TEXAS MEDICAID AND CHIP PROGRAM

REGULATORY REQUIREMENTS APPENDIX

PROVIDER

THIS TEXAS MEDICAID AND CHIP PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing ("Subcontractor") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of Texas Access Reform Program ("STAR"), the Medicaid STAR+PLUS Program ("STAR+PLUS"), the STAR Kids Program ("STAR Kids") and related programs (each a "State Program" and collectively, the "State Programs"), as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

Business Day: Any day other than a Saturday, Sunday, or a State or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

Children's Health Insurance Program (CHIP): The health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 USC §§ 1397aa-1397jj) and administered by HHSC.

Clean Claim: A claim submitted by a Provider for medical care or health care services rendered to a Covered Person, with the data necessary for Subcontractor or Health Plan to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837(claim type) encounter guides as follows:

(a) 837 Professional Combined Implementation Guide;
(b) 837 Institutional Combined Implementation Guide;
(c) 837 Professional Companion Guide;
(d) 837 Institutional Companion Guide; and
(e) National Council for Prescription Drug Programs (NCPDP) Companion Guide.

Covered Person: An individual who is currently enrolled with Health Plan for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement and throughout this Appendix.

Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage, including all services required by the State Contract and State and federal law.

DSHS: The Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare Community Plan of Texas, LLC or UnitedHealthcare Insurance Company, as applicable.

HHS Agency(ies): The Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

Health and Human Services Commission or HHSC: The administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, charged with administering the State Programs, or its designee, including but not limited to, the HHS Agencies.

Medicaid: Texas' managed care programs for Medicaid recipients, which includes both the STAR program (Texas mandatory managed care program for Medicaid recipients) and the STAR+PLUS program (Texas Medicaid managed care program designed to provide health care, acute and long-term services and support) under the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 USC § 1396 *et seq*).

Primary Care Physician or Primary Care Provider (PCP): A Provider who has agreed to provide accessible, continuous, comprehensive and coordinated care to Covered Persons participating in a State Program and who is responsible for providing initial and primary care to Covered Persons, maintaining the continuity of patient care for Covered Persons, and initiating referrals for care.

State: The State of Texas or its designated regulatory agencies.

State Contract: Health Plan's contract(s) with HHSC for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the State Programs.

State Program(s): The STAR, STAR+PLUS, STAR Kids and related programs. For purposes of this Appendix, State Programs may refer to the State agency(ies) responsible for administering the applicable State Programs.

Texas Health Steps (THSteps): The name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 USC § 1396d(r), and defined and codified at 42 CFR §§ 440.40 and 441.56-62. HHSC's rules are contained in 25 Texas Administrative Code, Chapter 33 (relating to EPSDT).

SECTION 3
PROVIDER REQUIREMENTS

The State Programs, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

3.1 **Covered Service Definitions**. Provider shall follow the State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Acute Care: Preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

(b) Behavioral Health Services: Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

(c) Emergency Behavioral Health Condition: Any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine: (1) requires immediate intervention and/or medical attention without which Covered Persons would present an immediate danger to themselves or others; or (2) renders Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

(d) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to body functions; (3) serious dysfunction of any body organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

(e) Emergency Services: Covered inpatient and outpatient services furnished by a Provider that is qualified to furnish such services under the State Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including post-stabilization care services.

(f) Health Care Services: the Acute Care, Behavioral Health Care, and health-related services that an enrolled population might reasonably require in order to be maintained in good health.

(g) Medically Necessary means:

(1) For Medicaid Covered Persons birth through age 20, the following THSteps services: (i) screening, vision, and hearing services; and (ii) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or conditions (A) must comply with the requirements of the *Alberto N., et al. v. Suehs, et al.* partial settlement agreements; and (B) may include consideration of other relevant factors, such as the criteria described below.

(2) For Medicaid and CHIP Covered Person, non behavioral health related Health Care Services (that for Medicaid Covered Persons birth through age 20 are not available through THSteps) that are: (i) reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and /or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Covered Person, or endanger life; (ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Covered Person's health conditions; (iii) consistent with health care practice guidelines and standards that are endorsed by professional recognized health care organizations or governmental agencies; (iv) consistent with the Covered Person's diagnoses; (v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; (vi) are not experimental or investigative; and (vii) are not primarily for the convenience of the Covered Person or Provider.

