

Molina Healthcare of Texas  
Attn: Contract Coordination – MP Amendment  
5605 MacArthur Blvd., Suite 400  
Irving, TX 75038



0339

HIDALGO COUNTY HEALTH DEPT  
1304 S 25TH AVE  
EDINBURG TX 78542-7205



Received  
Hidalgo County Health &  
Human Services Department

JUL 30 2019

1304 S. 25th Ave.  
Edinburg, Texas 78542

July 24, 2019

Dear Provider:

Molina Healthcare of Texas would like to take this opportunity to thank you for your participation in our network and for your continued commitment to serving our Molina Marketplace members.

We are updating our provider contracts to comply with all Texas Department of Insurance (TDI) regulations. We are asking you to review and sign the enclosed Marketplace Amendment to ensure we have a fully-executed amendment on file for all participating Marketplace providers.

Please note the enclosed amendment **will not** affect your reimbursement.

**Please return your signed amendment by August 23, 2019, your signed amendment can be returned via:**

- Email: [MHTContractRequest@MolinaHealthcare.com](mailto:MHTContractRequest@MolinaHealthcare.com)
- Fax: (877) 900-5655
- Mail: Molina Healthcare  
Attn: Contract Coordination  
5605 N. MacArthur Blvd, Suite 400  
Irving, TX 75038

If you have any questions or would like additional information, please contact Contract Coordination at [texasexpansioncontracting@molinahealthcare.com](mailto:texasexpansioncontracting@molinahealthcare.com). Representatives are available to assist you from 8 a.m. to 5 p.m. Monday through Friday.

Sincerely,

John J McGuinness  
VP Network Strategy

Received  
Billing Division

JUL 31 2019

Hidalgo County Health &  
Human Services Department

Enclosure(s): Health Insurance Marketplace Amendment



**MOLINA HEALTH INSURANCE MARKETPLACE PRODUCT AMENDMENT TO  
MOLINA HEALTHCARE OF TEXAS, INC.  
HOSPITAL or PROVIDER SERVICES AGREEMENT**

This Health Insurance Marketplace Amendment to the Hospital or Provider Services Agreement (“Amendment”) is made and entered into effective by the parties as set forth below.

This Amendment includes the following attached hereto and incorporated herein:

- Molina Health Insurance Marketplace Product Amendment
- Attachment D-Compensation Schedule For Molina Health Insurance Marketplace Product
- Attachment H-Molina Health Insurance Marketplace Product Requirements

**\* \* \* SIGNATURE AUTHORIZATION \* \* \***

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

HIDALGO COUNTY HEALTH DEPT  
**(“Provider”)**

**Molina Healthcare of Texas, Inc.**  
**(“Health Plan”)**

**Provider TIN**

Provider Signature:		Health Plan Signature:	
Signatory Name (Printed):		Signatory Name (Printed):	
Signatory Title (Printed):		Signatory Title (Printed):	
Signature Date:		Signature Date:	
Mailing Name and Address:		Mailing Name and Address:	Molina Healthcare of Texas, Inc. 5605 MacArthur Blvd, Suite 400 Irving, TX 75038



## MOLINA HEALTH INSURANCE MARKETPLACE PRODUCT AMENDMENT

This Amendment is made and entered by and between Health Plan and Provider with respect to the following facts:

- A. Whereas**, Health Plan and Provider have entered into a Hospital or Provider Services Agreement, or other corresponding health care services agreement or contract, as may have been amended from time to time (“Agreement”); and
- B. Whereas**, Provider contracts with Health Plan for Health Plan's Health Benefit Exchange product(s), and the parties desire to further memorialize such participation in this product.

**Now therefore**, in consideration of the rights and obligations contained herein, Health Plan and Provider agree to amend the Agreement as follows:

