care rendered by Provider. (UMCC Att. B-1, §8.1.7.)

c. **Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, 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 credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately 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 reassign Members to another provider.

e. **Provider Manual.** Health Plan will furnish a copy of the Provider Manual to Provider during orientation. Provider is bound by the terms of the Provider Manual, which may be amended from time to time at Health Plan's sole discretion. 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 additional operating procedures and policies for Providers which are communicated to Provider in writing by Health Plan.

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

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services to be performed under this Agreement.

g. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also 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 ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 **Licensure and Insurance.**

a. **Licensure.** Provider represents and warrants that it possesses any license/s that are required by law to deliver the services described herein, including a current narcotics number, if applicable. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

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, assessed a civil penalty under the provisions of Section 1128, 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. **Staffing Privileges for Providers.** Consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Every physician Provider shall maintain, at a minimum, professional liability insurance with limits of not less than one hundred thousand dollars ($100,000) per occurrence and three hundred thousand ($300,000) in the aggregate for the policy year and for each physician comprising Provider, or the limits required by the hospital at which Provider has admitting privileges. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five business days of a written request by Health Plan. (UMCC Att. A, §17.01(b).)

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e. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (i) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) any criminal investigations or proceedings against Provider; (iii) any convictions of Provider for crimes involving moral turpitude or felonies; and (iv) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

2.8 **Claims Payment.**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or program requirements, any claims that are not submitted within ninety-five (95) days of the date Covered Services that are the subject of the claim were provided shall not be eligible for payment, and Provider hereby waives any right to payment therefor. (UMCC Att. B-1, §8.1.18.5.)

b. **Timely Submission of Encounter Data.** Provider understands that Health Plan may have certain contractual reporting obligations which require timely submission of encounter data. Therefore, as applicable Provider shall submit encounter data to Health Plan within ninety (90) days of delivery of the service.

c. **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.

d. **Copayments and Deductibles.** Copayments are the only amounts Providers may collect from CHIP Members, except for costs associated with unauthorized non-emergency services provided to a Member by out-of-network providers for non-covered services. Provider shall not charge: (i) cost-sharing or deductibles to CHIP Members of Native American Tribes; (ii) copayment or deductibles to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; or (iii) copayments for well-child or well-baby visits or immunizations. (UMCC Att. A, §10.12(b).)

e. **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

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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 ninety-five (95) 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.).

f. **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 to Health Plan within forty-five (45) days of written notification by Health Plan of the overpayment, duplicate payment, or other excess payment. Should Provider discover excess money of any kind prior to being notified, Provider shall contact Health Plan and hold the money until it is determined to whom the money belongs. In addition to any other contractual or legal remedy, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider at any time after expiration of the forty-five (45) day notice period described above.

g. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review and audit Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, 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 or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. 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 access to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

h. **Member Billing.** Provider is prohibited from billing or collecting any amount from a Medicaid Member for health care services provided pursuant to this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service. (UMCC Att. A, §10.12(a).)

Health Plan shall initiate and maintain any 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

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CHIP Members. (UMCC Att. A, §§4.05 and 10.12; TIC §843.361, and 28 TAC §11.901(a)(1).).

i. **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).)

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

k. **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.)

l. **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

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.)

m. **Claims Processing Guidelines.** Health Plan shall provide at least ninety (90) days notice prior to implementing a change in the claims guidelines (except any change in claims processing entities, see Section 2.8.l), unless the change is required by statute or regulation in a shorter timeframe. (UMCC Att. B-1, §8.1.18.5.)

n. **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).)

o. **Availability of Coding Guidelines.** Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that Provider will receive under the Agreement, and Health Plan or its agent shall provide the coding guidelines and fee

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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; and (ii) disclose the information to a governmental agency involved in the regulation of health care or insurance. On Provider's request, Health Plan shall provide the name, edition, and model version of the software that Health Plan uses to determine bundling and unbundling of claims. (UMCM §7.1; TIC §843.321.)

p. **Appeals of Claims Payment Decisions.** The timeframes for appeals of claims payment decisions shall be as follows:

i. In the event that Health Plan requests repayment for a claim that was overpaid or paid in duplicate, or repayment of funds that were paid which were not provided for under this Agreement, Provider must contest Health Plan's request for repayment in writing within thirty (30) days of its receipt.
ii. In the event that Health Plan denies a Provider claim, Provider must submit a request for review of the denied claim within one hundred twenty (120) days of the initial denial.
iii. In the event that Provider believes Health Plan incorrectly paid a Provider claim, Provider must submit a request for correction or adjustment within one hundred twenty (120) days of the date of the remittance advice.
iv. Health Plan will use its best efforts to resolve all disputed claims within thirty (30) days of receipt.