(3) For Medicaid and CHIP Covered Persons, Behavioral Health Services (that for Medicaid Covered Persons birth through age 20 are not available through THSteps) that are: (i) reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder; (ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care; (iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided; (iv) are the most appropriate level or supply of service that can be safely provided; (v) could not be omitted without adversely affecting the Covered Person's mental and/or physical

health or the quality of care rendered; (vi) are not experimental or investigative; and (vii) are not primarily for the convenience of the Covered Person or Provider.

(h) Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within 24 hours but that does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

(i) Urgent Condition means a health condition, including an Urgent Behavioral Health Situation, that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within 24 hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

3.2 **Medicaid Eligibility**. If applicable, Provider must meet minimum requirements for participation in the State Programs. Provider may meet this requirement either by being enrolled with the State as a Medicaid provider or by demonstrating to Subcontractor that it meets the applicable minimum requirements for Medicaid participation. Health Plan and/or Subcontractor will exclude from its network any provider who has been suspended from the Medicare or Medicaid program in any state.

3.3 **Hold Harmless**. Provider is prohibited from billing or collecting any amount from a Covered Person for Covered 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. Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Agreement. In the event Health Plan or Subcontractor becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against Health Plan or Subcontractor will be through Health Plan's or Subcontractor's bankruptcy, conservatorship, or receivership estate. Provider further understands and agrees that Covered Persons may not be held liable for Health Plan's or Subcontractor's debts in the event of insolvency, nor shall HHSC assume liability for the actions of, or judgments rendered against Health Plan or Subcontractor, their employees, agents or subcontractors. And Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to Provider by Health Plan or Subcontractor or any judgment rendered against Health Plan or Subcontractor. HHSC's liability to Provider, if any will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code § 101.001 *et seq*.). This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.4 **Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the HHSC and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency. The HHSC may waive this requirement for itself, but

not for Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. All such waivers must be approved in writing by the HHSC.

Provider shall be responsible for any and all fines or penalties that may be assessed against Health Plan under Health Plan's contract with any state Medicaid agency or Centers for Medicare & Medicaid Services (CMS) that arise from Provider's failure to execute, deliver or perform its obligations under this Agreement. This paragraph will survive the termination of this Agreement.

3.5 **Hours of Operation; Appointment Access**. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

Provider shall provide timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract. Provider must provide Covered Services within the following timeframes:

(a) Emergency Services must be provided upon Covered Person presentation at the service delivery site, including at non-network and out-of-area facilities;
(b) Treatment for an Urgent Condition, including urgent specialty care, must be provided within 24 hours;
(c) Routine primary care must be provided within 14 days;
(d) Initial outpatient behavioral health visits must be provided within 14 days;
(e) Initial outpatient behavioral health visits must be provided within seven days upon discharge from an inpatient psychiatric setting;
(f) Community-Based Services for Non-MDCP STAR Kids Waiver Covered Persons must be initiated within 7 days from the date the MCO authorizes services unless the referring provider or Covered Person states otherwise;
(g) Prenatal care must be provided within 14 days of request, except for high-risk pregnancies or new Covered Persons in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
(h) PCPs must make referrals for specialty care on a timely basis, based on the urgency of the Covered Person's medical condition, but no later than 30 days; and
(i) Preventive health services for children, such as Texas Health Steps medical checkups, must be offered in accordance with the Texas Health Steps periodicity schedule. For a New Covered Person birth through age 20, overdue or upcoming Texas Health Steps medical checkups, must be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Covered Persons. The Texas Health Steps annual medical checkup for an Existing Covered Person 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 Covered Person" and "Existing Covered Person" are defined in HHSC Uniform Managed Care Manual, Chapter 12.4.

3.6 **Restrictions on Referrals**. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.7 **Records Retention**. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons.

(a) Such records shall be maintained for a period of not less than five (5) years from the close of the State Contract, or such other period as required by law. If records are under review or audit, they must be retained until the review or audit is complete.

(b) Provider agrees to provide to Health Plan and/or Subcontractor and HHSC all information required under the State Contract, including but not limited to the reporting requirements and other information related to Provider's performance of its obligations under the Agreement and any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or State laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

3.8 **Records Access.** Provider acknowledges and agrees that HHSC, the U.S. Department of Health and Human Services Commission Office of Inspector General ("OIG") and other authorized federal and state personnel shall have the right to evaluate through audit, inspection or other means, any records pertinent to the State Contract, including records pertaining to the quality, appropriateness and timeliness of services performed under the State Contract. Upon receipt of a record review request from the 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 business days of the request. 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 twenty-four (24) hours, Provider must provide the records requested at the time of the request or in less than twenty-four (24) hours. The request for record review includes clinical medical or dental records of Covered Persons; other records pertaining to the Covered Person; 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, 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; 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 Texas Administrative Code Chapter 371 Subchapter G.

