Aetna Better Health of Texas
Network Management
2777 N. Stemmons Freeway, Suite 1450
Dallas, TX 75207

Aetna Better Health of Texas is Expanding!

Dear Medical Care Provider:

The Texas Health and Human Services Commission (HHSC) has awarded a STAR+PLUS contract to Aetna Better Health of Texas to serve as a managed-care organization in the Bexar, Dallas, Harris, and Hidalgo service areas effective September 1, 2020. STAR+PLUS is a Texas Medicaid managed-care program integrating the delivery of Acute Care services and Long-Term Services and Supports (LTSS) for people who are age 65 or older, and/or are blind or disabled.

We are growing our network to meet the requirements of this new contract. The following are some of the benefits our health care plan offers:

- Timely claims payment
- Electronic claims submission
- Online portal for eligibility
- Responsive customer service
- Embedded network managers in your region

We would like to have you participate with our plan and to secure a contract with you and your organization. By signing, completing, and returning the contract documents enclosed, you have agreed to provide services in your service area.

Aetna Better Health would like to have these documents returned in the next two weeks.

If you have any questions, please feel free to contact our Network Managers at abhtxSTARPLUS@aetna.com.

Thank you for your partnership with Aetna Better Health of Texas.

Sincerely,

Cheryl L. Harding

Chief Executive Officer
Aetna Better Health of Texas health plan

Mary N. Downey

Director of Networks
Aetna Better Health of Texas health plan

Enclosures

Aetna Better Health of Texas Ancillary & Facility Application Data Form

You don't join us, we join you! We appreciate and thank you for your interest in allowing us to join you to serve all Aetna Better Health of Texas members. Please complete this data application accurately and correctly. Failure to provide all required data elements (identified by *) will result in delay in processing your application. If there are any questions, please email us at abhtxstarplus@aetna.com. Complete Page 2 and 3 for each location. If LTSS services are provided, also complete Page 4.

Entity Name*: Webb County

Doing Business As (DBA)*: Community Action Agency - Meals on Wheels Program

Provider Specialty*: Home - Delivered Meals

NPI/API*: 1952597734

Tax ID*: 74-6001587

Texas Provider Identifier (TPI)/Atypical Provider Identifier (API)*:

State License Number*:

CLIA Number:

Contact Name*: Isa Ramos
Contact Email Address: iramos@webbcountytx.gov
Contact Phone Number*: (956) 722-4664

Website: www.webbcountytx.gov

Address*:

Physical Address	Mailing Address
1310 Convent Ave Laredo, Tx. 78040	520 Reynolds Laredo, Tx. 78040

Phone Number(s)*: (956) 722-4664 (956) 7226078 (956) 791-6819

Fax: (956) 753-8660

Practice Location

Location Name*:

Primary Contact Name*:
Primary Contact Phone Number*:
Clinic Primary Contact Email Address:

Address*:

Phone Number*:

Fax Number:

Website Address:

Location TPI (if different from above):

Location Hours:

Weekday Office Hours (Specify Hours)	Mon Tue Wed Thurs Fri
Weekend Office Hours (Specify Hours)	Sat Sun

After Hours: Y ◯ N ◯

Accepting New Patients: Y ◯ N ◯

Age Restrictions:

Gender Restrictions:

Include in Directory: Y ◯ N ◯

Counties services available:

Clinic offering non-English (including ASL) languages by qualified interpreters:

Spanish ☐	French ☐	German ☐	Vietnamese ☐
Arabic ☐	Cantonese ☐	Hindi ☐	Bengali ☐
Mandarin ☐	Japanese ☐	Korean ☐	Other: ☐

Accessibility Options offered at this location:

Parking ☑	Wheelchair accessible ☑	Public Transit Access ☑
Accommodates Blind/Visually Impaired ☐	Accommodates Special Needs ☐	Accommodates Deaf/Hearing Impaired ☐
Adjustable Exam Table/Scale ☐	Exterior Building ☐	Interior Building ☐
Restroom ☑	Exam Rooms/Medical Equipment ☐	

Tele-services Offered:

