

**AMENDMENT TO THE  
PROVIDER/NETWORK PARTICIPATION AGREEMENT  
TO ADD AETNA BETTER HEALTH OF TEXAS INC.**

**THIS AMENDMENT** is between Aetna Health Inc., a Texas corporation, on behalf of itself and its Affiliates (“Company”), and \_\_\_\_\_ [insert provider name] (“Provider”).




**WHEREAS**, Company and Provider have entered into an agreement pursuant to which Provider agreed to participate in Company’s Texas provider networks (“Agreement”) for the provision of health care services to Company’s Members;

**WHEREAS**, Company and Provider desire to amend the Agreement to add Provider’s network participation in the Texas Medicaid, CHIP, and Medicare-Medicaid programs offered by Aetna Better Health of Texas Inc. (“Aetna Better Health”), as further described herein (collectively, the “Aetna Better Health Products”);

**NOW, THEREFORE**, in consideration of the mutual covenants and promises stated herein and in the Agreement, and other good and valuable consideration, Company and Provider agree as follows:

1. The **Product Participation Schedule**, the **Product Participation and Signature Sheet**, and/or the **Execution Sheet** (as the case may be, depending on your particular contract) of the Agreement is hereby amended to add the following:

Aetna Better Health Products: All plans or products offered by Aetna Better Health of Texas Inc. under an agreement with the State of Texas Health & Human Services Commission (“HHSC”) and/or the Centers for Medicare and Medicaid Services (“CMS”), or their successors, that involve programs offered under Title XIX or under Title XXI of the federal Social Security Act. This includes any of the following plans that Aetna Better Health of Texas Inc. may offer: (a) any Medicaid plans, (b) any Children’s Health Insurance Program (CHIP) plans, and/or (c) any integrated Medicare-Medicaid plans (a/k/a MMPs) that are available to individuals who are dually eligible for both Medicaid and Medicare. The Parties recognize that these plans and programs may undergo various transformations or name changes. This Amendment will be liberally construed to include Provider as a network provider in the products (or their successors) that Provider accepts by signature as indicated below.

<b>Texas Dept. of Insurance Lines of Business</b>	<b>Products</b>	<b>Product Compensation References – See the Services and Compensation Schedule</b>	<b>Provider Acceptance Signature (signature required in <u>each box</u>)</b>
Medicaid	STAR (Medicaid) STAR Kids (LTSS/DD/IDD) STAR+PLUS (Medicaid LTSS)	STAR (Medicaid) STAR Kids (LTSS/DD/IDD) STAR+PLUS (Medicaid LTSS)	
CHIP	CHIP (Children’s Health Insurance Plan)	CHIP (Children’s Health Insurance Plan)	
Medicare-Medicaid	Integrated Medicare-Medicaid Plan (a/k/a MMP or STAR+PLUS MMP)	Integrated Medicare-Medicaid Plan (a/k/a MMP or STAR+PLUS MMP)	

2. The Aetna Better Health Products described herein are administered by Aetna Better Health, which may be contacted in the following manners:

Mailing Address: 2777 N. Stemmons Freeway, Suite 1450  
Dallas, Texas 75207

Website: [www.aetnabetterhealth.com/texas](http://www.aetnabetterhealth.com/texas)

Email: [abhtxSTARPLUS@aetna.com](mailto:abhtxSTARPLUS@aetna.com)

3. This Amendment includes and incorporates by this reference the attached **Aetna Better Health of Texas Inc. Product Addendum** and its **Services and Compensation Schedule**, and its **Texas State Compliance Addendum**.
4. Except as expressly modified by this Amendment, all other terms, conditions, and limitations of the Agreement shall remain unchanged by this Amendment and shall remain in full force and effect; *provided, however*, that to the extent the Agreement includes any form of value-based or quality-of-care-based incentive or compensation components, those

components, and their corresponding terms and conditions, shall not apply to any of the Aetna Better Health Products or the services that Provider renders in connection therewith.

**PROVIDER**

**AETNA HEALTH INC.**

*On Behalf of Aetna Better Health of Texas Inc.*

By: \_\_\_\_\_



By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Printed Name: Cheryl L. Harding

Title: \_\_\_\_\_

Title: CEO

Tax I.D. Number: \_\_\_\_\_

NPI Number: \_\_\_\_\_

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**AETNA BETTER HEALTH OF TEXAS INC.  
PRODUCT ADDENDUM**

For purposes of this Aetna Better Health of Texas Inc. Product Addendum (the “Addendum”), the Provider, Facility, Group, Hospital, Physician, IPA, Ancillary Provider, Nurse Practitioner, PHO, or other healthcare provider, as the case may be and as defined in the participating provider agreement (the “Agreement”) that such provider has entered into with Aetna, on behalf of itself and all affiliates of Aetna Inc. (“Company”), shall be referred to herein as “Provider.” The applicability of this Addendum to each of the Aetna Better Health Products (as that term is defined below) shall be concurrent with the effective date of the respective contracts between Aetna Better Health of Texas Inc., on the one hand, and the State of Texas Health & Human Services Commission (“HHSC”) and/or the Centers for Medicare and Medicaid Services (“CMS”), on the other hand and as the case may be.

1. **Description.** This Addendum (which may be referred to as a “Product Addendum” in your particular contract) and its schedules and addenda are hereby incorporated into the Agreement, and shall govern Provider’s provision of Covered Services to Members who are covered under any Products offered by Aetna Better Health of Texas Inc. that are set forth on the Product Participation Schedule, the Product Participation and Signature Sheet, and/or the Execution Sheet (as the case may be, depending on your particular contract) of the Agreement (collectively, the “Aetna Better Health Products”).
2. **Acknowledgements.** Provider and Company each acknowledge that: (a) under the Agreement, Provider is currently a participating provider in one or more of the Texas products or provider networks of Company (and/or their affiliates or predecessors); (b) the Aetna Better Health Products are currently offered, underwritten, and/or administered by Aetna Better Health of Texas Inc. d/b/a Aetna Better Health of Texas (“Aetna Better Health”); (c) Aetna Better Health is an affiliate of Company and thereby has access to Provider’s services under the Agreement and this Addendum, and Aetna Better Health shall comply with all applicable terms, limitations, and conditions of the Agreement; (d) Company has designated Provider’s participation and enrollment in the provider network of the Aetna Better Health Products, with Aetna Better Health being the applicable payer with respect thereto; (e) the Aetna Better Health Products are a “Plan,” “Product,” and/or “Member Contract” as those terms may be used and defined in the Agreement, and have been expressly included as selected products through the Product Participation Schedule, the Product Participation and Signature Sheet, and/or the Execution Sheet (as the case may be, depending on your particular contract) of the Agreement; and (f) Provider acknowledges notice of and expressly authorizes the transfer of all payment/reimbursement information terms and obligations under the Agreement to Aetna Better Health.
3. **Provision of Covered Services.** In addition to the provider network of any other Plans and/or Products (as those terms may be defined in the Agreement) in which Provider has previously agreed to participate, Provider shall participate in the provider network of the Aetna Better Health Products and shall provide Covered Services, in accordance with the terms of the Agreement and this Addendum, to Members who are covered under the Aetna Better Health Products.
4. **Program Requirements.** Provider agrees to perform its obligations under the Agreement and this Addendum in accordance with the terms and conditions set forth herein and in all attachments thereto, including without limitation the **Texas State Compliance Addendum** (which may be referred to as a “State Compliance Addendum” in your particular contract) that is attached hereto and incorporated herein.
5. **Payment.** Subject to the terms of the Agreement and this Addendum, Aetna Better Health, as the applicable payer with respect to the Aetna Better Health Products, shall compensate Provider for Covered Services rendered to Members who are covered under an Aetna Better Health Product according to the terms set forth in the **Services and Compensation Schedule** (which may be referred to as a “Services and Rate Schedule” in your particular contract) that is attached hereto and incorporated herein. The attached **Services and Compensation Schedule** shall apply to all claims that Provider submits for Covered Services rendered to Members who are covered under an Aetna Better Health Product and, with respect to such claims and Covered Services, shall supersede any other rates set forth in the Agreement. The compensation rate set forth in the attached **Services and Compensation Schedule** shall not be applied to any claims that Provider submits for Covered Services rendered to Members who are covered under any product or plan offered by Company (and/or their affiliates) *other than* the Aetna Better Health Products.
6. **Assignment and Termination.** This Addendum, being intended to secure the services of and be personal to Provider, shall not be assigned or transferred by Provider without the prior written consent of Company. Company may assign this Addendum without the consent of Provider to any Company affiliate or any other entity upon thirty (30) days prior written notice. Any assignment by Company of this Addendum will have no effect on any other Product Addendum, Product

Participation, Product Attachment, or Regulatory Compliance Addendum (as the case may be, depending on your particular contract) that is a part of the Agreement. Likewise, if this Addendum is terminated, such termination shall not constitute termination of any other Product Addendum, Product Participation, Product Attachment, or Regulatory Compliance Addendum (as the case may be, depending on your particular contract) that is a part of the Agreement.

7. **Notice.** For purposes of any notice provision in the Agreement, the addresses of Aetna Better Health noted immediately below shall be an additional address to which Provider must send all required or permitted notices under the Agreement:

Affiliate Name	Address	City	State	Zip
Aetna Better Health of Texas Inc.	2777 N. Stemmons Freeway, Suite 1450	Dallas	Texas	75207
Aetna Medicaid Administrators	4500 E. Cotton Center Blvd.	Phoenix	AZ	85040

Furthermore, Aetna Better Health is hereby expressly added to any “Affiliate List” or analogous list in the Agreement that sets forth the Company affiliates that have access to Provider’s services under the Agreement.

8. **Authority and Liability Regarding Aetna Better Health.** Company represents and warrants that Aetna Better Health of Texas Inc. has duly authorized it (a) to incorporate this Addendum into the Agreement on Aetna Better Health’s behalf, and (b) to bind Aetna Better Health to the terms and provisions of the Agreement, as modified by this Addendum. Provider acknowledges that Aetna Better Health’s duties, obligations, and liabilities under the Agreement shall be strictly limited to the services that Provider renders to Members who are eligible and covered under an Aetna Better Health Product.
9. **New/Revised Definitions in the Agreement Applicable Only to Aetna Better Health Products.** The following definitions shall be applicable *only* to the Aetna Better Health Products and the relevant parties’ obligations with respect thereto; these definitions are hereby added to the Agreement and, in the case of a conflict with any existing language therein, shall govern and control with respect to an Aetna Better Health Product and such related obligations:
- Clean Claim.** A claim that can be processed without obtaining additional information from the Provider who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim that (a) is submitted within the proper timeframe as set forth in this Agreement; (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (*e.g.*, CPT-4, ICD-9, ICD-10, HCPCS, or their successors) as required by the applicable Federal or state regulatory authority (*e.g.*, U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier (“NPI”), date(s) of service, complete and accurate breakdown of services); (c) does not involve coordination of benefits; (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.
  - Covered Services.** Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan or Product. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be Medically Necessary, as determined in accordance with the Member’s applicable Plan or Product.
  - Medicaid Programs.** Plans or Products operated and/or administered by Company pursuant to a State Contract.
  - Never Events (Serious Reportable Events).** Extremely rare medical errors that should never happen to a patient. Never Events are those Serious Reportable Events set forth by the National Quality Forum (“NQF”) and which include, but are not limited to, errors such as surgery performed on the wrong body part or on the wrong patient, leaving a foreign object inside a patient after surgery, or discharging an infant to the wrong person.

- e. Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.
  - f. State Government Sponsor. A state agency or other governmental entity authorized to offer, issue, and/or administer one or more Plans or Products pursuant to the Social Security Act Title XIX or XXI, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s), Product or Program.
  - g. State Contract. Company's contract(s) with State Government Sponsors to administer Plans, Products, or Medicaid Programs identified in the **Product Participation Schedule**.
10. **New/Revised Provisions in the Agreement Applicable Only to Aetna Better Health Products**. The following provisions shall be applicable *only* to the Aetna Better Health Products and the relevant parties' obligations with respect thereto; these provisions are hereby added to the Agreement and, in the case of a conflict with any existing language therein, shall govern and control with respect to the Aetna Better Health Products and such related obligations:
- a. Policies. The term "Policies" (which may be referred to as "Programs & Procedures" or "policies and procedures" in your particular contract) include the enumerated examples set forth in the Agreement; any applicable participation criteria required by the State of Texas in connection with the Medicaid Programs; those policies and procedures set forth in the Company's and/or State Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media. Furthermore, notwithstanding anything to the contrary in the Agreement, Company may modify the Policies at its discretion to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Provider, and the Policies shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over the Addendum.
  - b. Cultural Competency. Provider shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.
  - c. Federal Law. In addition to the other federal laws, regulations, and legal mandates applicable to recipients of federal funds and/or transactions, Provider agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. § 1396 *et seq.*, and regulations promulgated thereunder, and Title IX of the Education Amendments of 1972 (regarding education programs and activities).
  - d. Provider Representations. In addition to Provider's other representations set forth in the Agreement, Provider furthermore represents, warrants, and covenants (as applicable) that Provider is, and will remain throughout the term of this Addendum: (i) in compliance with all applicable statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims, and prohibition of kickbacks; and (ii) certified to participate in the Medicaid and Medicare programs, with such certification/participation applicable to all Covered Services.
  - e. Medicaid Program Representations. In addition to Provider's other acknowledgements and representations set forth in the Agreement, Provider agrees as follows: Company has or shall seek State Contracts to serve beneficiaries of Medicaid Programs. To the extent Company participates in such Medicaid Programs, Provider agrees, on behalf of itself and any subcontractors of Provider acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Medicaid Programs. Provider acknowledges and agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors of Provider who provide or may provide Covered Services to Members of Medicaid Programs, and Provider represents and warrants that Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract, and all applicable laws, rules, and regulations and perform all requirements applicable to State Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Medicaid Programs, Provider acknowledges that compensation under this Addendum for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Addendum will be consistent and comply with the obligations of Company and/or State Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"),

and/or with any applicable state regulatory agency, to offer Medicaid Programs. Provider further agrees to allow State Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Provider's performance under this Addendum on an ongoing basis in accordance with Medicare/Medicaid laws, rules, and regulations. Provider acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with State Government Sponsor, CMS, or any applicable regulatory agency, to offer Medicaid Programs in a manner consistent with applicable laws, rules, and regulations, and that if any such activity or responsibility is delegated by Company to Provider, the activity or responsibility may be revoked if State Government Sponsor, CMS, or Company determine that Provider has not performed satisfactorily. Upon request, Provider shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS and/or any applicable regulatory agency, including without limitation, physician incentive plan information, if applicable. To the extent that Provider generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS and/or any applicable regulatory agency, Provider certifies, to the best of its knowledge and belief, that such data is accurate, complete, and truthful.