3.9 **Confidentiality and Privacy**.

(a) Provider must treat all information that is obtained through the performance of its obligations under 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 enrollees of State Programs.

(b) Provider may not use information obtained through the performance of its obligations under the Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Agreement.

(c) Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224 and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

(d) Provider shall comply with all applicable laws, rules, and regulations regarding information security, including, (1) Health and Human Services Enterprise Information Security Standards and Guidelines; (2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code; (3) HIPAA; and (4) The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the HHSC and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Health Plan, Subcontractor, and the HHSC of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide Health Plan, Subcontractor, and the HHSC with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Health Plan,

Subcontractor, and the HHSC to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

Should Provider publish or disclose confidential information without authorization, Health Plan, Subcontractor, and HHSC will be entitle to injunctive relief or any other remedies to which it is entitled under law or equity, and will have the right to recover from Provider all damages and liabilities caused by or arising from Provider's, its subcontractors', consultants', or agents' failure to protect confidential information.

3.10 **Compliance with Law**. 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 the State Contract, the State Programs, and all persons or entities receiving State and federal funds. Provider understands and agrees that any violation by Provider of a State or federal law relating to the delivery of Covered Services pursuant to the Agreement, or any violation of the State Contract, could result in liability for money damages, and/or civil or criminal penalties and sanctions under State and/or federal law. Provider further agrees that the following laws, rules, and regulations, and all subsequent amendments and modifications, apply to the Agreement:

(a) Environmental protection laws:

(i) Pro-Children Act of 1994 (20 USC § 6081 *et seq*.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;

(ii) National Environmental Policy Act of 1969 (42 USC § 4321 *et seq*.) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;

(iii) 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");

(iv) State Clean Air Implementation Plan (42 USC § 740 *et seq*.) regarding conformity of federal actions to State Implementation Plans under § 176(c) of the Clean Air Act; and

(v) Safe Drinking Water Act of 1974 (21 USC § 349; 42 USC § 300f-300j-9) relating to the protection of underground sources of drinking water;

(b) State and federal anti-discrimination laws:

(i) 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;

(ii) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);

(iii) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);

(iv) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);

(v) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);

(vi) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq*.);

(vii) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and

(viii) the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

(c) The Immigration and Nationality Act (8 U.S.C. §1101 et seq.) and all subsequent immigration laws and amendments; and

(d) the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191); and

(e) The Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et.seq.

3.11 **Physician Incentive Plans**. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Subcontractor, Health Plan, nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.12 **Provider Selection**. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of Providers, credentialing and recredentialing requirements and nondiscrimination. If Health Plan and/or Subcontractor delegates credentialing to Provider, Health Plan and/or Subcontractor will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

3.13 **Lobbying**. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no

federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions

3.14 **Excluded Individuals and Entities**. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, agents, employees, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR §1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR §1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Health Plan and/or Subcontractor any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at

http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. Subcontractor may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.15 **Cultural Competency**. Provider shall participate in Subcontractor's, Health Plan's, and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Provider shall provide information to Covered Persons regarding treatment options and alternatives in a manner appropriate to the Covered Person's condition and ability to understand.

3.16 **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 Uniform Managed Care Manual. Provider is prohibited from engaging in direct marketing to Covered Persons that is designed to increase enrollment in a particular health plan; however, Provider may engage in permissible marketing activities consistent with broad outreach objectives and application assistance.

3.17 **Fraud, Waste and Abuse Prevention**. Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste and abuse in the administration and delivery of services under the State Contract. Provider acknowledges and agrees to the following requirements:

(a) Investigations.

(i) HHSC Office of Inspector General (OIG) and/or the Texas Medicaid Fraud Control Unit (MFCU) must be allowed to conduct private interviews of Provider and its employees, agents, contractors and patients;

(ii) Requests for information from such entities must be complied with, in the form and language requested;

(iii) 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, pretrial conference, hearings, trials and in any other process, including investigations at Provider's own expense; and

(iv) Compliance with these requirements shall be at Provider's own expense.

(b) Compliance.