Telehealth: Y ◯ N ◯	Existing Patients Only: Y ◯ N ◯	Direct Telehealth Line:
Telemedicine: Y ◯ N ◯		
Telemonitoring: Y ◯ N ◯		

Behavioral Health (BH) Services

Indicate which BH services are provided at this location

Psychiatric/Mental Health		
Inpatient ☐	Partial Hospitalization Program (PHP) ☐	Intensive Outpatient Program (IOP) ☐
Residential ☐	Other (please specify): ☐	
Chemical Dependency, Substance Use		
Inpatient ☐	Partial Hospitalization Program (PHP) ☐	Intensive Outpatient Program (IOP) ☐
Residential ☑	Other (please specify):	

Cultural Competency Trained: Y ◯ N ◯

Long Term Support Services (LTSS) Information

LTSS Entity Name (if different from above):

Mark applicable LTSS service and corresponding API number if already assigned:

LTSS Service Category	Service Provided?	API Number (if assigned)
Adaptive Aids	☐	
Adult Foster Care	☐	
Assisted Living Residential Services in a 1 to 3-person home	☐	
Assisted Living Residential Services in a 4 to 6-person ALF	☐	
Cognitive Rehabilitation Therapy	☐	
Emergency Response Services	☐	
Employment Assistance	☐	
Financial Management Services	☐	
Home Delivered Meals	☑	
Minor Home Modifications	☐	
Nursing	☐	
Personal Assistance Services	☐	
Protective Supervision	☐	
Respite	☐	
Supportive Consultation	☐	
Supported Employment	☐	
Transition Assistance Services	☐	
Primary Home Care	☐	
Day Activity and Health Services	☐	
Physical Therapy	☐	
Speech Therapy	☐	
Occupational Therapy	☐	
Value Added	☐	
Personal Attendant Services for Community First Choice (CFC) only	☐	

Certification

To the best of my knowledge, I hereby certify that the information provided above is accurate.

Signature*: Date*:

Name*:

Designation*:

PROVIDER AGREEMENT

Aetna Better Health of Texas Inc., on behalf of itself and its Affiliates ("Company"), and Webb County dba CAA-MCW. [insert provider name], on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** that follow. It also includes and incorporates one or more of the following **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, **Product Addendum(a)**, or other attachments (collectively, the "Agreement"), as checked below:

	AGREEMENT PARTS
✓	This Cover & Signature Page
✓	General Terms and Conditions
✓	Medicaid Product Addendum
✓	Service and Rate Schedule (Medicaid Products and Medicare-Medicaid Plan (MMP))
✓	State Compliance Addendum (Medicaid Products and Medicare-Medicaid Plan (MMP))

EFFECTIVE DATE: [to be filled in ***BY AETNA*** upon credentialing completion] __________ ("Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider agrees that it has read and understood this Agreement, has had the opportunity to review it with an attorney of its choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER

By: Webb County

Printed Name: Tano E. Tijerina

Title: County Judge

FED. TAX I.D. #: __________

NPI NUMBER: __________

AETNA/COMPANY

By: __________

Printed Name: **Cheryl L. Harding**

Title: **CEO**

As required by Section 8.7 ("Notices") of this Agreement, notices shall be sent to the following addresses:

Provider:

____

____

____

____

Company:

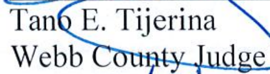
Aetna Better Health of Texas

Attn: Network Director

2777 N. Stemmons Fwy, Suite 1450

Dallas, TX 75207

WEBB COUNTY



Tano E. Tijerina
Webb County Judge
Date: 03/11/2020

ATTESTED:

Margie Ramirez-Ibarra
Webb County Clerk

APPROVED AS TO FORM:

Ray Rodriguez
Assistant General Counsel
Webb County Civil Legal Division*

*The General Counsel, Civil Legal Division's office, may only advise or approve contracts or legal documents on behalf of its clients. It may not advise or approve a contract or legal document on behalf of other parties. Our review of this document was conducted solely from the legal perspective of our client. Our approval of this document was offered solely for the benefit of our client. Other parties should not rely on this approval, and should seek review and approval of their own respective attorney(s).

Passed and approved by the Webb County Commissioners Court On March 9, 2020; item no. 18 .

