

ARTICLE I - DEFINITIONS

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to Medicaid.

Adjudicate means to deny or pay a Clean Claim.

Agreement means this Nursing Facility Provider Agreement, together with all amendments, attachments, and incorporated documents or materials.

Applied Income means the portion of the earned and unearned income of the STAR+PLUS Member, or if applicable the Member and the Member's spouse, that is paid under the Medicaid program to an institution or long-term care facility in which the Member resides.

CFR means the Code of Federal Regulations.

Clean Claim means a claim submitted by a provider for health care services rendered to a Member with the data necessary for the MCO to adjudicate and accurately report the claim. For purposes of this Agreement, claims for Nursing Facility Unit Rate services that meet DADS' criteria for clean claims submission are considered Clean Claims. Additional information regarding DADS' criteria for clean claims submission is included HHSC's Uniform Managed Care Manual.

CMS means the Centers for Medicare and Medicaid Services.

Covered Services means health care services the MCO must arrange to provide Members, including all services required by the MCO's contracts with HHSC for STAR+PLUS and all value-added services offered by the MCO.

DADS means the Department of Aging and Disability Services.

Day means calendar day unless otherwise specified.

DSHS means the Texas Department of State Health Services.

Dual Eligible means a Medicaid recipient who is also enrolled in Medicare.

Facility or Facilities means one or more licensed nursing facilities operated by the Provider and identified in Attachment *[insert reference to MCO's Attachment]* to this Agreement.

Form 3618 or Resident Transaction Notice means the form the Provider must use to inform the Health and Human Services Commission about transactions and changes (admissions or discharges) for Medicaid applicants and recipients in nursing facilities.

Form 3619 or Medicare/Skilled Nursing Facility Patient Transaction Notice means the form the Provider must use to inform the Health and Human Services Commission about transactions and changes (admissions or discharges) for Medicaid recipients or applicants approved by Medicare for a Medicare skilled nursing facility.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself, herself, or some other person. It includes any act that constitutes fraud under applicable federal or state law.

HHS means the U.S. Department of Health and Human Services.

HHSC means the Texas Health and Human Services Commission.

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

Medical Assistance Only (MAO) means a person that does not receive Supplemental Security Income benefits but qualifies financially and functionally for Medicaid assistance.

Medically Necessary has the meaning defined in 1 TAC § 353.2.

Member or Covered Person means an individual enrolled with the MCO and entitled to receive STAR+PLUS Covered Services.

Nursing Facility (also called nursing home or skilled nursing facility) means an entity or institution that provides organized and structured nursing care and services, and is subject to licensure under Texas Health and Safety Code, Chapter 242, as defined in 40 TAC § 19.101 and 1 TAC § 358.103.

Nursing Facility Add-on Services means the types of services that are provided in the Facility setting by the Provider or another network provider, but are not included in the Nursing Facility Unit Rate, including but not limited to emergency dental services; physician-ordered rehabilitative services; customized power wheel chairs; and augmentative communication devices.

Nursing Facility Unit Rate means the types of services included in the DADS daily rate for nursing facility providers, such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The Nursing Facility Unit Rate also includes applicable nursing facility rate enhancements and professional and general liability insurance. Nursing Facility Unit Rates exclude Nursing Facility Add-on Services.

OIG means the Office of Inspector General.

PASRR means the Preadmission Screening and Resident Review, a federally mandated program applied to all individuals seeking admission to a Medicaid-certified Nursing Facility. PASRR helps ensure that individuals are not inappropriately placed in nursing facilities for long-term care, and requires that all applicants to a Medicaid-certified nursing facility: (1) be evaluated for mental illness, intellectual disability, or both; (2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and (3) receive the services they need in those settings.

Program means the terms of coverage under an applicable benefit contract for which an *[insert reference to the MCO's Attachment]* is incorporated into this Agreement setting forth the Providers' reimbursement for a respective Program. Subject to the above sentence, "Program" may mean any Medicaid managed care program ("Medicaid") under which the MCO has authority to arrange for services for Covered Persons.

Provider Relations Specialist means a designated MCO representative who is proficient in Nursing Facility billing matters and able to resolve billing and payment inquiries.