(i) Provider is subject to all State and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and State Programs, as applicable;

(ii) 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;

(iii) Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the OIG, HHSC, CMS, the U.S. Department of Health and Human Services, FBI, Texas Department of Insurance (TDI), the Texas Attorney General's Medicaid Fraud Control Unit or other unit of State or federal government, upon request, and free-of-charge;

(v) 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

(vi) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by Subcontractor and/or Health Plan or a Covered Person to the HHSC OIG.

(c) Policies and Procedures. If Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), Provider must:

(i) Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of Provider as described in Section 1902(a)(68)(A) of the Social Security Act and the Deficit Reduction Act of 2005 (DRA). 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;

(ii) Include as part of such written policies detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste and abuse; and

(iii) 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.

3.18 **Audit or Investigation**. Provider acknowledges and agrees that it will provide, at no cost, the State Programs, the U.S. Department of Health and Human Services, the Office of the

Inspector General and/or the Texas Medicaid Fraud Control Unit, an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC, State or federal law enforcement agency, special or general investigation committee of the Texas Legislature, the U.S. Comptroller General, MCO Program personnel from HHSC or its designee, the Office of the State Auditor of Texas, any other State or federal entity identified by HHSC or engaged by HHSC or their authorized representatives with prompt, reasonable, and adequate access to the Agreement, and any records, books documents and papers that are related to the Agreement and/or Providers performance of its responsibilities under the Agreement.

(a) Provider must provide such access to service locations, facilities or installations, records, and software and equipment, in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed necessary to fulfill such purposes.

(b) Requests for access may be for, but are not limited to, the following purposes: examination; audit; investigation; contract administration; the making of copies, excerpts, or transcripts; or any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

(c) Provider understands and agrees that the acceptance of funds under this contract acts as acceptance of the authority of the State Auditor's Office (SAO), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested at no cost.

3.19 **Termination**. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and Health Plan, as applicable, all information necessary for the reimbursement of any outstanding Medicaid claims.

3.20 **Subcontracts**. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must include all of the requirements of this Appendix, and applicable requirements of the State Contract. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Subcontractor or Health Plan, to meet any additional State Program requirements that may apply to the services.

3.21 **Disclosure**. Provider shall cooperate with Subcontractor and Health Plan in disclosing information HHSC may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 C.F.R. §§ 455.104, 455.105, and 455.106. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for information. Additionally, Provider shall cooperate with the submission of fingerprints upon a request from the HHSC or CMS in accordance with 42 CFR 455.434.

3.22 **Advance Directives**. Provider must comply with the requirements of State and federal laws, rules and regulations relating to advance directives.

3.23 **Claims**. Provider must submit Clean Claims for processing and/or adjudication as directed by Health Plan and/or Subcontractor. Acceptable billing and coding requirements shall be set forth in the Provider's Agreement and/or applicable provider manual, protocols, policies and procedures provided or made available to Provider. Health Plan and/or Subcontractor, as applicable, will provide Provider at least ninety (90) days notice prior to implementing a change in the claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

3.24 **Complaints and Appeals.**

(a) Provider shall cooperate with Subcontractor's and Health Plan's applicable complaint, grievance and appeals processes as set forth in the provider manual(s) to ensure timely resolution and compliance with the State Contract, Texas Insurance Code Chapter 843 Subchapter G, as amended from time to time (for the CHIP Program), and 42 CFR § 438.414, as amended from time to time (for the STAR and STAR+PLUS Programs). Provider's cooperation shall include, but is not limited to, allowing designee access to a Covered Person's medical records, Provider participation in peer reviews of a Covered Person's health care, and meeting grievance and appeal requirements of the benefit plan and the State Programs, as applicable.

(b) Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Covered Person complaints.

3.25 **Costs of Non-covered Services.** Provider must inform Covered Persons of the costs for non-covered services prior to rendering such services and must obtain a signed private pay form from such Covered Person.

3.26 **Insurance.** Provider shall maintain, throughout the term of the Agreement, professional and comprehensive general liability and medical malpractice insurance. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one hundred thousand dollars ($100,000) per occurrence and three hundred thousand dollars ($300,000) in the aggregate, any additional limits required by the hospital at which Provider has admitting privileges, or such greater amount as required under the Provider's Agreement.

This provision will not apply if Provider is 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. This provision also will not apply to nursing facilities.

3.27 **Provider Identification Number.** 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). Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.)