- f. **Medicaid Program Requirements.** In addition to Provider's other obligations set forth in the Agreement, Provider, on behalf of itself and each employee, independent contractor, and/or subcontractor thereof, hereby agrees to perform its obligations under this Addendum in accordance with the terms and conditions set forth in the **Texas State Compliance Addendum**.
- g. **Government Approvals.** In addition to the other acknowledgements set forth in the Agreement: The relevant parties acknowledge that one or more Government Sponsors or other governmental authorities may recommend or require that various Company agreements, including this Addendum, be entered into prior to the issuance to Company of one or more approvals, consents, licenses, permissions, bid awards, or other authorizations from governmental authorities with jurisdiction over the subject matter of this Addendum, or which Company deems to be necessary or desirable in its sole discretion (collectively, the "Government Approvals"). Provider agrees that all Company obligations to perform, and all rights of Provider, under this Addendum are expressly conditioned upon the receipt of all Government Approvals. Failure of Company to obtain any Government Approvals shall impose no liability on Company under this Addendum.
- h. **Provider Obligation to Submit Claims.** Provider agrees to submit Clean Claims to Company for Provider Services rendered to Members. Provider agrees to submit claim and encounter data related to a Member enrolled in a Medicaid Program in the form and manner as specified by Company, and Provider certifies that any such data is accurate, complete, and truthful. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider. Provider will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. For claims Provider submits electronically, Provider shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Addendum or applicable law or regulation. Provider agrees that Company, or the applicable State Government Sponsor, will not be obligated to make payments for billings received more than one hundred and twenty (120) days (or such other period required by applicable state law or regulation) from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Provider provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Provider that resulted in the delayed submission. In addition, unless Provider notifies Company of its payment disputes within one hundred eighty (180) days, or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Provider does not timely bill Company or State Government Sponsors, or dispute any payment, timely as provided in this provision, Provider's claim for payment will be deemed waived and Provider will not seek payment from State Government Sponsors, Company, or Members. Provider shall pay on a timely basis all Participating Providers, employees, independent contractors, and subcontractors who render Covered Services to Members of Company's Plans for which Provider is financially responsible pursuant to this Agreement.

Provider agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Provider is billing on a CMS 1500, as of the effective date of this Addendum, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software

package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon State Government Programs, CMS, and other industry standards in the development of its rebundling logic.

In circumstances where the compensation under this Addendum is intended to include the services of Hospital-Based Physicians, Provider shall be financially responsible for payment to all Hospital-Based Physicians who render Covered Services to Members and such Hospital-Based Physicians shall look solely to Provider for payment. Notwithstanding, Company reserves the right to pay any Hospital-Based Physician for Covered Services for which Provider is financially responsible and for which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Provider has engaged in a pattern of late payments in the past. If Provider cannot resolve the claims submitted by the Hospital-Based Physicians, Company has the right to recoup other amounts owed in order to recover from Provider any money that Company has paid to the Hospital-Based Physicians.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to State Government Sponsor, CMS, or other industry source codes without obtaining any consent from Provider or any other party, and Company will provide, at the written request of Provider, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

- i. Company Obligation to Pay for Covered Services. Company shall make payments to Provider for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Provider for non-capitated Covered Services rendered to Members according to the lesser of (i) Provider's actual billed charges or (ii) the rates set forth in the **Services and Compensation Schedule**, attached hereto and made a part hereof. Company must pay ninety percent (90%) of all such Clean Claims from Provider within thirty (30) days following actual receipt; provided, further, Company must pay ninety-nine percent (99%) of all Clean Claims from Provider within ninety (90) days following actual receipt. Provider will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right to recoup any overpayment or payment made in error (*e.g.*, a duplicate payment or payment for services rendered by Provider to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Provider under this Addendum.

In the event that Provider identifies any overpayments by Company, Provider shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Provider's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Provider must provide Company with a written reason for the overpayment (*e.g.*, excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission, or termination alleging fraud or negligent misrepresentation or improper inducement.

Complaints or disputes concerning payments for the provision of services as described in this Addendum shall be subject to the Company's grievance-resolution system.

- j. Eligibility Determinations. In addition to Company's other recovery rights set forth in the Agreement, Company shall have the right to recover payments made to Provider if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided.

- k. Coordination of Benefits. Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination-of-benefit principles, and payment from the primary payer is less than the compensation payable under this Addendum without coordination of benefits, then Company or Government Sponsor will pay Provider the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Addendum, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Addendum without coordination of benefits, neither Company, Government Sponsor, nor the applicable Member shall have any obligation to Provider. Notwithstanding anything to the contrary in this section, in no event shall Provider collect more than Medicare allows if Medicare is the primary payer. Provider acknowledges that Medicaid is never the primary payer.
- l. Permitted Billing of Members. Provider may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance, and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Provider acknowledges that Company's denial or adjustment of payment to Provider based on Company's performance of utilization management is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise. Provider may bill or charge individuals who were not Members at the time that services were rendered. To protect Members, Provider agrees not to seek, accept, or rely upon waivers of the Member protections provided by this Addendum. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.
- m. Notices and Reporting. In addition to Provider's other notice and reporting obligations set forth in the Agreement, Provider will report the occurrence of and waive all charges related to those conditions specified under Section 5001(c) of the Deficit Reduction Act, Section 2702 of the Affordable Care Act, and any related or similar federal or state regulation, in accordance with the terms thereof.
- n. Immediate Termination or Suspension. In addition to the other bases for immediate termination set forth in the Agreement, this Addendum may be terminated by Company, upon notice to Provider and at Company's discretion, if the State Contract expires or is withdrawn or terminated.
- o. Obligations Following Termination. In addition to the Parties' other post-termination obligations set forth in the Agreement, the Parties agree that, upon termination or non-renewal of the Agreement or this Addendum for any reason other than occurrence of an event resulting in the immediate termination or suspension thereof, Provider shall remain obligated at Company's request to provide services, as applicable: (a) to a pregnant Member in the third trimester of pregnancy, throughout the term of the Member's pregnancy; (b) to any Member who is an inpatient at a hospital as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and/or (c) as otherwise required by applicable laws, government authorities, or State Government Sponsor directives. The terms of this Addendum, including the **Services and Compensation Schedule** hereto, shall apply to any such services.
- p. Use of Name. In addition to Provider's other consents to the use of its name and other identifying and descriptive material as set forth in the Agreement, Provider furthermore consents to Company's use thereof in connection with bids, proposals, and license or state contract applications.
- q. Confidentiality. In addition to the other confidentiality provisions set forth in the Agreement, the parties agree that the terms and conditions of this Addendum, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either party without express written consent of the other party or as required by law, by governmental authorities, or by express order by a court having jurisdiction over the party from whom disclosure is sought.
- r. Referrals. In addition to the other Policies with which Provider must comply as set forth in the Agreement, to the extent required by the terms of the applicable Plan, Provider shall refer or admit Members only to participating

providers for Covered Services, and shall furnish such participating providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission. In addition, to the extent possible, Provider shall refer Members with out-of-network benefits, if any, to participating providers. Provider shall be liable for any expenses resulting from a referral to a non-participating provider that Company did not pre-certify in advance, as permitted by applicable law.

- s. **Qualified Providers.** Provider shall exclude any physician or other provider from performing services in connection with this Agreement if such provider has been suspended or terminated from participation in Medicaid or Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Provider is prohibited from using any individual or entity (“Offshore Entity”) (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (*i.e.*, American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Provider further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.
  
- t. **Suspension or Debarment.** Provider represents, warrants and covenants, as applicable, that it and each Hospital-Based Physician:
  - 1. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and
  - 2. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and
  - 3. Has not within a five year period preceding execution of this Amendment had one or more public transactions terminated for cause or fault; and
  - 4. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and
  - 5. Will immediately report any change in the above status to Company; and
  - 6. Will maintain all appropriate licenses to perform its duties and obligations under this Agreement.

11. **Other Terms and Conditions.** All capitalized terms not otherwise defined in this Addendum shall have the respective meanings set forth in the Agreement. Except as otherwise modified or amended herein, all terms and conditions in the Agreement shall be incorporated into this Addendum and shall remain in full force and effect. In the event of any conflict between the terms of this Addendum, on the one hand, and any of the other terms of the Agreement, on the other hand, including any other attachments, schedules, exhibits, and/or addenda made part of the Agreement, the terms of this Addendum shall govern and control with respect to the provision of Covered Services to Members who are eligible and covered under an Aetna Better Health Product.

**AETNA BETTER HEALTH OF TEXAS INC.  
PRODUCT ADDENDUM**

**SERVICES AND COMPENSATION SCHEDULE**

**1.0 COMPENSATION**

Aetna Better Health shall compensate Provider for the Covered Services that Provider renders to Members covered under the Aetna Better Health Products, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider’s actual billed charges, whichever is less:

<b>TEXAS PROGRAM NAME</b>	<b>REIMBURSEMENT RATE</b>
STAR (MEDICAID) STAR Kids (DD/IDD) STAR+PLUS (Medicaid LTSS)	100% of Aetna Medicaid Market Fee Schedule
CHIP (Children’s Health Insurance Program)	100% of Aetna Medicaid Market Fee Schedule
Integrated Medicare-Medicaid Plan (a/k/a MMP or STAR+PLUS MMP)	100% of Aetna Medicare-Medicaid Plan (MMP) Market Fee Schedule

Note: If Provider has previously contracted with Company, under this Agreement or any other agreement, to render Covered Services to Members covered under (i) any Medicare Advantage plan, including without limitation any Dual-Eligible Special Needs Plans (D-SNPs or DSNPs), and/or (ii) any Commercial plan, then Provider shall continue to be compensated for such Covered Services in accordance with the separate compensation terms and claim-processing guidelines that are set forth in the Parties’ pre-existing agreement that governs such Medicare Advantage plans and/or Commercial plans, as the case may be. For the sake of clarity, the **Aetna Better Health of Texas Inc. Product Addendum** and its **Services and Compensation Schedule** shall *not* apply to or govern any Covered Services rendered to Members covered under such Medicare Advantage plans or Commercial plans.

**2.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS**

- A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.
- B. Aetna Medicare-Medicaid Plan (MMP) Market Fee Schedule (AMMPMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the residence of the Member, and the applicable Medicare Allowable Payment (Inpatient Services), Medicare Allowable Payment (Outpatient Services), or Medicare Physician Fee Schedule (as applicable).
- C. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Aetna Better Health, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and Aetna payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.
- D. Medicare Allowable Payment (Outpatient Services) is defined as the current payment that Provider shall receive from Aetna Better Health for outpatient services or procedures, pursuant to (a) the Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the provider-specific wage

index, or (b) if the value is not available as set forth in (a) above, then payable according to the applicable fee schedule as otherwise set forth in this Agreement. The Medicare Allowable Payment (Outpatient Services) is subject to Aetna Better Health's payment and processing guidelines and is final and will not be impacted by cost settlements, reconciliations, or any other retroactive adjustments performed by a Medicare Administrative Contractor (MAC) for both overpayments and underpayments. Pursuant to CMS rules, specific revenue codes are packaged when billed without HCPCS codes. Payment for these dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service reported with an applicable HCPCS codes. Therefore, separate payment will not be made for claims reported with these packaged revenue codes when billed without HCPCS codes. Consistent with this, Aetna Better Health will not make separate payment(s) for packaged revenue codes. Aetna Better Health will follow the OPSS payment updates as published annually by CMS in the OPSS final rule.

- E. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Aetna Better Health for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPSS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPSS cap payments, or the CMS conversion factors. Aetna Better Health plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Aetna Better Health and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Aetna Better Health payment policies apply to services paid based upon the Medicare Physician Fee Schedule.
- F. Medicare-Medicaid Plans (MMPs). Where Aetna Better Health is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Aetna Better Health shall compensate Provider at the AMMPMFS rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Aetna Better Health shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Aetna Better Health will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Aetna Better Health is not responsible for, supplemental or wrap-around payments unless required by Aetna Better Health's contracts with Government Sponsor.
- G. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

**AETNA BETTER HEALTH OF TEXAS INC.  
PRODUCT ADDENDUM**

**TEXAS STATE COMPLIANCE ADDENDUM**

This Texas State Compliance Addendum (“Compliance Addendum”) is incorporated by reference into the Agreement and applies to all Medicaid and CHIP products, including the Texas STAR, CHIP, STAR Kids, and STAR+PLUS programs, and to all integrated Medicare-Medicaid dual-eligible products, including the Texas STAR+PLUS Medicare-Medicaid Plan (a/k/a the MMP or dual-eligible demonstration), that are offered, operated, and/or administered by Aetna Better Health of Texas Inc. (hereinafter, “Company”), and to the eligible populations covered by the State Contract(s).