Regulatory Requirements means 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: this Agreement, MCO's managed care contract with HHSC, the STAR+PLUS Program, nursing facility services, and all persons or entities receiving state and federal funds.

SAO means the Texas State Auditor's Office.

Service Coordinator means the MCO representative with primary responsibility for providing service coordination and care management to STAR+PLUS Program Members.

Significant Traditional Provider or STP means a nursing facility provider, identified by HHSC, who has provided a significant level of care to Medicaid clients.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program that provides and coordinates Covered Services for preventive, primary, acute and long-term services and supports, and nursing facility care, to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children birth through age 20 who reside in nursing facilities will not participate in STAR+PLUS.

TAC means the Texas Administrative Code.

TDI means the Texas Department of Insurance.

UMCM means HHSC's Uniform Managed Care Manual, which is available on HHSC's website.

Waste means practices that are not cost-efficient.

ARTICLE II – HHSC REQUIREMENTS

2.1 Access to Records and Information

2.1.1 The Provider will provide, at no cost to HHSC or the MCO:

- (1) all information required under the MCO's managed care contract with HHSC, including the reporting requirements and other information related to the Provider's performance of its obligations under the contract; and
- (2) any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other Regulatory Requirements

The Provider must comply with the timelines, definitions, formats, and instructions specified by HHSC.

2.1.2 Upon receipt of a record review request from the HHSC OIG or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, the Provider must provide, at no cost to the requesting agency, the records requested within three business days of the request. If the HHSC OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request or in less than 24 hours, the Provider must provide the records requested at the time of the request or in less than 24 hours. The request for record review may include:

- (1) Members' clinical records;
- (2) other records pertaining to the Member;
- (3) any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services;
- (4) documents related to diagnosis, treatment, service, lab results, charting;

- (5) billing records, invoices, documentation of delivery items, equipment, or supplies;
- (6) business and accounting records or reports with backup support documentation;
- (7) financial audits;
- (8) statistical documentation;
- (9) computer records and data; and
- (10) 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 the HHSC OIG imposing sanctions against the provider as described in 1 TAC, Chapter 371, Subchapter G.

2.1.3 Provider must provide MCO access to Members' medical records, allow access to the Facility and other premises where records are kept, and provide MCO with reasonable notice of and the opportunity to participate in care planning discussions and activities.

2.2 Advance Directives. The Provider must comply with the requirements of state and federal laws, rules and regulations relating to advance directives.

2.3 Audit or Investigation

2.3.1 The following entities may request copies of this Agreement and any records, books, documents, paper, and any other information related to this Agreement or the Provider's performance of its responsibilities under this Agreement:

- (1) HHS, HHS OIG, or their designees;
- (2) Comptroller General of the United States or its designee;
- (3) MCO Program personnel from HHSC or its designee;
- (4) HHSC OIG;
- (5) Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;
- (6) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
- (7) SAO or its designee;
- (8) a state or federal law enforcement agency;
- (9) a special or general investigating committee of the Texas Legislature or its designee; (10) any other state or federal entity identified by HHSC, or any other entity engaged by HHSC; and
- (11) the MCO or any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of the MCO.

2.3.2 The Provider must provide prompt, reasonable, and adequate access wherever it maintains the information described in this section. The Provider must provide access in reasonable comfort, and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein.

2.3.3 Requests for access and information may include, but are not limited to, the following purposes:

- (1) examination;
- (2) audit;
- (3) investigation;
- (4) contract administration;
- (5) the making of copies, excerpts, or transcripts; or
- (6) for any other purpose HHSC believes is necessary for contract enforcement or to perform its regulatory functions.

2.3.4 The Provider must provide access and information at no cost to entities described in this section or their designees.

2.3.5 The Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the 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.

2.4 Changes to Provider Information. The Provider must notify the MCO and HHSC's administrative services contractor of any changes to the information included *[insert reference to MCO's Attachment]*.

2.5 Claims Submission and Payment for Nursing Facility Unit Rate Services

2.5.1 The payment methodology for Nursing Facility Unit Rates is described in *[insert reference to MCO's Attachment]*. The MCO must pay for Nursing Facility Unit Rates at or above the prevailing rate established by HHSC for the date of service. HHSC's website includes information concerning HHSC's prevailing rates: <http://www.hhsc.state.tx.us/rad/Long-term-svcs/nursing-facility/index.shtml>.