3.28 **Primary Care Physicians (PCPs).** If designated as a PCP, Provider must be accessible to Covered Persons 24 hours per day, 7 days per week. Further, PCPs must provide preventative care:

(a) to children under age 21 in accordance with AAP recommendations for CHIP Covered Services and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Covered Services; and

(b) to adults in accordance with the U.S. Preventative Task Force requirements.

PCPs must also assess the medical needs and behavioral health needs of Covered Persons for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Covered Persons' care with specialty care providers after referral and serve as a Medical Home to Customers.

3.29 **Professional Conduct.** While performing the services described in the Agreement, Provider agrees to:

(a) Comply with applicable State laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service location; and

(b) Otherwise conduct himself or herself in a businesslike and professional manner.

3.30 **Quality Assessment and Performance Improvement (QAPI).** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to comply with Subcontractor's and Health Plan's QAPI program requirements. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor or Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor, Health Plan, or Provider. Provider shall adhere to the quality assurance and utilization review standards of the applicable State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.31 **Gifts or Gratuities.** Provider may not offer or give anything of value to an officer or employee of HHSC or the State 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. A "thing of value" does not include contributions to public office holders or candidates for public officer that are paid and reported in accordance with State and/or federal law. Subcontractor may terminate the Agreement at any time for Provider's violation of this requirement.

3.32 **Third Party Recovery.** Provider understands and agrees that it may not interfere with or place any liens upon the State's right or Health Plan's right, acting as the State's agent, to recovery from third party resources.

3.33 **CHIP Co-payments and Deductibles**. Provider is responsible for collecting at the time of service any applicable CHIP co-payments or deductibles in accordance with CHIP cost-sharing limitations. Provider shall not charge:

(a) cost-sharing or deductibles to Covered Persons of Native American Tribes or Alaskan Natives;

(b) co-payments or deductibles to a Covered Person with an ID card that indicates the Covered Person has met his or her cost-sharing obligation for the balance of their term of coverage;

(c) co-payments for well-child or well-baby visits or immunizations (CHIP MCO and CHIP RSA).

(d) co-payments for routine preventive and diagnostic dental services (CHIP Dental).

Co-payments are the only amounts that Provider may collect from Covered Persons for CHIP Covered Services, except for costs associated with unauthorized non-emergency services provided to a Covered Person by out-of-network providers for non-covered services.

3.34 **Encounter Data**. Provider shall cooperate with Health Plan and Subcontractor to comply with Health Plan's and Subcontractor's obligation to prepare encounter data submissions, reports, and clinical information required under the State Contract including, without limitation, all child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract, and shall provide such data to Health Plan and Subcontractor in a format and timeframe required by Health Plan and Subcontractor pursuant to the requirements of the State Contract.

3.35 **Continuity of Treatment/Care**. Provider shall cooperate with Subcontractor and Health Plan to provide newly-enrolled Covered Persons with continuity of treatment, including coordination of care to the extent required under law or required to ensure that ongoing care is not disrupted or interrupted. Provider shall also coordinate with Subcontractor and Health Plan to ensure continuity of treatment in the event Provider's participation with Subcontractor terminates during the course of a Covered Person's treatment by Provider.

3.36 **Licensure**. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the HHSC that is terminated, suspended, denied, or not renewed as a result of any action of the HHSC, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to

provide the health care services and/or other related activities delegated to Provider by Subcontractor under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons. Claims for services performed during any period of noncompliance with these license requirements will be denied.

3.37 **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Health Plan and/or Subcontractor. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.38 **Transition of Covered Persons.** Provider shall cooperate with Health Plan and/or Subcontractor in the event an immediate transfer to another primary care physician or Medicaid managed care contractor is warranted if the Covered Person's health or safety is in jeopardy, as may be required under law.

3.39 **Updates to contact information**. Provider must inform Health Plan, Subcontractor, and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc.

3.40 **Cancellation of Product Orders.** As applicable, 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 must reduce, cancel, or stop delivery if Customer or Customer's authorized representative submits an oral or written request. Provider must maintain records documenting the request.

3.41 **Claim Submissions.** Provider shall comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.

3.42 **Electronic Visit Verification (EVV)**. If using the EVV system Provider shall maintain compliance with the following HHSC minimum standard requirements:

(a) The Provider must enter Member information, Provider information, and service delivery schedules (scheduled or non-scheduled) into the EVV system for validation either through an automated system or a manual system.

(b) The Provider must ensure that attendants providing services applicable to EVV are trained and comply with all processes required to verify service delivery through the use of EVV.