1. Section 2.9 **Claims Payment**, subsection c, **Compensation** (or equivalent section of the Agreement), is deleted and replaced with the following subsection:
  - c. **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D and its applicable sub-attachments, or equivalent attachment(s) of the Agreement, as applicable. Provider will accept such payment, applicable copayments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Health Plan will adjudicate (finalize as paid or denied adjudicated) Clean Claims within thirty (30) days from the date the claim is received for Members enrolled in Health Plan’s STAR or STAR Program, STAR+PLUS or STAR+PLUS Program, Children’s Health Insurance Program, and Children’s Health Insurance Program Perinatal Program. For any Clean Claims that are not adjudicated within thirty (30) days, Health Plan will pay eighteen percent (18%) interest calculated annually for Members enrolled in Health Plan’s STAR or STAR Program, STAR+PLUS or STAR+PLUS Program, Children’s Health Insurance Program, and Children’s Health Insurance Program Perinatal Program. However, duplicate claims filed prior to the expiration of thirty-one (31) days are not subject to any interest payment if not processed within thirty (30) days for Members enrolled in Health Plan’s STAR or STAR Program, STAR+PLUS or STAR+PLUS Program, Children’s Health Insurance Program, and Children’s Health Insurance Program Perinatal Program.
2. Section 2.13 **Compliance with Applicable Law** (or equivalent section of the Agreement) is amended by adding the following subsection f:
  - f. For Covered Services rendered to Members enrolled in a Molina Health Insurance Marketplace Product, Provider will comply with all statutory and regulatory requirements applicable to the Health Benefit Exchange, including the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; regulations at 45 CFR Parts 153, 155, and 156; Title 6, Chapter 843 of the Texas Insurance Code; and Title 28, T.A.C. §11.901.
3. Section 5.3 **Entire Agreement** (or equivalent section of the Agreement) is deleted and replaced with the following:

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5.3 **Entire Agreement.** This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid and CHIP products offered by Health Plan and listed in Attachment C, the UMCC is incorporated herein by reference and will be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

4. Section 5.11 **Attachments** (or equivalent section of the Agreement) is amended to add the following to the list of Attachments which are part of the Agreement:

“Attachment D-Compensation Schedule for Molina Health Insurance Marketplace Product”

“Attachment I-Molina Health Insurance Marketplace Product Requirements”

5. Section 5.12 (or next available section following the last section of Article 5 of the Agreement) is added as follows:

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

6. All cross-references to Attachment D in the Agreement not specifically addressed by this Amendment are revised as follows:

“Attachment D and its applicable sub-attachments”

7. Attachment B, Definitions (or equivalent attachment/section of the Agreement), is amended by adding the following defined terms:

**“Health Benefit Exchange** means the federal health benefit exchange established for Texas pursuant to the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; and regulations at 45 CFR Parts 153, 155, and 156.”

**“Molina Health Insurance Marketplace Product** means those health benefit programs offered and sold by Health Plan to individuals who obtain health coverage through the Health Benefit Exchange.”

8. Attachment C (Products/Benefits Inventory), or equivalent attachment/section of the Agreement, is amended by adding the following product:

“Molina Health Insurance Marketplace Product.”

9. Attachment D-Compensation Schedule for Molina Health Insurance Marketplace Product, attached hereto, is added.

10. Attachment I-Molina Health Insurance Marketplace Product Requirements, attached hereto, is added.

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11. Any reference to UMCC or UMCM in the Agreement will be applicable to the Molina Health Insurance Marketplace Product, unless stated otherwise by this Amendment or determined to be a violation of state or federal law.
12. The following Sections (or equivalent sections of the Agreement) are not applicable to the Molina Health Insurance Marketplace Product and are replaced, for purposes of the Molina Health Insurance Marketplace Product only, by Attachment H-Molina Health Insurance Marketplace Product Requirements, attached hereto:

Section 2.9, **Claims Payment**, subsection a, **Submitting Claims**  
Section 2.9, **Claims Payment**, subsection d, **Copayments and Deductibles**  
Section 2.9, **Claims Payment**, subsection e, **Coordination of Benefits**  
Section 2.9, **Claims Payment**, subsection f, **Offset**  
Section 2.9, **Claims Payment**, subsection h, **Member Billing**  
Section 5.9, **Arbitration**

13. There are no performance, bonus or special compensation programs applicable to the Molina Health Insurance Marketplace Product. Any such additional compensation requires a written amendment to this Agreement.
14. Health Plan and Provider recognize that this Amendment and/or the Agreement may require further amendments in the event that any federal, state or local agency, administration, board or other governing body requires changes to this Amendment or Agreement as a condition of approval. Health Plan will be entitled to revise this Amendment and/or the Agreement immediately without Provider's consent, if an additional amendment is being effected by Health Plan to comply with any federal, state or local agency, administration, board or other governing body request and/or regulatory requirement regarding the Molina Health Insurance Marketplace Product.
15. Effective Date. The effective date of this Amendment will be the last date that this Amendment is executed by Provider or by Health Plan.
16. Use of Defined Terms. Unless otherwise defined in this Amendment, capitalized terms utilized in this Amendment will have the same meaning(s) ascribed to such terms in the Agreement.
17. Incorporation of Recitals. The above recitals are hereby incorporated into this Amendment as if fully set forth herein.
17. No Other Modifications. Except as provided herein, the terms and conditions of the Agreement will remain the same, in full force and effect.



