

**PARTICIPATING GROUP PROVIDER AGREEMENT**

**BETWEEN**

**Driscoll Children's Health Plan  
(DCHP)**

**AND**

**HIDALGO COUNTY HEALTH DEPT**

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## DRISCOLL CHILDREN'S HEALTH PLAN

### PARTICIPATING GROUP PROVIDER AGREEMENT

THIS PARTICIPATING GROUP PROVIDER AGREEMENT ("Agreement") shall be effective \_\_\_\_\_ (the "Effective Date") by and between **HIDALGO COUNTY HEALTH DEPT** ("Group" or "Provider") and Driscoll Children's Health Plan ("DCHP").

WHEREAS, Driscoll Children's Health Plan is a health maintenance organization ("HMO") delivering managed Medicaid services under the state of Texas CHIP and STAR Programs which shall arrange for the provision of certain health care services to Members through cost-effective, coordinated health care delivery systems (sometimes referred to as the "Provider Network" or "Network");

WHEREAS, Group employs or otherwise contracts with experienced physicians or mid-level practitioners who are duly licensed to practice medicine in the state(s) identified in the DCHP Provider Application and meets DCHP's provider credentialing criteria;

WHEREAS, DCHP desires that Provider provide, and Provider agrees to provide, services to Members under the terms and conditions of this Agreement; and

WHEREAS, DCHP and Provider, in order to comply with all applicable regulatory requirements, agree to be bound by the provisions of this Agreement.

In consideration of the mutual covenants and conditions contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DCHP and Provider agree as follows:

#### SECTION I - DEFINITIONS

For purposes of this Agreement, the following terms have ascribed meaning:

- 1.1 Ancillary care provider. A health care professional, other than a hospital, physician or mid-level practitioner, who provides health care services, such as durable medical equipment, home health services, laboratory or diagnostic services, to Members.
- 1.2 Children's Health Insurance Program or CHIP. The health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.
- 1.3 Clean Claim. A request for payment for Covered Services submitted by Provider which is accurate, complete, in the format required by DCHP and as to which there is no issue (such as coordination of benefits) regarding DCHP's responsibility for payment. It is a claim that contains accurate and complete information in all fields required by HCFA 1500 or UB 04 form. A clean claim is one that can be adjudicated without additional information from provider of service or from a third party.
- 1.4 Covered Services. Those health care services Members are entitled to receive pursuant to their DCHP plan(s).
- 1.5 Emergency Care. Acute care services, emergency behavioral health services and health-related services provided in response to any condition requiring immediate intervention and/or medical treatment, including emergency labor and delivery and any medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses the average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; (c) in the case of a pregnant woman, possible harm to a fetus; (d) serious disfigurement; (e) serious dysfunction of any bodily organ or part; or (f) an emergency behavioral health condition.
- 1.6 Evidence of Coverage. The document that DCHP uses to describe the services and benefits to which a Member is entitled.
- 1.7 Medically Necessary Health Services. Health services other than behavioral health services which 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 medical conditions; and
  - c. consistent with healthcare practice guidelines and standards that are issued by professionally recognized healthcare organizations or governmental agencies.
- 1.8 Member. Any person who is covered by any DCHP plan.
- 1.9 Mid-Level Practitioner. A licensed or certified, as required in the State of Texas, advanced practice nurse, physician's assistant or certified nurse midwife who is an employee of, or independent contractor to, a Participating Physician.

- 1.10 Normal Charge. Usual and customary charge per individual unit of service.
- 1.11 Out-of-Area Urgent Care. Care that: (a) is needed urgently by a Member while he or she is outside the Service Area, the need for which could not reasonably have been anticipated before the Member left the Service Area and (b) cannot safely be postponed until the Member is able to return to the Service Area to obtain care from or through his or her Primary Care Provider (PCP). Out-of-Area Urgent Care does not include services provided by non-Participating providers after the point at which the Member could safely be transferred to the care of a Participating Provider.
- 1.12 Participating Hospital. A facility licensed under applicable state law as a general acute care hospital and which has contracted as an independent contractor with DCHP to provide certain Covered Services to Members.
- 1.13 Participating Provider. An appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with DCHP for the delivery of Covered Services to the DCHP Members.
- 1.14 Primary Care Physician (PCP). A Participating Provider who: (a) has been credentialed by DCHP as a Primary Care Physician and who engages in the practice of medicine; (b) supervises, coordinates, and provides initial and basic care to patients; (c) initiates patient referrals for Specialist Care Services and maintains continuity of patient care; and (d) who practices in the fields of general practice, internal medicine, pediatrics, or family medicine. A Primary Care Physician may also include a physician who practices in the fields of Obstetrics and Gynecology, a Mid Level practitioner or if approved by DCHP, a Specialist Provider.
- 1.15 Provider Manual. The manual prepared by DCHP and as amended from time to time which sets forth the policies and procedures for Provider to follow in delivering services to Members.
- 1.16 Service Area. The applicable Texas counties covered by each DCHP HMO product.
- 1.17 Specialist Provider. A Specialist is a Participating Physician who is credentialed by DCHP as a specialty care provider. Specialist Providers provide Covered Services to Members within the range of the physician's specialty..
- 1.18 State of Texas Access Reform ("STAR") Program. The Medicaid managed care program (HMO) for the State of Texas.
- 1.19 Texas Health and Human Services Commission ("HHSC"). HHSC oversees the STAR and CHIP programs. HHSC contracts with managed care organizations, such as DCHP, to administer the Medicaid and CHIP programs through a Uniform Managed Care Contract. The Uniform Contract may be found at:  
<http://www.hhsc.state.tx.us/medicaid/UniformManagedCareContract.pdf>
- 1.20 Uniform Managed Care Manual. The manual published by or on behalf of HHSC that contains policies and procedures required of all HMOs participating in the HHSC Programs. The Manual can be found online at  
<http://www.hhsc.state.tx.us/medicaid/UMCM/default.html>.

## SECTION II - RELATIONSHIP OF DCHP AND PROVIDER

- 2.1 Independent Contractors. No provision of this Agreement is intended to create or shall be construed to create any relationship between Provider and DCHP other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement nor shall any of the parties respective employees be construed to be the agent, employer or representative of the other. Nothing in this Agreement shall be construed to establish a relationship of partnership, joint venture, agency or employment between DCHP and Provider. Neither DCHP nor Provider has authority to enter into contracts or assume any obligations for the other nor make any warranties or representations on behalf of the other concerning the duties, obligations or services of the other except in accordance with the express terms of this Agreement or as otherwise authorized in writing by the other.
- 2.2 Responsibility for Medical Decisions. Provider acknowledges that DCHP does not and cannot practice medicine and that Provider shall be solely responsible for all medical decisions made by Provider in connection with the care of any Member, notwithstanding any recommendation, direction or other statement regarding such care or the coverage of such care that may be issued by or on behalf of DCHP with respect to such Member.
- 2.3 Confidentiality of Proprietary Information. DCHP and Provider acknowledge that in connection with their performance under this Agreement, each may have access to proprietary, non-public information concerning the other's business and operations ("Confidential Information"). DCHP and Provider agree that neither shall utilize nor disclose to any third party the other party's Confidential Information for any purpose other than the performance of this Agreement, except as required by law or expressly authorized by the other party. Any confidential material or information shall be returned to the originating party upon termination of the Agreement. Provider shall implement procedures to guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the Provider's office or DCHP.

- 2.4 Authority. Group warrants that it has the power and authority to obligate the persons providing services on behalf of Group to perform the duties pursuant to this Agreement. Each of Group's Participating Providers must be independently credentialed by DCHP to provide the services herein. Group agrees and each individual providing services on behalf of Group agrees that the obligations and responsibilities set forth in the this Agreement shall apply to each of them individually as if each individual provider executed this Agreement in his or her own name.