(c) Providers must notify MCOs of any ongoing issues with EVV contractors or unresolved issues with EVV systems.

(d) Providers must notify a Member's service coordinator if the Member refuses to allow home health attendants and nurses access to the Member's landline telephone to document when services begin and end.

(e) Providers must maintain service delivery visits verified in accordance with program requirements at least 90 percent per quarter.

(f) Providers must ensure all data elements required by HHSC are uploaded or entered into the EVV system completely, accurately, and before billing for services delivered.

(g) Providers must ensure that the Provider's attendant uses the EVV system in a manner prescribed by HHSC to call-in when service delivery begins and call-out when service delivery is completed each time services subject to EVV are delivered to a Member.

(h) Equipment provided by an EVV contractor to a Provider, if applicable, must be returned in good condition. If equipment is lost, stolen, marked, altered or damaged by the Provider, the Provider may be required to pay the replacement cost of the equipment.

3.43 **Lead Screening**. In accordance with Texas Health & Safety Code Chapter 88 and related rules at 25 Tex. Admin. Code Chapter 37, Subchapter Q, Provider must (1) report all blood lead results to the Childhood Lead Poisoning Program (if not performed at the DSHS state laboratory) and (2) follow-up on suspected or confirmed cases of childhood 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.

3.44 **Child Protection Litigation**. At the request of HHSC for DFPS, Providers must testify in court as needed for child protection litigation.

3.45 **E-Verify System.** During the term of this Agreement, Provider will utilize the U.S Department of Homeland Security's E-Verify system to determine the eligibility of all of persons employed by Provider to perform duties within Texas.

3.46 **Conflict of Interest.** Provider warrants that, to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to a conflict of interest affecting the services provided under this Agreement. For the purpose of this section "conflict of interest" is defined as personal or financial interest of Provider that either directly or indirectly: 1) impairs or diminishes Provider's ability to render impartial or objective assistance or advise to HHSC; and/or 2) provides Provider with an unfair competitive advantage in future HHSC procurements.

Provider will disclose to Subcontractor any conflict of interest in becomes aware of during the term of the Agreement.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 **Behavioral Health Services**.

(a) If Provider is a PCP, Provider must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems or disorders.

(b) If Provider provides inpatient psychiatric services to a Covered Person, Provider must schedule the Covered Person for outpatient follow-up 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 Covered Persons who have missed appointments within twenty-four (24) hours to reschedule appointments.

(c) All behavioral and physical health providers (including PCPs, OB/GYNs, internists, and other relevant provider types) must share amongst each other clinical information regarding Covered Persons with co-occurring behavioral and physical health conditions, to the extent allowed by federal law.

4.2 **Early Childhood Intervention (ECI)**. As applicable, Provider must cooperate and coordinate with local ECI programs to comply with federal and State requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Provider understands and agrees that any Medically Necessary Covered Services, including behavioral health services contained in an IFSP must be provided to the Covered Person in the amount, duration, scope and service setting established in the IFSP.

4.3 **Family Planning for Medicaid Covered Services.** If a Covered Person requests contraceptive services or family planning services under Medicaid Covered Services, Provider must also provide the Covered Person counseling and education about family planning and available family planning services. Provider shall not require parental consent for Covered Persons who are minors to receive family planning services. Provider must comply with State and federal laws and regulations governing Covered Person confidentiality (including minors) when providing information on family planning services to Covered Persons under Medicaid Covered Services.

4.4 **Network Acute Care Providers**. Acute Care Providers serving Medicaid Covered Persons must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in Medicaid, and must have a Texas Provider Identification Number (TPIN).

4.5 **THSteps Services**. As applicable, Provider must send all THSteps newborn screens to the DSHS Bureau of Laboratories or a DSHS-certified laboratory. Provider must include detailed identifying information for all screened newborn Covered Persons and each Covered

Person's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.

4.6 **Tuberculosis (TB)**. Provider must coordinate with the local TB control program to ensure that all Covered Persons with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). Provider must report to DSHS or the local TB control program any Covered Person who is non-compliant, drug resistant, or who is or may be posing a public health threat.

4.7 **Women, Infants and Children (WIC)**. Provider shall coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.

4.8 **Immunizations**. As applicable, Provider shall provide immunizations to Covered Persons in accordance with the education and training it receives from Subcontractor and/or Health Plan regarding: the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Covered Services; and the THSteps Periodicity Schedule for Medicaid Covered Services. Provider shall not refer children to Local Health Departments to receive immunizations. Provider shall also comply with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the vaccine information statement.