2.5.1.1 Notwithstanding *[insert reference to MCO's Attachment]*, if the Provider meets the requirements of 1 TAC § 353.608, "Minimum Payment Amounts to Qualified Nursing Facilities," the MCO will pay the Nursing Facility Unit Rate at or above the minimum payment amount as prescribed by § 353.608(c).

2.5.2 The MCO and the Provider understand and agree that the HHSC prevailing Nursing Facility Unit Rates are subject to change, including retroactive adjustments. If HHSC makes a retroactive rate adjustment to a Nursing Facility Unit Rate, the MCO must process the adjustment no later than 30 days after receipt of HHSC notification.

2.5.3 The Provider may submit claims for Nursing Facility Unit Rates through a portal operated by the MCO or its designee, or an HHSC-designated portal. The processes and requirements for submitting Clean Claims for adjudication are further described in the MCO's Provider Manual.

2.5.4 The MCO may deny a claim for Nursing Facility Unit Rates for failure to file timely if the Provider does not submit the claim to the MCO or its designee, or the HHSC-designated portal, within 365 days from the date of service.

2.5.5 The MCO will Adjudicate Clean Claims for Nursing Facility Unit Rates no later than 10 days after submission to the MCO or HHSC's designated portal, whichever occurs first.

2.5.6 If the Provider files a claim for Nursing Facility Unit Rates with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard described in Section 2.5.4, the MCO will process the claim without denying the resubmission for failure to timely file. The Provider must file the claim with the MCO by the later of: (1) 365 days after the date of service, or (2) 95 days after the date on the remittance and status report or explanation of payment from the other carrier or contractor.

2.5.7 The Provider is responsible for the coordination and delivery of services provided in the Facility setting that are included in the Nursing Facility Unit Rate.

2.6 Claims Submission and Payment for Nursing Facility Add-on Services

2.6.1 To the extent the Provider submits claims for Nursing Facility Add-on Services, the payment methodology for these services is described in *[insert reference to MCO's Attachment]*.

2.6.2 The Provider may submit claims for Nursing Facility Add-on Services through a portal operated by the MCO or its designee, or an HHSC-designated portal. The processes and requirements for submitting Clean Claims for adjudication are further described in the MCO's Provider Manual.

2.6.3 The MCO may deny a claim for Nursing Facility Add-on Services for failure to file timely if the Provider does not submit the claim to the MCO or its designee, or the HHSC-designated portal, within 95 days of the date of service.

2.6.4 The MCO will Adjudicate Clean Claims for Nursing Facility Add-on Services no later than 30 days after the claim is received by the MCO or its designee.

2.6.5 If the Provider files a claim for Nursing Facility Add-on Services with a third-party insurance resource, the wrong health plan, or with HHSC's administrative services contractor, and produces documentation verifying that the initial filing met the timeliness standard described in Section 2.6.3, the MCO will process the claim without denying the resubmission for failure to timely file. The Provider must file the claim with the MCO by the later of: (1) 95 days after the date of service, or (2) 95 days after the date on the remittance and status report or explanation of payment from the other carrier or contractor.

2.6.6 The Provider agrees to work with the MCO's Service Coordinator or other designated representative to coordinate all Medically Necessary Nursing Facility Add-on Services.

2.7 Claims Submission for Medicare Coinsurance

2.7.1 The MCO will pay the State's Medicare coinsurance obligation for a qualified Dual Eligible Member's Medicare-covered stay in a Nursing Facility. The MCO is not responsible for the State's Medicare cost-sharing obligation for a Dual Eligible Member's Medicare-covered Nursing Facility Add-on Services, which are adjudicated by either the State's fee-for-service claims administrator or the Dual Eligible Member's Medicare plan, as applicable to the Member.

2.7.2 The Provider may submit claims for Medicare Coinsurance through a portal operated by the MCO or its designee, or an HHSC-designated portal. The processes and requirements for submitting Clean Claims for adjudication are further described in the MCO's Provider Manual.

