# CITY OF EL PASO, TEXAS
# AGENDA ITEM
# DEPARTMENT HEAD'S SUMMARY FORM

**DEPARTMENT: Public Health**

**AGENDA DATE: CCA 5/31/16**

**CONTACT PERSON NAME AND PHONE NUMBER: Robert Resendes, Director 915-212-6500**

**DISTRICT(S) AFFECTED: All**

**STRATEGIC GOAL: Goal 8: Nurture and Promote a Healthy, Sustainable Community**

**SUBJECT:**
That the City Manager be authorized to execute the Participating Provider Agreement by and between Superior HealthPlan, Inc. and the City of El Paso, which allows for the City of El Paso to recuperate fees for public health services through Superior HealthPlan, Inc., a Medicaid managed care organization.

**BACKGROUND / DISCUSSION:**
The Department of Public Health provides immunization services to thousands of residents in 4 clinics across the City of El Paso. This contract will allow the City to bill Superior for immunization services rendered while making immunization encounters with patients easier – particularly in clinics where WIC services are collocated allowing for single-stop services for families.

**PRIOR COUNCIL ACTION:**
n/a

**AMOUNT AND SOURCE OF FUNDING:**
n/a

**BOARD/COMMISSION ACTION:**
n/a

*********************REQUIRED AUTHORIZATION*********************

**DEPARTMENT HEAD:** _____

*Information copy to appropriate Deputy City Manager*

**RESOLUTION**

**BE IT RESOLVED BY THE CITY COUNCIL FOR THE CITY OF EL PASO:**

That the City Manager be authorized to execute the Participating Provider Agreement by and between Superior HealthPlan, Inc. and the City of El Paso, which allows for the City of El Paso to recuperate fees for public health services through Superior HealthPlan, Inc., a Medicaid managed care organization.

**PASSED AND APPROVED THIS __ DAY OF _____ 2016.**

**CITY OF EL PASO, TEXAS**

_____
Oscar Leeser
Mayor

**ATTEST:**

_____
Richarda Duffy Momsen
City Clerk

**APPROVED AS TO FORM:**

_____
Josette Flores
Assistant City Attorney

**APPROVED AS TO CONTENT:**

_____
Robert Resendes, MBA, MT (ASCP)
Director, Department of Public Health

# PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between City of El Paso Texas ("Provider") and Superior HealthPlan, Inc. ("MCO").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a MCO (as hereafter defined), and Provider desires to participate in such products as a "participating provider," all as hereinafter set forth.

WHEREAS, MCO desires for Provider to provide such health care services to individuals in such products, and MCO desires to have Provider participate in certain of such products as a "participating provider," all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the parties hereby agree to the provisions set forth below.

## ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are hereby incorporated herein by reference and may be amended from time to time as provided herein.

1.2. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.3. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.4. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that (i) is employed by or has a contractual relationship with Provider, (ii) satisfies MCO credentialing criteria and has been approved for participation by a MCO to provide Covered Services (iii) has indicated Contracted Provider's agreement to comply with all provisions of this Agreement that are applicable to Contracted Provider by executing a Participating Provider Attestation attached hereto as Attachment C. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider and for which Provider has been approved for participation by MCO.

1.5. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by a Payor, under which a Company furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of the MCO's provider networks or vendor arrangements, except those excluded by MCO.

1.6. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.7. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

1.8. "Managed Care Organization" or "MCO" means (collectively or individually, as appropriate in the context) MCO and its affiliates, except those specifically excluded by MCO.

1.9. "Negative Balance" means an account balance in which Provider or Contracted Provider debits exceed credits as a result of MCO or Payor overpayments or payments made in error.

1.10. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with MCO to provide Covered Services to Covered Persons, and that is designated by the MCO as a "participating provider" in such Product.

1.11. "Payor" means the entity (including a MCO) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not a MCO, such entity contracts, directly or indirectly, with a MCO for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.12. "Payor Contract" means the contract with a Payor, pursuant to which a MCO furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of the MCO's provider networks or vendor arrangements, except those excluded by MCO. The term "Payor Contract" includes a MCO's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which the MCO or Payor arranges for the provision of Covered Services to eligible individuals.

1.13. "Product" means any program or health benefit arrangement designated as a "product" by a MCO (e.g., PPO Product, HMO Product, Medicaid Product, Medicare Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through MCO (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by MCO) that provides Covered Persons in such product with incentives or access to Participating Providers in such product.

1.14. "Product Attachment" means an Attachment setting forth certain requirements, terms and conditions specific to one or more Products, including certain provisions that must be included in a provider agreement under the laws of the State, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.15. "Provider Manual" means the manuals, requirements, policies and procedures adopted by MCO to be followed by Participating Providers, including, without limitation, those relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as the same may be amended from time to time by the MCO.

1.16. "Regulatory Requirements" means all applicable statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.17. "State" is defined as the state identified in the applicable Attachment.

## ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Attachment A that are applicable to Provider, the Contracted Provider,

or their services, and the other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a "Participating Provider" in each Product identified in a Product Attachment designated on the signature page of this Agreement.

2.2.1. If MCO desires to add one or more Contracted Providers to an additional Product, the MCO will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving the MCO written notice of its decision to opt-out within thirty (30) days of the MCO's giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not constitute "Participating Providers" in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that MCO or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No MCO or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Attachment C and/or D is the initial list of the Contracted Providers participating under this Agreement as of the Effective Date. Provider shall provide MCO on an annual basis or more often upon request with a list containing the names, office telephone numbers, tax identification numbers, hospital affiliations, specialties and board status (if applicable), addresses, State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the parties, and shall provide the MCO with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the parties.

2.2.4. Provider shall, at all times during the term of this Agreement, require all of its providers to participate (or be eligible and willing to participate) under this Agreement as "Contracted Providers." Subject to MCO's approval, Provider may add new providers to this Agreement as "Contracted Providers." In such case, Provider shall use best efforts to notify the MCO, in writing, of the prospective addition at least sixty (60) days in advance. Each such new provider may become a "Contracted Provider" once he, she or it meets the requirements contained elsewhere in this Agreement. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements. Each Contracted Provider shall direct or refer Covered Persons to Participating Providers, unless otherwise authorized by MCO or Payor.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of MCO and Payor, which generally will be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; policies and procedures requiring notification for certain Covered Services; medical management programs including those components relating to quality improvement, utilization management, disease management, and case management, and on-site reviews; grievance and appeal procedures; coordination of benefits and third party liability policies; and carve-out and third party vendor programs. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. MCO shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, MCO shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, MCO will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by MCO through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider agrees as follows: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare-certified provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all employees of Provider or the Contracted Provider will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice, (c) Provider or Contracted Provider does not have a Negative Balance account with MCO or Payor under a previous contractual agreement, nor does Provider or Contracted Provider have a Negative Balance with MCO or Payor under this Agreement that is outstanding greater than one hundred eighty (180) days. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by the MCO that such Contracted Provider has successfully completed the MCO's credentialing process.

2.6. Eligibility Determinations. Provider or the Contracted Provider shall verify whether an individual seeking Covered Services is a Covered Person. MCO will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. The MCO does not guarantee that persons identified as "Covered Persons" are eligible for benefits. If MCO, Payor or its delegate determines that an individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement.

2.7. Treatment Decisions. No MCO or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of a MCO or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality or medical treatment decisions or alternatives.

2.8. Carve-Out Vendors. Provider acknowledges that MCO may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as the Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by MCO for those Covered Services identified by MCO from time to time for a particular Product.

2.9. Disparagement Prohibition. Provider, each Contracted Provider and the officers of MCO shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with MCO's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this provision should be construed as limiting the ability of either party or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting MCO's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by MCO in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.10. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, MCO or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements.

2.11. Notice of Certain Events. Provider shall give written notice to MCO of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or the Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or the Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any lawsuit or claim filed or asserted against Provider or the Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify MCO in writing within ten (10) days, and in any such instance described in subsection (iv) above, Provider must notify MCO in writing within thirty (30) days, from the date it first obtains knowledge of the same.

2.12. Use of Name. Provider and each Contracted Provider hereby authorize each MCO to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Companies for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of a MCO without the MCO's prior written consent.

2.13. Compliance with Regulatory Requirements and Payor Contracts. Provider, each Contracted Provider and MCO agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on MCO , the MCO may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse the MCO for such amounts.

## ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Submission. As provided in the Provider Manual, Contracted Providers shall submit to the MCO or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to the MCO or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider

Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounters in accordance with the Provider Manual.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services hereunder. The applicable Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or MCO against amounts owed by the Payor or MCO to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

## ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) the applicable MCO and Payors, during regular business hours and upon prior notice; (ii) government agencies, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to MCO or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of their facilities and records by any MCO, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, Provider and each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

## ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. The Parties acknowledge that Provider is Self-insured. If at any time during the term of this Agreement, Provider is no longer self-insured, Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider, and any other person providing services hereunder on Provider's behalf, against any claim(s) of personal injuries or death alleged or caused by Provider's performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. If and when Provider is no longer self-insured, and upon MCO's request, Provider will furnish MCO with evidence of such insurance. If Provider complies with this insurance provision through a self-funded insurance plan, Provider shall maintain reserves in connection with such self-funded plan as required by MCO and shall provide to MCO, upon MCO's request, an opinion letter from an independent actuarial firm attesting to the financial adequacy of such reserves. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and have an annual aggregate of no less than three million dollars ($3,000,000) unless a lesser amount is accepted by MCO or where State law mandates otherwise. Provider will provide MCO with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of coverage.

5.2. Indemnification by Provider and Contracted Provider. To the extent permitted by applicable Texas law, Provider and each Contracted Provider shall indemnify and hold harmless (and at MCO's request defend) each Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by MCO. MCO agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by MCO or its directors, officers, agents or employees.

## ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Except as provided below or superseded by applicable Regulatory Requirements, any dispute between the parties (or involving a Contracted Provider) with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to each of the parties' satisfaction, or if there are no applicable procedures in the Provider Manual, then the parties agree that they shall engage in a period of good faith negotiations between designated representatives of the parties who have authority to settle the Dispute, which negotiations may be initiated by either party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate mediation pursuant to Section 6.2 below by providing written notice to the other party.