If there is any conflict between the terms of this Compliance Addendum and any of the other terms of the Agreement, including any attachments, schedules, exhibits, and/or addenda made part of the Agreement, the terms of this Compliance Addendum will govern and control; *provided, however*, that if there is any conflict between any of the terms of the Agreement, including this Compliance Addendum, and the State Contract, then the terms of the State Contract will govern and control.

For purposes of this Compliance Addendum, the term “Provider” shall mean the health care physician, provider, group, facility, or hospital executing the Agreement, as identified on the first page of the Agreement. Capitalized terms used and not otherwise defined in this Compliance Addendum shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the State Contract(s) or under Texas law.

**I. Texas Medicaid Managed-Care Required Provisions**

The State Contract(s) mandate(s) that Company’s provider agreements, including the Agreement, include mandatory provisions included in the Texas Health and Human Services Commission’s (“HHSC”) Uniform Managed Care Manual, Chapter 8.1, “Provider Contract Checklist” (UMCM, Chapter 8.1), among other provisions. Company’s Provider Manual and all amendments to the Provider Manual are incorporated by reference into the Agreement.

**A. Access to Records**

Provider agrees to provide to HHSC, at no cost:

1. All information required under Company’s managed care contract with HHSC, including but not limited to the reporting requirements and other information related to Provider’s performance of its obligations under the Agreement; and
2. Any information in Provider’s possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC. [CHIP, Uniform Managed Care Contract (UMCC), Att. B-1, § 8.1.20, CHIP Rural Service Area Contract (RSA), Att. B-1, § 8.1.20; STAR, UMCC, Att. B-1 § 8.1.20; STAR+PLUS, UMCC, Att. B-1 § 8.1.20, STAR+PLUS Expansion Contract (S+P Ex.), Att. B-1, § 8.1.20, STAR+PLUS Medicaid Rural Service Area (S+P MRSA), Att. B-1, § 8.1.22; STAR Health, Att. B-1 § 8.1.26; STAR Kids, Att. B-1 § 8.1.22; STAR+PLUS Dual Demonstration Medicare-Medicaid Plan Contract (Dual-Demo MMP) § 5.4.1]

Upon receipt of a record review request from the HHSC Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program-integrity functions, Provider must provide, at no cost to the requesting agency, the records requested within three (3) business days of the request. Provider must submit original documents, records, and accompanying business-records affidavits to representatives of the requesting agency. These records must also be provided to any agents and contractors related to the requesting agency. If the OIG or another state or

federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, Provider must provide the records requested at the time of the request or in less than 24 hours. The request for record review may include clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, and charting; billing records, invoices, documentation of delivery items, equipment or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; financial audits and statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining, and securing custody of the records may result in OIG imposing sanctions against Provider as described in 1 Tex. Admin. Code, Chapter 371, Subchapter G. Provider must provide Company with access to Member medical records, allow access to the facility or other premises where records are kept, and provide Company with reasonable notice of and the opportunity to participate in care-planning discussions and activities. [CHIP, UMCC, Att. B-1, § 8.1.19, RSA, Att. B-1, § 8.1.19; STAR, UMCC, Att. B-1 § 8.1.19; STAR+PLUS, UMCC, Att. B-1 § 8.1.19, S+P Ex., Att. B-1, § 8.1.19, S+P MRSA, Att. B-1, § 8.1.21; STAR Health, Att. B-1 § 8.1.25; STAR Kids, Att. B-1 § 8.1.21; Dual-Demo MMP § 5.4.1]

**B. Administrative Requirements.** Provider must inform both Company and HHSC’s administrative services contractor of any changes to Provider’s address, telephone number, group affiliation, etc. [CHIP, UMCM, Ch. 3.3; STAR, UMCM, Ch. 3.3; STAR+PLUS, UMCM, Ch. 3.3; STAR Health, UMCM, Ch. 3.14; STAR Kids, UMCM, Ch. 3.34; Dual-Demo MMP §§ 2.7.11, 2.15.5.2.1, 2.15.5.2.13.1]

**C. Advance Directives.** Provider must comply with the requirements of applicable state and federal laws, rules, and regulations relating to advance directives for all STAR, STAR+PLUS, STAR Health, STAR Kids, and Dual-Demo MMP Members. [STAR, UMCC, Att. B-1 § 8.2.11; STAR+PLUS, UMCC, Att. B-1 § 8.2.11, S+P Ex., Att. B-1, § 8.1.32, S+P MRSA, Att. B-1, § 8.1.34; STAR Health, Att. B-1

§ 8.1.34.1; STAR Kids, Att. B-1 § 8.1.35; Dual-Demo MMP § 5.3.3]

#### D. Audit or Investigation.

Provider agrees to provide, at no cost, the following entities or their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or Provider's performance of its responsibilities under the Agreement:

1. The United States Department of Health and Human Services or its designee;
2. The Comptroller General of the United States or its designee;
3. Company personnel from HHSC or its designee;
4. The Office of Inspector General;
5. The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
6. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
7. The Office of the State Auditor of Texas or its designee;
8. A State or federal law enforcement agency;
9. A special or general investigating committee of the Texas Legislature or its designee;
10. Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC; and
11. Company or any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of Company.

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.

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 at no cost.

[CHIP, UMCC, Att. A, §§ 9.02, 9.04, RSA, Att. A, §§ 9.02, 9.04; STAR, UMCC, Att. A, §§ 9.02, 9.04; STAR+PLUS, UMCC, Att. A, §§ 9.02, 9.04, S+P Ex., Att. A, §§ 9.02, 9.04, S+P MRSA, Att. A, §§ 9.02, 9.04; STAR Health, Att. A, §§ 9.02, 9.05; STAR Kids, Att. A, § 9.05 & Att. B-1 § 9.02; Dual-Demo MMP §§ 2.1.5, 2.16.4.1, 5.4.1.2, Appendix C § C.2.1]

#### E. Behavioral Health

1. Providers who are Primary Care Physicians (PCPs) must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders, and such PCPs may provide any clinically appropriate behavioral health services within the scope of their practice. [CHIP, UMCC, Att. B-1, § 8.1.15.4, RSA, Att. B-1, § 8.1.15.4;

STAR, UMCC, Att. B-1 § 8.1.15.4; STAR+PLUS, UMCC, Att. B-1 § 8.1.15.4, S+P Ex., Att. B-1, § 8.1.15.4, S+P MRSA, Att. B-1, § 8.1.15.4; STAR Health, Att. B-1 § 8.1.17.4; STAR Kids, Att. B-1 § 8.1.16.3; Dual-Demo MMP, Appendix C § C.6.3.1]

2. 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 (7) days from the date of discharge. Behavioral health providers must contact Members who have missed appointments within 24 hours to reschedule appointments. [CHIP, UMCC, Att. B-1, § 8.1.15.5, RSA, Att. B-1, § 8.1.15.5; STAR, UMCC, Att. B-1 § 8.1.15.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.15.5, S+P Ex., Att. B-1, § 8.1.15.5, S+P MRSA, Att. B-1, § 8.1.15.5; STAR Health, Att. B-1 § 8.1.17.5; STAR Kids, Att. B-1 § 8.1.16.4; Dual-Demo MMP, Appendix C §§ C.6.4.3, C.6.4.4]
3. All Providers that are all behavioral health or physical health providers (including PCPs, OB/GYNs, internists, and other relevant provider types) must share amongst each other clinical information regarding Members with co-occurring behavioral and physical health conditions, to the extent allowed by federal law. [CHIP, UMCC, Att. B-1, § 8.2.7.2.3; STAR, UMCC, Att. B-1, § 8.2.7.2.3; STAR+ PLUS, UMCC, Att. B-1, § 8.2.7.2.3; STAR Health, UMCC, Att. B-1, § 8.2.7.2.3; STAR Kids, UMCC, Att. B-1, § 8.2.7.2.3]

**F. Cancellation of Product Orders.** If Provider offers delivery services for covered products, such as durable medical equipment (DME), limited home health supplies (LHHS), or outpatient drugs or biological products, Provider must reduce, cancel, or stop delivery if the Member or the Member's authorized representative submits an oral or written request. Provider must maintain records documenting the request. This section applies to STAR, CHIP, STAR+PLUS, STAR Health, and STAR Kids Members. [CHIP, UMCC, Att. B-1, § 8.1.27, RSA, Att. B-1, § 8.1.27; STAR, UMCC, Att. B-1 § 8.1.27; STAR+PLUS, UMCC, Att. B-1 § 8.1.27, S+P Ex., Att. B-1, § 8.1.44, S+P MRSA, Att. B-1, § 8.1.16.7; STAR Health, Att. B-1 § 8.1.21; STAR Kids, Att. B-1 § 8.1.17.17]

#### G. Claims Payment

1. The process for payment of claims applicable to the Agreement, including the address/entity to which Provider must submit claims, is set forth in Company's Provider Manual. If Company changes its claims-processing or claims-adjudication entity, Company shall notify Provider in writing at least thirty (30) days prior to the effective date of the change, or if such advance notice is not possible, Company shall give Provider a thirty (30) day extension on its claims-filing deadline to ensure that claims are routed to the correct claims-processing center. Information required for the submission of a clean claim is described in the Agreement and in Company's Provider Manual. Provider's rate of compensation is identified in the Services and Compensation/Rate Schedule to the Agreement. Where compensation is based on the Texas Medicaid fee schedule, Provider may obtain information about the fee schedule by contacting Company at the address or telephone number listed in Company's Provider Manual. There is no charge for this information. [CHIP, UMCC, Att. B-1, §§ 8.1.4.8 & 8.1.18.5, RSA, Att. B-1, §§ 8.1.4.8 & 8.1.18.5; STAR, UMCC, Att. B-1 §§ 8.1.4.8 & 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 §§ 8.1.4.8 & 8.1.18.5, S+P Ex., Att. B-1, §§ 8.1.4.8 & 8.1.18.5, S+P MRSA, Att. B-1, §§ 8.1.4.8 & 8.1.20.5; STAR Health, Att. B-1 §§ 8.1.4 & 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5; Dual-Demo MMP §§ 2.7.4.1, 2.17.3.2, 5.1.9.1]

2. Notwithstanding anything in the Provider Manual to the contrary, Company shall pay clean claims for: (1) healthcare services within thirty (30) days from receipt; (2) pharmacy services no later than eighteen (18) days of receipt if submitted electronically or twenty-one (21) days of receipt if submitted non-electronically. Company will pay Provider interest at a rate of 18% per annum on all clean claims that are not adjudicated within thirty (30) days. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5; Dual-Demo MMP §§ 5.1.9.3, 5.1.9.4, 5.1.9.5]
  3. Provider must comply with the requirements of Texas Government Code § 531.024161 regarding the submission of claims involving supervised providers. [CHIP, UMCC, Att. B-1, § 8.1.18.1, RSA, Att. B-1, § 8.1.18.1; STAR, UMCC, Att. B-1 § 8.1.18.1; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.1, S+P Ex., Att. B-1, § 8.1.18.1, S+P MRSA, Att. B-1, § 8.1.20.1; STAR Health, Att. B-1 § 8.1.24.1; STAR Kids, Att. B-1 § 8.1.20.1; Dual-Demo MMP § 2.18.1.8]
  4. Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that Provider will receive under the Agreement, and that will allow Provider to determine that Provider is being compensated in compliance with the Agreement. Company will provide a provider-specific summary and explanation of all payment and reimbursement methodologies, including the coding guidelines, not later than thirty (30) days after receipt of the request. Company will provide notice of changes to the coding guidelines and fee schedule that will result in a change of payment not later than the 90th day before the date the change takes effect, unless the change is required by statute or regulation in a shorter timeframe. Provider may terminate the Agreement in accordance with the termination provisions of the Agreement on or before the 30th day after Provider receives information requested without penalty or discrimination in participation in other health care products or plans. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5; Dual-Demo MMP § 2.7.5.8, Appendix C § C.6.1.15; TEX. INS. CODE § 843.321; 28 TEX. ADMIN. CODE § 11.901(c)]
  5. In no event is Company required to provide specific information to Provider that would violate any applicable copyright law or licensing agreement. Instead of providing information withheld on the basis of copyright law or licensing agreement, Company shall provide Provider a summary of the information that will allow a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made under the terms of the Agreement for covered services that are rendered to Members. A physician or provider who receives such information may only (1) use or disclose the information for the purpose of practice management, billing activities and other business operations; and (2) disclose the information to a governmental agency involved in the regulation of health care or insurance. [Tex. Ins. Code § 843.321; 28 TEX. ADMIN. CODE § 11.901(c)]
  6. Program violations arising out of performance of the Agreement are subject to administrative enforcement by the HHSC OIG as specified in 1 Tex. Admin. Code, Chapter 371, Subchapter G. [CHIP, UMCC, Att. B-1, § 8.1.18.5, RSA, Att. B-1, § 8.1.18.5; STAR, UMCC, Att. B-1 § 8.1.18.5; STAR+PLUS, UMCC, Att. B-1 § 8.1.18.5, S+P Ex., Att. B-1, § 8.1.18.5, S+P MRSA, Att. B-1, § 8.1.20.5; STAR Health, Att. B-1 § 8.1.24.5; STAR Kids, Att. B-1 § 8.1.20.5; Dual-Demo MMP § 2.1.4.4, 2.1.5.8, Appendix C § C.6.6]
- H. Complaints and Appeals**
1. Company's complaint and appeal processes applicable to Provider under the terms of the Agreement are set forth in Company's Provider Manual. [CHIP, UMCC, Att. B-1, § 8.4.1, RSA, Att. B-1, § 8.4.10; STAR, UMCC, Att. B-1 § 8.2.4; STAR+PLUS, UMCC, Att. B-1 § 8.2.4, S+P Ex., Att. B-1, § 8.1.25, S+P MRSA, Att. B-1, § 8.1.27; STAR Health, Att. B-1 § 8.1.31; STAR Kids, Att. B-1 § 8.1.27; Dual-Demo MMP § 2.7.6.6.4.1]
  2. 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.
- I. Confidentiality**
1. Provider must treat all information that is obtained through the performance of the services included in the Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. [CHIP, UMCC, Att. A, § 11.01(a), RSA Att. A, § 11.01(a); STAR, UMCC, Att. A, § 11.01(a); STAR+PLUS, UMCC, Att. A, § 11.01(a), S+P Ex., Att. A, § 11.01(a), S+P MRSA, Att. A, § 11.01(a); STAR Health Att., A, § 11.01(a); STAR Kids, Att. A, § 11.01(a); Dual-Demo MMP § 5.2, Appendix C §§ C.3.6, C.6.1.5]
  2. Provider shall not use information obtained through the performance under the Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Agreement. [CHIP, UMCC, Att. A, § 11.01(c), RSA, Att. A, § 11.01(c); STAR, UMCC, Att. A, § 11.01(c); STAR+PLUS, UMCC, Att. A, § 11.01(c), S+P Ex., Att. A, § 11.01(c), S+P MRSA, Att. A, § 11.01(c); STAR Health, Att. A, § 11.01(c); STAR Kids, Att. A, § 11.01(c); Dual-Demo MMP § 5.2, Appendix C §§ C.3.6, C.6.1.5]
  3. 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 PHI. [CHIP, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a), RSA, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a); STAR, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a); STAR+PLUS, UMCC, Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a), S+P Ex., Att. A, §§ 7.02, 7.07, 11.01, & 11.03(a), S+P MRSA, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a); STAR Health, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a); STAR Kids, Att. A, §§ 7.02, 7.06, 11.01, & 11.03(a); Dual-Demo MMP § 5.2, Appendix C §§ C.3.6, C.6.1.5]
- J. Costs of Non-Covered Services.** Provider must inform Members of the cost for non-covered services prior to rendering such services and must obtain a signed private pay form from