### SECTION III - DCHP'S OBLIGATIONS

- 3.1 General. DCHP shall be responsible for all payment and administrative activities necessary or required for the operation of a health maintenance organization. Such activities shall include but are not limited to, contracting with physicians and other health care providers for the provision of covered services, credentialing of physicians and providers, administration of Utilization Management and Quality Improvement programs, capital financing, marketing, advertising, customer service, claims processing, maintenance of management information systems, maintenance of network directory and records, accounting, management and other services and procedures required by law or regulation.
- 3.2 Policies and Procedures. DCHP shall develop and implement policies and procedures on grievance, utilization review, drug utilization, quality assurance, credentialing and other policies or procedures as required by law or regulation or as necessary for administration of Covered Services. Provider is expected to become familiar with and follow all applicable DCHP policies and procedures.
- 3.3 Provider Manual. DCHP shall make available to Provider the DCHP Provider Manual (to be periodically updated) and the terms of which are made part of this Agreement and are incorporated herein by reference. The Provider Manual details the applicable rules, regulations, policies and procedures of DCHP as they relate to the provision of services under this Agreement. The Provider Manual can be accessed from the DCHP website at <http://www.dchpkids.com/providermanuals.asp>.
- 3.4 Member/Provider Communications. DCHP is prohibited from imposing restrictions upon a Provider's free communication with Members regarding the Member's medical conditions, treatment options, costs, DCHP referral policies, and other DCHP policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.
- 3.5 PCP Selection. DCHP shall notify Provider of a Member's selection of or assignment to Provider as that Member's Primary Care Physician within 30 working days of the selection or assignment of the Member to Provider's member panel.
- 3.6 Volume. DCHP does not, by this Agreement or otherwise, promise, warrant or guarantee Provider any minimum number of Members on Provider's panel or as referrals to Provider.
- 3.7 Retaliation. DCHP is prohibited from engaging in any retaliatory action against Provider, including termination or refusal to renew this Agreement, because Provider has, acting on behalf of the Member, reasonably filed a complaint with any agent against DCHP or appealed a decision of DCHP.
- 3.8 Economic Profiling. If DCHP conducts or uses economic profiling of Provider, DCHP shall make available to Provider upon request, the economic profile of that Provider, including the standards by which the Provider is measured. The use of an economic profile must recognize the characteristics of Provider's practice that may account for variations from expected costs.
- 3.9 Non-Discrimination. DCHP shall comply with Title VI of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Federal Rehabilitation Act of 1973, and all requirements imposed by the regulations implementing these acts and all amendments to the laws and regulations. The regulations provide in part that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in or denied any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds. DCHP agrees to comply with the Texas Health and Safety Code, as amended, relating to workplace and confidentiality guidelines regarding AIDS and HIV, currently cited in Section 85.113. DCHP agrees that it shall not discriminate against any individual based on that individual's pre-existing medical condition or disability.
- 3.10 Member Notice of Provider Termination. DCHP shall provide Members currently being treated by Provider with thirty (30) days' written notice prior to the effective date of termination of Provider. In the event of Immediate Termination as defined below in Section XI, notice shall be provided to Members within 30 days from the effective date of the termination.
- 3.11 Injunction or Other Action. DCHP shall initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency or any Member to collect payment over and above allowable co-payments or deductibles, excluding payment for services not covered under DCHP plan(s). Additionally, this provision does not restrict a CHIP Dental Network Provider from collecting payment for services that exceed a CHIP member's benefit cap.
- 3.12 DCHP Orientation. DCHP shall provide initial orientation to all Providers regarding applicable DCHP policies and procedures, DCHP Provider Manual, and other relevant information, upon request of DCHP or Provider. Provider agrees to cooperate with all ongoing training or orientation efforts of DCHP, including making Provider's staff available as requested by DCHP.

## SECTION IV - PROVIDER'S OBLIGATIONS

In addition to any other obligations set forth in the Agreement, Provider warrants, understands and agrees as follows:

- 4.1 Identity of Group Providers. Group shall provide the services set forth in this Agreement through the Providers identified on Attachment B attached hereto and incorporated herein by reference.
- 4.2 Professional Relationship: Responsibility and Non Exclusivity. Provider shall be solely responsible for all medical advice and services Provider performs or prescribes with regard to Members. This Agreement shall not be deemed in any way to limit or restrict Provider from entering other arrangements or programs of a similar nature with other managed care entities.
- 4.3 Coordinated Care. Provider shall participate in the systems established by DCHP designed to facilitate the coordination of healthcare services received by Members. Subject to medical judgment, a Member's care interests and express instructions and recognizing that a level of a Member's Covered Services may be affected by Provider's rendering of services, Provider shall abide by the rules and regulations of DCHP that govern referrals of Members and reporting of clinical encounter data.
- 4.4 Verification of Member Eligibility. Prior to providing or arranging for the provision of Covered Services for a Member, Provider shall verify each Member's eligibility for benefits in accordance with the standards, policies, procedures, rules, and regulations of DCHP contained in the Provider Manual.
- 4.5 DCHP Policies and Procedures and Provider Manual. Provider understands and agrees that the terms of Provider Manual, as amended from time to time, are incorporated into this Agreement. Provider expressly agrees to review the Provider Manual as regularly and as necessary to comply with its terms and to abide by all of its terms and conditions. Further, Provider and all members of Group are expected to become familiar with and follow all applicable DCHP policies and procedures.
- 4.6 Advance Directives. Provider must comply with the requirements of state and federal laws, rules, and regulations relating to advance directives.
- 4.7 Availability of Services. Provider shall provide all Covered Services in the same manner, in accordance with the same accepted medical standards, and within the same time availability, offered to all of Provider's patients. Provider or his or her approved delegate must be available to provide Covered Services to Members seven (7) days per week, twenty-four (24) hours per day, as described further in this Agreement and the Provider Manual.
- 4.8 Preventive Care. PCPs must provide preventive care:
  - a. to children under age 21 in accordance with American Academy of Pediatrics recommendations for Medicaid Managed Care Members and the Texas Health Steps (THSteps) program published in the THSteps Manual for Medicaid Members; and
  - b. to adults in accordance with the U.S. Preventative Task Force requirements.
- 4.9 Provision of Non-Covered Services. In the event that Provider provides any services other than Covered Services to any Member, prior to the provision of such services, Provider shall advise the Member, in writing: (a) of the nature of the service, (b) that the service is not a Covered Service for which DCHP shall pay, and (c) that the Member shall be responsible for paying for the service. Provider must obtain a signed Advance Beneficiary Notice/Private Pay Form from such a Member and produce a copy of such to DCHP, upon request.
- 4.10 Liability for Payments. Except as otherwise provided in this Agreement, Provider shall not bill, charge or attempt to collect payments, other than allowable co-payments, from any Member for any services provided under this Agreement, including the difference between the amount of reimbursement payable under this Agreement and the Provider's Normal Charges for the services rendered. Provider recognizes that Members are protected from liability payments that are the responsibility of DCHP. Provider agrees that all of the provision in this section shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members. Provider further understands and agrees that:
  - a. 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.
  - b. In no event, including but not limited to nonpayment by DCHP, DCHP insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons (other than DCHP) acting on his/their behalf for Covered Service provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments made in accordance with the terms of the Evidence of Coverage between DCHP and the Member.