6.2 Mediation. In the event the informal dispute resolution process set forth in Section 6.1 is exhausted without resolution, either party wishing to pursue the dispute shall submit it to a mediation proceeding, which shall be attended by both parties and which, unless both parties agree otherwise, shall be conducted by a mutually selected independent mediator The American Health Lawyers Association who is familiar with managed health care The costs of the mediation shall be shared equally by all parties to such mediation. Each party shall bear its own costs for participating in the mediation proceeding. If as a result of the mediation, a voluntary settlement is reached and the parties agree that such settlement shall be reduced to writing, the mediator shall be deemed appointed and constitute an arbitrator for the sole purpose of signing the mediation agreement. Such agreement

shall be and have the same force and effect as an arbitration award and judgment may be entered upon it in accordance with applicable law in any court having jurisdiction thereof. Except as required by law or to evidence compliance with the terms, any such settlement agreement shall remain confidential and shall not be disclosed to any third party. In the event no settlement is reached, the parties may pursue available remedies under applicable law. The parties agree (1) to hereby waive any statutory, constitutional or common law right to a jury trial and (2) that neither party is entitled to an award of special, indirect, punitive or exemplary damages. In no event may any litigation be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of this Agreement.

## ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the effective date designated by MCO on the signature page of this Agreement ("Effective Date"), and will remain in effect for an initial term of one (1) year(s), after which it will automatically renew for terms of one (1) year each, unless this Agreement is sooner terminated as provided in this Agreement or either party gives the other party written notice of non-renewal of this Agreement not less than ninety (90) days prior to the renewal date of this Agreement. In addition, either party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product, effective as of the renewal date of this Agreement, by giving the others written notice of such non-renewal not less than ninety (90) days prior to the renewal date of this Agreement; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either party giving the other party at least ninety (90) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either party giving at least sixty (60) days prior written notice of termination to the other party if such other party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other party (or the Contracted Provider) fails to cure the breach within the thirty (30) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, MCO has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected, or (iii) Provider or Contracted Provider have a Negative Balance with MCO or Payor under this Agreement greater than one thousand dollars ($1,000) that has been outstanding greater than one hundred eighty (180) days. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by MCO, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a party giving written notice thereof to the other party if the other party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by MCO giving written notice thereof to Provider if the Contracted Provider fails to adhere to MCO's credentialing criteria, including, but not limited to, if the Contracted Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by MCO, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

## ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship among the parties is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated or transferred by Provider without MCO's prior written consent. MCO shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of MCO, or purchaser of the assets or stock of MCO, or the line of business or business unit primarily responsible for carrying out MCO's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of the parties hereto will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the parties signing it for their benefit and the benefit of each Company. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than MCO, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the parties.

8.7.1. MCO may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by MCO to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. MCO may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies MCO in writing of its objection to such amendment to the base agreement or any of its attachments during the thirty (30) day period following the giving of such notice by MCO, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment, MCO may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product or Products (or any component program of, or Coverage Agreement in connection with, such Product or Products).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between the MCO and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

| To MCO at: | To Provider at: |
|---|---|
| Attn: President | Attn: Director |
| Superior HealthPlan, Inc. | City of El Paso Texas |
| 2100 South IH-35, Suite 202 | 5115 El Paso Drive |
| Austin, TX 78704 | El Paso,TX 79905 |

or to such other address as such party may designate in writing.

8.12. Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party's employees, or any other similar cause beyond the reasonable control of such party.

8.13. Proprietary Information. Subject to the provisions of the Texas Public Information Act, neither party shall disclose to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other party during the course of this Agreement, except to agents of such party as necessary for

such party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to a Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without MCO's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with MCO.

* * * * *

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date set forth beneath their respective signatures.

| **Superior HealthPlan, Inc.** | **City of El Paso Texas**<br>(Legibly Print Name of Provider) |
|---|---|
| Signature: | Signature: |
| Print Name: Michael Diel | Print Name: |
| Title: Senior Vice President, Network Development and Contracting | Title: |
| Date: | Date: |
| ECM #: 186591 | Tax Identification Number: 74-6000749 |

| **To be completed by MCO only:** |
|---|
| Effective Date of Agreement: |

| Included in Agreement | Attachment/Exhibit |
|---|---|
| X | Attachment A – Contracted Provider – Specific Provisions |
| X | Attachment B – State Mandated Provisions |
| X | Attachment C – Participating Provider Attestation |
| X | Attachment D – Participating Facility/Provider Listing |
| X | Attachment E – STAR, STAR+PLUS, STAR Kids, CHIP, CHIP Perinate Product Attachment |
| X | Attachment F – Medicaid Comprehensive Healthcare Program for Foster Care Product Attachment |
| X | Attachment G – Compensation Schedule - STAR, STAR+PLUS, STAR Kids, CHIP, CHIP Perinate, STAR Health |
| X | Attachment H – Medicare Advantage Product Attachment |
| X | Exhibit 1 of Attachment H – Compensation Schedule – Medicare Advantage |
| X | Attachment I – Commercial Exchange Product Attachment |
| X | Exhibit 1 of Attachment I – Commercial Exchange Regulatory Requirements |
| X | Exhibit 2 of Attachment I – Compensation Schedule – Commercial Exchange |

| **To be complete by MCO only:** | |
|---|---|
| **Provider Product Participation** | **Effective Date of Agreement** |
| CHIP and CHIP Perinate | |
| STAR | |
| STAR+PLUS | |
| STAR Kids | |
| Foster Care (STAR Health) | |
| Medicare Advantage | |
| Commercial Exchange | |

APPROVED AS TO FORM:

Josette Flores
Assistant City Attorney

APPROVED AS TO CONTENT:

Robert Resendes, MBA, MT(ASCP)
Department of Public Health, Director

**ATTACHMENT A**
**CONTRACTED PROVIDER-SPECIFIC PROVISIONS**

Provider and Contracted Providers shall comply with the applicable provisions of this Exhibit.

1. Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 Cancellation of Product Orders. A Hospital that offers delivery services for Covered Services and 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 the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Hospital must maintain records documenting the request.

2. Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall abide by MCO's formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 Cancellation of Product Orders. A Provider and each Contracted Provider that offers delivery services for Covered Services and 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 the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Provider and Contracted Provider must maintain records documenting the request.

3. Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 Cancellation of Product Orders. A Provider and each Contracted Provider that offers delivery services for Covered Services and 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 the Covered Person or the Covered Person's authorized representative submits an oral or written request. The Provider and Contracted Provider must maintain records documenting the request.

4. FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provision applies.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and MCO has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to MCO at any time upon request. FQHC shall promptly notify MCO if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

**ATTACHMENT B**
**STATE-MANDATED PROVISIONS**

MCO and Provider shall comply with the following provisions, which are required by State law to be included in this Agreement, as such provisions may be amended from time to time by the State.

1. As used in this Agreement, the term "State" refers to the State of Texas.

2. No Retaliation. MCO shall not terminate, refuse to renew this Agreement or take any retaliatory action against Provider as a result of any complaints filed by Provider on behalf of a Covered Person or policyholder, against MCO or due to an appeal of a decision made by MCO.

3. No Indemnification. MCO shall not interpret any provision of this Agreement to require Provider to indemnify MCO for any tort liability resulting from the acts or omissions of MCO.

4. Posting of Complaint Notice. Provider shall post in its office a notice to Covered Persons regarding the process for resolving complaints with MCO. Such notices must include the Texas Department of Insurance's toll-free number for filing complaints.

5. Compliance with Prompt Payment Regulations. Payor will make payments for Covered Service(s) provided by Provider to Medicaid Covered Persons within thirty (30) days of its receipt of Clean Claims submitted in accordance with the requirements of this Agreement, subject to coordination of benefits rules and eligibility verification. Payor shall comply with the applicable requirements of TEX. INS. CODE chapter 843 and 28 TEX. ADMIN. CODE §§ 21.2801 *et.seq.* relating to the prompt payment of Clean Claims.

6. Special Rules Relating to Capitation Reimbursement. In the event that any of the Product Attachments provide for Capitation Reimbursement based on a Covered Person's PCP selection, Payor will begin making payments calculated from that date of the Covered Person's enrollment which shall be no later than sixty (60) days following the date the Covered Person selected or has been assigned to a PCP. If no such selection or assignment has been made within such sixty (60) day period, the applicable Capitation Reimbursement shall be held by Payor in reserve until such time as there is a selection and retroactive payments can be made. MCO shall notify the PCP of his or her selection by a Covered Person within thirty (30) business days of the selection or assignment.

   Payor will make Capitation Reimbursement payments to PCP on or before the fifteen ($15^{th}$) working day of the month in which services are provided.

7. Covered Person Hold Harmless. Provider shall look only to the applicable Payor and agree to hold Covered Persons harmless for compensation for all Covered Services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Payor, Payor insolvency, or breach of this Agreement or an Attachment, shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against, Medicare, Medicaid, Covered Persons or persons (other than Payor) acting on the Covered Persons' behalf (including but not limited to the applicable participating employer group or Payor) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments on Payor's behalf made in accordance with the terms of the applicable MCO Coverage Plan, nor does this provision affect the right of Provider to collect fees for services provided to Covered Persons which do not constitute Covered Services (unless Payor denied payment on the basis of lack of Medical Necessity or Provider's failure to comply with the terms and conditions of this Agreement or any Attachment) or for which Covered Person has specifically otherwise assumed financial responsibility, in writing, prior to the time that services were rendered. Provider further agrees that this section shall: (i) survive the termination of this Agreement or any Attachment, regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider and a Covered Person, persons acting on the Covered Persons' behalf (other than MCO), and the participating employer, Payor, or group

contract holder; and (iii) be construed to be for the benefit of Covered Persons, persons acting on the Covered Person's behalf (other than MCO), and the participating employer, Payor, or group contract holder. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such changes.

8. Pre-termination Review. Prior to the termination of this Agreement by MCO, MCO shall provide a written explanation to Provider of the reasons for termination. Prior to the effective date of the termination and to the extent required by the laws and regulations applicable to health maintenance organizations, Provider may request a review of MCO's proposed termination, to be held within a period not to exceed sixty (60) days of Provider's request. At Provider's request, the review shall be conducted on an expedited basis. Such review shall be conducted by the physicians, including at least one primary care physician, if available, appointed to serve on MCO's Quality Improvement Committee. MCO shall consider, but shall not be bound by, the decision reached by the advisory review panel. Upon Provider's request, MCO shall provide Provider with a copy of this decision and of MCO's determination with respect to termination of this Agreement. This review shall not be required for termination under circumstances involving "Imminent Harm" as follows: (i) imminent harm to a Covered Person's health; (ii) fraud or misfeasance; or (iii) action by a state medical or other physician licensing board or other government agency that effectively impairs the ability of a Provider to practice medicine. MCO shall not notify Covered Persons of the termination until the earlier of the effective date of termination or the date that the advisory review panel makes its recommendations except in situations involving Imminent Harm.