such a Member. [CHIP, UMCC, Att. B-1, § 8.1.23, RSA, Att. A, § 10.11(a)(7); STAR, UMCC, Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. B-1, § 8.1.23, S+P Ex., Att. A, § 10.10, S+P MRSA, Att. A, § 10.10; STAR Health, Att. A, § 10.09; STAR Kids, Att. A, § 10.09; Dual-Demo MMP § 2.4.2]

**K. Durable Medical Equipment.** Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and Company's Provider Manual under the heading "DURABLE MEDICAL EQUIPMENT AND OTHER PRODUCTS NORMALLY FOUND IN A PHARMACY" for information regarding the scope of coverage of durable medical equipment (DME) and other products commonly found in a pharmacy. For qualified children, this includes medically necessary over-the-counter drugs, diapers, disposable/expendable medical supplies, and some nutritional products. It also includes medically necessary nebulizers, ostomy supplies or bed pans, and other supplies and equipment for all qualified Members. Company encourages Provider's pharmacy's participation in providing these items to Medicaid clients. This section applies to STAR, STAR+PLUS, STAR Health, STAR Kids, and Dual-Demo MMP Members. [STAR, UMCC Att. B-1, § 8.1.21; STAR+PLUS, UMCC Att. B-1, § 8.1.21, S+P Ex. Att. B-1, § 8.1.42, S+P MRSA Att. B-1, § 8.1.16; STAR Health Att. B-1, § 8.1.20; STAR Kids Att. B-1, § 8.1.17; Dual-Demo MMP § 2.7.6.6.5]

**L. Early Childhood Intervention (ECI).** Providers 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 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. This section applies to STAR, CHIP, STAR+PLUS, STAR Health, and STAR Kids Members. [CHIP, UMCC, Att. B-1, § 8.1.9, RSA, Att. B-1, § 8.1.9; STAR, UMCC, Att. B-1 § 8.1.9; STAR+PLUS, UMCC, Att. B-1 § 8.1.9, S+P Ex., Att. B-1, § 8.1.9, S+P MRSA, Att. B-1, § 8.1.9; STAR Health, Att. B-1 § 8.1.9; STAR Kids, Att. B-1 § 8.1.10]

**M. Electronic Visit Verification (EVV).** Providers using the EVV system for services provided to STAR+PLUS, STAR Health, STAR Kids, and Dual-Demo MMP Members must maintain compliance with HHSC minimum standards detailed in the Uniform Managed Care Manual, Chapter 8.7, Section IX. [STAR+PLUS, UMCC, Att. B-1 § 8.2.17, S+P Ex., Att. B-1, § 8.1.33.3, S+P MRSA, Att. B-1, § 8.1.35.3; STAR Health, Att. B-1 § 8.1.37; STAR Kids, Att. B-1 § 8.1.36.1; Dual-Demo MMP § 2.1.4.6]

**N. Family Planning**

1. If a STAR, STAR+PLUS, STAR Health, STAR Kids, or Dual-Demo MMP Member requests contraceptive services or family-planning services, Provider must also provide the Member counseling and education about family planning and available family-planning services.
2. Provider cannot require parental consent for STAR, STAR+PLUS, STAR Health, or STAR Kids Members who are minors to receive family planning services.
3. Provider must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family-planning services to STAR, STAR+PLUS, STAR Health, STAR Kids, or Dual-Demo MMP Members.

[STAR, UMCC, Att. B-1 § 8.2.2.2; STAR+PLUS, UMCC, Att. B-1 § 8.2.2.2, S+P Ex., Att. B-1, § 8.1.22.2, S+P MRSA, Att. B-1, § 8.1.24.2; STAR Health, Att. B-1 § 8.1.28.2; STAR Kids, Att. B-1 § 8.1.24.2; Dual-Demo MMP § 2.8.2.1.4]

**O. Fraud and Abuse**

Provider will cooperate with Company and any State or federal anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse, or misconduct in connection with the services rendered hereunder in violation of state or federal law, Provider shall immediately report such activity directly to Company's chief compliance officer or in accordance with Company's Provider Manual. Provider is not limited in any respect in reporting actual or suspected fraud, abuse, or misconduct to Company.

Provider furthermore understands and agrees to the following:

1. HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider and its employees, agents, contractors, and patients;
2. Requests for information from such entities must be complied with, in the form and language requested;
3. Provider and its 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 at Provider's own expense;
4. Compliance with these requirements will be at Provider's own expense;
5. Providers are subject to all state and federal laws and regulations relating to fraud, abuse, or waste in health care and the Medicaid and/or CHIP Programs, as applicable;
6. 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;
7. 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;
8. If Provider places required records in another legal entity's records, such as a hospital, Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
9. Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by Company or a Member, to the HHSC Office of Inspector General.

[CHIP, UMCC, Att. A, Art. 9; B-1, § 8.1.19, RSA, Att. A, Art. 9; B-1, § 8.1.19; STAR, UMCC, Att. A, Art. 9; B-1, § 8.1.19; STAR+PLUS, UMCC, Att. A, Art. 9; B-1, § 8.1.19, S+P Ex., Att. A, Art. 9; B-1, § 8.1.19, S+P MRSA, Att. A, Art. 9; B-1, § 8.1.21; STAR Health, Att. A, Art. 9; B-1, § 8.1.25; STAR

Kids, Att. A, Art. 9; B-1, § 8.1.21; Dual-Demo MMP § 2.1.5; Appendix C § C.6.6]

If Provider receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), then Provider must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Provider. The policies must provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws about civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A) of the Social Security Act.
2. Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A) of the Social Security Act, the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

[STAR, UMCC, Att. A, Art. 9; B-1, § 8.1.19; STAR+PLUS, UMCC, Att. A, Art. 9; B-1, § 8.1.19, S+P Ex., Att. A, Art. 9; B-1, § 8.1.19, S+P MRSA, Att. A, Art. 9; B-1, § 8.1.21; STAR Health, Att. A, Art. 9; B-1, § 8.1.25; STAR Kids, Att. A, Art. 9; B-1, § 8.1.21; Dual-Demo MMP § 2.1.5.9, Appendix C § C.6.6]

**P. Insurance.** Provider shall maintain, during the term of the Agreement, Professional Liability Insurance of at least \$100,000 per occurrence and \$300,000 in the aggregate, or, where applicable, the limits required by the hospital at which Provider has admitting privileges. This provision will not apply if Provider is (i) a state or federal unit of government, or a municipality, that is required to comply with, and is subject to, the provisions of the Texas and/or Federal Tort Claims Act, or (ii) is a nursing facility provider. [CHIP, UMCC, Att. A, § 17.01(b), RSA, Att. A, § 17.01(b); STAR, UMCC, Att. A, § 17.01(b); STAR+PLUS, UMCC, Att. A, § 17.01(b), S+P Ex., Att. A, § 17.01(b), S+P MRSA, Att. A, § 17.01(b); STAR Health, Att. A, § 17.01(b); STAR Kids, Att. A, § 17.01(b); Dual-Demo MMP §§ 4.9.2.1, 4.9.3.2, 4.9.3.4]

#### Q. Laws, Rules and Regulations

Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies, and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and Company's managed care contract with HHSC, the HHSC programs, 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 the Agreement, or any violation of Company'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. [CHIP, UMCC, Att. A, § 7.02, RSA, Att. A, § 7.02; STAR, UMCC, Att. A, § 7.02; STAR+PLUS, UMCC, Att. A, § 7.02, S+P Ex., Att. A, § 7.02, S+P MRSA, Att. A, § 7.02; STAR Health, Att. A, § 7.02; STAR Kids Att. A, § 7.02; Dual-Demo MMP, Appendix C § C.1]

Provider understands and agrees that the following laws, rules, regulations, and all amendments or modifications thereto, apply to the 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 (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. State and federal anti-discrimination laws:
    - a. Title VI of the Civil Rights Act of 1964, (42 U.S.C. § 2000d *et seq.*) and, as applicable, 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
    - b. Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);
    - c. Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 *et seq.*);
    - d. Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
    - e. Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);
    - f. Food Stamp Act of 1977 (7 U.S.C. § 200 *et seq.*);
    - g. Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and
    - h. The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to the Agreement;
  3. The Immigration and Nationality Act (8 U.S.C. § 1101 *et seq.*) and all subsequent immigration laws and amendments;
  4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191); and
  5. The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17931 *et seq.*

[CHIP, UMCC, Att. A, §§ 7.04-7.07, RSA, Att. A, §§ 7.04-7.07; STAR, UMCC, Att. A, §§ 7.04-7.07; STAR+PLUS, UMCC, Att. A, §§ 7.04-7.07, S+P Ex., Att. A, §§ 7.04-7.07, S+P MRSA, Att. A, §§ 7.04-7.07; STAR Health, Att. A, §§ 7.04-7.06; STAR Kids, Att. A, §§ 7.04-7.06; Dual-Demo MMP, Appendix C § C.1]

**R. Lead Screening.** In accordance with Texas Health and Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, for all STAR, STAR+PLUS, STAR Health, or STAR Kids Members, Provider must (1) report all blood lead results to the Child Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up on suspected or confirmed cases of lead exposure with the Childhood Lead Poisoning Prevention Program, and follow the Centers for Disease Control and Prevention guidelines for testing children for lead and follow-up actions for children with elevated lead levels located at [http://www.dshs.state.tx.us/lead/pdf\\_files/pb\\_109\\_physician\\_reference.pdf](http://www.dshs.state.tx.us/lead/pdf_files/pb_109_physician_reference.pdf). [STAR, UMCC, Att. B-1 §§ 8.2.2.3.1 & 8.2.10;

STAR+PLUS, UMCC, Att. B-1 §§ 8.2.2.3.1 & 8.2.10, S+P Ex., Att. B-1, §§ 8.1.22.3.1 & 8.1.31, S+P MRSA, Att. B-1, §§ 8.1.24.3.1 & 8.1.33; STAR Health, Att. B-1 § 8.1.28.3.5; STAR Kids, Att. B-1 §§ 8.1.24.3 & 8.1.33]

#### S. Liability

In the event Company becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against Company will be through Company's bankruptcy, conservatorship, or receivership estate.

Provider hereby agrees that in no event, including, but not limited to, nonpayment by Company, Company's insolvency or breach of the 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 Company acting on their behalf for Covered Services provided pursuant to the Agreement. [UMCM, Chapter 8.1, no. 44; TEX. INS. CODE § 843.361; 28 TEX. ADMIN. CODE § 11.901(a)]. This provision shall not prohibit collection from a Member for any non-covered service and/or Copayment amounts in accordance with the terms of the applicable Member's health benefits and the Agreement. Provider further agrees that: (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (2) 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.

Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, Company, 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 Company or any judgment rendered against Company. HHSC's liability to Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRAC. & REM. CODE §101.001 *et seq.*). [CHIP, UMCC, Att. A, § 4.05, RSA, Att. A, § 4.05; STAR, UMCC, Att. A, § 4.05; STAR+PLUS, UMCC, Att. A, § 4.05, S+P Ex., Att. A, § 4.05, S+P MRSA, Att. A, § 4.05; STAR Health, Att. A, § 4.06; STAR Kids, Att. A, § 4.05; Dual-Demo MMP §§ 5.1.11.1.1.1, 5.3.5]

#### T. Marketing

Provider agrees to comply with state and federal laws, rules, and regulations governing marketing. In addition, Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/Company Managed Care Contract (which includes HHSC's Uniform Managed Care Manual). [CHIP, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, RSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR+PLUS, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; S+P Ex., Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P MRSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Health, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Kids, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; Dual-Demo MMP §§ 2.7.6.6.16, 2.15.1]

Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance. [CHIP, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, RSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR+PLUS, UMCC, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P Ex., Att. B-1, § 8.1.6 & UMCM, Ch. 4.3, S+P MRSA, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Health, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Kids, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; Dual-Demo MMP §§ 2.7.6.6.16, 2.15.1]

Health, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; STAR Kids, Att. B-1, § 8.1.6 & UMCM, Ch. 4.3; Dual-Demo MMP §§ 2.7.6.6.16, 2.15.1]

**U. Company's Responsibility.** Company will initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Provider from collecting allowable copayment and deductible amounts from CHIP Members. Additionally, this provision does not restrict a CHIP Dental Provider from collecting payment for services that exceed a CHIP member's benefit cap. [CHIP, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, RSA, Att. A, §§ 4.05 & 10.12; STAR, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, S+P Ex., Att. A, §§ 4.05 & 10.10, S+P MRSA, §§ 4.05 & 10.10; STAR Health, §§ 4.06 & 10.10; STAR Kids, §§ 4.05 & 10.09; Dual-Demo MMP § 5.3.5]

**V. Provider Network Requirements, Medicaid Agreements, TPI and NPI.** Network Acute Care Providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program and must have a Texas Provider Identification Number (TPIN). All Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D. [CHIP, UMCC, Att. B-1, § 8.1.4, RSA, Att. B-1, § 8.1.4; STAR, UMCC, Att. B-1 § 8.1.4; STAR+PLUS, UMCC, Att. B-1 § 8.1.4, S+P Ex., Att. B-1, § 8.1.4, S+P MRSA, Att. B-1, § 8.1.4; STAR Health, Att. B-1 § 8.1.4; STAR Kids, Att. B-1 § 8.1.4]

**W. Member Communications.** Nothing contained in the Agreement is intended to interfere with or hinder free communications between Provider and Member regarding a patient's medical condition and/or treatment options, Company's referral and other policies, including financial incentives or arrangements, and all managed care plans with whom Provider contracts. [STAR, UMCC, Att. B-1 § 8.2.5; STAR+PLUS, UMCC, Att. B-1 § 8.2.5, S+P Ex., Att. B-1, § 8.1.26, S+P MRSA, Att. B-1, § 8.1.28; STAR Health, Att. B-1 § 8.1.32; STAR Kids, Att. B-1 § 8.1.28; Dual-Demo MMP § 5.1.10.1]

**X. Provider Reports of Abuse, Neglect or Exploitation.** Provider must inform Company of any reports of abuse, neglect, or exploitation made regarding a STAR+PLUS, STAR Health, STAR Kids, or Dual-Demo MMP Member. This includes Provider self-reports and reports made by others that Provider becomes aware of. [STAR+PLUS, UMCC, Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.3.12, S+P Ex., Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.1.52, S+P MRSA, Att. A, Art. 2, Definitions & Att. B-1, §§ 8.1.4.6 & 8.1.53; STAR Health, Att. A, Art. 2, Definitions, & Att. B-1, § 8.1.4.4.2; STAR Kids, Att. A, art. 2, Definitions & Att. B-1, § 8.1.4.4; Dual-Demo MMP §§ 1.2, 2.9.1.1.13.8, 5.1.14]

#### Y. Payment for Services

Provider is prohibited from billing or collecting any amount from a STAR, STAR+PLUS, STAR Health, STAR Kids, or Dual-Demo MMP Member for health care services provided pursuant to the 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. [STAR, UMCC, Att. B-1 § 8.1.23; STAR+PLUS, UMCC, Att. B-1 § 8.1.23, S+P Ex., Att. A, § 10.10, S+P MRSA, Att. A, § 10.10; STAR Health, Att. A, § 10.09; STAR Kids, Att. A, § 10.09; Dual-Demo MMP, Appendix C § C.3.1]

Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Agreement. [CHIP, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, RSA, Att. A, §§ 4.05 & 10.12; STAR, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23; STAR+PLUS, UMCC, Att. A, § 4.05 & Att. B-1, § 8.1.23, S+P Ex., Att. A, §§ 4.05 & 10.10, S+P MRSA, Att. A, §§ 4.05 & 10.10; STAR Health, Att. A, §§ 4.06 & 10.09; STAR Kids, Att. A, §§ 4.05 & 10.09; Dual-Demo MMP § 5.3.5]

Provider is responsible for collecting at the time of service any applicable CHIP co-payments in accordance with CHIP cost-sharing limitations. Provider shall not charge: (1) cost-sharing or deductibles to CHIP members of Native American Tribes or Alaskan Natives; (2) co-payments to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; (3) co-payments for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA); or (4) co-payments for routine preventive and diagnostic dental services (CHIP Dental). Co-payments are the only amounts Provider may collect from CHIP Members except for costs associated with unauthorized non-emergency services provided to Member by out-of-network providers for non-covered services. [CHIP, UMCC, Att. B-1, § 8.1.23, RSA, Att. A, § 10.11 & Att. B-1, § 8.1.25]

- Z. Pharmacies.** If prior authorization for a medication is not immediately available, a 72-hour emergency supply may be dispensed when the pharmacist on duty recommends it as clinically appropriate and when the medication is needed without delay. Please consult the Vendor Drug Program Pharmacy Provider Procedures Manual, the Texas Medicaid Provider Procedures Manual, and Company's Provider Manual for information regarding reimbursement for 72-hour emergency supplies of prescription claims. It is important that pharmacies understand the 72-hour emergency supply policy and procedure to assist Medicaid clients. [CHIP, UMCC, Att. B-1, § 8.1.21.1, RSA, Att. B-1 § 8.1.24.1; STAR, UMCC, Att. B-1, § 8.1.21.1; STAR+PLUS, UMCC, Att. B-1, § 8.1.21.1, S+P Ex., Att. B-1 § 8.1.42.1, S+P MRSA, Att. B-1 § 8.1.16.2; STAR Health, Att. B-1 § 8.1.20.2; STAR Kids, Att. B-1 § 8.1.17.2; Dual-Demo MMP §§ 2.5.7.1.5.9, 2.6.5.1.4.3, 2.7.6.6.5, 2.8.3.10, 2.9.1.1.13.6]

- AA. Primary Care Physicians (PCPs).** PCPs must be accessible to Members twenty-four (24) hours per day, seven (7) days per week. [CHIP, UMCC, Att. B-1, § 8.1.4, RSA Att. B-1 § 8.1.3; STAR, UMCC, Att. B-1, § 8.1.4; STAR+PLUS, UMCC, Att. B-1, § 8.1.4, S+P Ex., Att. B-1 § 8.1.4, S+P MRSA, Att. B-1 § 8.1.4; STAR Health, Att. B-1 § 8.1.4.2; STAR Kids, Att. B-1 § 8.1.4.10.1; Dual-Demo MMP § 2.8.1.1]

To the extent applicable, PCPs must provide preventative care:

1. to children under age twenty-one (21) in accordance with AAP recommendations for CHIP Members and CHIP Perinatal Newborns, and the Texas Health Steps (THSteps) periodicity schedule published in the THSteps Manual for Medicaid Members and/or the Texas Medicaid Provider Procedures Manual; and
2. to adults in accordance with the U.S. Preventative Task Force requirements.  
[CHIP, UMCC, Att. B-1, § 8.1.4.2, RSA, Att. B-1 § 8.1.3.1; STAR, UMCC, Att. B-1, § 8.1.4.2; STAR+PLUS, UMCC, Att. B-1, § 8.1.4.2, S+P Ex., Att. B-1 § 8.1.4.2, S+P MRSA, Att. B-1 § 8.1.4.2; STAR Health, Att. B-1 § 8.1.4.2; STAR Kids, Att. B-1 § 8.1.4.10.1]

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 Members' care with specialty care providers after referral. Also, PCPs must serve as a Medical Home to Members. [CHIP, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, RSA, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2; STAR, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2; STAR+PLUS, UMCC, Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, S+P Ex., Att. A, Art. 2, "PCP" Definition & Att. B-1, § 8.1.4.2, S+P MRSA, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4; STAR Health, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4.2; STAR Kids, Att. A, Art. 2, "PCP" Definition & Att. B-1 § 8.1.4.10.1; Dual-Demo MMP § 2.7.1.12.5, Appendix C § C.6.3]

- BB. Professional Conduct.** While performing the services described in the Agreement, Provider agrees to:
1. comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
  2. otherwise conduct themselves in a businesslike and professional manner. [CHIP, UMCC, Att. A, § 4.07, RSA, Att. A, § 4.07; STAR, UMCC, Att. A, § 4.07; STAR+PLUS, UMCC, Att. A, § 4.07, S+P Ex., Att. A, § 4.07, S+P MRSA, Att. A, § 4.07; STAR Health, Att. A, § 4.08; STAR Kids, Att. A, § 4.07; Dual-Demo MMP § 2.7.3.1]

- CC. Quality Assessment and Performance and Improvement (QAPI).** Provider agrees to comply with Company's QAPI Program requirements. [CHIP, UMCC, Att. B-1, § 8.1.7, RSA, Att. B-1 § 8.1.7; STAR, UMCC, Att. B-1, § 8.1.7; STAR+PLUS, UMCC, Att. B-1, § 8.1.7, S+P Ex., Att. B-1 § 8.1.7, S+P MRSA, Att. B-1 § 8.1.7; STAR Health, Att. B-1 § 8.1.7; STAR Kids, Att. B-1 § 8.1.7; Dual-Demo MMP §§ 2.7.5.3.2, 2.7.6.5, 2.14]

- DD. Service Coordination.** All Home and Community Support Services Agency (HCSSA) providers, adult day care providers, and residential care facility providers must notify Company if a STAR+PLUS, STAR Kids, or Dual-Demo MMP Member experiences any of the following: a significant change in the Member's physical or mental condition or environment; hospitalization; an emergency room visit; or two or more missed appointments.

- EE. Termination.** The Agreement sets forth Company's process for terminating the Agreement. For CHIP HMOs and managed care organizations participating in the CHIP Perinatal Program, the process must comply with the Texas Insurance Code and TDI regulations. For all programs, Company must follow the procedures outlined in applicable state and federal law regarding termination of a provider contract, including requirements of Texas Insurance Code § 843.306 and 28 Tex. Admin. Code § 11.901. [CHIP, UMCC, Att. B-1, § 8.1.4.9, RSA, Att. B-1 § 8.1.4.9; STAR, UMCC, Att. B-1, § 8.1.4.9; STAR+PLUS, UMCC, Att. B-1, § 8.1.4.9, S+P Ex., Att. B-1 § 8.1.4.9, S+P MRSA, Att. B-1 § 8.1.4.9; STAR Health, Att. B-1 § 8.1.4.10; STAR Kids, Att. B-1 § 8.1.4.7; Dual-Demo MMP, Appendix C § C.6.1.2]

- FF. 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. Company may terminate the Provider contract at any time for violation of this requirement. This section applies to Providers that render services to STAR, CHIP, STAR+PLUS, STAR Health, and STAR Kids Members. [CHIP, UMCC, Att. A, § 12.03(b)(5), RSA, Att. A, § 12.03(b)(5); STAR, UMCC, Att. A, § 12.03(b)(5); STAR+PLUS, UMCC, Att. A, § 12.03(b)(5), S+P Ex., Att. A, § 12.03(b)(5), S+P MRSA, Att. A, § 12.03(b)(5); STAR Health, Att. A, § 12.03(b)(5); STAR Kids, Att. A, § 12.03(b)(5)]

**GG. Third-Party Recovery.** Provider understands and agrees that it may not interfere with or place any liens upon the State's right or Company's right, acting as the State's agent, to recover from third-party resources. [CHIP, UMCC, Att. B-1, § 8.4.3, RSA, Att. B-1 § 8.1.21; STAR, UMCC, Att. B-1, § 8.2.8; STAR+PLUS, UMCC, Att. B-1, § 8.2.8, S+P Ex., Att. B-1 § 8.1.29, S+P MRSA, Att. B-1 § 8.1.31; STAR Health, Att. B-1 § 8.1.34; STAR Kids, Att. B-1 § 8.1.31; Dual-Demo MMP § 5.1.4.1, Appendix C]

**HH. THSteps.** As applicable to STAR, STAR+PLUS, STAR Health, or STAR Kids Members, Providers must send all THSteps newborn screens to the Texas Department of State Health Services (DSHS), formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Providers 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. [STAR, UMCC, Att. B-1, § 8.2.2.3; STAR+PLUS, UMCC, Att. B-1, § 8.2.2.3, S+P Ex., Att. B-1 § 8.1.22.3, S+P MRSA, Att. B-1 § 8.1.24.3; STAR Health, Att. B-1 § 8.1.28.3.3; STAR Kids, Att. B-1 § 8.1.24.3]

**II. Tuberculosis.** Providers must coordinate with the local tuberculosis (TB) control program to ensure that all STAR, STAR+PLUS, STAR Health, STAR Kids, and Dual-Demo MMP Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). Providers must report to 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. [STAR, UMCC, Att. B-1, § 8.2.2.6; STAR+PLUS, UMCC, Att. B-1, § 8.2.2.6, S+P Ex., Att. B-1 § 8.1.22.6, S+P MRSA, Att. B-1 § 8.1.24.6; STAR Health, Att. B-1 § 8.1.28.6; STAR Kids, Att. B-1 § 8.1.24.6; Dual-Demo MMP § 2.8.5.1.1.4]

**JJ. Women, Infants and Children (WIC).** Providers must coordinate with the Women, Infants and Children (WIC) Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. [CHIP, UMCC, Att. B-1, § 8.1.10, RSA, Att. B-1 § 8.1.10; STAR, UMCC, Att. B-1, § 8.1.10; STAR+PLUS, UMCC, Att. B-1, § 8.1.10, S+P Ex., Att. B-1 § 8.1.10, S+P MRSA, Att. B-1 § 8.1.10; STAR Health, Att. B-1 § 8.1.10; STAR Kids, Att. B-1 § 8.1.11; Dual-Demo MMP § 2.8.5.1.5.3]

**KK. Waiting Times.** Provider must provide services within the following timeframes:

1. Emergency Services must be provided upon the Members presentation at the service delivery site;
2. Treatment for Urgent Condition, including urgent specialty care, must be provided within 24 hours;
3. Routine primary care must be provided within 14 days;
4. Initial outpatient behavioral health visits must be provided within 14 days;
5. Community Long-Term Services and Supports for Non-HCBS STAR+PLUS Members must be initiated

within 7 days from the date Company authorizes services unless the referring provider or Member state otherwise;

6. PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Member's condition, but no later than 30 days;
7. Pre-natal care must be provided within 14 days, except for high-risk pregnancies or new members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
8. Preventative health services for adults must be offered within 90 days; and
9. Preventative health services for children, including well-child check must be offered to CHIP members in accordance with the American Academy of Pediatrics periodicity schedule. For Medicaid Members, well-child check must be offered in accordance with the Texas Health Steps periodicity schedule. For new Members birth through age 20, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, must be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child members. The Texas Health Steps annual medical checkup for an existing Member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in Chapter 12.4 of the UMCM.