- c. DCHP has the sole responsibility for payment of services rendered by Provider under this Agreement and that HHSC is not liable or responsible for such payment. In the event of DCHP insolvency or cessation of operations, Provider's sole recourse shall be against DCHP through the bankruptcy, conservatorship, or receivership estate of DCHP.
  - d. Members may not be held liable for DCHP's debts in the event of the entity's insolvency.
  - e. HHSC does not assume liability for the actions of, or judgments rendered against DCHP, 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 DCHP or any judgment rendered against DCHP. HHSC's liability to Provider, if any, shall be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).
- 4.11 Provider Collection of Payments Above Allowed Amounts: Provider is responsible for collecting at the time of the service any applicable co-payments or deductibles given the limitations on those co-payments and deductibles as set out in accordance with the terms of the Evidence of Coverage between DCHP and Member.
- 4.12 Primary Care Physician (PCP) Services. All PCP Providers agree to accept as patients all Members who are eligible to select Provider as a PCP and who have selected Provider as their PCP. Provider agrees to provide or arrange for the provision of appropriate Covered Services within the scope of Provider's practice to such Members. PCP shall refer Members to Specialist Providers only in accordance with the policies and procedures established by DCHP as set forth in the Provider Manual.
- 4.13 Specialist Provider Services. If credentialed by DCHP as a Specialist Provider, Provider agrees to accept as patients all Members who are referred by PCPs participating in the DCHP Network based upon Specialist Provider's specialty, and to provide or arrange for the provision of appropriate Covered Services within the scope of Provider's practice to such Members. Specialist Provider shall refer Members to other Specialist Providers only in accordance with the policies and procedures established by DCHP as set forth in the Provider Manual.
- 4.14 Specialist Providers as PCPs. Specialty Providers may function as PCPs for certain Members with disabilities or chronic or complex health needs upon approval of DCHP. The Specialist Provider must agree to perform all PCP duties required in this Agreement and the Provider Manual. PCP duties must be within the scope of the Specialty Provider's license.
- 4.15 Hospital Affiliation and Privileges. Provider shall maintain in effect the appropriate level of privileges to practice at one or more Participating Hospitals, unless arrangements are otherwise approved by DCHP through its credentialing process. Provider shall immediately notify DCHP in the event that Provider's privileges are revoked, limited, surrendered, or suspended or if Provider takes a leave of absence at any hospital or health care facility including any Participating Hospital.
- 4.16 Insurance Coverage. Provider shall purchase and maintain at all times during the term of this Agreement, professional liability insurance, general comprehensive liability insurance and workers' compensation insurance in amounts as may be required by DCHP from time to time, but in no event, less than the amount required by law. Professional liability insurance limits shall be, at a minimum, \$100,000 per occurrence \$300,000 aggregate. Tail or prior acts insurance shall be maintained as may be necessary to avoid a gap in coverage for claims arising from services rendered during the term of this Agreement. Provider shall, upon written request, provide to DCHP certificates of insurance or actuarial certification of an adequately funded trust evidencing the foregoing coverage. Provider shall provide DCHP with at least thirty (30) days notification before any reduction in the amount of coverage, any adverse changes in policy terms, or cancellation or non-renewal of any required coverage. Provider shall immediately inform DCHP in writing if he or she receives notice or otherwise learns that its insurance coverage is to be terminated or materially modified in any way.
- 4.17 Obligation to Continue Care. In the event that DCHP becomes insolvent or fails for any reason to pay compensation for Covered Services as required by this Agreement, Provider nevertheless agrees that, at DCHP's request, Provider shall continue to treat, according to the terms of this Agreement, Members then under a course of active treatment until provision has been made for their assignment to another provider or until such treatment has been completed, whichever occurs first, or for such longer period as may be required by law. Such period shall not exceed the period for which a Member's premiums have been paid (where applicable) except that Persons under a course of treatment or any Member confined to an inpatient facility shall continue until such treatment has been completed or until such Member is discharged or another provider has assumed care of such Member. Provider shall not bill Members or persons acting on their behalf for Covered Services rendered during such period.
- 4.18 Reports. Provider shall provide such documents, data, information, and other material to DCHP as is necessary for DCHP to comply with reporting requirements of governmental and accrediting agencies.

- 4.19 State and Federal Laws, Rules and Regulations. In accordance with DCHP's managed care contract with HHSC for the CHIP and STAR programs, the following shall also apply:
- a. CLIA. Provider shall comply with all requirements of the Clinical Laboratory Improvement Act ("CLIA"), and implementing regulations. Upon execution of this Agreement, Provider agrees to furnish written verification to DCHP that its own laboratory(ies), if any, and those with which it conducts business related to Members, has (have) a CLIA certificate of registration or a waiver, and a CLIA identification number. Provider also shall furnish annually to DCHP a written list of diagnostic tests performed in its laboratory(ies), if any, and those with which it conducts business related to Members. Provider shall notify DCHP of changes in the CLIA status of its laboratory(ies), and those with which it conducts business related to Members, in writing within five (5) days of such changes.
  - b. HHSC Requirements. Provider understands and agrees that it is subject to all state and federal laws, rules, regulations and waivers, policies and guidelines and court-ordered consent decrees, settlement agreements or other court orders that apply to the Agreement and DCHP's managed care contract with HHSC, the HMO Program, and any and all persons or entities receiving state and federal funds. Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the DCHP's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
  - c. State and Federal Laws. Provider agrees to follow all applicable state and federal rules and regulations relating to the provision of services under this Agreement. Provider further understands and agrees that following laws, rules, and regulations, and all amendments or modifications thereto, also apply to this Agreement:
    1. Environmental protection laws:
      - a) 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;
      - b) 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;
      - c) Clean Air Act and Water Pollution Control Act regulations and 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");
      - d) 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
      - e) 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;
    2. Anti-discrimination laws:
      - a) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
      - b) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
      - c) Americans with Disabilities Act of 1990 (Public Law 101-336); and
      - d) Title 40, Texas Administrative Code, Chapter 73;
    3. The Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) regarding employment verification and retention of verification forms;
    4. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (Public Law 104-191);
    5. The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH") (Public Law 111-5, 123 Stat 115); and
    6. Managed Care Laws. Provider agrees to comply with all other state and federal laws and regulations relating to the Texas Medicaid Program and the Medicaid managed care program adopted by HHSC, Texas Department of Health ("TDH"), Texas Department of Human Services ("TDHS"), Texas Department of Insurance ("TDI"), Texas Department of Mental Health and Mental Retardation ("TDMHMR"), and any other State agency that is delegated authority to operate Medicaid or managed care programs.
  - d. Federal Health Care Programs Exclusion. Provider represents, warrants and covenants that Provider has not been excluded from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or Title XXI (CHIP) under any of the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. Section 1320-a-7) or Executive Order 12549. Provider must notify DCHP within three (3) days of the time Provider receives notice of any action being taken against Provider which could result in exclusion from any DCHP plan.

- 4.20 Waste, Fraud and Abuse. The parties acknowledge that DCHP and Provider are subject to all state and federal laws and regulations relating to fraud and abuse in health care, Medicaid, and CHIP. Provider must cooperate and assist any state or federal agency with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must provide originals and/or copies of all records and information requested and allow access to premises and provide records to authorized agent(s), HCFA, the U.S. Department of Health and Human Services (DHHS), FBI, TDI, or other unit of state government. Provider must provide all copies of records free of charge. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by DCHP to the State. Provider understands and agrees to the following:
- a. HHSC Office of Inspector General (“OIG”) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Providers and their employees, agents, contractors, and patients;
  - b. Requests for information from such entities must be complied with, in the form and language requested;
  - c. Providers and their employees, agents, and contractors must 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;
  - d. Compliance with these requirements will be at the Provider’s own expense;
  - e. Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the STAR Medicaid and/or CHIP Programs, as applicable;
  - f. Provider must 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;
  - g. Provider must provide originals and/or copies of any and all information, allow access to premises and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (“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;
  - h. If the Provider places required records in another legal entity’s records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
  - i. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by DCHP or a Member to the HHSC OIG.
- 4.21 Representations and Warranties. Provider hereby represents that all of the information and documentation provided by Provider to DCHP prior to and during the term of this Agreement, including but not limited to that set forth in an application to become a Provider and in credentialing materials, is true and correct, and Provider hereby agrees to update any such information and documentation within three (3) business days if any change should occur regarding any such information or documentation previously provided to DCHP. Failure to do so is a material breach of this Agreement and is grounds for termination.
- 4.22 Notifications. Provider must disclose the following information to DCHP prior to the execution of this Agreement and upon execution, must immediately (within three (3) business days) advise DCHP in writing of any changes regarding:
- a. Any disciplinary or other action or proceeding by any licensing authority, medical professional organization, or governmental agency including, but not limited to, the state and federal agencies that administer Medicare, Medicaid, or CHIP;
  - b. Any claim, suit or other action or proceeding involving a Member alleging medical malpractice against Provider which has resulted in a judgment against or has been settled on the basis of any payment by or on behalf of Provider; or
  - c. Any litigation or administrative action against Provider relating to the provision of healthcare services.
- 4.23 Reporting Changes of Provider Information. Provider shall notify DCHP and Members in writing at least thirty (30) calendar days prior to any change in Provider’s business address, business telephone number, and tax identification number.
- 4.24 Notice Resolving Complaints Provider agrees to post, in all offices where Members are seen, a notice to Members on the process for resolving complaints with DCHP. The notice must include the Texas Department of Insurance’s toll-free telephone number for filing complaints.
- 4.25 Non-Discrimination. Provider agrees as follows:
- a. Provider shall comply with Title VI of the Civil Rights Act of 1964 (as amended), the Americans with Disabilities Act of 1990, Section 504 of the Federal Rehabilitation Act of 1973, and all requirements imposed by the regulations implementing these acts and all amendments of the laws and regulations. The regulations provide in part that no person in the United States shall, on the grounds of race, color, national origin, sex, age, disability, political beliefs or religion, be excluded from participation in or denied any aid, care, service or other benefits, or be subjected to any discrimination under any program or activity receiving federal funds;
  - b. Provider shall not discriminate against any individual based on that individual’s pre-existing medical condition or disability; and