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or have a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act ("ACA") (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (a) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (b) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (c) change in the ownership or management of Provider; and (d) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. 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.

1.4 **Claims Submission and Payment.** Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment, or payment or claim denial dispute, within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider practice, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (a) Company and Provider negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (b) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Provider and the Participating Provider.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment.** Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

(a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and

(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and

(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category;

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate or include Provider, any specific Group Provider(s) or any specific Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation) or specialty program. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (iii) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of

criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (i) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member;

or (ii) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution and Mediation**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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APPENDIX 1 - DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider who is employed by or contracted with Provider or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, 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. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

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MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include Medicaid Products, as defined below.

1. **Definitions.**

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. Medicaid Product(s). Those publicly funded or subsidized managed-care programs for Medicaid, Children's Health Insurance Program (CHIP), and/or other low-income or otherwise qualified individuals that are operated and/or administered by Company, as set forth in the **Service and Rate Schedule (Medicaid Products and Medicare-Medicaid Plan (MMP))**, which may include without limitation managed long-term services and supports (a/k/a MLTSS) programs and any integrated Medicare-Medicaid plans (a/k/a MMPs).

   c. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products and Medicare-Medicaid Plan (MMP))** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products and Medicare-Medicaid Plan (MMP))** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Product Addendum**. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products and Medicare-Medicaid Plan (MMP)))

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following Medicaid Product(s):

A. The Medicaid and/or CHIP Plans offered by Company within the State.

B. The integrated Medicare-Medicaid Plans (a/k/a MMPs) offered by Company within the State.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, 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:

Medicaid and/or CHIP Plans:	100% of Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans (MMPs):	100% of Aetna Medicare-Medicaid Plan (MMP) Market Fee Schedule

3.0 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 Company, 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 Company 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 Company'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, Company will not make separate payment(s) for packaged revenue codes. Company will follow the OPPS payment updates as published annually by CMS in the OPPS final rule.

E. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company 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 (OPPS) 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 OPPS cap payments, or the CMS conversion factors. Company 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 Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

F. Medicare-Medicaid Plans (MMPs). Where Company 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), Company 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), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company 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 Company is not responsible for, supplemental or wrap-around payments unless required by Company'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)).

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TEXAS
STATE COMPLIANCE ADDENDUM
(Medicaid Products and Medicare-Medicaid Plan (MMP))

This Texas State Compliance Addendum (Medicaid Products and Medicare-Medicaid Plan (MMP)) ("Medicaid 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 Medicaid 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 Medicaid Addendum will govern and control; *provided, however*, that if there is any conflict between any of the terms of the Agreement, including this Medicaid Addendum, and the State Contract, then the terms of the State Contract will govern and control.

For purposes of this Medicaid 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 Medicaid 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

Proprietary

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

Proprietary

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. [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, § 8.16 & 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, § 8.16 & 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]

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-

Proprietary

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

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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

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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. [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 Medicaid 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]

Proprietary

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/recredentialing, 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;

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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.]

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Instructions for Electronic Funds Transfer (EFT) Enrollment/Change/Cancellation

Please use this guide to prepare/complete your Electronic Funds Transfer (EFT) Authorization Agreement Form. Missing, illegible or incomplete information within the agreement form will delay the benefits of participating in EFT. The following is a reference guide only, do not fax or email the instructions with the completed authorization form. Return Pages 2-3 ONLY. If you prefer to enroll/change/cancel electronically, please go to our website at www.aetnamedicaid.com for the electronic form and instructions. If you have questions about the authorization agreement form or the enrollment process, please call Provider Relations at 1-800-306-8612 or email us at TXProviderEnrollment@aetna.com.

Please note that the descriptions for the data elements contained in the Electronic Funds Transfer (EFT) Authorization Form have been placed in an Appendix to make it easier to complete the form. Please refer to the Appendix when completing the form.

☐ **Are you using one authorization agreement form per tax id number?**
- Enrollment forms containing more than one tax id will be returned.

☐ **Did you remember to put the NPI # on the authorization agreement form?**
- Enrollment forms without an NPI number (if the provider is required to have an NPI) will be returned.
- List additional NPI numbers to be enrolled in the space provided at the end of the enrollment form.