4.9 **Pharmacy.** 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 Health Plan's and Subcontractor's Administrative Guide 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.

4.10 **Durable Medical Equipment.** Please consult the Texas Medicaid Provider Procedures Manual, Durable Medical Equipment (DME) and Comprehensive Care Program (CCP) sections, and Administrative Guide Provider Manual 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. Health Plan and Subcontractor encourage your pharmacy's participation in providing these items to Medicaid clients.

4.11 **Service Coordination.** All Home and Community Support Services Agency (HCSSA) providers, adult day care providers and residential care facility providers must notify Health Plan and/or Subcontractor if a Customer experiences any of the following:

(a) a significant change in the Member's physical or mental condition or environment;
(b) hospitalization;
(c) an emergency room visit; or
(d) two or more missed appointments.

4.12 **Interventions in Mental Health Services**. Provider must comply with 25 Tex. Admin. Code, Part 1, Chapter 415, Subchapter F, "Interventions in Mental Health Services," when providing Mental Health Rehabilitative Services and Mental Health Targeted Case Management.

4.13 **First Dental Home Initiative.** If Provider is a First Dental Home Initiative provider, Provider certifies that he or she has completed the training and registration requirements for Texas Health Steps First Dental Home Initiative.

4.14 **Dental Providers.** This provision is applicable to Providers who are dentists.

(a) 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 Covered Persons for referral to specialty care providers and provide referrals as needed; and

(3) coordinate Covered Persons' care with specialty care providers after referral.

(b) Providers that are dentists must provide:

(1) Urgent care, including urgent specialty care, within 24 hours; and

(2) Therapeutic and diagnostic care within 14 days.

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 30 days.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 **Prompt Payment**. Subcontractor or Health Plan (as applicable) shall pay Provider on a timely basis as set forth in the Agreement, the State Contract and applicable State and federal law and regulations, including but not limited to 42 U.S.C. 1396u-2(f) and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. Subcontractor or Health Plan (as

applicable) shall adjudicate (finalize as paid or denied adjudicated) for: (1) healthcare services within thirty (30) days from the date it receives the Clean Claim from Provider; (2) pharmacy services no later than eighteen (18) days of receipt if submitted electronically or twenty-one (21) days if submitted non-electronically.

Subcontractor or Health Plan (as applicable) shall pay Provider interest at a rate 18% per annum on all Clean Claims that are not adjudicated within thirty (30) days. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan (as applicable) otherwise requests assistance from Provider, Subcontractor or Health Plan (as applicable) will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 **Claims Processing/Adjudication**. Health Plan and/or Subcontractor shall notify Provider in writing of any changes related to the entities to which Provider must submit claims for processing and/or adjudication at least thirty (30) days prior to the effective date of such change. If Health Plan and/or Subcontractor is unable to provide a 30-day notice, Health Plan and/or Subcontractor shall give Provider a thirty (30) day extension on its claims filing deadline to ensure claims are routed to the correct processing center.

5.3 **Non-Discrimination Against Providers**. Neither Subcontractor nor Health Plan shall discriminate with respect to participation, reimbursement, or indemnification of a Provider who is acting within the scope of the Provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision shall not be construed as prohibiting Health Plan and/or Subcontractor from limiting a Provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Health Plan and/or Subcontractor that are designed to maintain quality of care practice standards and control costs.

5.4 **Provider/Covered Person Communications.** Neither Health Plan nor Subcontractor shall prohibit or otherwise restrict Provider, when acting within the lawful scope of Provider's licensure and practice, from advising or advocating on behalf of a Covered Person who is Provider's patient about the Covered Person's medical conditions, treatment options, Subcontractor's or Health Plan's referral policies, and other Subcontractor or Health Plan policies, including financial incentives or arrangements and all managed care plans with whom Provider contracts. Provider must inform Subcontractor and/or Health Plan of any reports of abuse, neglect, or exploitation made regarding a Covered Person. This includes Provider self-reports and reports made by others that Provider becomes aware of.

5.5 **High-Risk Covered Persons**. Neither Health Plan nor Subcontractor shall discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.