- c. If Provider closes Provider's practice(s) to new patients, such closure shall apply to all prospective patients without discrimination or regard to payor or source of payment for health care services. Should Provider subsequently re-open Provider's practice(s) to new patients, Provider agrees to accept Members as patients to the same extent and in the same manner as non-Member patients seeking health care services. Health care services shall be made available to Members without discrimination on the basis of type of health benefits plan, source of payment, sex, age, race, color, religion, national origin, health status or disability. Provider shall provide health care services to Members in the same manner as provided to their other patients and in accordance with prevailing practices and standards of the profession.

4.26 Marketing. Provider agrees as follows:

- a. Provider shall permit DCHP to designate and make public reference to Provider in marketing materials prepared in accordance with state requirements, as applicable. Provider shall not use the name or trademark of DCHP unless first approved in writing by DCHP. Provider agrees that DCHP may include in its directories of Participating Providers, Member handbooks and other materials distributed to Members the names, addresses, telephone numbers and other information with respect to Provider, so as to assist Members in obtaining access to Provider's services.
- b. DCHP and Provider each have a proprietary interest in their respective legal and business names. Except as permitted by above, neither shall use the other's name in any advertising, marketing or other publicity materials without the other's prior written consent, which consent shall not be unreasonably qualified, withheld or delayed.
- c. Provider shall comply with HHSC's direct marketing policies and procedures as set forth in HHSC's Uniform Managed Care Manual and as set forth in the Provider Manual. Provider is prohibited from engaging in direct marketing to DCHP members that is designated to increase enrollment in a particular health plan to the extent such activities are prohibited by rules and regulations related to marketing. This provision shall not be interpreted to constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance

4.27 Nondisclosure. Provider shall not disclose the terms of this Agreement including, but not limited to, the payment arrangements, without the prior written consent of DCHP. This subsection shall survive the termination of this Agreement.

4.28 Review Authority. Provider understands and agrees that HHSC or its agent has the right to review all arrangements or agreements between DCHP and Provider, despite any confidentiality provisions to the contrary.

4.29 Early Childhood Intervention ("ECI"). Provider must cooperate and coordinate with local 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 Covered 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.

4.30 Professional Conduct. While performing the services described in this Agreement, Provider agrees to comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and otherwise conduct him or herself in a businesslike and professional manner.

4.31 Medicaid Provider Agreement. Provider 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 (TPI). All Providers must have a National Provider Identification (NPI) in accordance with 45 C.F.R. Part 162, Subpart D.

4.32 Modifications. Provider agrees that any modification, addition or deletion of the provisions of this Agreement shall become effective no earlier than 30 days after administrative agent or TDI is notified of the change in writing. If administrative agent or TDI do not provide written approval within 45 days from receipt of notification, then changes can be considered provisionally approved. Modifications, additions or deletions, which are required by the administrative agent or TDI or by changes in state or federal law, are effective immediately.

## **SECTION V - MEDICAL SERVICES**

5.1 Services to be Provided and Arranged. Provider shall provide Covered Services that the Provider is qualified by education training and licensure to perform. Providers who agree to act as a Primary Care Physician shall also coordinate Covered Services received by Members from Specialist Providers and other health care professionals.

5.2 Standards of Medical Practice. In providing or arranging for the provision of Covered Services to Members, Provider shall observe the standards of care, skill and diligence that are applicable to the type of treatment involved. Providers who employ non-physician practitioners to assess the healthcare needs of and provide treatment to Members shall have policies in effect that describe the exact duties of such non-physician practitioners.

- 5.3 Coordination of Care. It is the responsibility of the Primary Care Physician to coordinate Covered Services provided to Members in accordance with this Agreement, including assisting the Member in obtaining Covered Services. The Primary Care Physician has the responsibility to:
- a. Recognize the role that family members have as primary care givers for children and assure their participation in decision making;
  - b. Provide appropriate health education and instructions to the Member or, if the Member is a child, to family members or primary care givers;
  - c. Provide medically appropriate referrals to Participating Providers;
  - d. Assure appropriate transfer of medical information between the primary care providers, specialty care providers, and ancillary care providers;
  - e. Assure that hospital discharge planning is conducted for each admitted Member;
  - f. Assure that pre-admission planning occurs for the Member in all non-emergency hospital admissions;
  - g. Assure that the home and community arrangements are available before the hospital discharge of the Member;
  - h. Provide information concerning appropriate social support services;
  - i. Provide after-hours coverage;
  - j. Provide assistance with hospital arrangements, including meeting Members in the emergency room (ER) or calling the ER with relevant information about the Member;
  - k. Assist in the development of alternatives to hospitalization when medically appropriate;
  - l. Provide timely follow-up after emergency care or hospitalization;
  - m. Assure that there is on-going communication between the Primary Care Physician and Specialist Provider(s) while the Member is undergoing specialty care; and
  - n. Assure integration of Member's medical home needs with home and community support services;
- 5.4 Behavioral Health.
- a. PCPs. Providers who are Primary Care Physicians must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs must assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Member's care with specialty care providers after referral.
  - b. Inpatient Psychiatric Services. Providers who provide inpatient psychiatric services to a Member must schedule the member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.
- 5.5 Specialty Care. Providers who are participating Specialist Providers shall provide or arrange to provide all covered specialist care for Members. Specialist Providers shall provide the following:
- a. Medically appropriate specialty covered services;
  - b. Consultation with the PCP concerning the diagnostic, treatment and follow-up recommendations;
  - c. Information to the Member or family of the diagnostic, treatment, and follow-up recommendations, in consultation with the PCP; and
  - d. Appropriate health education for Members and their families in the management of the Member's special needs.
- 5.6 Hospital and Other Care. Except for Emergency Care, Provider shall arrange for all other Covered Services, such as hospital admissions, ambulatory surgery, home healthcare, rehabilitation and physical therapy and invasive diagnostics. Only Provider shall render all such services, unless DCHP has given prior authorization for the use of a non-Participating Provider, either in writing or by telephone with subsequent written confirmation. Referrals to non-Participating Providers shall be prospectively reviewed by DCHP. If a Member presents in the emergency room for urgent or routine care or if Member requires post stabilization treatment following an emergency, Provider shall contact DCHP or the primary care physician before rendering care.
- 5.7 Emergency Care. In circumstances where it is reasonably possible for Provider to do so, Provider shall provide, arrange for, or assist in arranging for Covered Emergency Care.
- 5.8 Mental Health and Chemical Dependency Care. Providers shall direct any Member who appears to be in need of mental health or chemical dependency services to the entity designated by DCHP to provide or arrange for the provision of Covered mental health and chemical dependency services to Members. Should DCHP alter its arrangements for such services, DCHP shall notify Provider.
- 5.9 Referrals. Consistent with medical practice and in accordance with accepted community professional standards for rendering quality medical care, all healthcare providers to which Provider refers Members for Covered services, such as hospitals, transplant or hemophilia centers, ambulatory surgery centers, home healthcare providers, laboratory facilities and physical and rehabilitation therapy providers, shall be Participating Providers.
- 5.10 Care Coordination. Provider agrees to actively participate in DCHP care coordination activities, including medical case management and care planning, in accordance with the DCHP policies and procedures as referenced in this Agreement and the Provider Manual.