☐ **Have you attached a pre-printed voided check with the account holder imprinted on the check or bank letter for new enrollments or changes in bank information?**
- Enrollment requests cannot be processed without this information.
- A voided check/bank letter must accompany the form. Deposit Slips, starter checks, handwritten or altered checks will not be accepted. The banking information on the voided check/bank letter must match what is listed on the form.

☐ **Need to change or cancel an existing enrollment?**
- Complete a new authorization agreement form to make changes to an existing enrollment or to cancel an existing enrollment. Complete all parts of the form and mark the appropriate choice in the Submission Information section of the form. You are responsible for notifying Aetna Better Health of any changes in your information.

☐ **Has the form been signed by the appropriate individuals?**
- Unsigned forms will be returned.

☐ **Have you completed all sections?**
- Please type or print all requested information clearly. Incomplete and/or illegible fields will cause the form to be returned.

☐ **Have a completed form to submit? Forms can be submitted by fax or email.**
- Completed new or change authorization agreement forms with voided check and/or bank letter and completed cancellation authorization agreement forms can be submitted through one of the following methods:
  Fax to: Aetna Better Health, Finance EFT Enrollment at 1-855-596-8401. **Only one form per fax.** Faxes containing multiple forms will be returned.
  Email to: MBU-TexasFinance@aetna.com. **Only one form per email**. Emails containing multiple forms will be returned.

☐ **Need to check the status of your EFT enrollment?**
- Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.
- A confirmation letter will be sent to the Provider Address on the enrollment form once setup is complete.
- A $0.00 pre-note test transaction will be sent to your financial institution. The pre-note period can take 10-15 days from the processing date of the approved Electronic Funds Transfer (EFT) Authorization Agreement Form.
- Changes to existing banking information will trigger a new 10 to 15 day pre-note period.
- The online instructions on our website at **www.aetnamedicaid.com** will instruct you to contact Provider Relations at **1-800-306-8612** or email TXProviderEnrollment@aetna.com with any questions or to check enrollment status.

☐ **Have you contacted your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements from the NACHA ACH/EFT payment file?**
- Your financial institution must be a participating member of the Automated Clearinghouse Association (ACH) and accept the CCD+ format. You must proactively contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for the successful reassociation of the EFT payment with the ERA remittance advice.

☐ **Do you have a Late or Missing EFT payment or ERA remittance advice?**
- If you have not received your EFT payment or the corresponding ERA remittance advice by the 4th business day after you receive either the EFT payment or ERA remittance advice, contact your Provider Relations representative at **1-800-306-8612** or email us at TXProviderEnrollment@aetna.com or fax us at 1-866-510-3710.

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Electronic Funds Transfer (EFT) Authorization Agreement Form

Page 2 – Definitions for DEG group data elements contained in Appendix.

DEG1	Provider Information
Provider Name	Webb County
Doing Business As Name (DBA)	Community Action Agency- Meals on Wheels
Provider Address Street	520 Reynolds
City	Laredo
State/Province	TX.
ZIP Code/Postal Code	78040

DEG2	Provider Identifiers Information									
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)										
National Provider Identifier (NPI)	1	9	5	2	5	9	7	7	3	4

DEG3	Provider Contact Information
Provider Contact Name	Isa Ramos
Telephone Number	(956) 722-4664 (956) 722-6078 (956) 791-6819
Email Address	iramos@webbcountytx.gov
Fax Number	(956) 753-8660

DEG7	Financial Institution Information								
Financial Institution Name									
Financial Institution Address Street									
City									
State/Province									
ZIP Code/Postal Code									
Financial Institution Routing Number									
Type of Account at Financial Institution									
Provider's Account Number with Financial Institution									

Account Number Linkage to Provider Identifier - Select from one of the two below

☐ Provider Tax Identification Number (TIN) 74-6001587

☐ National Provider Identifier (NPI) 1952597734

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Electronic Funds Transfer (EFT) Authorization Agreement Form

Page 3 - Definitions for DEG group data elements contained in Appendix.