9. Continuity of Treatment. Unless this Agreement terminates for reasons of medical competence or professional behavior, termination shall not release Payor of its obligation to compensate Provider for the continued care and treatment of any Covered Person who is under Special Circumstances (as defined below). As used in this section, "Special Circumstances" shall mean a Covered Person who has a disability, an acute condition, a life-threatening illness, who is past the twenty-fourth (24th) week of pregnancy, or who has a condition that Provider reasonably believes could cause harm to the Covered Person if such care or treatment is discontinued. To be reimbursed for providing continued care and treatment under this section, Provider must identify the Covered Person's Special Circumstances to MCO, request that the Covered Person be permitted to continue treatment under Provider's care and agree not to seek payment from the Covered Person of any amounts for which the Covered Person would not be responsible if this Agreement were not terminated. Compensation to Provider shall be in accordance with the fee schedule in effect as of the termination date. Treatment of Special Circumstances as described herein shall be governed by the dictates of medical prudence and Medical Necessity. The requirements of this section shall not extend beyond ninety (90) days from the effective date of termination, or beyond nine (9) months in the case of a Covered Person who at the time of the termination has been diagnosed with a terminal illness; provided, however, the obligation of the Payor for reimbursement to a Covered Person shall, for a pregnant Covered Person who at the time of termination is past the twenty-fourth (24th) week of pregnancy, extend through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. In addition to the foregoing, termination shall not release Provider or MCO/Payor from liability to others with respect to services rendered to Covered Persons, monies paid, or other actions through the date of termination, nor shall it relieve Provider of his or her obligation not to bill Covered Persons for Covered Services. This section shall survive termination of this Agreement for any reason.

10. Disclosure of Claims Processing Information. Upon Provider's request, MCO shall provide information to assist Provider in determining that he or she is being compensated in accordance with this Agreement. The information shall provide a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made to Provider for Covered Services rendered pursuant to this Agreement. The information shall include a summary and explanation of the payment and reimbursement methodologies that MCO will use to pay Clean Claims submitted by Provider, including but not limited to fee schedules, coding methodologies, bundling processes, downcoding policies, descriptions of any other applicable policy or procedure used by MCO that may affect payment to Provider, and any addenda, schedules, exhibits or policies used by MCO in carrying

out the payment of Clean Claims submitted by Provider. If source information outside the control of MCO, such as State Medicaid or federal Medicare fee schedules, is the basis for fee computation under this Agreement, MCO shall identify such source and explain the procedures by which Provider may readily access the source electronically, telephonically, or as otherwise agree to be the parties. In complying with this section, MCO shall not be required to provide specific information that would violate any applicable copyright law or licensing agreement. In such circumstances, MCO shall provide a summary of the information withheld, which will allow a reasonable and sufficiently trained and experienced person to determine the payments to be made under this Agreement. MCO may provide the information by any reasonable method, including by email, computer disks, paper copies, or access to an electronic database, and shall provide the information within thirty (30) days after MCO receives the Provider's request. MCO shall provide Provider with ninety (90) days prior written notice of any amendments, revisions, or substitutions of the information required to be provided by MCO under this section.

Subject to the provisions of the Texas Public Information Act, Provider is prohibited by law and by this Agreement from using or disclosing the information provided to MCO pursuant to this section for any purpose other than Provider's practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance. Provider may not use the information provided by MCO to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a Covered Person or to misrepresent any aspect of the services. Provider may not rely upon information provided by MCO pursuant to this section about a service as a representation that a Covered Person is covered for that service under the terms of the Covered Person's MCO Coverage Plan.

Upon receiving information under this section, Provider may terminate this Agreement on or before the 30th day after the date Provider received the information without penalty or discrimination in participation in other health care products or plans. Reasonable advance notice must be given to Covered Persons being treated by Provider prior to the termination.

11. Records relating to Other Insurance. Provider shall retain in Provider's records updated information concerning a Covered Person's other health benefit plan coverage.

**ATTACHMENT C**
**PARTICIPATING PROVIDER ATTESTATION**

WHEREAS, Superior HealthPlan, Inc. ("MCO"), has executed an agreement with City of El Paso Texas ("Provider") dated _____ pursuant to which Contracted Provider has agreed to provide Covered Services to Covered Persons through the Participating Provider Agreement (the "Agreement"); and

WHEREAS, Provider has requested that the undersigned Contracted Provider serve as a provider under the Agreement and Contracted Provider so desires to participate; and

WHEREAS, as a condition of such participation and Provider's designation as a "Contracted Provider" under this Agreement, Contracted Provider must satisfy MCO's credentialing criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Agreement that are applicable to Contracted Providers.

NOW THEREFORE, Contracted Provider hereby agrees as follows:

1. Contracted Provider agrees to provide Covered Services to Covered Persons in accordance with the requirements of the Agreement that are applicable to Contracted Providers so long as Contracted Provider qualifies as a Contracted Provider.

2. Contracted Provider understands and agrees that his/her initial and continued participation as a Contracted Provider under the Agreement is contingent upon meeting and complying with MCO's credentialing standards and otherwise complying with the terms and conditions of the Agreement.

3. Contracted Provider acknowledges that MCO expressly reserves the right to reject, suspend, and/or terminate his/her participation under the Agreement for breaching or otherwise failing to: (i) comply with the term of the Agreement or any Attachment thereto; (ii) meet MCO's credentialing requirements; or (iii) comply with the Provider Manual.

4. This Attestation shall be effective as of _____.

Contracted Provider

Signature: _____

Print Name: _____

Specialty: _____

Date: _____

NPI: _____

**ATTACHMENT D**
**PARTICIPATING FACILITY/PROVIDER LISTING**

**[TO BE INSERTED]**

**ATTACHMENT E**
**STAR, STAR+PLUS, STAR Kids, CHIP and CHIP Perinate PRODUCT ATTACHMENT**

This Attachment is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between parties set forth above with the effective date set forth above.

Provider has entered into the Agreement with MCO. This Attachment is intended to supplement the Agreement by setting forth the Medicaid-specific and CHIP-specific requirements with which Provider must comply in order to participate in the STAR, STAR+PLUS, STAR Kids, CHIP and/or CHIP Perinatal programs, as those terms are defined below.

## ARTICLE I
## DEFINITIONS

The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

1.1. ***"CHIP"*** means the Children's Health Insurance Program as authorized under Title XXI of the federal Social Security Act and Texas Senate Bill 445, codified as Chapter 62, Texas Health & Safety Code.

1.2. ***"CHIP Perinate"*** is an individual CHIP Perinatal Program beneficiary who is identified prior to birth and is enrolled to receive Covered Services from MCO pursuant to the terms of the CHIP Perinatal Contract.

1.3. ***"CHIP Perinatal Contract***" means the agreements then in effect between MCO and the State of Texas, as revised or replaced from time to time, pertaining to the provision of Covered Services by MCO to its Covered Persons who are beneficiaries of the State CHIP Perinatal Program and who enroll to receive care through MCO.

1.4. ***"CHIP Perinate Newborn"*** means a CHIP Perinate who has been born alive.

1.5. ***"CHIP Perinatal Program"*** means the State of Texas program in which HHSC contracts with health maintenance organizations to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn members.

1.6. ***"Clean Claim"*** means a claim submitted by a Participating Health Care Provider for medical care or health care services rendered to a Covered Person, with all documentation reasonably necessary for MCO to process the claim.

1.7. ***"Covered Person"*** is an individual STAR, STAR+PLUS, STAR Kids, CHIP, or CHIP Perinatal beneficiary who is eligible and has enrolled to receive Covered Services from MCO pursuant to the terms of the STAR, STAR+PLUS, STAR Kids, CHIP or CHIP Perinatal Contract. An ***"Assigned Covered Person"*** is a Covered Person who has chosen Provider to serve as his or her Primary Care Physician (or "***PCP***").

1.8. ***"Emergency Care"*** means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.9. ***"HHSC"*** means the Texas Health and Human Services Commission.

1.10. ***"Primary Care Provider" or "PCP"*** means a physician or provider who has agreed with the MCO to be responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

1.11. ***"STAR"*** (which stands for State of Texas Access Reform) is the program in Texas that provides managed care services for beneficiaries of the State Medicaid program.

1.12. ***"STAR Kids"*** is the managed care program in Texas for recipients under the age of 21 who receive SSI or SSI-related Medicaid.

1.13. ***"STAR+PLUS"*** is the Medicaid managed care program in Texas that provides and coordinates preventive, primary, acute and long term care to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through SSI/MAO.

1.14. ***"STAR, STAR+PLUS, STAR Kids and CHIP Contracts" or "State Contracts"*** means the agreements then in effect between MCO and the State, as revised or replaced from time to time, including, but not limited to, the STAR, STAR+PLUS, STAR Kids and CHIP Contracts awarded to MCO pursuant to the STAR, STAR+PLUS, STAR Kids and CHIP programs as implemented by the State. It also includes the CHIP Perinatal Contract(s).

1.15. ***"State Agency"*** means the State agency which administers the STAR, STAR+PLUS, STAR Kids and CHIP (including CHIP Perinatal) managed care programs, as implemented from time to time.

## ARTICLE II
## COMPLIANCE WITH STATE AGENCY REQUIREMENTS

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

2.2. Upon receipt of a record review request from the Health and Human Services Commission 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 state or federal agency, the records request within three (3) 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 and/or in less than 24 hours, Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to 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, 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 Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.3. Updates to Contact Information. Provider must inform both the MCO and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc.

2.4. Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

2.5. Provider agrees to provide 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 the Provider's performance of its responsibilities under the State Contracts:

a) MCO program Personnel from HHSC or its designee;
b) The U.S. Department of Health and Human Services or its designee;
c) The Office of Inspector General;
d) The Texas Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
e) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
f) A state or federal law enforcement agency;
g) A special or general investigating committee of the Texas Legislature or its designee;
h) The U.S. Comptroller General or its designee;
i) The Office of the State Auditor of Texas or its designee; and
j) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

2.6. Provider must provide access wherever it maintains such records, books, documents, and papers and 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: 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.

2.7. 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.

2.8. 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 and disorders.

2.9. If Provider provides inpatient psychiatric services to a Covered Person, Provider must schedule the Covered Person 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 Service Providers must contact Covered Persons who have missed appointments within 24 hours to reschedule such appointments.

2.10. In order to submit a Clean Claim, Provider must provide the information set forth under Clean Claims in the Participating Health Care Provider Manual.

2.11. MCO will provide the Provider at least ninety (90) days notice prior to implementing a change in the claims guidelines set forth in the Participating Health Care Provider Manual, unless the change is required by statute or regulation in a shorter timeframe.