- 5.11 Non-contracted Health Care Providers. All health care providers not contracted with DCHP but utilized by Provider in providing Covered Services to Members, including but not limited to, mid-level practitioners, nurses, laboratory technicians, x-ray technicians, medical assistants and other ancillary care providers, must comply with all applicable training, licensing and certification requirements, and must practice only within the scope of their licenses and certifications as permitted by law. Provider shall (i) maintain records with respect to such health professionals that are sufficient to document such compliance and provide such proof to DCHP upon request; (ii) appropriately supervise such health professionals in the performance of their duties; and (iii) require all such health professionals to accurately identify themselves to Members. Provider shall ensure that such health professionals obtain and maintain whatever type and amount of professional liability insurance as may be required by DCHP for that class of provider.
- 5.12 Family Planning. Provider agrees to provide Members requesting contraceptive services or family planning with counseling and education about family planning and available family planning services. Provider cannot require parental consent for members who are minors to receive family planning services. Provider must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.
- 5.13 Tuberculosis. Provider must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). Provider must report to the Texas 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.
- 5.14 THSteps. THSteps Providers must comply with all requirements of the THSteps program including sending all THSteps newborn screens to the DSHS Bureau of Laboratories or a DSHS certified laboratory. Provider must 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.
- 5.15 Women, Infants and Children ("WIC"). Provider must coordinate with the WIC Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- 5.16 HIV-Infection. Provider agrees to refer Members with HIV infection to public health agencies for in-depth prevention counseling, ongoing partner elicitation and notification services and other prevention support services. Provider agrees to direct-counsel or refers an HIV-infected Member about the need to inform and refer all sex and/or needle-sharing partners who might have been exposed to the infection for prevention counseling and antibody testing.

## SECTION VI - RECORDS

- 6.1 Records. Provider shall maintain the medical, financial and administrative records concerning services provided to Member that Provider would maintain in the normal course of business and in compliance with applicable federal and state laws, and the DCHP Provider Manual. Provider shall maintain, with respect to each Member receiving Covered Services, a single standard record in such form, containing such information, and which is preserved for six (6) years from the last date health care services were provided to Member or as required by law, whichever is longer. Provider further agrees to obtain any necessary releases from Members with respect to their records and the information contained therein to permit state and federal agencies access to such records. DCHP and Provider agree that each Member's medical records shall be treated as confidential so as to comply with all state and federal laws. Provider shall participate in any system established by DCHP to facilitate the sharing of records, subject to applicable confidentiality requirements. This section shall specifically survive the termination of this Agreement.
- 6.2 HHSC Access to Records. Provider agrees to provide HHSC:
- a. all information required under the Network Provider Contract, including but not limited to the reporting requirements and other information related to the Network Provider's performance of its obligations under the contract;
  - b. 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; and
  - c. all information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.
- 6.3 Audit or Investigation. Provider understands and agrees to the following:
- a. Provider shall provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider contract and any records, books, documents, and papers that are related to the contract and/or the Provider's performance of its responsibilities under this contract:
    1. HHSC and MCO Program personnel from HHSC;
    2. US Department of Health and Human Services;
    3. Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;
    4. An independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
    5. State or Federal law enforcement agency;

6. Special or general investigation committee of the Texas Legislature;
7. The U.S. Comptroller General;
8. The Office of the State Auditor of Texas; and
9. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

- b. Provider must provide access wherever it maintains such records, books, documents, and papers. Provider must 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:
1. examination;
  2. audit;
  3. investigation;
  4. contract administration;
  5. the making of copies, excerpts, or transcripts; or
  6. any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.
- c. Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.

- 6.4 Transfer and Confidentiality. Provider agrees to cooperate in the transfer of Members' medical records to other health care professionals, to assume any cost associated therewith, and to transfer any medical records in Provider's custody within ten (10) days of a Member's request. Provider further agrees to cooperate with DCHP and any state or federal agency in making available, and in arranging or allowing inspection of, such records as may be required under state or federal law or regulation or as may be appropriate to disclose to such authorities in connection with their assessment of quality of care or investigation of Member grievances or complaints. DCHP and Provider agree that Members' medical records shall be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records.
- 6.5 Other Records. During the term of this Agreement, Provider shall, upon request of DCHP, furnish any other record related to services furnished pursuant to this Agreement, or a copy thereof. Upon termination or expiration of this Agreement, Provider shall provide copies of all such records to DCHP prior to final settlement of all claims and outstanding issues upon request.
- 6.6 Production of Records Notwithstanding Termination. Notwithstanding termination of this Agreement, the access to records that is granted hereunder in this Section shall survive the termination of this Agreement.
- 6.7 Confidentiality (HIPAA). Provider must treat all information that is obtained through the performance of the services included in this Agreement and/or amendment as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement. Provider shall 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 on his or her behalf; however, Provider understands and agrees that HHSC may request the transfer of 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. 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.

## **SECTION VII – COMPLAINTS AND APPEALS**

- 7.1 DCHP Process defined in Provider Manual. Provider shall cooperate with DCHP's complaints and appeals process and agrees that all communications and records relating to benefit determinations and appeals, complaints, grievances or provider disputes will follow the complaints and appeals process as set forth in the Provider Manual and section 11.10 of this Agreement.

## **SECTION VIII - UTILIZATION MANAGEMENT**

- 8.1 DCHP Utilization Management Program. Provider shall cooperate with and participate in DCHP's utilization management program ("UM"), and shall comply with DCHP's guidelines, standards and procedures for UM activities (collectively, the "DCHP UM Program") including, but not limited to, precertification of elective admissions and procedures, referral processes, reporting of clinical encounter data, pre-admission, discharge planning, and oversight of any delegated UM activities, as contained in the Provider Manual. Provider shall maintain policies and procedures that meet DCHP minimal requirements as described in the Provider Manual. Provider must coordinate discharge plans with the hospital, PCP, Member and or family and specialty care providers, as appropriate. DCHP's UM procedures must provide for a review by a specialist of the same, or a similar, specialty as the provider or provider to whom a referral is requested before DCHP may deny a referral.

- 8.2 UM Review. Provider agrees to allow DCHP to conduct utilization management activities, including but not limited to, review of services and patient records, pre-admission review of all elective admissions of Members and concurrent review of all Covered Services rendered to hospitalized Members. DCHP shall apply prospective and/or retrospective review techniques to monitor and most effectively use specialist, facility, and ancillary provider services. DCHP shall have the right to monitor the provision of all health care services to Members under this Agreement and to evaluate the medical necessity, quality and appropriateness of care ordered or provided by Provider. All such activities shall be conducted by an appropriate health care professional, such as a physician or registered nurse, designated by DCHP shall perform such activities. Providers providing or arranging care for Members shall cooperate with DCHP and its designees with respect to the management of such Members' care, including cooperating in DCHP's provision of (a) concurrent utilization review and discharge planning for Members receiving inpatient care and (b) case management with respect to Members whose care is expected to be high cost and/or long-term as determined by DCHP.
- 8.3 Responses to Requests for Treatment. Provider shall abide by DCHP's minimum access standards which shall at all times comply with current state and federal regulations and appropriate accrediting body standards.
- 8.4 Coverage Determinations. If a question arises concerning whether a particular service is a Covered Service under DCHP, Provider shall promptly, with due regard for the urgency of the Member's medical condition, refer such question to DCHP, and shall cooperate with DCHP in the resolution of such question in accordance with DCHP's UM program.