[CHIP, UMCC, Att. B-1, § 8.1.3.1, RSA, Att. B-1 § 8.1.3.1; STAR, UMCC, Att. B-1, § 8.1.3.1; STAR+PLUS, UMCC, Att. B-1, § 8.1.3.1, S+P Ex., Att. B-1 § 8.1.3.1, S+P MRSA, Att. B-1 § 8.1.3.1; STAR Health, Att. B-1 § 8.1.3.1; STAR Kids, Att. B-1 § 8.1.3.1; Dual-Demo MMP § 2.7.1.12]

**LL. Mental Health Providers.** As applicable to STAR, STAR+PLUS, STAR Health, STAR Kids, or Dual-Demo MMP Members, Provider must comply with 25 Tex. Admin. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing Mental Health Reimbursement Services and Mental Health Targeted Case Management. [STAR, UMCC, Att. B-1, § 8.2.7.3; STAR+PLUS, UMCC, Att. B-1, § 8.2.7.3, S+P Ex., Att. B-1 § 8.1.28.2, S+P MRSA, Att. B-1 § 8.1.30.1; STAR Health, Att. B-1 § 8.1.1.7.8; STAR Kids, Att. B-1 § 8.1.30.1; Dual-Demo MMP § 2.7.3.4]

**MM. Texas STAR Health Government Program.** To the extent that (i) Company administers and/or arranges for the provision of health care services to Members under the Texas STAR Health Government Program, and (ii) Provider is a participating provider in such STAR Health Government Program under the terms of the Agreement, then the following additional terms shall also apply:

Providers who are behavioral health providers must:

1. Submit to Company for inclusion into the Health Passport treatment plans and referrals to other providers.
2. Document the outcome measurement scores in the Health Passport.
3. Function as a member of the PCP Team by coordinating with the PCP and Service Manager as appropriate.
4. Testify in court as needed for child protection litigation. [STAR Health, Att. B-1, § 8.1.17]

Providers who are behavioral health providers must provide a monthly summary form, to be provided by Company. The following information must be included in the monthly summary form for the Health Passport:

1. Primary and secondary (if present) diagnosis.
2. Assessment information, including results of a mental status exam.
3. Brief narrative summary of the Member's clinical visits/progress.
4. Scores on each outcome rating form(s).
5. Referrals to other providers or community resources.
6. Referrals to providers or community resources.
7. Evaluations of each Member's progress at intake, monthly, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan.
8. Any other relevant care information.

[STAR Health, Att. B-1, §§ 8.1.12 & 8.1.17]

Providers who are PCPs must use the Texas Health Steps BH forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders, including possible substance abuse or chemical dependency. The PCP must submit completed Texas Health Steps screening and evaluation results to Company to include in the Health Passport. [STAR Health, Att. B-1, § 8.1.17]

Coordination Between Behavioral Health Services Provider and PCP. Provider must comply with the most recent version of the *Psychotropic Medication Utilization Parameters for Foster Children* found at [http://www.dfps.state.tx.us/Child\\_Protection/medical\\_Services/guide-psychotropic.asp](http://www.dfps.state.tx.us/Child_Protection/medical_Services/guide-psychotropic.asp). [STAR Health, Att. B-1, § 8.1.17.4]

Provider Responsibilities. At the request of HHSC for Texas Department of Family and Protective Services (DFPS), Providers must testify in court as needed for child protection litigation. [STAR Health, Att. B-1, § 8.1.11]

PCPs must:

1. either be enrolled as THSteps providers or refer Members due for a THSteps check-up to a THSteps provider;
2. refer Members for follow-up assessments or interventions clinically indicated as a result of the THSteps check-up, including the developmental and behavioral components of the screening;
3. submit information from the THSteps forms and documents to the Health Passport.

[STAR Health, Att. B-1, § 8.1.4.2]

#### **NN. Dentists.**

Main Dentists must:

1. provide children enrolled in CHIP (birth through age 18) with preventive services in accordance with the American Academy of Pediatric Dentistry (AAPD) recommendations, and children enrolled in Medicaid (birth through age 20) with preventive services in accordance with the Texas Health Steps dental periodicity schedule;
2. assess the dental needs of Members for referral to specialty care providers and provide referrals as needed; and
3. coordinate Members' care with specialty care providers after referral.

[STAR Health, Att. B-1, § 8.1.18.2]

To the extent that Company administers and/or arranges for the provision of health care services to Members under a First Dental Home Initiative Government Program, and Provider is considered a participating provider in such Program under the terms of the Agreement, then Provider certifies that he or she has completed the training and registration requirements for Texas Health Steps First Dental Home Initiative providers. [STAR Health, Att. B-1, § 8.1.18.1]

Dental Providers must provide:

1. Urgent care, including urgent specialty care, within 24 hours of a Member's request; and
2. Therapeutic and diagnostic care within 14 days of a Member's request.

In addition, Main Dentists must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than thirty (30) days of a Member's request. [STAR Health, Att. B-1, § 8.1.3.1]

**OO. Medical Consent Requirements.** For STAR Health Members, Providers must comply with medical consent requirements in Texas Family Code § 266.004, which require the Member's Medical Consenter to consent to the provision of medical care. [UMCM, Chapter 8.1, no. 52] Providers must notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Texas Family Code § 266.009. [STAR Health, Att. B-1, § 8.1.3]

**PP. Cost Reporting for LTSS Providers.** Provider must submit cost reports to HHSC or its designee in the manner and format required by HHSC. If Provider fails to comply with this requirement, Company must and shall withhold payments to Provider until HHSC instructs Company to release them.

**QQ. Debts or Back Taxes.** Any payment due to Provider under a Medicaid/CHIP program may be first applied toward any debt or back taxes Provider owes the State of Texas or the federal government. Company may so apply payments until the debt or back taxes are paid in full.

**RR. State-Mandated Requirements for STAR+PLUS Nursing Facility Providers.** To the extent that (i) Company administers and/or arranges for the provision of health care services to Members under the STAR+PLUS program, and (ii) Provider is a participating nursing facility under that STAR+PLUS program, then the Parties shall abide by the terms and conditions set forth in the chapter of the HHSC UMCM entitled "State-Mandated Requirements for STAR+PLUS Nursing Facility Providers," as may be subsequently amended, and as currently available at Chapter 8.6 of the UMCM at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/handbooks/umcm/8-6.pdf> (the "State-Mandated UMCM STAR+PLUS Requirements Chapter"). If there is a conflict between the terms of any provision of this Compliance Addendum outside of this Section RR, on the one hand, and the terms of the State-Mandated UMCM STAR+PLUS Requirements Chapter, on the other hand, the terms of the State-Mandated UMCM STAR+PLUS Requirements Chapter shall govern and control the parties' rights, claims, payments, insurance, credentialing/licensure, and other obligations with respect to any STAR+PLUS nursing-facility services.

**SS. STAR+PLUS Dual Demonstration Medicare-Medicaid Government Program (a/k/a Dual-Demo MMP).** To the extent that (i) Company administers and/or arranges for the provision of health care services to Members under the STAR+PLUS Dual-Demo MMP, and (ii) Provider is a

participating provider in such Dual-Demo MMP under the terms of the Agreement, then the following additional terms shall also apply to Provider and to any downstream and related entities of Provider:

1. Provisions Required Under Applicable CMS/HHSC Contract.

- a. The delegated activities and reporting requirements, if any, for which Provider is responsible are contained in the Agreement. Provider shall perform all such delegated activities and reporting requirements in compliance with 42 C.F.R. §§ 422.504, 423.505, 438.6(l), and 438.230(b)(1), as applicable. Company shall revoke the delegation activities and reporting requirements or specify other remedies in instances where CMS, HHSC, or Company determine that Provider has not performed its delegated activities or reporting requirements satisfactorily. [Dual-Demo MMP, Appendix C §§ C.1, C.3.3, C.3.4]
- b. Provider shall retain, as applicable, the following information for a period of no less than ten (10) years, as measured from the final date of the contract period or from the date of completion of any audit, whichever is later: enrollee grievance and appeal records as set forth in 42 C.F.R. § 438.416; base data as set forth in 42 C.F.R. § 438.5(c); MLR reports as set forth in 42 C.F.R. § 438.8(k); and the data, information, and documentation specified in 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610. HHS, CMS, the Comptroller General, HHSC, and their respective designees, shall have the right to audit, evaluate, and inspect, and Provider shall make available for any such audit, evaluation, or inspection, any and all books, records, contracts, and computer or other electronic systems of Provider, and/or any premises, physical facilities, or equipment of Provider where Medicaid-related activities or work is conducted, that pertain to any aspect of services and activities performed, or determination of amounts payable under Company's contract with the State. The foregoing rights to inspect, evaluate, and audit any pertinent information shall exist for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. [Dual-Demo MMP, Appendix C § C.2]
- c. Provider shall not hold Members liable for payment of any fees that are the obligation of Company. [Dual-Demo MMP, Appendix C § C.3.1]
- d. Any services or other activity performed by Provider shall be performed in accordance with Company's contractual obligations to CMS and HHSC. [Dual-Demo MMP, Appendix C § C.3.2]
- e. Provider's performance under the Agreement will be monitored by Company on an ongoing basis and Company may impose corrective action as necessary. [Dual-Demo MMP, Appendix C § C.3.5]
- f. Provider agrees to safeguard Member privacy and confidentiality of Member health records. [Dual-Demo MMP, Appendix C § C.3.6]
- g. Provider must comply with all federal and state laws, regulations, and CMS instructions. [Dual-Demo MMP, Appendix C § C.3.7]
- h. To the extent that Provider provides credentialing of medical providers under the Agreement: (a) the

credentials of medical professionals affiliated with the Provider will be reviewed by Company; or (b) the credentialing process will be reviewed and approved by Company and Company shall audit the credentialing process on an ongoing basis. [Dual-Demo MMP, Appendix C § C.4]

- i. To the extent that Company has delegated the selection of providers under the Agreement to Provider, Company retains the right to approve, suspend, or terminate that arrangement. [Dual-Demo MMP, Appendix C § C.5]
- j. Company shall provide a written statement to Provider of the reason or reasons for termination for cause, as applicable. [Dual-Demo MMP, Appendix C § C.6.1.2]
- k. Company is obligated to pay Provider under the terms of the Agreement, which includes a prompt-payment provision that has been developed and agreed to by both Company and Provider, and that is compliant with state and federal law. [Dual-Demo MMP, Appendix C § C.6.1.3]
- l. Provider shall provide all services under the Agreement in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [Dual-Demo MMP, Appendix C § C.6.1.4]
- m. Provider shall abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of medical records, and other health and enrollment information. [Dual-Demo MMP, Appendix C § C.6.1.5]
- n. Provider shall ensure that medical information is released in accordance with applicable federal or state law, or pursuant to court orders or subpoenas. [Dual-Demo MMP, Appendix C § C.6.1.6]
- o. Provider shall maintain Member records and information in an accurate and timely manner. [Dual-Demo MMP, Appendix C § C.6.1.7]
- p. Provider shall ensure timely access by Members to the records and information that pertain to them. [Dual-Demo MMP, Appendix C § C.6.1.8]
- q. Provider shall not hold Members liable for Medicare Part A and B cost sharing, and all Medicare Parts A and B services must be provided at zero cost-sharing to Members. [Dual-Demo MMP, Appendix C § C.6.1.9]
- r. Provider shall ensure that its EMTALA obligations are fulfilled as required by law and the Agreement shall not create any conflicts with any hospital actions required to comply with EMTALA. [Dual-Demo MMP, Appendix C § C.6.1.10]
- s. Provider, including without limitation all primary care providers, shall not close or otherwise limit acceptance of Members as patients unless the same limitations apply to all commercially insured Members. [Dual-Demo MMP, Appendix C § C.6.1.11]
- t. Company shall not refuse to contract with or pay Provider for the provision of Covered Services solely because Provider has in good faith: (a) communicated with or advocated on behalf of one or more of the prospective, current, or former patients of Provider

regarding the provisions, terms, or requirements of Company's health benefit plans as they relate to the needs of such patients; or (b) communicated with one or more of the prospective, current, or former patients of Provider with respect to the method by which Provider is compensated by Company for services provided to the patient. [Dual-Demo MMP, Appendix C § C.6.1.12]