2.12. The Participating Health Care Provider Manual includes information concerning which entity/entities Provider must submit claims to for processing and/or adjudication. MCO must notify Provider in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If MCO is unable to provide thirty (30) days notice, MCO must give Provider a thirty (30)-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

2.13. Provider acknowledges and agrees that program violations arising out of performance of the Agreement are subject to administrative enforcement by the Texas Health and Human Services Commission Office of Inspector General (OIG) as specified in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.14. The Participating Health Care Provider Manual includes information concerning the complaint and appeal process that applies to Participating Health Care Providers.

2.15. 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.

2.16. Provider must treat all information that is obtained through the performance of the services included in this Attachment 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.

2.17. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement.

2.18. Provider shall protect the confidentiality of Covered Person Protected Health Information (PHI), including patient records. Provider must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

2.19. Provider shall not transfer an identifiable Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act on his or her behalf; however, Provider understands and agrees that HHSC may ask it to transfer a Covered Person's record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Covered Person.

2.20. 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 health and behavioral health services contained in an IFSP must be provided to the Covered Person in the amount, duration, scope and setting established in the IFSP.

2.21. If a Covered Person requests contraceptive services or family planning services, Provider must also provide the Covered Person counseling and education about family planning and available family planning services.

2.22. Provider cannot require parental consent for Covered Persons who are minors to receive family planning services.

2.23. 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.

2.24. Provider understands and agrees to the following:

(a) HHSC Office of Inspector General ("**OIG**") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider, Provider's employees, agents, contractors, and patients;

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

(c) Provider and Provider's 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 the Provider's own expense; and

(d) Compliance with these requirements will be at Provider's own expense.

2.25. Provider understands and agrees to the following:

(a) Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable;
(b) 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;
(c) 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, 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;
(d) 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
(e) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or a Covered Person to the HHSC Office of Inspector General.

2.26. Provider understands and agrees that if Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), Provider must:

(a) Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of 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).
(b) Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.
(c) Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

2.27. 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; MCO's contract(s) with HHSC; the Medicaid and CHIP 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 this Agreement, or any violation of MCO's contract(s) with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

2.28. Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement:
(i) 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.

(ii) 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. Code § 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 this Agreement.

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

(iv) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") (Public Law 104-191); and,

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

2.29. In the event MCO becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against MCO will be through MCO's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that Covered Persons may not be held liable for MCO's debts in the event of the entity's insolvency.

2.30. Provider understands and agrees that the HHSC does not assume liability for the actions of, or judgments rendered against, MCO, 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 MCO or any judgment rendered against MCO. 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.).

2.31. Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/MCO Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).

2.32. Provider is prohibited from engaging in direct marketing to Covered Persons that is designed to increase enrollment in a particular health plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

2.33. MCO will initiate and maintain any action necessary to stop a Provider or a Provider's 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 Network Provider from collecting allowable copayment and deductible amounts from CHIP Covered Persons.

2.34. Provider must be licensed in the State of Texas to provide the Covered Services for which the MCO is contracting with Provider, and not be under sanction or exclusion from the Medicaid Program. If Provider is serving Medicaid Covered Persons, he/she must be enrolled as a Medicaid provider and have a Texas Provider Identification Number ("*TPIN*"). Effective May 23, 2007, Provider (those serving both Medicaid and CHIP Covered Persons) must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D).

2.35. MCO is prohibited from imposing restrictions upon Provider's free communication with a Covered Person about the Covered Person's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

2.36. Provider is prohibited from billing or collecting any amount from a Medicaid Covered Person for Covered Services provided pursuant to this Attachment. 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.

2.37. If Provider is a PCP, Provider's services must be accessible to Covered Persons 24 hours per day, 7 days per week, and Provider must have acceptable after-hours telephone availability.

2.38. While performing the services described in the Agreement, Provider agrees to comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and otherwise conduct themselves in a businesslike and professional manner.

2.39. Provider agrees to comply with the MCO's QAPI Program requirements.

2.40. MCO must follow the procedures outlined in Section 843.306 of the Texas Insurance Code if terminating the Agreement with Provider. At least ninety (90) days before the effective date of the proposed termination of this Agreement, MCO must provide a written explanation to Provider of the reasons for termination. MCO may immediately terminate this Agreement in a case involving (a) imminent harm to patient health; (b) 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 (c) fraud or malfeasance.

Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of the MCO'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, including at least one representative in Provider's specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of MCO. The decision of the advisory review panel must be considered by MCO but is not binding on MCO. 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 the MCO must communicate the MCO's decision to Provider. MCO must provide to Provider, on request, a copy of the recommendation of the advisory review panel and MCO's determination.

2.41. Provider may not offer or give any thing 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. MCO may terminate the Agreement at any time for violation of this requirement.

2.42. Provider understands and agrees that it may not interfere with or place any liens upon the state's right or MCO's right, acting as the state's agent, to recovery from third party resources.

2.43. Texas Health Steps providers must send all Texas Health Steps 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. Such providers 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.

2.44. 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 the 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.

2.45. Provider 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.

2.46. If Provider is a PCP, Provider must provide preventive care (1) to children under age 21 in accordance with AAP recommendations for CHIP Covered Persons and CHIP Perinatal Newborns; and the Texas Health Steps periodicity schedule found in the Texas Health Steps Manual for Medicaid Covered Persons, and (2) to adults in accordance with the U.S. Preventative Task Force requirements.

2.47. If Provider is a PCP, Provider must assess the medical 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. PCPs must serve as a medical home to Covered Persons.

2.48. Provider must inform Covered Persons of the costs for non-covered services prior to rendering such services and obtain a signed Private Pay form from such Covered Persons.

2.49. Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.

2.50. Termination of Provider Contracts. Unless prohibited or limited by applicable law, as soon as possible and at least 30 days prior to the effective date of the MCO's termination of this Agreement, MCO must provide written notice to (i) Provider that it will no longer be a part of the Participating Health Care Provider Network; (ii) the HHSC Administrative Services Contractor; and, (iii) affected Covered Persons. Affected Covered Persons include all Covered Persons in a PCP's panel and all Covered Persons who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home-based or office-based care in the past 12 months.

2.51. Provider is responsible for collecting at the time of service any applicable CHIP co-payments or deductibles in accordance with CHIP cost-sharing limitations.

2.52. Provider shall not charge: (i) cost-sharing or deductibles to CHIP Covered Persons of Native American Tribes or Alaskan Natives; (ii) co-payments or deductibles to a CHIP 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; and (iii) co-payments for well-child or well-baby visits or immunizations.

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

2.54. Payment of Clean Claims. All provider claims shall be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims shall be adjudicated (finalized as paid or denied) within thirty (30) days from the date of claim receipt. MCO shall offer Provider the option of submitting and receiving claims information through electronic data interchange ("**EDI**") that allows for

automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats. MCO shall pay Provider interest at a rate of 1.5% per month (18% per annum), calculated daily, for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline.

2.55. MCO shall not pay any claim submitted by Provider if Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud and abuse. MCO shall not pay any claim submitted by Provider if Provider is on payment hold under the authority of HHSC or its authorized agent(s), or has pending accounts receivable with HHSC.

2.56. MCO must adjudicate all appealed claims to a paid or denied status within 30 days of receipt of the appealed claim.

2.57. MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 days of the date of service. If Provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, MCO shall process the claim without denying for failure to timely file. MCO shall send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient, and pended deficient claim to allow Provider to easily identify the claim number, date of service, type of service, claim codes, Covered Person's name, and Covered Person ID number. MCO shall finalize all claims, including appealed claims, within 24 months of the date of service.

2.58. MCO shall inform Provider about the information required to submit a claim at least 30 days prior to the operational start date of the State Contract(s). Such claims submission requirements, including claims coding and processing guidelines, are found in MCO's Participating Health Care Provider Manual, which is a part of this Agreement.

2.59. Provider shall comply with the HIPAA confidentiality provisions of Section 2.13 of the Agreement.

2.60. Provider shall comply with the provisions of Section 5.1 of the Agreement.

2.61. Provider acknowledges and agrees that the Participating Health Care Provider Manual is incorporated into the Agreement by Section 2.4 of the Agreement.

2.62. Provider understands that CHIP Perinate Newborns are eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate. A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

2.63. Provider understands that when a Covered Person enrolls in MCO's CHIP Perinatal Plan, all traditional CHIP members in the Covered Person's household will be disenrolled from their current health plans and prospectively enrolled in MCO's traditional CHIP Plan. All members of the household must remain in MCO's CHIP Plan through the end of the Covered Person's enrollment period.

2.64. Provider agrees to provide CHIP Perinatal Covered Services to Covered Persons as set forth in the HHSC Uniform Managed Care Contract Terms and Conditions, Attachment B-2.2, and any corresponding guidelines published by HHSC.

2.65 Providers must comply with the requirements of Texas Government Code §531.024161, regarding the submission of claims involving supervised providers.

2.66 For STAR+PLUS Covered Persons, all Home and Community Support Services Agency providers, adult day care providers, and residential care facility providers must notify MCO if a Covered Person experiences any of the following:

i) a significant change in the Covered Person's physical or mental condition or environment;
ii) hospitalization
iii) an emergency room visit, or
iv) two or more missed appointments.

## ARTICLE III
## ADDITIONAL STATE REQUIREMENTS

Provider acknowledges and agrees that, following the effective date of this Attachment, the State Agency may require that new or modified provisions be included in this Attachment. In such event, MCO shall notify Provider in writing of the new or modified provisions to be incorporated into this Attachment, and Provider shall comply with such provisions as of the compliance effective date established by the State.

**ATTACHMENT F**
**MEDICAID COMPREHENSIVE HEALTHCARE PROGRAM FOR FOSTER CARE PRODUCT ATTACHMENT**

This Attachment is incorporated into the Participating Provider Agreement (the "Agreement") entered into by and between parties set forth above with the effective date set forth above.

Pursuant to the requirements of the Medicaid Comprehensive Healthcare Program for Foster Care ("CHPFC"), as defined below, Provider must comply with the Medicaid-specific provisions and with the CHPFC requirements set forth in Article II of this Attachment in order to participate in the Medicaid Comprehensive Healthcare Program for Foster Care.

## ARTICLE I
## DEFINITIONS

The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

1.1 "***Administrative Services Contractor***" (or "***ASC***") means an entity performing Medicaid managed care administrative services functions, including enrollment or claims payment functions, under contract with HHSC.

1.2 "***Caregiver***" means the DFPS-authorized caretaker for a Foster Care Covered Person, including the Foster Care Covered Person's foster parent(s), relative(s), or 24-hour child-care facility staff.