### SECTION IX - QUALITY MANAGEMENT AND IMPROVEMENT

- 9.1 Quality Management and Improvement Program. Provider shall cooperate with and participate in all quality management and improvement ("QM/QI") activities conducted by DCHP, including participating in peer review activities, providing data for QM/QI studies, and implementation of educational and corrective action plans as indicated, as set forth in the Provider Manual.
- 9.2 Quality Indicators. Provider shall use a systematic process of quality assessment and improvement in accordance with DCHP's quality improvement plan, including the use of quality indicators provided by DCHP that are objective and measurable and based on current knowledge and clinical experience. Provider shall report to DCHP quality indicators upon request.
- 9.3 Quality Improvement Committee. Provider agrees to cooperate with and timely respond to all requests and directions from the DCHP Quality Improvement Committee ("QIC").
- 9.4 Complaints. Provider shall cooperate with DCHP's complaint and grievance process to ensure timely resolution and compliance with the grievance provisions of the state and federal government as applicable. Cooperation shall include, but is not limited to, allowing DCHP's designee to access a Member's medical records, Provider participation in peer reviews of a Member's healthcare, and meeting grievance and appeal requirements of DCHP. Provider is required to keep clean copies of complaint forms and appeal procedures on file at his/her offices/facilities. Provider shall be required to distribute copies of such materials to Members upon request by mail or telephone. 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.
- 9.5 Notifications. Provider shall promptly, within three (3) business days, notify DCHP, in writing, if he or she becomes aware of any of the following arising in connection with healthcare services rendered to a Member:
- an adverse outcome that is both serious and unexpected;
  - commencement of a medical malpractice lawsuit or other legal proceeding, or a written statement of intention to commence a medical malpractice lawsuit or other legal proceeding against Provider; or
  - an incident reported by Provider to his or her professional liability insurance carrier, or to a governmental body with authority over professional conduct.

Subject to all applicable peer review, medical committee, attorney-client, and attorney work product confidentiality protections applicable to the Provider and DCHP, Provider shall cooperate in any investigation or review undertaken with respect to any of the foregoing circumstances.

- 9.6 On-Site Reviews. Provider shall cooperate in any on-site reviews undertaken by DCHP concerning DCHP's QM/QI activities. Such reviews shall be conducted at reasonable intervals with reasonable notice during normal business hours.
- 9.7 Corrective Actions. Provider shall implement any corrective action required by DCHP in response to quality deficiencies identified in the course of its QM/QI activities.

### SECTION X - PAYMENT FOR SERVICES

- 10.1 Payment for Services. DCHP shall pay Provider in accordance with the payment arrangements for Covered Services set forth in Attachment A for DCHP Members.

- 10.2 Schedule of Benefits and Determination of Covered Services. DCHP shall be solely responsible for the determination of the extent of coverage under a Member's group agreement or individual subscriber contract. Provider acknowledges that he or she has an independent responsibility to provide medical care to Members, and that any action by DCHP pursuant to utilization review or management, referral management and discharge planning programs in no way absolves Provider of the responsibility to provide appropriate medical care to Members.
- 10.3 Coverage Verification. Prior to providing or arranging for the provision of Covered Services for a Member, Provider shall verify each Member's eligibility for benefits in accordance with the procedures set out in the DCHP Provider Manual.
- 10.4 Collection from Members. Provider is responsible for collecting at the time of the service any applicable co-payments or deductibles given the limitations on those co-payments and deductibles as set out in accordance with the terms of the Evidence of Coverage between DCHP and DCHP Member.
- a. CHIP Plan Members. Provider shall not charge co-payments or deductibles to DCHP CHIP Plan Members of Native American Tribes; co-payments or deductibles to a DCHP CHIP Plan 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 co-payments for well-child or well-baby visits or immunizations.
- b. STAR Plan Members. Provider is prohibited from billing or collecting any amount from a STAR plan Member for health care services provided pursuant to this Agreement.
- 10.5 Special Circumstances. Except for the event of a Provider's Immediate Termination (as set forth below) termination of this Agreement does not release DCHP from its obligation to reimburse Providers who are treating a Member of "special circumstance". Special circumstance means a condition such that the treating provider reasonably believes that discontinuing care by the treating provider could cause harm to the Member, and may include conditions such as disabilities, acute conditions, life-threatening illnesses or care of a Member past the twenty-fourth week of pregnancy. Provider must identify the special circumstance to DCHP and must agree not to seek payment from the Member of any amounts for which the Member would not be responsible if the Provider were still a Participating Provider. Disputes regarding the necessity for continued treatment by Provider in situations involving termination shall be resolved in accordance with the procedures set forth in the Provider Manual and in accordance with applicable state and federal law. This section does not extend the obligation of DCHP to reimburse a terminated provider for ongoing treatment of Member beyond the 90th day after the effective date of the termination, or beyond nine months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of DCHP to reimburse the terminated Provider for provision of services to a Member who at the time of the termination is past the 24th week of pregnancy extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.
- 10.6 Payment of Claims. Provider agrees to comply with the reimbursement and billing procedures required by DCHP including, but not limited to, coordination of benefit, subrogation procedures and, if applicable, Medicare, Medicaid, and CHIP. Provider shall use the standard CMS 1500 or such other claim form designated by DCHP to bill for services rendered. DCHP shall pay Clean Claims submitted by Provider for Covered Services provided to Members in accordance with the reimbursement rates set forth in the Agreement, and the following:
- a. Clean Claims Elements. Provider shall submit a Clean Claim by providing the required data elements specified in the Provider Manual, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which Provider has been properly notified as necessary, and any coordination of benefits or non-duplication of benefits information, if applicable.
- b. Clean Claims Submission. Provider shall submit Clean Claims to DCHP in the format approved by DCHP to the address noted in the Provider Manual and/or the Provider Quick Reference Tool. Provider shall submit Clean Claims bills to DCHP within ninety-five (95) days after the date of discharge in the case of inpatient Covered Services, or after the date such services are rendered in the case of all other Covered Services. DCHP shall not be obligated to pay any claim submitted after the timely filing period. Any change in claims processing addresses shall be forwarded to the Provider at least thirty (30) days prior to the effective date of the change. Should DCHP be unable to notify Provider in advance of the change, an extension of 30 days shall be given to all claim submission deadlines to ensure proper forwarding.
- c. Deficient Claims. If a submitted claim is determined by DCHP to be deficient, DCHP shall notify Provider that the claim is deficient within fifteen (15) calendar days of receipt of the claim.
- d. Payment of Clean Claims. DCHP shall adjudicate (finalize as paid or denied adjudicated) Clean Claims within 30 days from the date the claim is received by DCHP. DCHP shall pay Provider interest at a rate of 1.5% per month (18% per annum) on all Clean Claims that are not adjudicated within 30 days.