DEG8	Submission Information
Reason for Submission – Select from below	
☑	New Enrollment
☐	Change Enrollment
☐	Cancel Enrollment
Include with Enrollment Submission – Select from below	
☐	Voided Check
☐	Bank Letter
Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	

Authorization Agreement – By signing above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below. In addition, I represent and warrant that all of the information that I have provided to Aetna Better Health is accurate and complete.

Electronic Funds Transfers (EFT) Authorization Agreement

We, the Provider, certify that the bank account information listed on this form is under our direct control. We authorize Aetna Better Health, on behalf of itself and its affiliates (hereinafter "Aetna Better Health"), to initiate credit entries to the account at the bank listed on this form for all claims payments. We authorize and request the bank to accept credit entries by Aetna Better Health to such account and to credit the same to such account.

We, the Provider, understand that if our account is closed and a new Electronic Funds Transfer (EFT) Authorization Agreement Form has not been submitted and processed, we will not receive payment until our bank returns the funds to Aetna Better Health. This authorization remains in effect until we submit an updated Electronic Funds Transfer (EFT) Authorization Agreement Form requesting termination or change and until such time that Aetna Better Health has had a reasonable opportunity to act on such request or Aetna Better Health notifies us that this service has been terminated. If our depository information changes, we agree to submit an updated Electronic Funds Transfer (EFT) Authorization Agreement Form to that effect.

Aetna Better Health will not debit or deduct funds directly from my bank account for claim overpayments and or refund requests but, If Aetna Better Health credits more money than the correct benefits amount to the account, due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error), Aetna Better Health will pursue immediate repayment with the Provider.*

* Aetna Better Health strictly adheres to the National Automated Clearing House Association (NACHA) guidelines.

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Additional National Provider Identification (NPI) to be enrolled		
NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI
NPI	NPI	NPI

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Appendix - Data Element Names and Descriptions – To be used for completing the Electronic Funds Transfer (EFT) Authorization Agreement Form

DEG1	PROVIDER INFORMATION
Data Element Name	**Description**
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person(s) who actually own it and are responsible for it
Provider Address - Street	The number and street name where a person or organization can be found
Provider Address - City	City associated with provider address field
Provider Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country

DEG2	PROVIDER IDENTIFIERS INFORMATION
Data Element Name	**Description**
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identifier Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digits number). This means that the numbers do not carry other information about the healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

DEG3	PROVIDER CONTACT INFORMATION
Data Element Name	**Description**
Provider Contact Name	Name of a contact in provider office for handling EFT issues
Telephone Number	Associated with contact person
Email Address	An electronic mail address at which the health plan might contact the provider
Fax Number	A number at which the provider can be sent facsimiles

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Appendix - Data Element Names and Descriptions – To be used for completing the Electronic Funds Transfer (EFT) Authorization Agreement Form

DEG7	FINANCIAL INSTITUTION INFORMATION
Data Element Name	**Description**
Financial Institution Name	Official name of the provider's financial institution
Financial Institution Address - Street	Street address associated with receiving depository financial institution name field
Financial Institution Address - City	City associated with receiving depository financial institution address field
Financial Institution Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country
Financial Institution Address – ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice

DEG8	SUBMISSION INFORMATION
Data Element Name	**Description**
Include with Enrollment Submission – Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers
Include with Enrollment Submission – Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment

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Instructions for Electronic Remittance Advice (ERA) Enrollment/Change/Cancellation

Please use this guide to prepare/complete your Electronic Remittance Advice (ERA) Authorization Agreement Form. Missing, illegible or incomplete information within the agreement form will delay the benefits of participating in ERA. The following is a reference guide only, do not fax, or email the instructions with the completed authorization form. Return Pages 2-3 ONLY. If you prefer to enroll/change/cancel electronically, please go to our website at www.aetnamedicaid.com for the electronic form and instructions. If you have questions about the authorization agreement form or the enrollment process, please contact TX Provider Enrollmentat 1-800-306-8612, or email us atTXProviderEnrollment@aetna.com.

Please note that the descriptions for the data elements contained in the Electronic Remittance Advice (ERA) Authorization Form have been placed in an Appendix to make it easier to complete the form. Please refer to the Appendix when completing the form.