1.3 "***Clean Claim***" means a claim submitted by a Participating Health Care Provider for medical care or health care services rendered to an FC Covered Person, with documentation reasonably necessary for MCO to process the claim. MCO may not require a Participating Health Care Provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

1.4 "***Covered Services***" means health care services SHPN (as defined below) must arrange to provide to FC Covered Persons, including all services required by the Foster Care Program Contract, state and federal law, and all value-added services negotiated by SHPN and HHSC. Covered Services include, without limitation, acute care, behavioral health services, dental services, vision services, and court-ordered medical services.

1.5 "***DFPS***" means the Texas Department of Family and Protective Services or its successor agency.

1.6 "***Emergency Behavioral Health Condition***" means 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 FC Covered Persons would present an immediate danger to themselves or others, or (2) that renders FC Covered Persons incapable of controlling, knowing or understanding the consequences of their actions.

1.7 "***Emergency Care***" means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

1.8 "***Emergency Medical Condition***" means a medical condition manifesting itself by acute symptoms of recent onset and 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:

(a) placing the patient's health in serious jeopardy;
(b) serious impairment to bodily functions;
(c) serious dysfunction of any bodily organ or part;
(d) serious disfigurement; or
(e) serious jeopardy to the health of a pregnant woman or her unborn child.

1.9 "***Emergency Services***" means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Foster Care Program 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.

1.10 "***Foster Care Covered Person***" or "***FC Covered Person***" is an individual included within the definition of "Target Population" and enrolled under the CHPFC.

1.11 "***Foster Care Program Contract***" means the agreement between Superior HealthPlan Network ("***SHPN***") and the State of Texas, as revised or replaced from time to time, pertaining to the provision of services by SHPN to FC Covered Persons who are beneficiaries of the State's Medicaid Comprehensive Healthcare Program for Foster Care.

1.12 "***Health Care Service Plan***" means an individualized plan developed with and for FC Covered Persons with special health care needs. The Health Care Service Plan includes, but is not limited to, the following:

(a) the FC Covered Person's history;
(b) summary of current medical and social needs and concerns;
(c) short and long term needs and goals;
(d) a treatment plan to address the FC Covered Person's physical, psychological, and emotional health care problems and needs including a list of services required, their frequency, and a description of who will provide such services.

The Health Care Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for FC Covered Persons in the Early Childhood Intervention ("***ECI***") Program.

1.13 "***Health Passport***" means an electronic health record used to document information regarding medical services provided to an FC Covered Person.

1.14 "***HHSC***" refers to the Texas Health and Human Services Commission, which is the State agency responsible for the administration of the CHPFC.

1.15 "***Medicaid Comprehensive Healthcare Program for Foster Care***" (or "***CHPFC***") is the statewide program designed to provide comprehensive medical and behavioral health Medicaid services to members of the Target Population through a managed care provider network.

1.16 "***Medical Consenter***" means the person who may consent to medical care for the FC Covered Person under Chapter 266 of the Texas Family Code.

1.17 "***Medically Necessary***" means:

Non-behavioral health related Health care services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of an FC Covered Person, or endanger life;
(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of an FC Covered Person's health conditions;
(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
(d) consistent with the diagnoses of the conditions;
(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(f) are not experimental or investigative; and
(g) are not primarily for the convenience of the FC Covered Person or Provider; and

Behavioral health services that are:

(a) are 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;
(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
(d) are the most appropriate level or supply of service that can safely be provided;
(e) could not be omitted without adversely affecting the FC Covered Person's mental and/or physical health or the quality of care rendered;
(f) are not experimental or investigative; and
(g) are not primarily for the convenience of the FC Covered Person or Provider.

1.18 "***Primary Care Provider***" ***(or "PCP")*** means a physician or provider who has agreed with the MCO to provider a medical home to Foster Care Covered Persons and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

1.19 "***PCP Team***" means a Covered Person's PCP, other Providers, and the Covered Person's Medical Consenter, who agree to function as an interdisciplinary team. If requested by the Covered Person's Medical Consenter, the Covered Person's Caregiver may be included in the PCP Team. The PCP Team may also include an FC Covered Person's DFPS caseworker and SHPN Service Coordinator.

1.20 "***Service Manager(s)***" perform the functions of Service Management.

1.21 "***State Medicaid Agency***" means the State agency which administers the State Medicaid managed care program, as implemented from time to time.

1.22 "***Substitute Care***" means the placement of a child or young adult who is in the conservatorship of DFPS in care outside the child's or young adult's home. The term includes foster care, institutional care, adoption or placement with a relative of the child or young adult.

1.23 "***Target Population***" means children and young adults in Substitute Care and/or one of the following categories: (1) DFPS conservatorship, (2) emancipated minors and young adults age 18-22 who voluntarily agree to continue in a foster care placement, or (3) young adults who have exited foster care and are participating in the foster care youth transitional Medicaid program.

1.24 "***Texas Health Steps***" is the name adopted by the state of Texas for the federally mandated EPSDT program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to

the federal EPSDT requirements contained in 42 U.S.C. §1396d(r), and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to EPSDT).

## ARTICLE II
## COMPLIANCE WITH STATE MEDICAID AGENCY AND CHPFC REQUIREMENTS

2.1 Provider agrees to provide the Texas Health and Human Services Commission ("***HHSC***"): (a) all information required under the Foster Care Program Contract, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the Agreement; and (b) any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or State laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions specified by HHSC.

2.2 Upon receipt of a record review request from the Health and Human Services Commission 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 state or federal agency, the records request within three (3) 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 and/or in less than 24 hours, Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to 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, 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 Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.3 Updates to Contact Information. Provider must inform both SHPN and HHSC's administrative services contractor of any changes to Provider's address, telephone number, group affiliation, etc.

2.4 Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

2.5 Provider agrees to provide 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 the Provider's performance of its responsibilities under the Foster Care Program Contract:

(a) SHPN program Personnel from HHSC or its designee;
(b) The U.S. Department of Health and Human Services or its designee;
(c) The Office of Inspector General;
(d) The Texas Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
(e) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
(f) A state or federal law enforcement agency;
(g) A special or general investigation committee of the Texas Legislature or its designee;
(h) The U.S. Comptroller General or its designee;
(i) The Office of the State Auditor of Texas or its designee; and
(j) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC

2.6 Provider must provide access wherever it maintains such records, books, documents, and papers and 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: 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.

2.7 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.

2.8 If Provider provides inpatient psychiatric services to an FC Covered Person, Provider must schedule the FC Covered Person 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 Service Providers must contact FC Covered Persons who have missed appointments within 24 hours to reschedule such appointments.

2.9 In order to submit a Clean Claim, Provider must provide the information set forth under Clean Claims in the Participating Health Care Provider Manual.

2.10 MCO will provide the Provider at least ninety (90) days notice prior to implementing a change in the claims guidelines set forth in the Participating Health Care Provider Manual, unless the change is required by statute or regulation in a shorter timeframe.

2.11 The Participating Health Care Provider Manual includes information concerning which entity/entities Provider must submit claims to for processing and/or adjudication. MCO must notify Provider in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If MCO is unable to provide thirty (30) days notice, MCO must give Provider a thirty (30)-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

2.12 Provider acknowledges and agrees that program violations arising out of performance of the Agreement are subject to administrative enforcement by the Texas Health and Human Services Commission Office of Inspector General (OIG) as specified in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

2.13 The Participating Health Care Provider Manual includes information concerning the complaint and appeal process that applies to Participating Health Care Providers.

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

2.15 Provider must treat all information that is obtained through the performance of the services included in this Attachment 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 the Medicaid, CHIP, and Foster Care Programs.

2.16 Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this Agreement.

2.17 Provider shall not transfer an identifiable Foster Care Covered Person record, including a patient record, to another entity or person without written consent from the Covered Person or someone authorized to act on his or her behalf; however, Provider understands and agrees that HHSC may ask it to transfer a Covered

Person's record to another agency if HHSC determines that the transfer is necessary to protect either the confidentiality of the record or the health and welfare of the Foster Care Covered Person.

2.18 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 health and behavioral health services contained in an IFSP must be provided to the FC Covered Person in the amount, duration, scope and setting established in the IFSP.

2.19 If an FC Covered Person requests contraceptive services or family planning services, Provider must also provide the FC Covered Person counseling and education about family planning and available family planning services.

2.20 Provider cannot require parental consent for FC Covered Persons who are minors to receive family planning services.

2.21 Provider must comply with state and federal laws and regulations governing FC Covered Person confidentiality (including minors) when providing information on family planning services to FC Covered Persons.

2.22 Provider understands and agrees to the following:

(a) HHSC Office of Inspector General ("***OIG***") and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider, Provider's employees, agents, contractors, and patients;
(b) requests for information from such entities must be complied with, in the form and language requested;
(c) Provider and Provider's 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 the Provider's own expense; and
(d) Compliance with these requirements will be at Provider's own expense.

2.23 Provider understands and agrees to the following:

(a) Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care or dental care and the Medicaid and/or CHIP Programs, as applicable;
(b) 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; 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, 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;
(c) 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
(d) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by the MCO or an FC Covered Person to the HHSC Office of Inspector General.

2.24 Provider understands and agrees that if Provider receives annual Medicaid payments of at least $5 million (cumulative, from all sources), Provider must:

(a) Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of 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).

(b) Include as part of such written policies detailed provisions regarding the Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

(c) Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and Provider's policies and procedures for detecting and preventing Fraud, Waste, and Abuse.

2.25 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; MCO's and SHPN's contract(s) with HHSC; the Medicaid, CHIP and FC 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 this Agreement, or any violation of MCO's or SHPN's contract(s) with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

2.26 Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement:

(i) 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.

(ii) state and federal anti-discrimination laws:

(a) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (42 U.S.C. § 2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15 (29 U.S.C. § 794);

(b) Section 504 of the Rehabilitation Act of 1973 (42 U.S. Code § 12101 et seq.);

(c) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 6101-6107);

(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 this Agreement.

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

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

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

2.27 In the event MCO becomes insolvent or ceases operations, Provider understands and agrees that its sole recourse against MCO will be through MCO's bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that FC Covered Persons may not be held liable for MCO's debts in the event of the entity's insolvency.

2.28 Provider understands and agrees that the HHSC does not assume liability for the actions of, or judgments rendered against, MCO, 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 MCO or any judgment rendered against MCO. 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.).

2.29 Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/MCO Managed Care Contract (which includes HHSC's Uniform Managed Care Manual).

2.30 Provider is prohibited from engaging in direct marketing to FC Covered Persons that is designed to increase enrollment in a particular health plan. This prohibition does not constrain Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

2.31 MCO will initiate and maintain any action necessary to stop a Provider or a Provider's employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any FC Covered Person to collect payment from HHSC, an HHS Agency, or any FC Covered Person, excluding payment for non-covered services.