- e. Notice of Revisions to Clean Claim Elements. DCHP may revise its requirements for data elements, attachments or additional Clean Claim elements that have previously been properly included as elements of a Clean Claim by providing advance written notice to Provider of such revisions. The notice shall identify with specificity the revisions and or additions to data elements, attachments, or additional Clean Claim elements, and must be received by the Provider at least ninety (90) calendar days before the DCHP enforces such revisions to the requirements of a Clean Claim unless the change is required by statute or regulation in a shorter timeframe.
  - f. Disclosure of Fee Schedule and Coding Information. DCHP shall provide to Provider, upon written request, information necessary to determine that Provider is being compensated in accordance with this Agreement. Provider may make the request for information by any reasonable and verifiable means. DCHP may provide the required information by any reasonable method through which Provider can access the information, including e-mail, computer disks, paper or access to an electronic database. DCHP shall provide the fee schedules and other required information by the 30th day after the date that DCHP receives the request. DCHP may make any amendments, revisions or substitutions of any information provided pursuant to this paragraph by providing Provider with at least sixty (60) calendar days written notice of such amendment, revision or substitution. Provider that receives information under this paragraph: (i) may not use or disclose the information for any purpose other than the Provider's practice management and billing activities; (ii) may not use this information to knowingly submit a claim for payment that does not accurately represent the level, type or amount of Covered Services that were actually provided to a Member or to misrepresent any aspect of the Covered Service; and (iii) may not rely upon information provided pursuant to this paragraph about a Covered Service as verification that a Member is covered for that Covered Service.
  - g. Authority. Provider's delegating authority for claims preparation and/or signature authority for filing claims to a member of the office staff or to a billing service remain responsible for the actions of their employees or billing services.
- 10.7 Coordination of Benefits. Payments for Covered Services provided to each Member are subject to coordination with other benefits payable or paid to or on behalf of the Member in accordance with applicable statutes, laws, rules and regulations and in accordance with its Plans. In cases where a Member has coverage, which requires or permits coordination of benefits with another third party payor, Payors shall coordinate their benefits with such other payor(s). In the event Medicare is the primary payor, Payors shall pay Provider the amount of deductible, coinsurance and/or other plan benefits which are not covered services under Title XVIII of the Social Security Act, as amended, subject to the benefit limits and applicable rates of the applicable Plan. In no event shall Payors pay an amount which when combined with payments from the other payor(s) exceeds the contracted rate provided in this Agreement.
- 10.8 Third Party Payers. Provider agrees to assist DCHP in determining the availability of other benefits and in obtaining any documentation required to facilitate collection of benefits owed by third party payers. Provider understands and agrees that Provider may not interfere with or place any liens upon the state's right or DCHP's right, acting as the state's agent, to recovery from third party resources.
- 10.9 No Inducement to Limit Services. No financial incentive or payment from DCHP is made directly or indirectly to Provider as an inducement to reduce or limit medically necessary services to Members.
- 10.10 Third Party Recovery. Provider understands and agrees that it may not interfere with or place any liens upon the state's right or DCHP's right, acting as the state's agent, to recovery from third party resources.

## **SECTION XI - TERM, TERMINATION AND MODIFICATION**

- 11.1 Initial Term and Renewal: Termination. This Agreement shall be in effect for an initial three (3) year term commencing on the Execution Date and shall continue in effect for successive one-year terms unless it is terminated as provided in this Section.
- 11.2 Immediate Termination. DCHP may immediately terminate this Agreement under the following conditions:
- a. Provider presents imminent harm to a patient's health;
  - b. Provider has an action against him or her by a state medical or dental board or another licensing board or government agency that effectively impairs the Provider's ability to practice medicine, dentistry or another profession;
  - c. for reasons of fraud or malfeasance by the Provider;
  - d. Provider fails to meet DCHP's credentialing or recredentialing criteria; or
  - e. Provider is excluded from participation in any federal health care program;

Further, this Agreement shall automatically and immediately terminate if there is a lack of sufficient funding for any government product or DCHP is no longer a participant in the program. DCHP shall make best efforts to provide reasonable written advance notice to Provider upon learning that sufficient funding for plan may be discontinued.

- 11.3 Termination for Gifts or Gratuities. Provider may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than \$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. DCHP may terminate this Agreement at any time for violation of this requirement.
- 11.4 Termination For Cause. If either party materially breaches this Agreement and the breach is of such a nature that it cannot be cured within thirty (30) days, or if the breach could be cured but is not cured within thirty (30) days of the breaching party's receipt from the other party of written notice of the breach, the other party may immediately terminate this Agreement by giving written notice of termination to the breaching party which includes the reasons for termination.
- 11.5 Termination Without Cause. This Agreement may be terminated by either party without cause on at least ninety (90) days prior written notice to the other. Provider shall continue to provide Covered Services to Members during the ninety (90) day period.
- 11.6 Provider Termination Procedures. Other than for reasons of Immediate Termination (as defined above) the following apply:
- a. At least 30 days before the effective date of a termination of this Agreement, DCHP shall provide written explanation to the Provider of the reasons for the termination.
  - b. Within 60 days of the termination notice date Provider may request a review of DCHP's proposed termination by an advisory review panel. The advisory review panel shall be composed of physicians and providers, as those terms are defined in Texas Insurance Code § 843.306, as amended, including at least one representative in the provider's specialty or a similar specialty, if available, appointed to serve on the standing quality improvement committee or utilization review committee of DCHP. The decision of the advisory review panel must be considered but is not binding on DCHP. The decision of the advisory review panel must be considered by DCHP but it is not binding on DCHP. DCHP shall provide Provider, on request, a copy of the recommendation of the advisory review panel and DCHP's determination.
- 11.7 Notice to Members. Except in cases of Immediate Termination, DCHP shall provide notification of a Provider's termination to those Members currently receiving care from that Provider and the Members of the Provider's panel if Provider is a PCP at least 30 days before the effective date of the termination. In cases of Immediate Termination notice shall be given to Members as soon as reasonably practicable but in no event in more than thirty (30) days from the effective date of the termination.
- 11.8 Termination in the Event of Bankruptcy. To the extent permitted by applicable law, either DCHP or Provider may terminate this Agreement upon the bankruptcy of the other. As used in this Section, bankruptcy of an entity shall mean (i) the filing of a petition commencing a voluntary case against the entity under the United States Bankruptcy Code; (ii) a general assignment by the entity for the benefit of creditors; (iii) the insolvency of the entity; (iv) the inability of the entity to pay its debts as they become due; (v) the filing by the entity of any petition or answer in any proceeding seeking for itself or consenting to, or acquiescing in, any insolvency, receivership, composition, readjustment, liquidation, dissolution, or similar relief under any present or future statute or regulation, or the filing by the entity of an answer or other pleading admitting or failing to deny or to contest the material allegations of a petition filed against it in any such proceedings; (vi) the entity's seeking or consenting to, or acquiescence in, the appointment of, any trustee, receiver or liquidator of it, or any material part of its property; or (vii) the commencement against the entity of an involuntary case under the United States Bankruptcy Code, or a proceeding under any receivership, composition, readjustment, liquidation, insolvency, dissolution, or like law or statute, which case or proceeding is not dismissed or vacated within (60) sixty days.
- 11.9. Post-Termination. Except for reasons of Immediate Termination as defined above, the termination or expiration of this Agreement shall not relieve Provider of the responsibility to continue a Member's course of treatment that began prior to such termination or expiration until the Member can, without medically injurious consequences, be transferred to the care of another Participating Provider. Providers who render services to Members pursuant to this Section shall be compensated at the contracted rate or DCHP's standard fee-for-service rates, whichever is greater. Provider shall not require such Members to pay any amount in excess of what would have been paid had the Provider remained a Participating Provider. Provider shall cooperate with the Member and DCHP to arrange an orderly transfer of the Member's care to another Participating Provider including without limitation providing all medical information necessary for the transfer of the Member's care, subject to and in accordance with state and federal laws and regulations regarding the confidentiality of patient medical records. Such records shall be provided at no cost. Any question regarding the necessity of continued treatment shall be directed to the DCHP Medical Director. The termination or expiration of this Agreement shall not prejudice the rights or obligations of DCHP or Provider that accrued before such termination or expiration. Once DCHP or Provider gives notice of non-renewal or notice of intention to terminate under any other provision of this Section, DCHP may eliminate Provider from its provider directories, member handbooks and other Member materials.
- 11.10 Dispute Resolution. In the event of a dispute regarding this Agreement between the Parties to this Agreement, the following procedure shall be used to resolve the dispute prior to either party pursuing other remedies:
- a. Informal Discussions. Upon receipt of a written or oral notice of a dispute from either Party, both Parties must make good faith effort through informal discussions to resolve the dispute.