**ATTACHMENT D-COMPENSATION SCHEDULE**  
**FOR MOLINA HEALTH BENEFIT EXCHANGE PRODUCT**

**Compensation for Health Insurance Marketplace.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the Health Insurance Marketplace Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) an amount equivalent to one-hundred percent (100%) of the Medicaid Fee-For-Service Program set forth by the State of Texas, in effect on the date of service.

In the event that there is no payment rate in the Medicare Fee-For-Service Program fee schedule as of the date of service, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) an amount equivalent to seventy percent (70%) of the allowable rate under the applicable Medicare Fee-For-Service Program fee schedule allowable payment rate (adjusted for locality or geography), as of the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to one-hundred percent (100%) of the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography), as of the date of service.

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

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**ATTACHMENT H**  
**MOLINA HEALTH INSURANCE MARKETPLACE PRODUCT REQUIREMENTS**

This Attachment H sets forth the Molina Health Insurance Marketplace Product requirements. The provisions of this Attachments will apply to all Members enrolled in Molina Health Insurance Marketplace Product or other product governed by the Texas Insurance Code. All of the provisions listed in this Attachment are inapplicable to Members in Health Plan's STAR or STAR Program, STAR+PLUS or STAR+PLUS Program, Children's Health Insurance Program, Children's Health Insurance Program Perinatal Program, Medicare Advantage or Medicare Advantage Special Needs Plan. In the event that any of the provisions in the Agreement conflict with the provisions of this Attachment, the provisions of this Attachment will control for all Members enrolled in Molina's Health Insurance Marketplace Product. The Agreements and this Attachment will be automatically modified to conform to subsequent regulatory requirements.

1. **Claim Submission.** Provider will submit all claims to Health Plan no later than the ninety-fifth (95<sup>th</sup>) day after the date the Provider provides health care services for which the claim is made. Provider may: (1) mail a claim by United States mail, first class, or by overnight delivery service; (2) submit the claim electronically; (3) fax the claim; or (4) hand deliver the claim. If the Provider fails to submit the claim within ninety-five (95) days of the date the Provider provides health care services, the Provider forfeits the right to payment, unless the failure is a result of a catastrophic event that substantially interferes with the normal business operations of the Provider. All claims will be submitted in a form acceptable to and approved by Health Plan, and will include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures.
2. **Duplicate Claim Submission.** A Provider may not submit a duplicate claim for payment before the forty-sixth (46<sup>th</sup>) day after the original claim was submitted.
3. **Determination of Claim and Penalties for Late Payment of Claims.** Health Plan shall make determinations of claims and follow the penalties associated for late payment of Clean Claims pursuant to Texas Insurance Code, Chapter 843, and/or federal law, as applicable.
4. **Coordination of Benefits.** Provider and Health Plan shall follow the requirements related to coordination of benefits pursuant to Texas Insurance Code, Chapter 843, and/or federal law, as applicable.
5. **Offset.** Health Plan may recover an overpayment to Provider if Health Plan provides written notice of the overpayment to the Provider that includes the basis and specific reasons for the request for recovery of funds not later than the 180<sup>th</sup> day after the date the Provider receives the payment, and the Provider does not make arrangements for repayment of the funds on or before the 45<sup>th</sup> day after the date the physician or provider receives the notice. The Provider may choose to appeal the request if the Provider disagrees with the request for recovery.
6. **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement will be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. Any remaining claim or controversy will be resolved through binding arbitration conducted by a single arbitrator in accordance with the American Arbitration Association (AAA) Commercial Arbitration Rules, then in effect, in San Antonio, Texas; provided, however, matters that primarily involve Provider's professional competence or conduct will not be eligible for arbitration. If possible, the arbitrator will be an attorney with at least fifteen (15) years' experience, including at least five

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(5) years' experience in managed health care. The parties will conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator will have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. Each party will bear its own costs and expenses, including its own attorneys' fees, and will bear an equal share of the arbitrator's and administrative fees. For actions pertaining to recover payment pursuant to Texas Insurance Code Chapter 843, Subchapter J, each party will have the opportunity to recover reasonable attorney's fees and court costs from arbitrator. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within (1) one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

7. **Member Hold Harmless.** Provider hereby agrees that in no event, including, but not limited to non-payment by the Health Plan, Health Plan insolvency, or breach of this agreement, will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than Health Plan acting on their behalf for services provided pursuant to this agreement. This provision will not prohibit collection of supplemental charges or copayments made in accordance with the terms of the Agreement between Health Plan and Member. Provider further agrees that:
- (i) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and will be construed to be for the benefit of the Health Plan Member; and
  - (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of such proposed changes.
8. **Deductibles and Copayments.** Provider may bill a Member for any co-payment, deductible or co-insurance obligation applicable to Member's Health Plan product. Provider may not waive a deductible or copayment by the acceptance of an assignment.