2.32 Provider must be licensed in the State of Texas to provide the Covered Services for which the MCO is contracting with Provider, and not be under sanction or exclusion from the Medicaid Program. Provider must be enrolled as a Medicaid provider and have a Texas Provider Identification Number ("***TPIN***"). Effective May 23, 2007, Provider must also have a National Provider Identification Number (NPI) (see 45 C.F.R. Part 162, Subpart D). However, Provider and other Participating Health Care Providers are not required to serve Medicaid populations that are not included in the CHPFC.

2.33 MCO is prohibited from imposing restrictions upon Provider's free communication with an FC Covered Person about the FC Covered Person's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

2.34 Provider is prohibited from billing or collecting any amount from an FC Covered Person for Covered Services provided pursuant to this Attachment. Federal and State laws provide severe penalties for any provider who attempts to bill or collect any payment from an FC Covered Person for a Covered Service.

2.35 If Provider is a PCP, Provider's services must be accessible to FC Covered Persons 24 hours per day, 7 days per week, and Provider must have acceptable after-hours telephone availability.

2.36 While performing the services described in the Agreement, Provider agrees to comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations, and otherwise conduct themselves in a businesslike and professional manner.

2.37 Provider agrees to comply with the MCO's QAPI Program requirements.

2.38 MCO must follow the procedures outlined in Section 843.306 of the Texas Insurance Code if terminating the Agreement with Provider. At least ninety (90) days before the effective date of the proposed termination of this Agreement, MCO must provide a written explanation to Provider of the reasons for termination. MCO may immediately terminate this Agreement in a case involving (a) imminent harm to patient health; (b) 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 (c) fraud or malfeasance.

2.39 Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of the MCO'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, including at least one representative in Provider's specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of MCO. The decision of the advisory review panel must be considered by MCO but is not binding on MCO. 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 the MCO must communicate the MCO's decision to Provider. MCO must provide to Provider, on request, a copy of the recommendation of the advisory review panel and MCO's determination.

2.40 Provider may not offer or give any thing 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. MCO may terminate the Agreement at any time for violation of this requirement.

2.41 Provider understands and agrees that it may not interfere with or place any liens upon the state's right or MCO's right, acting as the state's agent, to recovery from third party resources.

2.42 Texas Health Steps providers must send all Texas Health Steps 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. Such providers must include detailed identifying information for all screened newborn FC Covered Persons and each FC Covered Person's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.

2.43 Provider must coordinate with the local TB control program to ensure that all FC Covered Persons with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy ("***DOT***"). Provider must report to the 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.

2.44 Provider 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.

2.45 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 and disorders.

2.46 If Provider is a behavioral health provider, Provider must: (1) submit to the MCO 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; and (4) testify in court as needed for child protection litigation.

2.47 If Provider is a PCP, Provider must provide preventive care (1) to children under age 21 in accordance with AAP recommendations for CHIP Covered Persons and CHIP Perinatal Newborns; and the Texas Health Steps Manual for Medicaid and FC Covered Persons, and (2) to adults in accordance with the U.S. Preventative Task Force requirements.

2.48 Provider must comply with medical consent requirements in Texas Family Code §266.004 that require the FC Covered Person's Medical Consenter to consent to the provision of medical care. Provider does not need the medical consent of the FC Covered Person's Medical Consenter to provide Emergency Services for a FC Covered Person that has an Emergency Medical Condition. Provider 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. The notification must be documented in the FC Covered Person's Health Passport.

2.49 If Provider is a PCP, Provider must comply with the following to participate in the CHPFC:

(a) Either be enrolled as a Texas Health Steps provider or refer FC Covered Persons due for a Texas Health Steps checkup to a Texas Health Steps provider;

(b) Refer FC Covered Persons for follow-up assessments or interventions clinically indicated as a result of the Texas Health Steps checkup, including the developmental and behavioral components of the screening; and

(c) Submit information from the Texas Health Steps forms and documents to the Health Passport.

2.50 If Provider is a PCP, Provider must assess the medical and behavioral health needs of FC Covered Persons for referral to specialty care providers and provide referrals as needed. FC Covered Persons can access behavioral health treatment without prior approval from the PCP. PCPs must coordinate FC Covered Persons' care with specialty care providers after referral. PCPs must serve as a medical home to Covered Persons.

2.51 If Provider is a behavioral health provider, Provider must provide a monthly summary form, to be provided by MCO. The following information must be included in the monthly summary form for the Health Passport:

(a) Primary and secondary (if present) diagnosis.
(b) Assessment information, including results of a mental status exam.
(c) Brief narrative summary of the Member's clinical visits/progress
(d) Scores on each outcome rating form(s).
(e) Referrals to other providers or community resources.
(f) Health Care Service Plans and referrals to providers.
(g) Evaluations of each Covered Person's progress at intake, monthly, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan.
(h) Any other relevant care information.

2.52 Provider is prohibited from billing or collecting any amount from an FC Covered Person for Covered Services covered by the Foster Care Program Contract. Provider must inform FC Covered Persons of the costs for non-covered services prior to rendering such services and obtain a signed private pay form from such FC Covered Persons.

2.53 Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to this Agreement.

2.54 Termination of Provider Contracts. Unless prohibited or limited by applicable law, as soon as possible and at least 30 days prior to the effective date of the MCO's termination of this Agreement, MCO must provide written notice to (i) Provider that it will no longer be a part of the Participating Health Care Provider Network; (ii) the HHSC Administrative Services Contractor; and, (iii) affected FC Covered Persons. Affected FC Covered Persons include all FC Covered Persons in a PCP's panel and all FC Covered Persons who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home-based or office-based care in the past 12 months.

2.55 Provider must testify in court as needed for child protection litigation relating to FC Covered Persons.

2.56 Health Passports. MCO and the FC Covered Person's Providers, as appropriate, will be responsible for updating each FC Covered Person's Health Passport with the required medical information. Provider shall submit all applicable information for the Health Passport either (i) by inputting data directly into the Health Passport at the point of service through a web-based interface or (ii) submitting the required information to MCO for entry into the Health Passport.

2.57 If Provider is a PCP, Provider must use the Texas Health Steps behavioral health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. FC Covered Persons must be screened for behavioral health problems, including possible substance abuse or chemical dependency. Provider must submit completed Texas Health Steps screening and evaluation results to the MCO to include in the Health Passport.

2.58 Provider must comply with the "*Psychotropic Medication Utilization Parameters for Foster Children*" found at http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-psychotropic.asp, as amended or modified from time to time.

2.59 Payment of Clean Claims. All provider claims shall be processed within 30 days from the date of claim receipt by the MCO. All provider claims that are Clean Claims shall be adjudicated (finalized as paid or denied) within thirty (30) days from the date of claim receipt. MCO shall offer Provider the option of submitting and receiving claims information through electronic data interchange ("***EDI***") that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats. MCO shall pay Provider interest at a rate of 1.5% per month (18% per annum), calculated daily, for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline.

2.60 MCO shall not pay any claim submitted by Provider if Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for fraud and abuse. MCO shall not pay any claim submitted by Provider if Provider is on payment hold under the authority of HHSC or its authorized agent(s), or has pending accounts receivable with HHSC.

2.61 MCO must adjudicate all appealed claims to a paid or denied status within 30 days of receipt of the appealed claim.

2.62 MCO may deny a claim for failure to file timely if a provider does not submit the claim to the MCO within 95 days of the date of service. If Provider files with the wrong health plan, or with the HHSC Administrative Services Contractor, and produces documentation verifying the initial timely claims filing within 95 days of the date of service, MCO shall process the claim without denying for failure to timely file. MCO shall send a remittance and status report or other remittance written communication that includes detailed information for each adjudicated, denied deficient, and pended deficient claim to allow Provider to easily identify the claim number, date of service, type of service, claim codes, FC Covered Person's name, and FC Covered Person ID number. MCO shall finalize all claims, including appealed claims, within 24 months of the date of service.

2.63 MCO shall inform Provider about the information required to submit a claim at least 30 days prior to the operational start date of the CHPFC. Such claims submission requirements, including claims coding and processing guidelines, are found in MCO's Participating Health Care Provider Manual, which is a part of this Agreement.

2.64 Provider shall comply with the HIPAA confidentiality provisions of Section 2.13 of the Agreement.

2.65 Provider shall comply with the provisions of Section 5.1 of the Agreement.

2.66 Provider acknowledges and agrees that the Participating Health Care Provider Manual is incorporated into the Agreement by Section 2.4 of the Agreement.

2.67 Providers must comply with the requirements of Texas Government Code §531.024161, regarding the submission of claims involving supervised providers.

**ATTACHMENT G**
**MEDICAL GROUP COMPENSATION SCHEDULE**

**STAR, STAR+PLUS, STAR Kids, CHIP, CHIP Perinate, STAR Health**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Provider to Covered Persons enrolled in a Medicare Product. Where the Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

For Covered Services provided to Covered Persons, Payor shall pay Group the lesser of: (i) Group's Allowable Charges; or (ii) one hundred percent (100%) of the current State Medicaid fee schedule, not to exceed one hundred percent (100%) of Medicare applicable to the provider type and/or provider specialty of Group, in effect on the date of service.

Notwithstanding anything to the contrary contained herein, in no event will the rate or fee payable hereunder, paid by Payor exceed the applicable, final, minimum payment rate required in sections 1902(a)(13), 1902(jj), 1932(f), and 1905(dd) of the Social Security Act, as amended by the Patient Protection and Affordable Care Act of 2010 ("PPACA"), Health Care and Education Reconciliation Act of 2010 ("HCERA"), or other such legislation.

***Additional Provisions:***

1. Supplemental Payments for Qualified Providers. HHSC or its administrative services contractor shall determine if Provider or Contracted Providers are Qualified Providers eligible to receive supplemental payments under PPACA, as amended by Section 1202 of the HCERA, and corresponding federal regulations at 42 C.F.R. §§ 438.6 and 438.814. HHSC shall provide a supplemental payment report to Payor that identifies the required payments and Payor shall issue the supplemental payment to Provider. Provider agrees to comply with the federal regulations cited in this section and pass through all applicable supplemental payments Payor makes to Provider to the eligible Contracted Provider.

2. Medicaid Fee Schedule. Payor utilizes the current Texas Medicaid Fee Schedule as published at: http://public.tmhp.com/FeeSchedules/Default.aspx for the provider's specialty.

3. Code Change Updates. . Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency; or (iii) if a date is not established by such governmental agency or the product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

4. Fee Schedule Updates. Updates to the State Medicaid fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to the fee schedule.

5. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual.

***Definitions:***

1. **Allowed Amount** means the amount designated as the maximum amount payable to a Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services.

2. **Allowable Charges** mean those Group billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

**ATTACHMENT H**

**MEDICARE ADVANTAGE AND**
**CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION**
**ADDENDUM**

This Medicare Advantage and Capitated Financial Alignment Demonstration Addendum ("Addendum") to the participating provider agreement ("Agreement") between Superior HealthPlan, Inc. ("MCO") and City of El Paso Texas ("Provider") is made and entered into by and between MCO and Provider (each a "Party" and, collectively, the "Parties") effective as of _____, and supplements and amends the terms of the Agreement with respect to the provision of Covered Services to Covered Persons (as such terms are defined herein) enrolled in a Medicare Advantage plan ("MA Plan"), a Medicare Advantage – Prescription Drug plan ("MA-PD Plan"), and/or a Capitated Financial Alignment Demonstration plan ("STAR+PLUS Medicare-Medicaid Plan" or "STAR+PLUS MMP") (each such MA Plan, MA-PD Plan and STAR+PLUS Medicare-Medicaid Plan to be alternatively referred to herein as a "Medicare Plan," and collectively as the "Medicare Plans").

**WHEREAS**, MCO and Provider are bound by the Agreement, pursuant to which Provider has agreed to provide Covered Services to Covered Persons as specified therein;

**WHEREAS**, MCO and Provider mutually and respectively desire to amend the Agreement to include the provision of Covered Services as defined in this Addendum to Covered Persons who are enrolled in a Medicare Plan;

**WHEREAS**, Provider is certified to participate in the State Medicaid program, and, to the extent that Provider qualifies as a Medicare Provider or Supplier, Provider has signed a participation agreement with CMS and has been approved by CMS as meeting conditions for coverage of Provider's services;

**WHEREAS**, MCO or a Payor has been accepted by CMS, or has an application pending with CMS, to participate in the Medicare Advantage Program and/or a Capitated Financial Alignment Demonstration Program; and

**WHEREAS**, the Parties agree to supplement and amend the Agreement to include the requirements applicable to Participating Health Care Providers' participation under the Medicare Plans.

**NOW THEREFORE**, in consideration of the mutual promises of the Parties, the sufficiency of which is hereby acknowledged, the Parties agree as set forth below:

**1. DEFINITIONS.** The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Addendum. Capitalized terms not otherwise defined in this Addendum shall be defined as set forth in the Agreement.

1.1 Capitated Financial Alignment Demonstration Program means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 Clean Claim means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 CMS means Centers for Medicare and Medicaid Services.

1.4 CMS Contract means the contract between MCO or a Payor and CMS, or among MCO or a Payor, CMS and the State, that governs the terms of MCO's or the Payor's participation in a Medicare Plan.

1.5 Covered Persons means those individuals who are enrolled in a Medicare Plan.

1.6 Covered Services means those services which are covered under a Medicare Plan.

1.7 HHS means the United States Department of Health and Human Services.

1.8 Medicare Advantage Program means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.9 State means one or more applicable state governmental agencies of the State of Texas.

**2. COVERED SERVICES.** Provider shall furnish Covered Services to Covered Persons as set forth herein.

**3. SUBCONTRACTOR OBLIGATIONS.** To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under the Agreement or this Addendum, including any downstream entity, subcontractor or related entity, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Addendum.

**4. GOVERNMENT RIGHT TO INSPECT.** Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Addendum or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, records, including medical records and documentation of the Provider, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Addendum, or as the Secretary of HHS may deem necessary to enforce the CMS Contract. Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination date of this Addendum or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies the Payor at least 30 days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by the Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Addendum. To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider's obligations under this Addendum, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Article IV. *42 C.F.R. § 422.504 (e)(2).*

**5. CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS.** Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (3) maintaining the records and information in an

accurate and timely manner; and (4) ensuring timely access timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

**6. HOLD HARMLESS.**

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of the Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i)*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with the Payor. Provider shall accept payment from the Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

**7. COMPLIANCE WITH CMS CONTRACT.** Provider shall perform its obligations under this Addendum in a manner consistent with and in compliance with MCO's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §422.504(i)(3)(iii)*

**8. PROMPT PAYMENT.** The Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Addendum. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by MCO at such address as may be designated by MCO. *42 C.F.R. §422.520(b)(1) and (2)*

**9. COMPLIANCE WITH FEDERAL AND STATE LAWS.** MCO, Provider, Payor, and any related party or other contractor or subcontractor shall comply with all applicable laws, regulations and CMS and/or State instructions. *42 C.F.R. §422.504(i)(4)(v)*

**10. DELEGATION OF DUTIES.** In the event that MCO delegates to Provider any function or responsibility imposed pursuant to the State Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Addendum shall be subject to the prior written approval of MCO and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

10.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Delegated Credentialing Agreement or Delegated Services Agreement attached to this Agreement. If such attachment is not executed, no administrative functions shall be deemed as delegated.

10.2 CMS, MCO and the Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, MCO or the Payor determine that such parties have not performed satisfactorily.

10.3 The Payor will monitor the performance of the parties on an ongoing basis.

10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by MCO, or the credentialing process will be reviewed and approved by MCO and MCO must audit the credentialing process on an ongoing basis.

10.5 If MCO or a Payor delegates the selection of providers, contractors, or subcontractors, MCO and the Payor retain the right to approve, suspend, or terminate any such arrangement.

*42 C.F.R. 422.504(i)(4) and (5)*

**11. SAFEGUARDING OF PRIVACY.** Provider shall comply with all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. Provider shall comply with MCO's and the Payor's policies and procedures with respect to the safeguarding of privacy of individually identifiable information relating to an Covered Person. *42 C.F.R. §§422.504(a)((13); 422.118*

**12. NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS.** Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

**13. SERVICE AVAILABILITY.** Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

**14. CULTURAL COMPETENCE.** Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

**15. FOLLOW-UP CARE.** Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

**16. ADVANCE DIRECTIVES.** Provider shall comply with MCO's and the Payor's policies and procedures concerning advance directives. *42 C.F.R. §422. 128(b)(1)(ii)(E).*

**17. PROFESSIONALLY RECOGNIZED STANDARDS OF CARE.** Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

**18. CONTINUATION OF BENEFITS.** Provider shall provide Covered Services as provided in the Agreement and this Addendum: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Addendum. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

**19. PHYSICIAN INCENTIVE ARRANGEMENTS.** If Provider is a physician or physician group, neither the Payor nor MCO shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. If the physician incentive plan places Provider at substantial financial risk (as determined under

§ 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with § 422.208(f) of this section. MCO or the Payor must provide to CMS the information specified in §422.210 for all physician incentive plans (if any). *42 C.F.R. §422.208.*

**20. INFORMATION DISCLOSURES TO CMS.** Provider shall cooperate with MCO and the Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

**21. NOTICE OF PROVIDER TERMINATIONS.** MCO shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

**22. RISK ADJUSTMENT DATA.** Provider shall provide to MCO complete and accurate risk adjustment data as required by CMS. *42 C.F.R. §422.310(d)(3), (4)*. Upon MCO's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. *42 C.F.R. §422.310(e).*

**23. COMPLIANCE WITH MCO POLICIES.** If Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon MCO's request, consult with MCO regarding MCO's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with MCO's quality assurance and performance improvement programs.*§42 C.F.R. 422.504(a)(5).*

**24. WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION.** In the event MCO suspends or terminates this Addendum with respect to Provider or any physicians employed or contracted with Provider, MCO shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by MCO, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

**25. NOTICE OF WITHOUT CAUSE TERMINATION.** MCO and Provider must provide at least sixty (60) days written notice to each other before terminating this Addendum without cause. *42 C.F.R. §422.202(d)(4).*

**26. COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS.** MCO and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

**27. EXCLUDED PRACTITIONERS.** Provider warrants to MCO and each Payor (a) that Provider and each of its owners, employees and contractors who provide health care, utilization review, medical social work, or any administrative services under or in connection with the Agreement (collectively "Personnel") (i) are not listed on the General Services Administration's Excluded Parties List System ("GSA List"), and (ii) are

not suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program (collectively, "Government Payor Programs"), and (b) that, to Provider's knowledge, there are no pending or threatened governmental investigations that may lead to suspension or exclusion of Provider or Personnel from Government Payor Programs or may cause for listing on the GSA List. *42 C.F.R. §422.752(a)(8).*

**28. COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS.** Provider shall cooperate and comply with all applicable State, federal MCO and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to MCO and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

**29. OFFSHORE SUBCONTRACTORS.** Provider shall disclose to MCO in writing, within 30 days of signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *Health Plan Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

**30. SCOPE AND CONFLICTS.** Nothing in this Addendum shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Addendum. In the event of any inconsistencies between this Addendum and any provision of the Agreement in connection with Provider's provision of Covered Services to Covered Persons, the provisions of this Addendum shall govern. In the event that any provision of this Addendum conflicts with the provisions of any statute or regulation applicable to MCO, the provisions of the statute or regulation shall have full force and effect.

**31. TERMINATION.** This Addendum shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. The Addendum may be further terminated by MCO immediately upon written notice to the Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or is suspended or excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b(f), or any form of state Medicaid program.

**EXHIBIT 1**
**to**
**ATTACHMENT H**

**COMPENSATION SCHEDULE**
**PHYSICIAN SERVICES**
**MEDICAL GROUP**

**City of El Paso Texas**

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Provider to Covered Persons enrolled in a Medicare Product. Where the Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for physician Covered Services rendered to Covered Persons who are eligible for Medicare and enrolled in a Superior HealthPlan, Inc. MA Plan, MA-PD or STAR+PLUS MMP shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for physician Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicare payment rate in effect on the date of service to include applicable Medicare coinsurance and/or deductibles.

The maximum compensation for physician Covered Services rendered to Covered Persons that are Medicaid Covered Services and are not Medicare Covered Services shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule the Allowed Amount for physician Covered Services is the lesser of: (i) Allowable Charges; or (ii) the Payor's reimbursement schedule, which shall be the amount payable by Medicaid, to include any Medicaid coinsurance and/or deductibles, based on the Medicaid payment rate in effect on the date of service.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency; or (iii) if a date is not established by such governmental agency or the product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). However, the date of implementation of any fee schedule updates, i.e. the date beginning on which such fee change is used for reimbursement ("Fee Change Implementation Date") shall be the later of: (i) the date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Code Change Effective Date.

3. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

***Definitions:***

1. **Allowed Amount** means the amount designated as the maximum amount payable to a Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services.

2. **Allowable Charges** means a Provider's billed charges for services that qualify as Covered Services.