☐ **Are you using one authorization agreement form per tax id number?**

- Enrollment forms containing more than one tax id will be returned.

☐ **Did you remember to put the NPI # on the authorization agreement form?**

- Enrollment forms without an NPI number (if the provider is required to have an NPI) will be returned.
- List additional NPI numbers to be enrolled in the space provided at the end of the enrollment form.

☐ **Additional Information**

- Please contact your vendor for additional information on which distribution method to utilize as each vendor/clearinghouse may have a different distribution method.
- If you do not use a vendor and have questions, please contact TX Provider Enrollment at **1-800-306-8612**,or email TXProviderEnrollment@aetna.com.
- If you would like to link directly with Emdeon please contact Emdeon Sales at 1-877-363-3666. There may be an additional cost associated with linking directly with Emdeon.

☐ **Need to change or cancel an existing enrollment?**

- Complete a new authorization agreement form to make changes to an existing enrollment or to cancel an existing enrollment. Complete all parts of the form and mark the appropriate choice in the Submission Information section of the form. You are responsible for notifying Aetna Better Health any information changes.

☐ **Has the form been signed by the appropriate individuals?**

- Unsigned forms will be returned.

☐ **Have you completed all sections?**

- Please type or print all requested information clearly. Incomplete and/or illegible fields will cause the form to be returned.

☐ **Have a completed form to submit? Forms can be submitted by fax or email.**

- Completed new, change and cancellation authorization agreement forms can be submitted through one of the following methods:
  Fax to: Aetna Better Health of Texas, TX Provider Enrollment 866-510-3710. **Only one form per fax.**Faxes containing multiple forms will be returned.
  Email to: TXProviderEnrollment@aetna.com. **Only one form per email**. Emails containing multiple forms will be returned.

☐ **Need to check the status of your ERA enrollment?**

- Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.
- The online instructions on our website at **www.aetnamedicaid.com** will instruct you to contact TX Provider Enrollment at **1-800-306-8612** or email TXProviderEnrollment@aetna.comwith any questions or to check enrollment status.

☐ **Have you contacted your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Reassociation Data Elements from the NACHA ACH/EFT payment file?**

- Your financial institution must be a participating member of the Automated Clearinghouse Association (ACH) and accept the CCD+ format. You must proactively contact your financial institution to arrange for the delivery of the CORE-required Minimum CCD+ Data Elements necessary for the successful reassociation of the EFT payment with the ERA remittance advice.

☐ **Do you have a Late or Missing EFT payment or ERA remittance advice?**

- If you have not received your EFT payment or the corresponding ERA remittance advice by the 4th business day after you receive either the EFT payment or ERA remittance advice, contact your TX Provider Enrollment at **1-800-306-8612**,email us atTXProviderEnrollment@aetna.com, or fax us at 1-866-510-3710.

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Electronic Remittance Advice (ERA) Authorization Agreement

Page 2 – Definitions for DEG group data elements contained in Appendix.

DEG1	PROVIDER INFORMATION
Provider Name	
Doing Business As Name (DBA)	
Provider Address Street	
City	
State/Province	
Zip Code/Postal Code	
DEG2	**PROVIDER IDENTIFIERS INFORMATION**
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	
DEG3	**PROVIDER CONTACT INFORMATION**
Provider Contact Name	
Telephone Number	
Email Address	
Fax Number	
DEG7	**ELECTRONIC REMITTANCE ADVICE INFORMATION**
Preference For Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Select from below	
Provider Tax Identification Number (TIN)	
National Provider Identifier (NPI)	
Method of Retrieval	
DEG8	**ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION**
Clearinghouse Name	
Clearinghouse Contact Name	
Telephone Number	
Email Address	
DEG10	**SUBMISSION INFORMATION**
Reasons For Submission – Select from below	

☐ **New Enrollment**

☐ **Change Enrollment**

☐ **Cancel Enrollment**

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Electronic Remittance Advice (ERA) Authorization Agreement

Page 3 – Definitions for DEG group data elements contained in Appendix.