- b. Negotiation/Initial Meeting. If the parties are unable to resolve the dispute through informal discussions after fifteen days (15) notice of the dispute, either party may submit a written complaint to the other party describing the nature of the dispute and a proposal for resolving any dispute. The other party must respond in writing within fifteen (15) days with a detailed explanation of its position and a response accepting, rejecting or modifying the proposed solution. If the proposal for resolving the dispute is not fully accepted by the other party, a meeting shall be held within thirty (30) days of receipt of the other party's written response. All Parties shall be present or represented by individuals with full decision making authority regarding the matters in dispute (the "Initial Meeting").
- c. Mediation. If, within thirty (30) days following the Initial Meeting, the Parties have not resolved the dispute, the dispute shall be submitted to Mediation. The Mediator shall be chosen by the parties and shall be mutually agreeable to both parties. Each Party shall bear its proportionate share of the costs of Mediation, including the mediator's fee.
- d. Location. The Initial Meeting and Mediation shall be conducted in Corpus Christi, Nueces County, Texas.

## **SECTION XII – MISCELLANEOUS**

- 12.1 Indemnification of State. Provider agrees to hold harmless the State of Texas, all state officers and employees, and all Members in the event of non-payment by DCHP to Provider. Provider further agrees to indemnify and hold harmless the State and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses that may in any manner accrue against the State or its agents, officers or employees through the intentional conduct, negligence or omission of Provider, any shareholder, partner or any other individual or entity holding an equitable interest in Provider, its agents, officers, employees or contractors. Provider further agrees that: (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of DCHP's Members, and that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or persons acting on their behalf. In so far as such contrary agreement relates to liability for payment for continuation of Covered Services provided under the terms and conditions of this continuation of benefits provision.
- 12.2 Force Majeure. Notwithstanding anything in this Agreement to the contrary, DCHP and Provider shall each be excused, discharged and released from performance under this Agreement to the extent such performance is limited, delayed or prevented in whole or in part for any reason whatsoever not reasonably within the control of the affected party, including but not limited to any acts of God, war, invasion, acts of foreign enemy, hostilities (whether war be declared or not), any strike and/or industrial dispute, work stoppage, embargo or ban, non-performance of suppliers, transportation delays or by any law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing obligations under this Agreement, and as soon as such conditions cease, the party affected thereby shall promptly fulfill its obligations under this Agreement.
- 12.3 Amendments. Notwithstanding any other provisions to the contrary, this Agreement may be amended in any respect by DCHP at any time by giving thirty (30) days written notice to Provider accompanied by a description of the amendment. Modifications, additions or deletions that are required by changes in State or Federal law are effective immediately.
- 12.4 Entire Agreement. This Agreement and the attachments hereto constitute the entire understanding of DCHP and Provider with respect to the subject matter hereof, superseding all oral or written, previous or contemporaneous agreements between DCHP and Provider with respect to such subject matter.
- 12.5 Waiver. The waiver by DCHP or Provider of a breach or violation of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach or violation. No act, delay or omission done, suffered or permitted by DCHP or Provider shall be deemed to exhaust or impair any right, remedy or power of such party hereunder.
- 12.6 Severability. Should any clause or provision hereof be held to be invalid or legally unenforceable, such ruling shall in no way affect the validity or enforceability of any other clause or provision hereof, and this Agreement shall be reformed to eliminate such invalid or unenforceable provision in a manner that most closely approximates the intent of DCHP and Provider with respect to this Agreement.
- 12.7 Binding Force. The words Provider and DCHP as used herein shall include, apply to, bind and benefit the permitted successors and assigns of Provider and DCHP and any person or entity expressly authorized to act on behalf of either of them. Provider represents and warrants that he or she has entered into such contractual or other legally binding arrangements as are necessary to ensure that the provisions of this Agreement creating obligations on Provider that are enforceable by DCHP against such Provider. Upon request, DCHP may review any documents created or agreed to by Provider to comply with this subsection.
- 12.8 Governing Law and Venue. This Agreement shall be governed in all respects by federal laws and regulations and the laws and regulations of the State of Texas, including its choice of law rules, except to the extent such laws and regulations are pre-empted or superseded by federal law or regulation. Venue for any dispute arising from or relating to this Agreement shall be Corpus Christi, Nueces County, Texas.

- 12.9 Assignment. This Agreement shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of DCHP. This Agreement may be assigned by DCHP without prior written consent.
- 12.10 Conformance with Law. Each party shall carry out all activities undertaken by it pursuant to this Agreement in conformance with all applicable federal, state and local laws, rules and regulations. The relationships and transactions contemplated by this Agreement may be subject to regulation by state or federal government authorities. In the event that any action of a government authority impairs, limits or delays DCHP's performance of any obligation hereunder, DCHP shall be excused from such performance, and DCHP's failure to perform such obligation for such reason shall not constitute a breach of this Agreement.
- 12.11 Offset. Provider agrees that upon determination by DCHP that overpayment is due from Provider to DCHP, DCHP shall be entitled to recover such overpayments provided that DCHP shall provide Provider with written notice of the overpayment and request reimbursement within 30 days of the date of the notice. If reimbursement is not received within 30 of the date of the notice, DCHP shall be entitled to offset such overpayment against any amounts due and payable by DCHP to Provider.
- 12.12 Third Party Beneficiaries. Except as is otherwise specifically provided in this Agreement with respect to Payors, the parties have not created and do not intend to create by this Agreement any rights in other parties as third party beneficiaries of this Agreement, including, without limitation, Members.
- 12.13 Agreement Governs. Unless required otherwise by state or federal law, rule or regulation, to the extent that there is any conflict between the terms of this Agreement and any ancillary obligation created or documented, including the Provider Manual, the terms of this Agreement shall govern.
- 12.14 Construction. This Agreement shall not be construed more strictly against one party than any other by virtue of the fact that it may have been prepared by counsel for one of the parties, it being recognized that each party has contributed substantially and materially to the preparation of this Agreement.
- 12.15 Captions. The captions of and sections in this Agreement are for convenience of reference only, shall not define or limit the provisions hereof and shall not have any legal or other significance whatsoever.
- 12.16 Responsibility of the Parties. Each party and all other persons or organizations affiliated with such party and any of such party's shareholders, directors, partners, trustees, employees, agents, and officers are solely liable for any and all claims, loss, damages, liability, costs, expenses, including reasonable attorneys' fees), judgments and interest thereon, appeal bonds, or obligations whatsoever for or in connection with any personal or bodily injury (including death) or other damages to any Member or property due to the actions or omissions of such party or anyone for whom such party may be liable, and/or such party's employees, partners, officers, agents, directors, or trustees.
- 12.17 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid; hand delivery; overnight prepaid delivery; or confirmed facsimile, to the parties at the addresses set forth in the below signature line.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed personally or by their duly authorized officers or agents.

DRISCOLL CHILDREN'S HEALTH PLAN

**HIDALGO COUNTY HEALTH DEPT**

\_\_\_\_\_  
Signature

Mary Dale Peterson MD  
Print Name

CEO  
Title  
615 N Upper Broadway, Suite 1621  
Corpus Christi, Texas 78401  
Address

361-694-6551  
Telephone Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

**Attachment A**  
**REIMBURSEMENT SCHEDULE**  
**DRISCOLL CHILDREN'S HEALTH PLAN**  
**PARTICIPATING PROVIDER RATES**

**All DCHP Plans:** Provider shall be reimbursed for all DCHP program members at the lesser of billed charge or 100% of the current State of Texas Medicaid Fee Schedule in effect at the time of this Agreement. Fee Schedules will be updated per HHSC MCO contractual requirements after a thirty (30) day system load process following DCHP notification from the state of the new Medicaid Fee Schedule.

Reimbursement amounts shall be reduced by appropriate co-payment or coinsurance amounts listed in this Agreement.

In office Clinical Laboratory Improvement Amendments (CLIA) Certified Laboratory services provided under the guidelines stated in the DCHP Provider Manual are reimbursed at 100% of the State of Texas Medicaid Fee Schedule

**APPLICABLE NATIONAL PROVIDER IDENTIFIER(S) (NPI) AND LOCATION(S)**

**NPI: 1932146636**  
**1304 S 25TH ST**  
**EDINBURG, TX 78539**