5.6 **Termination, Revocation and Sanctions**. In addition to its termination rights under the Agreement, Subcontractor and/or Health Plan shall have the right to revoke any functions or activities delegated to Provider under the Agreement or impose other sanctions consistent with

the State Contract if in Subcontractor's or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Additionally, any program violations arising out of performance of the Agreement are subject to administrative enforcement by the Health and Human Services Commission Office of Inspector General (OIG) as specified in 1 Texas Administrative Code, Chapter 371, Subchapter G. Subcontractor and/or Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

5.7 **Enforcement**. Subcontractor and/or Health Plan will initiate and maintain any action necessary to stop Provider or its employee, agent, assign, trustee or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Covered Person to collect payment from HHSC, an HHS Agency, or any Covered Person, excluding payment for non-covered services. This provision does not restrict a CHIP provider from collecting allowable copayment and deductible amounts from CHIP Covered Persons. Additionally, this provision does not restrict a CHIP dental provider from collecting payment for services that exceed a Covered Person's CHIP benefit cap.

5.8 **Emergency Services**. Health Plan shall provide coverage for an Emergency Medical Condition and any necessary Emergency Services without regard to prior authorization.

5.9 **No Incentives to Limit Medically Necessary Services.** Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

SECTION 6
OTHER REQUIREMENTS

6.1 **Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan have provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 **Covered Person Claims Issues.** Provider, Subcontractor, and Health Plan are prohibited from including in any contract or other arrangement with Covered Persons any language which limits the Covered Person's ability to contest claims payment issues, or that binds the Covered Person to the Provider's, Subcontractor's, or Health Plan's interpretation of such contract terms.

6.3 **Monitoring.** As required under the State Contract, Subcontractor and/or Health Plan shall perform ongoing monitoring of Provider and shall perform periodic formal reviews of Provider consistent with the requirements of State and federal law and the State Contract. As a result of such monitoring activities, Subcontractor or Health Plan shall identify to Provider any

deficiencies or areas for improvement mandated under the State Contract and Provider shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor or Health Plan and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan, and Provider practice and/or the performance standards established under the State Contract.

6.4 **Health Care Acquired/Preventable Conditions.** Subcontractor, Health Plan, and Provider acknowledge and agree that Subcontractor and Health Plan are prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by the HHSC.

6.5 **Termination**. In addition to the termination provisions set forth in the Agreement, Subcontractor and Provider acknowledge and agree to the following:

(a) For CHIP providers, termination of the Agreement shall comply with the Texas Insurance Code and Texas Department of Insurance regulations.

(b) Subcontractor and Health Plan must follow the procedures outlined in the applicable state and federal law regarding termination of a provider contract, including requirements of § 843.306 of the Texas Insurance Code and 28 Tex. Admin. Code §11.901.

6.6 **No Exclusivity**. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Health Plan or Subcontractor, or as prohibiting or penalizing Health Plan or Subcontractor for contracting with other providers.

6.7 **Claims Payment Information.** If the Agreement references a fee schedule that is not attached to the contract, Health Plan and/or Subcontractor shall, at no charge to Provider:

(a) clearly identify source of such information, if such fee schedule is outside of Subcontractor's or Health Plan's control, such as the Texas Medicaid fee schedule. Provider shall have access to fee schedule either electronically at www.unitedhealthcareonline.com or telephonically, as further discussed in Subcontractor's and/or Health Plan's Administrative Guide Provider Manual;

(b) ensure Provider has access to fee schedule, electronically, telephonically or, upon request, as a hard copy, if such fee schedule is within Subcontractor's or Health Plan's control. Provider shall have access to fee schedule electronically at www.unitedhealthcareonline.com or telephonically, as further discussed in Subcontractor's and/or Health Plan's Administrative Guide Provider Manual. Subcontractor shall, upon request from Provider, provide a hard copy of such fee schedule and all information necessary to determine the amount of compensation, no later

than 10 business days from receipt of request. For purposes of this requirement, the term "all information necessary" to determine compensation has the meaning assigned in 28 Tex. Admin. Code § 11.901(a)(11).

6.8 **Non-Agency**. Neither Subcontractor, Health Plan, Provider nor Provider's employees or subcontractors may act as agents or representatives of HHSC or the State of Texas.

6.9 **Off-Shoring.** Subcontractor and Provider acknowledge and agree that all work performed under this Agreement must be performed exclusively within the United States, as that term is defined in the State Contract. Further, the performance of any work or the maintenance of any information relating or obtained under this Agreement is forbidden to occur outside of the United States except as specifically authorized or approved by HHSC.