2.7.3 The MCO may deny a claim for Medicare Coinsurance for failure to file timely if the Provider does not submit the claim to the MCO or its designee, or the HHSC-designated portal, within 365 days of the date of service.

2.7.4 The MCO will Adjudicate Clean Claims for Medicare Coinsurance no later than 10 days after after submission to the MCO or HHSC's designated portal, whichever occurs first..

2.7.5 If the Provider files a claim for Medicare Coinsurance with a third-party insurance resource, the wrong health plan, or with the wrong HHSC portal, and produces documentation verifying that the initial filing met the timeliness standard described in Section 2.7.3, the MCO will process the claim without denying the resubmission for failure to timely file. The Provider must file the claim with the MCO by the later of: (1) 365 days after the date of service, or (2) 95 days after the date on the remittance and status report or explanation of payment from the other carrier or contractor.

2.8 Claims Submission, Payment, and Recoupment – General Requirements for All Claims

2.8.1 The MCO will send a remittance and status report or other electronic remittance communication that includes detailed information for each adjudicated, denied deficient, and pending deficient claim to allow the Provider to easily identify the claim number, date of service, type of service, claim codes, Member name, Member ID number, and reason code.

2.8.2 The Provider must comply with the requirements of Texas Government Code § 531.024161, regarding the submission of claims involving supervised providers.

2.8.3 The MCO will issue a final disposition of all pending and appealed claims no later than 24 months after the date of service.

2.8.4 The MCO will provide the Provider at least 90 days' notice prior to implementing a change in its claims guidelines, unless a law, rule, or regulation requires the change to be made in a shorter timeframe.

2.8.5 The MCO will notify the Provider in writing of any changes in the list of claims processing or adjudication entities at least 30 days prior to the effective date of change. If the MCO is unable to provide 30 days' notice, it will give the Provider a 30-day extension on its claims filing deadline so that claims may be routed to the correct processing center.

2.8.6 The MCO will pay Network Providers interest at a rate of 18% per annum on all clean claims that are not adjudicated within the 10 and 30-day requirements.

2.8.7 MCO will withhold all or part of payment for a claim submitted by the Provider if:

- (1) the Provider has been excluded or suspended from the Medicare, Medicaid, or CHIP programs for Fraud, Waste, or Abuse;
- (2) the Provider is on full or partial payment hold under the authority of HHSC or its authorized agent(s);
- (3) the Provider has debts, settlements, or pending payments due to HHSC, or the state or federal government; or
- (4) a claim for Nursing Facility Unit Rates does not comply with DADS' criteria for clean claims.

2.8.8 The Provider understands and agrees that it must submit claims for Medicare-covered services for Dual Eligible Members to the Medicare payer.

2.9 Collection of Applied Income

2.9.1 No later than three business days after the effective date of this Agreement, the MCO will provide the name and contact information of a Service Coordinator or other designated representative who will assist with the collection of applied income from Members. The MCO must notify the Provider within ten days of any change to the assigned Service Coordinator or representative.

2.9.2 The Provider must make reasonable efforts to collect applied income, document those efforts, and notify the Service Coordinator or the MCO's designated representative when it has made two unsuccessful attempts to collect applied income in a month. This provision in no way subrogates the Provider's existing regulatory and licensing responsibilities related to the collection of applied income, including the requirements of 40 TAC § 19.2316.

2.10 Complaints and Appeals

2.10.1 The processes and requirements for submitting Provider appeals regarding claims payment and complaints to the MCO are described in the MCO's Provider Manual.

2.10.2 The Provider understands and agrees that the MCO and HHSC reserve the right and retain the authority to make reasonable inquiry and to conduct investigations into complaints or appeals by Members, the Provider, or other providers.

2.11 Confidentiality

2.11.1 The Provider must treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes information relating to applicants or recipients of STAR+PLUS and other HHSC programs.

2.11.2 The Provider may 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.

2.11.3 The Provider will protect the confidentiality of Member Protected Health Information (PHI), including patient records. Provider must comply with all applicable federal and state laws, rules, and regulations, including the HIPAA Privacy and Security Rule, governing the use and disclosure of PHI.