Authorized Signature	
Written Signature of Person Submitting Enrollment	
Printed Name of Person Submitting Enrollment	
Printed Title of Person Submitting Enrollment	

Authorization Agreement – By signing above, I hereby agree that I have read and agree to the terms and conditions stated in the Authorization Agreement below.

Authorization Agreement

Electronic Remittance Advice (ERA)

An ERA is an electronic version of a payment explanation of benefits (EOB)explaining claims payment or denial.

This authorization is to remain in effect until Aetna Better Health has received an ERA cancellation notification from me that affordsAetna Better Health a reasonable opportunity to act on it.Please allow 10-15 business days for processing once enrollment is received. Processing times may vary depending on number of enrollments received, accuracy of the information provided and how legible the form is.

Additional Required Information For Enrollment – MUST BE COMPLETED

ERA Receiver Information**		
Receiver ID		
Distribution Method** (must indicate one method)	❑ FTP Internet Log ID (8 characters) ❑ TSO ID ❑ NDMs Node Name (unique vendorID) lower case ❑ Emdeon Office (email address)***	**Distribution**

ERA Receiver Information and Distribution Method Choices:**

1. Emdeon Office*** is a suite of Emdeon practice management products, which includes a multitude of provider products.Emdeon Office should only be selected if you as the provider use the suite of Emdeon Office practice management products.
2. FTP Internet- this may be an FTP log on or it may be used to list the payment manager connection. MEDICOM is the distribution method when using payment manager.
3. TSO Mailbox- this is a dial up connection.
4. NDM S Node- this is typically used for 837 claim submissions.

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Additional InformationRequired If Enrolling in Emdeon Payment Manager – Offered at no additional cost		
Check the correct box to indicate a Payment Manager request	Yes ☐ No ☐	Both ERA and Payment Manager ☐
If Payment Manager, does a User ID already exist?	Yes ☑ No ☐	Payment Manager User ID: iramos@webbcountytx.gov.

Additional National Provider Identification (NPI) to be enrolled		
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**
NPI	**NPI**	**NPI**

General Reference Information

Payer Information	
Payer ID: **Aetna Better Health 38692**	**Tax ID:** **06-6033492**

Emdeon Confirmations – Internal Use Only
Send Emdeon 835 enrollment confirmations to: TXProviderEnrollment@aetna.com

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DEG1	PROVIDER INFORMATION
Data Element Name	**Description**
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person(s) who actually own it and are responsible for it
Provider Address - Street	The number and street name where a person or organization can be found
Provider Address - City	City associated with provider address field
Provider Address – State/Province	ISO 3166-2 two character code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

DEG2	PROVIDER IDENTIFIERS INFORMATION
Data Element Name	**Description**
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identifier Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digits number). This means that the numbers do not carry other information about the healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

DEG3	PROVIDER CONTACT INFORMATION
Data Element Name	**Description**
Provider Contact Name	Name of a contact in provider office for handling ERA issues
Telephone Number	Associated with contact person
Email Address	An electronic mail address at which the health plan might contact the provider
Fax Number	A number at which the provider can be sent facsimiles

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DEG7	ELECTRONIC REMITTANCE ADVICE INFORMATION
Data Element Name	**Description**
Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Select from below	Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFTpayment
Provider Tax Identification Number (TIN)	
National Provider Identifier (NPI)	
Method of Retrieval	The method in which the provider will receive the ERA from the health plan (e.g., download from health plan website, clearinghouse, etc.)

DEG8	ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION
Data Element Name	**Description**
Clearinghouse Name	Official name of the provider's clearinghouse
Clearinghouse Contact Name	Name of a contact in clearinghouse office for handling ERA issues
Telephone Number	Telephone number of contact
Email Address	An electronic mail address at which the health plan might contact the provider's clearinghouse

DEG10	SUBMISSION INFORMATION
Data Element Name	**Description**
Reason for Submission - Select from below	
New Enrollment	
Change Enrollment	
Cancel Enrollment	
Authorized Signature	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
Written Signature of Person Submitting Enrollment	A (usually cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity
Printed Name of Person Submitting Enrollment	The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment
Printed Title of Person Submitting Enrollment	The printed title of the person signing the form; may be used with electronic and paper-based manual enrollment