- u. Provider is not required to indemnify Company for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against Company based on Company's management decisions, utilization review provisions, or other policies, guidelines, or actions. [Dual-Demo MMP, Appendix C § C.6.1.13]
- v. Provider shall comply with Company's requirements for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. [Dual-Demo MMP, Appendix C § C.6.1.14]
- w. Company shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in Company's procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided thirty (30) days before the effective date of such modification unless such other date for notice is mutually agreed upon between Company and Provider or unless such change is mandated by CMS or HHSC without thirty (30) days' prior notice. [Dual-Demo MMP, Appendix C § C.6.1.15]
- x. Provider shall not bill Members for charges for Covered Services other than Part D pharmacy co-payments, if applicable. [Dual-Demo MMP, Appendix C § C.6.1.16]
- y. No payment shall be made by Company to Provider, and Provider shall not seek payment from Company, for a Provider Preventable Condition as defined in 42 C.F.R. § 447.26(b). Provider shall, as a condition of payment from Company and to the extent that Provider directly furnishes services, comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by Company and/or HHSC. [Dual-Demo MMP, Appendix C §§ C.6.1.17, C.6.1.18]
- z. Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements in 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. Contracts or arrangements with first tier, downstream, and related entities shall not include incentive plans that include a specific payment to Provider as an inducement to deny, reduce, delay, or limit specific, medically necessary services, and (a) Provider shall not profit from provision of Covered Services that are not medically necessary or medically appropriate, and (b) Company shall not profit from denial or withholding of Covered Services that are medically necessary or medically appropriate. Nothing herein shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments

or shared-risk agreements that are made with respect to physicians or physician groups or that are made with respect to groups of Members if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services, and equipment provided or authorized by another physician or health care provider, comply with the paragraph that immediately follows. [Dual-Demo MMP, Appendix C § C.6.2]

Company shall not impose a financial risk on Provider for the costs of medical care, services, or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following: (a) stop-loss protection; (b) minimum patient population size for the Provider or Provider group; and (c) identification of the health care services for which Provider or Provider group is at risk. [Dual-Demo MMP, Appendix C § C.7]

- aa. All contracts or arrangements with first tier, downstream, and related entities for laboratory testing sites that provide services must include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number. [Dual-Demo MMP, Appendix C § C.8]
- bb. Nothing shall be construed to restrict or limit the rights of Company to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers. [Dual-Demo MMP, Appendix C § C.9]
- cc. To the extent that Provider is a primary care physician (PCP), Company must develop and disseminate policies to Provider regarding clinical coordination between behavioral health service providers and PCPs, and must train Provider (a) on how to screen for and identify behavioral health disorders, (b) on Company's referral process for behavioral health services, and on the clinical coordination requirements for such services, and (c) on coordination and quality of care, such as behavioral health screening techniques for PCPs and new models of behavioral health interventions. [Dual-Demo MMP, Appendix C §§ C.6.3.2, C.6.3.3, C.6.3.4]
- dd. To the extent that Provider is a behavioral health provider: (a) Provider shall refer a Member with known or suspected and untreated physical health problems or disorders to his/her PCP for examination and treatment, with the consent of the Member or his/her legally authorized representative (LAR), and Provider shall only provide physical health care services if it is licensed to do so; and (b) Provider shall send initial and quarterly (or more frequently if clinically indicated) summary reports of that Member's behavioral health status to his/her PCP, with the consent of the Member or his/her LAR. [Dual-Demo MMP, Appendix C §§ C.6.4.1, C.6.4.2]
- ee. To the extent that Provider is a nursing facility provider, Provider shall use the state and federally required assessment instrument, as amended or modified, to assess Members and to supply current medical information for medical necessity determinations, and shall thereafter promptly deliver all completed assessments to Company. [Dual-Demo MMP, Appendix C §§ C.6.5.1, C.6.5.2]

- ff. To the extent that Provider provides Medicare-covered services, Provider shall be enrolled as a Medicare provider in order to submit claims for reimbursement or otherwise participate in the Medicare program. To the extent that Provider provides Medicaid-covered services, Provider shall be enrolled in the Texas Medicaid program, if such enrollment is required by HHSC's rules or policy, in order to submit claims for reimbursement or otherwise participate in the Texas Medicaid program. [Dual-Demo MMP § 2.7.2.1.1, 2.7.2.1.2]
- gg. Provider must maintain locations that are ADA compliant and accessible to all Members, including Members with disabilities, and must maintain capacity to deliver services in a manner that reasonably accommodates the needs of Members. [Dual-Demo MMP §§ 2.7.2.3, 2.7.5.10, 2.8.1.7]
- hh. Provider shall be responsive to the linguistic, cultural, ethnic, racial, religious, age, gender, and other unique needs of any minority, homeless population, Members with disabilities (both congenital and acquired disabilities), or other special population served by Company. This responsiveness includes the capacity to communicate with Members in languages other than English, when necessary, as well as those with a vision or hearing impairment. [Dual-Demo MMP § 2.7.2.4]
- ii. Provider shall understand and comply with its obligations under state or federal law to assist Members with skilled medical interpreters and the resources that are available to assist Provider to meet these obligations. [Dual-Demo MMP § 2.7.2.5]
- jj. Provider shall maintain a strong understanding of disability, recovery, and resilience cultures, and long term supports and services. [Dual-Demo MMP § 2.7.2.7]
- kk. If Provider is an acute-care hospital or specialty hospital, Provider must be able to provide Covered Services to Members twenty-four (24) hours per day, seven (7) days per week. [Dual-Demo MMP § 2.7.2.9]
- ll. Provider will collaborate with Company on any matters related to readiness review under the Dual-Demo MMP contract. [Dual-Demo MMP § 2.2.1.2.2.1]
- mm. Provider shall collaborate with Company, as requested and required under the Dual-Demo MMP contract, on activities relating to care coordination and Member care plans. [Dual-Demo MMP §§ 2.5.7.2, 2.6.3]
- nn. As requested and required under the Dual-Demo MMP contract, Provider shall actively participate as a member of the Service Coordination Team to perform the functions and tasks that are required of the Service Coordination Team under the Dual-Demo MMP contract. [Dual-Demo MMP § 2.5.2]
- oo. If Provider is a PCP associated with a nursing facility, Provider must have admitting privileges to hospitals within Company's provider network. [Dual-Demo MMP § 2.7.2.10]
- pp. Provider shall not engage in any practice with respect to any Member that constitutes unlawful discrimination under any state or federal law or regulation, including, but not limited to, practices that violate the provisions

of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90. [Dual-Demo MMP § 2.7.3.7.9]

- qq. Provider shall comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal-related healthcare programs, including Medicare, Medicaid, and/or Children's Health Insurance Program, and shall upon Company's request provide all required disclosures in accordance with 42 C.F.R. § 455, 42 C.F.R. § 1002.3, and otherwise. [Dual-Demo MMP §§ 2.7.3.7.10, 2.7.5.10, 5.1.6.1]
  - rr. Provider must be appropriately and continually licensed or certified, as applicable, pursuant to federal and state requirements and the terms of the Dual-Demo MMP contract. Provider shall notify Company immediately if Provider has lost any required license or state or federal approval, or has been excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 *et seq.*
  - ss. Provider shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Members. [Dual-Demo MMP § 2.8.1.6]
  - tt. If a Provider provides any emergency services to a Member, the Provider must promptly notify the Member's PCP of the Member's screening and treatment. [Dual-Demo MMP §§ 2.8.6.5.1, 2.8.6.9]
  - uu. Provider shall not impose any cost-sharing amounts (including without limitation deductibles, coinsurance, or copayments) on Indian Members served by an Indian Health Care Provider or through referral under contract health services. [Dual-Demo MMP, Appendix A § A.3.3]
2. Other Medicare Provisions. The provisions in this section and its subsections below apply to any integrated Medicare-Medicaid plan (a/k/a "MMP") that Company offers or administers to individuals who are dually eligible for both Medicaid and Medicare ("Company's MMPs") in connection with a contract with the Centers for Medicare and Medicaid Services ("CMS"). The Members who are covered under Company's MMPs shall collectively be referred to as the "MMP Members." The term "Applicable Law" or "applicable law" as used in the Agreement shall include, as it relates to this section and its subsections below, all applicable orders, directives, instructions, sub-regulatory guidance, and other requirements of any Officials (as defined below), including requirements for MMPs that pertain to participation as a First Tier or Downstream Entity in the Medicare Program.
- a. Definitions.
    - i. CMS Contract: The contract(s) with CMS governing Company's MMPs.
    - ii. Completion of Audit: Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of Company or of any First Tier, Downstream, or Related Entity.
    - iii. Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Company's MMPs, below the level of the arrangement

- between a Medicare organization and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
- iv. Excluded Entity: A person or entity listed on the Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) List of Excluded Individuals and Entities and the General Services Administration System for Awards Management (“SAM”), or appearing on the Federal Preclusion List.
  - v. Exclusion Lists: Collectively, the HHS OIG List of Excluded Individuals and Entities and the SAM.
  - vi. Final Contract Period: The final term of the applicable CMS Contract governing Company’s MMPs.
  - vii. First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with a Medicare organization to provide administrative services or health care services for MMP Members.
  - viii. MMP Member: A Medicare-eligible individual who has enrolled in a Company MMP.
  - ix. Officials: Federal and state regulatory agencies or officials with jurisdiction, including but not limited to CMS, HHS, the Comptroller General and their designees.
  - x. Offshore: Physically located outside of one of the fifty United States or one of the United States Territories (*i.e.*, American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).
  - xi. Policies: Company’s policies and procedures that relate to this Agreement, including, but not limited to, participation criteria; Provider Manuals; clinical policy bulletins; credentialing/rec credentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. This includes but is not specifically limited to Medicare Policies.
  - xii. Provider Manual: Company’s handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers, including but not limited to Medicare-specific content.
- b. Payment.
- i. Reimbursement. Reimbursement for Covered Services provided to MMP Members shall be made in accordance with the applicable Service and Rate Schedule attached to the Agreement. Provider acknowledges that payments made to Provider by Company are made in whole or in part with federal funds and subject Provider to those laws applicable to individuals/entities receiving federal funds. [45 C.F.R. Part 84 and 45 C.F.R. Part 91].
  - ii. Prompt Pay. In accordance with 42 C.F.R. § 422.520(b)(1), Company shall pay clean claims submitted by Provider for Covered Services provided to MMP Members within thirty (30) calendar days of receipt. For purposes of this provision, the term “clean claim” shall have the meaning assigned in 42 C.F.R. § 422.500.
- iii. Overpayments. Company shall have the right to pursue overpayments from Provider within three (3) years from the claim adjudication date.
  - iv. Medicare Payment Adjustment. Company shall not pay any amounts beyond the amounts set forth in the applicable Service and Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or Applicable Law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare organizations may be adjusted as the result of legislation, regulation, executive order, or other federal mandate (“Medicare Payment Adjustment”). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company’s payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider until the earlier of the date (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance-based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) and its implementing regulations, as may be amended from time to time.
- c. Subcontracting. Provider shall require all of its subcontractors, if any, to comply with Applicable Law.
- i. Contract Requirements. Provider shall include in Provider’s contracts with subcontractors all contractual and legal obligations required to appear in such contracts under Applicable Law. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.
  - ii. Delegation. If Provider delegates to a subcontractor a service required by this Agreement, and the service is required under the terms of Company’s CMS Contract, Provider’s subcontract shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates a function to Provider, Company retains the right to approve, suspend, or terminate such delegation.
- d. Compliance Obligations.
- i. Compliance with CMS Contract, Law. Any services performed by Provider for Company’s MMPs shall be consistent with Company’s obligations under its CMS Contract and comply with Applicable Law. [42 C.F.R. §§ 422.504(i)(3)(iii), 422.504(i)(4)(v), 423.505(i)(3)(iii), 423.505(i)(4)(iv)].

- ii. Compliance with Medicare Policies. In addition to complying with the obligations set forth in the underlying Agreement, Provider shall comply with Policies applicable to Company's MMPs, including, but not limited to, those contained in the Provider Manual, as modified by Company from time to time. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes. [42 C.F.R. § 422.503] and [42 C.F.R. § 422.504] and [Medicare Managed Care Manual, Chapter 11, Section 100.4].
- iii. Grievances/Appeals. Provider agrees to cooperate with Company in resolving Medicare complaints, appeals, and grievances in accordance with Applicable Law. [42 C.F.R. § 422.504(a)(7)].
- iv. Offshore Services. If Provider (or its subcontractors) provides services for Company's MMPs that involve the receipt, processing, transferring, handling, storing or accessing of Protected Health Information ("PHI") Offshore ("Offshore Services"), Provider agrees to complete Company's Offshore Services Attestation prior to the commencement of Offshore Services (where possible), within fifteen (15) days of a material change in scope or delivery of Offshore Services, and no less than annually. [42 C.F.R. §§ 422.504(i)(4) and (5)].
- v. Excluded Entities. Provider agrees that no person or entity that provides services, directly or indirectly, for Company's MMPs, may be an Excluded Entity under Section 1128 or 1128A of the Social Security Act. Provider shall screen the Exclusion Lists prior to initially hiring/contracting and monthly thereafter to ensure no employee or subcontractor appears on Exclusion Lists. If any employee or subcontractor appears on an Exclusion List or is otherwise prohibited from receiving payment under the Medicare program by federal law, Provider will remove such individual or entity from any direct or indirect work on Company's MMPs and promptly notify Company of the same.
- vi. Compliance Program and Anti-Fraud Initiatives. Provider shall maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud, waste, and abuse ("FWA"). Such compliance program shall include dissemination to employees and Downstream Entities of (a) written policies and/or standards of conduct articulating the entity's commitment to compliance with Applicable Law, initially within ninety (90) days of hire/contracting, and at least annually thereafter, (b) communications regarding the obligation to report potential non-compliance or FWA issues (internally and to payers, including Company, as applicable), and a no-tolerance policy for retaliation or retribution for good faith reporting, and reporting mechanisms to employees and Downstream Entities, and (c) appropriate training and

education to ensure familiarity with and compliance with the compliance program. Provider, through its compliance program, shall establish and maintain a process to: oversee and ensure that employees and Downstream Entities perform applicable services for Company's MMPs consistent with this Agreement and Applicable Law and shall require implementation of disciplinary actions and corrective actions up to terminations where needed to ensure such compliance. Provider shall require that any Downstream Entity maintains an effective compliance program consistent with the requirements of this section. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)] and [42 C.F.R. §423.505].