2.12 Cost Reports. The Provider must submit cost reports to HHSC or its designee in the manner and format required by HHSC. If the Provider fails to comply with this requirement, the MCO will hold payments to the Provider until HHSC instructs the MCO to release them.

2.13 Credentialing

2.13.1 The MCO will deem a nursing facility that is Medicaid-certified and licensed by and contracted with DADS to have met the MCO's credentialing standards for providing Nursing Facility Unit Rate services.

2.13.2 Additional information regarding the MCO's credentialing and re-credentialing requirements for providing Nursing Facility Add-on Services is located in the MCO's Provider Manual.

2.14 Debts or Back Taxes. Any payment due to the Provider under this Agreement may be first applied toward any debt or back taxes the Provider owes the State of Texas or the federal government. The MCO may so apply payments until the debt or back taxes are paid in full.

2.15 Family Planning

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

2.15.2 Provider must comply with state and federal laws, rules, and regulations governing Member confidentiality when providing information on family planning services to Members.

2.16 Fraud, Waste, and Abuse

2.16.1 Provider will cooperate with the MCO and any State, Federal programs related to anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of state or federal law, Provider will immediately report such activity directly to the MCO's Chief Compliance Officer or in accordance with the Provider Manual. Provider is not limited in any respect in reporting actual or suspected fraud, abuse, or misconduct to the MCO.

2.16.2 The Provider understands and agrees:

- (1) it must allow the MCO, the HHSC OIG, and the Texas Medicaid Fraud Control Unit to conduct private interviews of patients and the Provider, including its employees, agents, and subcontractors;
- (2) it must comply with requests for information from such entities in the form and language requested;
- (3) the Provider and its employees, agents, and subcontractors must cooperate fully with these 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; and
- (4) compliance with these requirements will be at the Provider's own expense.

2.16.3 The Provider understands and agrees:

- (1) it is subject to all state Regulatory Requirements relating to Fraud, Waste, or Abuse in health care and the STAR+PLUS Program;
- (2) it 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, Waste, or Abuse;
- (3) it must provide originals or copies of any and all information as requested by HHSC or the state or federal agency, allow access to premises, and provide records to the HHSC OIG, HHSC, CMS, HHS, HHS OIG, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
- (4) If it places required records in another legal entity's records, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
- (5) it must report any suspected Fraud, Waste, or Abuse including any suspected Fraud, Waste, or Abuse committed by the MCO or a Member to the HHSC OIG.

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

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

2.17 Liability

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

2.17.2 The Provider understands and agrees that the MCO's Members may not be held liable for the MCO's debts in the event of the MCO's insolvency.

2.17.3 The Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, the MCO, its employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by the MCO or any judgment rendered against the MCO. HHSC's liability to the 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.*).

2.18 Liability Insurance. The Provider is not required to maintain liability insurance during the term of this Agreement.

2.19 Licensure

2.19.1 The Provider or the Facilities listed in Attachment *[insert reference]* are licensed by DADS to maintain the Facilities, and must maintain licensure during the term of this Agreement. The Provider, Facilities, and their employees, agents, and subcontractors are or will become familiar with the materials and information issued by DADS to regulate nursing facility licensure including regulations, rules, policies, procedures; notices, bulletins, or information packages issued by DADS or its designated representatives.

2.19.2 Provider understands and agrees that:

(1) It will comply with all state and federal Regulatory Requirements governing nursing facilities, including as applicable:

- (a) Title 42 C.F.R., Chapter IV;
- (b) Texas Human Resources Code Chapter 32;
- (c) Texas Human Resources Code Chapter 102;
- (d) Texas Health and Safety Code Chapters 242, 250, 253, and 260; and
- (e) Title 40, TAC Chapter 19.

(2) It is currently, and for the term of the Agreement will remain, a Texas Medicaid participating provider under applicable state and federal Regulatory Requirements.

(3) All employees, agents, and subcontractors will perform their duties in accordance with the above-referenced licensure and Regulatory Requirements, as well as all applicable national, state and local standards of professional ethics and practice.

2.19.3 This Agreement is dependent on the Facilities maintaining certification of compliance with Medicaid nursing facility standards and program requirements. The Provider acknowledges that this Agreement automatically terminates for a Facility on the date the Facility's certification of Medicaid compliance is terminated by the CMS or DADS, and that the Provider is not entitled to payment for services provided to Members during the time the Facility does not have a certification of compliance with Medicaid standards and program requirements.