The format for appeals of claims payment decisions shall be as follows:

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

2.9 Compliance with Applicable Law.

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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, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement, the UMCC, Health Plan's health benefits programs, and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by Provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation 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 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.)

2.10 **Provider Non-Solicitation.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another medical group, PA, IPA, or provider without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this

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provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.11 **Fraud and Abuse.** Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the State, Provider shall consult with the appropriate State agency prior to and during the course of any such investigations.

In addition, 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.)

2.12 **Gifts and Gratuities.** Provider shall not offer or give any thing 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

Initials of authorized representative of Provider:

($50.00) and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. Health Plan may terminate this Agreement at any time for violation of this provision. (UMCC Att. A, §12.03(b)(5).)

2.13 **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.)

2.14 **Payments which are the Responsibility of a Capitated Provider.** In the event a provider, such as a medical group or IPA or PHO, receives capitation from Health Plan and is responsible for providing or arranging for Covered Services for certain Members (a "Capitated Provider"), Provider shall look solely to such Capitated Provider, and not Health Plan, for payment of Covered Services provided to such Members, and the Capitated Provider, not Health Plan, is financially responsible for paying any and all related claims. In the event Health Plan receives any claims for services that are the responsibility of a Capitated Provider, Health Plan shall return the claims unpaid and/or at its election redirect the claims to the Capitated Provider.

2.15 **Reciprocity Agreements.** Provider agrees 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. In the event Provider is a Capitated Provider, Provider agrees to accept usual and customary rates in effect in the geographic area for services provided to beneficiaries of the government-sponsored program that covers the Member.

2.16 **Reassignment of Members.** Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the health and safety of one or more Members. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When Health Plan reassigns Member(s), Provider shall forward copies of the medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

2.17 **Notice to Members of Network Changes.** Where Provider is a medical group, IPA, or any other similar organization, Provider shall provide Health Plan and Members with timely written notification in the event a constituent specialty provider terminates its contract with Provider. Said written notification shall be in compliance with all state and federal laws or government sponsored program requirements.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

Initials of authorized representative of Provider: SL

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

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 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.)

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

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** The term shall commence on the Effective Date indicated by Health Plan on the signature page of this Agreement 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.

Initials of authorized representative of Provider: SK

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 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 limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. 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;

e. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

g. 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;

h. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

Initials of authorized representative of Provider: SD

i. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

j. Provider violates the prohibition against gifts and gratuities set forth in Section 2.12.

4.6 **Member Notice.** Prior to the effective date of termination of this Agreement by either Provider or Health Plan, Health Plan 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 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **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 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.

5.3 **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.

5.4 **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.

5.5 **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.

5.6 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy,

Initials of authorized representative of Provider: SL

directive, or government sponsored program requirement. Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that thirty (30) day period, the amendment shall be deemed accepted by and shall be binding upon Provider.

5.7 **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.8 **Dispute Resolution Process.**

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

i. Provider shall submit any dispute (other than any dispute relating to payment or non-payment of a claim, which is subject to Section 2.8p) 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 2.8p) within seven (7) business days.

ii. Health Plan shall investigate and resolve disputes within thirty (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.)

5.9 **Arbitration.** 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. Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the American Arbitration Association ("AAA") Commercial Arbitration Rules, then in effect, in Dallas, Texas; provided, however, matters that primarily involve Provider's professional competence or conduct shall not be eligible for arbitration. If possible, the arbitrator shall be an attorney with at least fifteen (15) years' experience, including at least five (5) years' experience in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may

Initials of authorized representative of Provider: SL

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

5.10 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, 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:

Molina Healthcare of Texas, Inc.
5605 MacArthur Blvd, Suite 400, Irving, Texas 75038-2617
Fax #: (972) 756-9275
Attention: Provider Contracting

If to Provider:

Sumana Ketha MD, PA
2925 Skyway Circle North, Irving, TX, 75038
Fax#: (972) 791-8211
Attention: Administrator

The parties may change the names and addresses noted above through written notice in compliance with this Section. 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, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

Initials of authorized representative of Provider SK

5.11 **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 –Health Care Services
Attachment G-1 – Medicare Program Requirements – Delegated Services

Initials of authorized representative of Provider:

SIGNATURE AUTHORIZATION

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 its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Sumana Ketha MD, PA **Molina Healthcare of Texas, Inc.**

Provider Signature:	S. Ketha	Health Plan Signature:	Joan A Robnett
Signatory Name (Printed):	SUMANA KETHA	Signatory Name (Printed):	Joan Robnett
Signatory Title (Printed):	Director	Signatory Title (Printed):	VP, Network Management and Operations
Signature Date:	8/13/13.	Signature Date:	9/24/2013
		Effective Date:	(To be completed by Health Plan) 11/1/13