## ATTACHMENT I

## COMMERCIAL-EXCHANGE PRODUCT ATTACHMENT

This Commercial-Exchange Product Attachment ("Product Attachment") is incorporated into the Agreement between Provider and MCO. It supplements the Agreement by setting forth specific terms and conditions that apply to the Commercial-Exchange Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation.

1. Commercial-Exchange Product. The term "Commercial-Exchange Product" refers to those programs and health benefit arrangements offered by or available from or through MCO or a Payor that provide incentives to Covered Persons to utilize the services of certain contracted providers. The Commercial-Exchange Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which MCO, an Affiliate, or its delegate furnishes administrative services or other services in support of a health care program for an individual or group of individuals, which may include access to one or more of the MCO's or Payor's provider networks or vendor arrangements, and which may be provided in connection with a state or governmental-sponsored, employer-sponsored, or other private health insurance exchange. The Commercial-Exchange Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

2. Participation. (a) Unless otherwise specified in this Product Attachment and as limited by subsection (b) below, all Participating Providers under the Agreement will participate in the Commercial-Exchange Product as "Participating Providers," and will provide to Covered Persons enrolled in or covered by a Commercial-Exchange Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Participating Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Participating Providers, to comply with and abide by the provisions of the Agreement, including this Product Attachment and the Provider Manual.

(b) Provider and Participating Providers may only identify themselves as a Participating Provider for those Commercial-Exchange Products in which the Participating Provider actually participates as provided in this Agreement. Provider acknowledges that MCO or a Payor may have, develop or contract to develop various Commercial-Exchange Products or provider networks that have a variety of provider panels, program components and other requirements. Neither MCO nor any Payor warrants or guarantees that any Participating Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Commercial-Exchange Product.

3. Attachment. This Product Attachment includes, at Exhibit 1, the applicable State and federal Regulatory Requirements with which Participating Providers are required to comply in connection with their participation in the Commercial-Exchange Product. Any additional Regulatory Requirements that may apply to Participating Providers are or will be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference. This Product Attachment also includes a Compensation Schedule at Exhibit 2.

4. Term. The term of the Participating Providers' participation in the Commercial-Exchange Product will commence as of the Effective Date and, thereafter, will be coterminous with the term of the Agreement unless a party or a Participating Provider terminates the participation of the Participating Provider in the Commercial-Exchange Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

5. Construction. This Product Attachment modifies, supplements and forms a part of the Agreement. Except as otherwise provided in this Product Attachment, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of any conflict or inconsistency between the terms and conditions of this Product Attachment and the terms and conditions of the Agreement, the terms and conditions of this Product Attachment will control with respect to the Commercial-Exchange Product. To the extent Provider or

any Participating Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Participating Provider shall request clarification from MCO.

**EXHIBIT 1**
**to**
**ATTACHMENT I**

**COMMERCIAL-EXCHANGE PRODUCT**
**REGULATORY REQUIREMENTS**

This Exhibit sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to the Commercial-Exchange Product.

A. MCO Requirements. For a Commercial-Exchange Product that is an MCO Product, Participating Providers and MCO are required to comply with the provisions of Attachment B (State-mandated Provisions) to their Agreement, with the following exception described below:

1. Section 5 (Compliance with Prompt Payment Regulations) shall be revised to delete the reference to "Medicaid Covered Persons" and to replace it with "Covered Persons" and revised to replace the phrase "within thirty (30) days of its receipt" with "within forty-five (45) days of its receipt."

B. Insurance Company Requirements. For a Commercial-Exchange Product for which the Payor is not an MCO, Participating Providers and the Payor are required to comply with the following provisions:

TX-1 Batched Claims. No Payor or delegate or clearinghouse of a Payor or delegate may refuse to process or pay an electronically submitted clean claim, as that term is defined in Tex. Ins. Code Ann. § 843.336, as may be amended, because the claim is submitted together with or in a batch submission with a claim that is not a clean claim. (TEX. INS. CODE ANN. §§ 843.323; 1301.0641)

TX-2 Upon the giving or receipt of any notice to termination or non-renewal of a Participating Provider's participation under a Coverage Agreement, the Participating Provider will immediately provide the MCO or Payor with a list of the Covered Persons currently being treated by the Participating Provider. If the MCO or Payor terminates the participation of a Participating Provider under a Coverage Agreement, the MCO, Payor or its delegate will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. If Provider or a Participating Provider terminates the participation of the Participating Provider under a Coverage Agreement, the Participating Provider will provide notice to each Covered Person currently being treated by the affected Participating Provider of the impending termination of the Participating Provider's participation as a Participating Provider under the Covered Person's Coverage Agreement. (TEX. INS. CODE ANN. §§ 1301.152; 1301.160)

TX-3 Podiatrists. If a Participating Provider is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners, the provisions set forth in this Section apply. The Participating Provider may request, and the Payor shall provide not later than the thirtieth ($30^{th}$) day after the date of the request, a copy of the coding guidelines and payment schedules applicable to the compensation that the Participating Provider receives or will receive under this Attachment. The Payor may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules. The Participating Provider may, while practicing within the scope of the law regulating podiatry, provide x-rays and nonprefabricated orthotics covered by the Coverage Agreement. (TEX. INS. CODE ANN. §§ 843.311, 1301.062)

TX-4 Claim Submission; Prompt Payment.

TX-4.1 As required by applicable State law, Provider and each Participating Provider shall submit a claim no later than the ninety-fifth ($95^{th}$) day after the date of service. A claim not submitted within such time frame may be denied for payment, unless the failure to submit the claim in compliance with this section is a

result of a catastrophic event that substantially interferes with the normal business operations of the Provider or the Participating Provider. Neither Provider nor a Participating Provider (or any delegate) shall submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim was submitted. (TEX. INS. CODE ANN. §§ 843.337, 1301.102)

TX-4.2 Except as otherwise provided in applicable State law, Payor shall determine whether a clean claim submitted by Provider or a Participating Provider for Covered Services is payable not later than the forty-fifth (45th) day after the date on which a clean claim in a nonelectronic format is received, or not later than the thirtieth (30th) day after the date on which a clean claim in an electronic format is received. Except as otherwise provided in applicable State law, Payor shall pay clean claims submitted by Provider or a Participating Provider for Covered Services on or before the later of (i) the forty-fifth (45th) day after the date on which the claim for payment is received with the documentation reasonably necessary to process the claim, or (ii) the last day in the time period specified in the Agreement or the Provider Manual for payment of claims. (TEX. INS. CODE ANN. §§ 843.336-843.354; 1301.064, and 1301.101-109)

TX-5 Waiver of Electronic Claims. When expressly required by applicable State law, a waiver of any requirement under the Agreement or this Product Attachment for the electronic submission of a claim made with respect to a Coverage Agreement may be obtained in accordance with the process set forth in the Provider Manual. (TEX. INS. CODE ANN. § 1213.003)

TX-6 Gag Clause. Neither MCO nor Payor shall limit, prohibit, or attempt to prohibit Provider or a Participating Provider from discussing with or communicating in good faith with Covered Persons that are patients or a person designated by a Covered Person that is a patient with respect to: (a) information or opinions regarding the Covered Person's health care, including the patient's medical condition or treatment options; (b) information or opinions regarding the terms, requirements, or services of the Coverage Agreement as they relate to the medical needs of the Covered Person; or (c) the termination of the Agreement or the fact that the Participating Provider will otherwise no longer be providing medical care, dental care, or health care services under the Coverage Agreement. Neither MCO nor Payor shall in any manner penalize, terminate, or refuse to compensate for Covered Services a Provider or Participating Provider for communicating in a manner protected by this section with a current, prospective, or former patient that is a Covered Person, or a person designated by a patient that is a Covered Person. (TEX. INS. CODE ANN. §§ 843.363, 1301.067)

TX-7 Complaint Resolution. The Agreement or Provider Manual, as applicable, sets forth or identifies the mechanism to be used utilized in resolving complaints initiated by a Covered Person, Provider or a Participating Provider. (TEX. INS. CODE ANN. § 1301.055)

TX-8 Discounted Fees. Provider and each Participating Provider agree that to the extent that Provider or a Participating Provider is compensated on a discounted fee basis, the Covered Person may be billed only on the discounted fee and not the full charge for services. (TEX. INS. CODE ANN. § 1301.061)

TX-9 Overpayments. Neither MCO nor Payor may recover an overpayment to Provider or a Participating Provider if, not later than the one hundred eightieth (180th) day after the date the Participating Provider receives the payment, the Payor, MCO or one of their delegates provides written notice of the overpayment to Provider or the Participating Provider that includes the basis and specific reasons for the request for recovery of funds, and either Provider or the Participating Provider makes arrangements for repayment of the requested funds on or before the forty-fifth (45th) day after the date the notice is received. (TEX. INS. CODE ANN. §§ 843.350, 1301.132)

**EXHIBIT 2**
**to**
**ATTACHMENT I**

**COMPENSATION SCHEDULE**
**PROFESSIONAL SERVICES**

**City of El Paso Texas**

This Compensation Schedule sets forth the maximum reimbursement amounts for the provision of Covered Services to Covered Persons in a Commercial-Exchange Product. For Covered Services rendered to a Covered Person and billed under a Contracted Provider's tax identification number ("TIN"), that has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by Provider and Contracted Providers according to the terms of the Agreement and this Compensation Schedule and specific to the services rendered. Payment under this Compensation Schedule is subject to the requirements set forth in the Agreement, which includes reducing the Allowed Amount by the applicable Cost-Sharing Amounts.

For Covered Services rendered to a Covered Person, Contracted Provider's maximum compensation shall be the Allowed Amount. Except as otherwise provided in this Compensation Schedule, the Allowed Amount is the lesser of: (i) the Contracted Provider's Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicare fee schedule.

***Additional Provisions:***

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date (Code Change Effective Date) that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency; or (iii) if a date is not established by such governmental agency or the product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

2. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). However, the date of implementation of any fee schedule updates, i.e. the date beginning on which such fee change is used for reimbursement ("Fee Change Implementation Date") shall be the later of: (i) the date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Code Change Effective Date.

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amounts in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless

specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures Payment for multiple outpatient surgical or scope procedures performed on a Covered Person by a Contracted Provider during one occasion of surgery shall be based on an amount equal to the highest payment grouper specified above for which an outpatient surgical or scope procedure has been performed. Reimbursement for the second and third procedures will each be at fifty percent (50%). No payments shall be made for additional outpatient surgery or scope procedures performed during the same occasion of surgery.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

***Definitions:***

1. **Allowed Amounts** means the amount designated as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments for Covered Services.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Contracted Provider** means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

4. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.