2.20 Marketing

2.20.1 The Provider agrees to comply with state and federal Regulatory Requirements governing marketing. In addition, the Provider agrees to comply with HHSC's marketing policies and procedures, as set forth in the UMCM, Chapter 4.3.

2.20.2 The Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition does not prohibit the Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

2.21 Member Communications. The MCO is prohibited from imposing restrictions upon the Provider's free communication with a Member about the Member's medical conditions, treatment options, MCO referral policies, and other MCO policies, including financial incentives or arrangements and all other health plans with whom the Provider contracts.

2.22 Notice to the MCO of Adverse Change in Medical Condition and Other Events. To facilitate care coordination, the Provider must provide notice to the MCO's designated Service Coordinator via phone, facsimile, email or other electronic means no later than one business day after the following events:

- (1) a significant, adverse change in the Member's physical or mental condition or environment that could potentially lead to hospitalization;
- (2) an admission to or discharge from the Nursing Facility, including admission or discharge to a hospital or other acute facility, skilled bed, long term services and supports provider, non-contracted bed, another nursing or long term care facility; and
- (3) an emergency room visit.

Notice is not required when a Member is absent from the Facility for a therapeutic home visit.

2.23 Nursing Facility Admissions and Discharges

2.23.1 The Provider is responsible for collecting and timely submitting Minimum Data Set (MDS) forms and documentation to DADS, including all information necessary for Resource Utilization Group (RUG) determinations. HHSC or its designee will determine whether the Member meets medical necessity criteria for nursing facility admissions.

2.23.2 The Provider must submit Form 3618 or Form 3619, as applicable, to HHSC's administrative services contractor electronically no later than 72 hours after a Member's admission or discharge from the Medicaid nursing facility vendor payment system, as required by 40 TAC § 19.2615.

2.23.3 The Provider must complete and submit PASRR Level I screening information to HHSC's administrative services contractor, as required by 40 TAC §17.302.

2.23.4 The Provider must include the MCO in the notification process when it initiates an involuntary discharge of a Member from a Facility.

2.24 Order of Documents. In the event of any conflict between this Agreement and any of its attachments or incorporated documents or materials, this Agreement will control.

2.25 Payment for Covered Services

2.25.1 The Provider is prohibited from billing or collecting any amount from a Medicaid Member for Covered Services provided under this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.

2.25.2 The Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered under this Agreement.

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

2.26 Private Pay for Non-covered Services. The Provider must inform Members of the costs for non-covered services prior to rendering these services and must obtain a signed private pay form from the Member.

2.27 Provider Identifiers. The Provider must enter into and maintain a Medicaid provider agreement with the State to participate in the Medicaid Program, and must maintain a National Provider Identifier (NPI).

2.28 Provider Relations Specialist for Billing and Payment Inquiries

2.28.1 No later than three business days after the effective date of this Agreement, the MCO will provide the name and contact information of a Provider Relations Specialist. The MCO must notify the Provider within ten days of any change to the assigned Provider Relations Specialist.

2.28.2 A Provider Relations Specialist must return a call regarding billing and payment matters no later than 72 hours after the Provider places the call.

2.29 Professional Conduct. While performing the services described in this Agreement, the Provider will comply with applicable state and federal Regulatory Requirements and HHSC's requests regarding personal and professional conduct generally applicable to the service location(s); and require its employees, agents, and subcontractors to conduct themselves in a businesslike and professional manner.

2.30 Provider Manual, Policies, and Procedures

2.30.1 The MCO will make available to Provider the applicable Provider Manual(s) referencing the MCO's policies and procedures for each Program. Provider will comply with the terms of the Provider Manual and all MCO policies and procedures communicated to Provider by the MCO. The MCO will provide Provider with at least 30 days prior written notice of any material modifications to the MCO's Provider Manual(s) or other applicable policies and procedures, unless otherwise required by a Program. In the event of a conflict between the terms of this Agreement and the Provider Manual(s) or any MCO policy or procedure for a Program, the terms of this Agreement will govern. Provider Manual requirement is inclusive of all applicable, current DADS published handbooks related to Provider's requirements to remain licensed, certified and contracted with DADS.