Initials of authorized representative of Provider: SK

ATTACHMENT A

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

Y	Primary Care Physician:
N	Specialist:
Y	**Medical Group/PA/IPA** **(a list of constituent members with their License No., TPIN, and DEA numbers is attached and incorporated herein)**
N	Ancillary Provider:
N	Pharmacy
N	Other:

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

Provider Name	Sumana Ketha MD, PA	Billing Address: 2925 Skyway Circle North, Irving, TX, 75038
Telephone No.	972-639-5838	
Facsimile No.	972-791-8211	
Email Address	drketha@sumanakethamdpa.com	
Tax I.D. No.	20-1401614	
License No.	K7311	
Texas Provider Identification Number (TPIN)	183413701	Physical Address (if different than above): 2925 Skyway Circle North, Irving, TX, 75038
NPI (or UPIN if NPI not yet designated)	NPI: 1356565865 UPIN: _____	
DEA No.	BK6230281	

(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.

S. Ketha
Provider Signature

SUMANA KETHA
Signatory Name (Printed)

MD
Signatory Title (Printed)

8/13/13.
Signature Date

Initials of authorized representative of Provider: SK

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	Sumana Ketha, MD	Billing Address: 2925 Skyway Circle North, Irving, TX, 75038
Telephone No.	972-639-5838	
Facsimile No.	972-791-8211	
Email Address	drketha@sumanakethamdpa.com	
Tax I.D. No.	20-1401614	
License No.	K 7311	Physical Address (if different than above):
Texas Provider Identification Number (TPIN)	38961107	
NPI (or UPIN if NPI not yet designated)	NPI: 1962447805 UPIN:	
DEA No.	BK6230281	

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

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

Initials of authorized representative of Provider: SK

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

3. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

4. **Clean Claim** means a completed 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.)

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

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

7. **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.

8. **Emergency Services** means inpatient and/or outpatient Covered Services 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 serious jeopardy;
   b. serious impairment to bodily functions;
   c. serious dysfunction of any bodily organ or part;
   d. serious disfigurement; or
   e. in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child. (UMCC Att. A, §2.)

9. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.

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

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

Initials of authorized representative of Provider: SK

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

13. **IPA** means Independent Practice Association.

14. **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.

15. **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.

16. **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.

17. **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.

18. **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 appropriate facilities and 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;
    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.)

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

20. **Provider** means the person(s) and/or entity identified in the first paragraph and Attachment A. Where Provider is a PA, IPA or any other entity which under Texas law is permitted to enter the Agreement on behalf of one or more providers of professional services, Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the contracting entity. All of said persons are bound by the terms of this Agreement.

21. **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

Initials of authorized representative of Provider: SR

that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

22. **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.

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

24. **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.

25. **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.

26. **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.

Initials of authorized representative of Provider: SL

ATTACHMENT C

Products/Programs

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

STAR- **STAR or STAR Program** means the State of Texas Access Reform program and is administered through HMOs throughout the State of Texas. HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, and acute care covered services to non-disabled, low-income children and families, and pregnant women, SSI and SSI- related adults and children who do not receive Medicare, pursuant to Title XIX of the Social Security Act and Texas Administrative Code, Title 1, Part 15, Chapter 353.

CHIP HMO - **Children's Health Insurance Program** or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC. (UMCC Att. A, Article 2. Definitions).

STAR+PLUS - **STAR+PLUS or 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 MAO 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)

CHIP PERINATE - **CHIP Perinatal Program** means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program. (UMCC Att. A, Article 2. Definitions).

Medicare Advantage (Molina Medicare Options)

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

Initials of authorized representative of Provider: SL

ATTACHMENT D

Compensation Schedule

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with products/programs as specified in Attachment C, on a fee-for-service basis, at the lesser of; (i) Provider's billed charges, or (ii) the allowable 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, CHIP HMO, CHIP PERINATE, and STAR+PLUS: Covered Services shall be paid at an amount equivalent to 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.

Medicare Advantage (Molina Medicare Options) and MA-SNP (Molina Medicare Options Plus): Covered Services shall be paid at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

Initials of authorized representative of Provider: SB

ATTACHMENT E

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).)

5) ***Capitation.***

In the event Provider receives capitation, the language required by 28 TAC §11.901(a)(9), (10) is incorporated into this Agreement.

Initials of authorized representative of Provider:

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 twenty-four (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.)

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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 the Health Plan's Members may not be held liable for the Health Plan's debts in the event of the entity's insolvency. (UMCM, Ch 8.1.37)

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.)

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.)

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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.)

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ATTACHMENT G

MEDICARE PROGRAM REQUIREMENTS ---HEALTH CARE SERVICES

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

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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)(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) 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) 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)).

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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.

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.

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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.

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)).

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