- vii. Home Infusion Drugs. If Provider dispenses home infusion drugs that are covered under Medicare Part D to a MMP Member and such MMP Member has MA-PD coverage offered by Company ("Home Infusion Drug") then Provider agrees that the home infusion drugs section in the Provider Manual shall, as required by Applicable Law, be considered a part of this Agreement.
- viii. Marketing. Provider shall comply with the Medicare Communications and Marketing Guidelines ("MCMGs") and shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. [Medicare Communications and Marketing Guidelines, as may be updated from time to time].
- ix. Provider Directory. Provider shall promptly provide Company with notice of any changes in Provider information set forth in Company's provider directory, including Provider's ability to accept new patients, the closing of a Provider's panel, the retirement or a provider leaving the group, or other similar changes at least thirty (30) days prior to the effective date of the change or no later than 10 days after such event. Provider shall respond to requests from Company for updated directory information within ten (10) calendar days of receipt of such request. [42 C.F.R. § 422.111(b)(3)] and [Medicare Managed Care Manual, Chpt. 4, § 110.2]
- e. MMP Member Protections.
  - i. Hold Harmless. Provider shall not hold MMP Members liable for payment of any fees that are the legal obligation of Company/Medicare organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
  - ii. Continuation of Benefits. If Company's CMS Contract terminates or Company becomes insolvent or fails to make payment under this Agreement, Provider shall continue to provide Covered Services to MMP Members who are hospitalized through the date of discharge and shall be prohibited from billing MMP Members for such Covered Services. [42 C.F.R. § 422.504(g)(2)(i) and (ii)].
  - iii. Non-Covered Services. Provider must hold MMP Members harmless for the cost of non-covered services, except for normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles), unless the MMP Member has

received a pre-service organization determination notice of denial from Company before such services are rendered by Provider. This restriction on holding an MMP Member financially responsible for non-covered services does not apply in instances where a service is never covered by Medicare under any circumstance. [CMS, Memorandum to Medicare Advantage Plans, *et al.*, “Improper Use of Advance Notices of Non-coverage” (May 5, 2014).] [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 C.F.R. § 423.505(i)(3)(i)].

- iv. Dual-Eligible Cost Share. Provider shall not hold MMP Members who are eligible for both Medicare and Medicaid liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Provider shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will: (1) accept Company’s payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)]

f. Records and Audit.

- i. Maintenance of Records. Provider shall preserve records applicable to MMP Members and to Company’s MMPs, including its compliance with Applicable Law and this Agreement for the longer of: (i) the period of time required by State and federal law, or (ii) ten (10) years. In addition, to the extent applicable, Provider shall comply with 42 C.F.R. § 422.2480(c) and maintain all records containing data used by Company to calculate Medicare medical loss ratios (“MLRs”) for Company’s MMPs and/or evidence needed by Company and/or Officials to validate MLRs (collectively, “MLR Records”) for ten (10) years from the year in which such MLRs are filed by Company.
- ii. Audit. Provider agrees that Officials, including but not limited to HHS, the Comptroller General, or their designees, have the right to directly or indirectly audit, evaluate, and inspect any pertinent information possessed by Provider or its Downstream Entities and relating to Company’s MMPs and any CMS Contract for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of First Tier and Downstream Entities) (collectively, “Records”) through ten (10) years from the final date of the Final Contract Period of the CMS Contract or from the date of Completion of Audit, whichever is later. Provider shall notify Company within two (2) business days of any request by an Official, or their designees, to audit or evaluate Provider Records, and to the extent feasible, shall provide Company the right to participate in any such evaluation of Provider. [42 C.F.R. §§ 422.504(i)(2)(i), (ii), and (iv)] and [42 C.F.R. § 423.505(i)(2)(i), (ii), and (iv)]
- iii. Confidentiality and Accuracy of Records. Provider will comply with the confidentiality and MMP Member record accuracy requirements,

including: (1) abiding by all federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with Applicable Law, or pursuant to valid court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by MMP Members to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 C.F.R. § 423.136]

- iv. Submission and Certification of Encounter Data. Provider acknowledges that Company is required to provide CMS, other Officials, and accrediting organizations with encounter data, including medical records and claims data. Provider shall routinely provide such encounter data to Company in the form and manner requested by Company. Provider certifies that such encounter data shall be accurate, complete and truthful to the best of its knowledge and belief. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for MMP Members is inaccurate, incomplete, or erroneous, and cooperate with Company to correct erroneous encounter data.
- v. Company Oversight/Information and Records. Provider acknowledges and agrees that Company shall monitor, shall have the right to audit, and remains accountable for, the functions and responsibilities performed by Provider for Company’s MMPs. Accordingly, in addition to specific requirements for information and records set forth in this provision, Provider agrees to promptly provide to Company any information and records, including without limit, MLR Records, if applicable, and information and records that are reasonably needed by Company: (1) for administration of Company’s MMPs, (2) to monitor and audit performance of Provider and its subcontractors with this Agreement, Applicable Law, and requirements of accreditation agencies, including information regarding Provider’s oversight and monitoring of its Downstream Entities (including a summary of any results of such activities), and (3) to fulfill any reporting requirements Company may have to CMS or other Officials, including information about any physician incentive plan that Provider may have relating to this Agreement. Provider shall complete an attestation from Company to confirm its compliance with requirements of this Agreement as it relates to Company’s MMPs upon request and agrees that Company may require corrective actions in the event of non-compliance. Ultimately, should Company determine such noncompliance has not been or is not capable of being corrected to Company’s satisfaction, Company may terminate Provider’s participation in Company’s MMPs in accordance with the terms of the Agreement.

**II. Texas State Regulatory Requirements**

The following provisions are required by state law. The definitions found in TIC § 843.002 and 28 TAC § 11.2, as amended, are herein incorporated by this reference.

**A. Continuity of Care**

The termination of the Agreement, except for reason of medical competence or professional behavior, does not release the obligation of Company to reimburse Provider who is treating a Member of special circumstance, such as a Member who has a disability, acute condition, life threatening illness, is past the twenty-fourth (24th) week of pregnancy, or other condition, at no less than the rates provided for in the Agreement for the Member's care in exchange for continuity of ongoing treatment of a Member receiving Medically Necessary treatment such that Provider reasonably believes that discontinuing care by Provider could cause harm to the patient. Special circumstance shall be identified by Provider who must request that the Member be permitted to continue treatment under Provider's care and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if the Agreement had not terminated. Any dispute between Company and Provider regarding the necessity of continued treatment by Provider shall be resolved in accordance with the process set forth in the Provider Manual. Company will continue to reimburse Provider for treating a Member who has special circumstances until (1) the 90th day after the effective date of the termination; or (2) if the Member has been diagnosed with a terminal illness at the time of termination, the expiration of the nine-month period after the effective date of the termination; or (3) if a Member is past the 24th week of pregnancy at the time of termination, through delivery of the child and for immediate postpartum care and a follow-up checkup within the six-week period after delivery. TEX. INS. CODE §§ 843.309 & 843.362; 28 TEX. ADMIN. CODE § 11.901(b)(2).

#### **B. Provider Termination and Notice to Members**

At least 90 days before the effective date of the proposed termination of the Agreement, Company must provide a written explanation to Provider of the reasons for termination. Company may immediately terminate the Agreement in a case involving: (1) imminent harm to patient health; (2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs Provider's ability to practice medicine, dentistry, or another profession; or (3) fraud or malfeasance.

Not later than 30 days following receipt of the termination notice, Provider may request a review of Company's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, as those terms are defined in § 843.306 of the Texas Insurance Code, including at least one representative in Provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of Company. The decision of the advisory review panel must be considered by Company but is not binding on Company. Within 60 days following receipt of Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and Company must communicate its decision to Provider. Company must provide Provider, on request, a copy of the recommendation of the advisory review panel and Company's determination. Provider is entitled, upon request, to an expedited review process.

Reasonable advance notice will be given to a Member of the impending termination from the plan of Provider who is currently treating the Member. If the Agreement is being terminated for reasons related to imminent harm, Company

may notify Members immediately. TEX. INS. CODE § 843.306-309; 28 TEX. ADMIN. CODE §§ 11.901(b)(2), (b)(3) & (d).

#### **C. Member Grievance Dispute Resolution**

The Section of the Agreement titled "Member Grievance Dispute Resolution" shall be deleted in its entirety and replaced with the following:

Provider agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures); (b) provide Company with the information necessary to resolve same; and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Provider information concerning the Member appeal, grievance and external review procedures at the time of entering into the Agreement. As required by state law, Provider shall post a notice to Members on the process for resolving complaints with Company including the Department of Insurance toll-free telephone number for filing complaints. TEX. INS. CODE § 843.283; 28 TEX. ADMIN. CODE § 11.901(b)(4). Company shall not terminate or refuse to renew the Agreement or otherwise retaliate against Provider because Provider reasonably filed a complaint or an appeal on behalf of a Member. TEX. INS. CODE § 843.281; 28 TEX. ADMIN. CODE § 11.901(b)(1).

#### **D. Electronic Claims Submission**

In the event of a systems failure, or a catastrophic event that substantially interferes with the business operations of the physician or Provider, Provider may submit non-electronic claims for the number of calendar days during which substantial interference with business operations occurs as of the date of the catastrophic event or systems failure. Provider shall provide written notice of Provider's intent to submit non-electronic claims to Company within five calendar days of the catastrophic event or systems failure. TEX. INS. CODE § 1213.002; 28 TEX. ADMIN. CODE §§ 11.901(b)(10) & 21.3701.

Provider may submit a request for a waiver of the electronic submission requirements of the Agreement in any of the following circumstances:

1. No method available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C.F.R., Parts 160 and 162) do not support all of the information necessary to process the claim.
2. The operation of small physician and provider practices. This exception applies to those physicians and Providers with fewer than ten full-time-equivalent employees, consistent with 42 C.F.R. § 424.32(d)(1)(viii).
3. Demonstrable undue hardship, including fiscal or operational hardship.
4. Any other special circumstances that would justify a waiver.

Provider's request for a waiver must be in writing and must include documentation supporting the issuance of a waiver.

TEX. INS. CODE § 1213.003; 28 TEX. ADMIN. CODE §§ 21.3701 & 11.901(b)(10).

**E. Overpayments**

Provider agrees that Company may recover a refund due to an overpayment or completion of an audit if Company notifies Provider in writing not later than one hundred and eighty (180) days after the overpayment or completion of the audit. If Provider has not made arrangements to repay or otherwise appeal Company's notice within forty-five (45) days of Company's notice of overpayment or within thirty (30) days of notice of completion of audit, Company will offset the amount of the overpayment against future payments owing to Provider for any reason. If Provider disagrees with Company's request for recovery of overpayment or refund, Provider may appeal the request in writing as provided for in Company's notice of its intent to recover the overpayment. [TEX. INS. CODE § 843.350]

If Provider receives an overpayment from a Member, Provider must refund the amount of the overpayment to the Member not later than the 30th day after Provider determines that an overpayment has been made. TEX. INS. CODE § 1661.005; 28 TEX. ADMIN. CODE § 11.901(b)(11).

**F. Coordination of Benefits**

Provider agrees to collect and maintain primary payor information in the Member's medical or billing records and to provide such information to Company so that Company can coordinate benefits according to the Member's health benefits and the Agreement. 28 TEX. ADMIN. CODE § 11.901(b)(12).

**G. Expedited Credentialing**

If Physician joins an established medical group that has a current contract in force with Company, Company will expedite credentialing of Physician for the limited purposes set out below, provided Physician:

1. is licensed in Texas by, and in good standing with, the Texas Medical Board;
2. submits all documentation and other information required by Company as necessary to enable Company to begin the credentialing process to include Physician in the issuer's health benefit plan network; and
3. agrees to comply with the terms of Company's Participating Provider contract currently in force with the applicant Physician's established medical group. [TEX. INS. CODE § 1452.103.]

On submission by Physician of the information above, Company will treat the applicant Physician as if the Physician were a participating provider in the health benefit plan network for payment purposes only when the applicant Physician provides services to Members, including:

1. authorizing the applicant Physician to collect copayments, if any, from the Members; and
2. making payments to the applicant Physician. [TEX. INS. CODE § 1452.104.]

If, on completion of the credentialing process, Company determines that the applicant Physician does not meet Company's credentialing requirements:

1. Company may recover from the applicant Physician or the Physician's medical group an amount equal to the

difference between payments for in-network benefits and out-of-network benefits; and

2. applicant Physician or the Physician's medical group may retain any copayments collected or in the process of being collected as of the date of the issuer's determination. [TEX. INS. CODE § 1452.106.]

A Member is not responsible and shall be held harmless for the difference between in-network copayments paid by the Member to a Physician who is determined to be ineligible and Company's charges for out-of-network services. Physician and the Physician's medical group may not charge the enrollee for any portion of the Physician's fee that is not paid or reimbursed by Company. [TEX. INS. CODE § 1452.107.]