2.30.2 The Provider will at all times cooperate and comply with the requirements, policies, programs, and procedures ("Policies") described in the Provider Manual, which include, but are not limited to:

- (1) STAR+PLUS Covered Services;
- (2) service coordination;
- (3) utilization management, including prior authorizations for Nursing Facility Add-on Services;
- (4) Provider responsibilities;
- (5) Member and Provider complaints and appeals processes;
- (6) verification of Member eligibility;

- (7) additional STAR+PLUS benefits;
- (8) encounter and claims submission requirements;
- (9) Member rights and responsibilities;
- (10) STAR+PLUS enrollment and disenrollment;
- (11) credentialing and re-credentialing requirements for Nursing Facility Add-on Service providers; and
- (12) special access requirements, such as interpreter and translation services.

2.30.3 The Provider Manual is incorporated by reference into this Agreement.

2.31 Quality Initiatives

2.31.1 The Provider agrees to comply with the MCO's quality assessment and performance improvement initiatives, as applicable to Nursing Facility providers.

2.31.2 The MCO will cooperate with and provide reasonable support for the Provider's quality initiatives, to the extent that the MCO determines the Provider's quality initiatives are compatible with the MCO's overall quality program objectives.

2.32 Regulatory Requirements

2.32.1 Provider understands and agrees that it is subject to all state and federal Regulatory Requirements that apply to this Agreement and the MCO's managed care contract with HHSC, the STAR+PLUS Program, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation of state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the MCO's contract with HHSC resulting from the Provider's failure to comply with state or federal law, could result in liability for money damages and civil or criminal penalties and sanctions.

2.32.2 Provider understands and agrees that the following laws, rules, and regulations, and all subsequent amendments or modifications, apply to this Agreement:

(1) environmental protection laws:

- (a) 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;
- (b) 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");
- (c) 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
- (d) Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;

(2) state and federal anti-discrimination laws:

- (a) Title VI of the Civil Rights Act of 1964, (42 U.S.C. §2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15;
- (b) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- (c) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 et seq.);
- (d) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- (e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- (f) Food Stamp Act of 1977 (7 U.S.C. §200 et seq.);
- (g) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16; and
- (h) the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

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

(4) Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and

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

2.32.3 STAR+PLUS Program violations arising out of performance of this Agreement are subject to administrative enforcement by the HSHC OIG as specified in 1 TAC, Chapter 371, Subchapter G.

2.33 Right to Recovery and Recoupment

2.33.1 The MCO will be entitled to offset and recoup an amount equal to any overpayments or improper payments made by the MCO to the Provider against any payments due and payable by the MCO to the Provider under this Agreement.

2.33.2 Upon determination that any recoupment, improper payment, or overpayment is due from the Provider to the MCO, the MCO will first give the Provider written notice of recoupment and request reimbursement via the method described in the MCO's Provider Manual. If reimbursement is not received from the Provider within 45 days following the date of such notice, the MCO will be entitled to offset such overpayment against other amounts due and payable by the MCO to the Provider, except as provided in Section 2.33.5. Additionally, if the State of Texas invokes a regulation requiring that MCOs be audited by the Recovery Audit Contractor (RAC) mandated by the Affordable Care Act and the CMS, then the MCO will be afforded the same rights as the RAC in terms of audit access and timeframes for recoveries.

2.33.3 Except as provided below, the MCO must complete all audits of a Provider claim no later than two years after the receipt the claim. This two-year limitation does not apply:

- (1) in cases of Fraud, Waste or Abuse that the MCO did not discover within the two-year period following receipt of a claim;
- (2) the RAC or the officials and entities identified in Section 2.3.1 conclude an examination, audit, or inspection of a Provider more than two years after the MCO received the claim; or
- (3) if HHSC has recovered a payment from the MCO based on the Member's Program ineligibility.

2.33.4 If additional payment is due to the Provider as a result of an audit, the MCO must pay the Provider no later than 30 days after it completes the audit.

2.33.5 If an audit reveals that the MCO is due a refund from the Provider, the MCO must send the Provider written notice, as described in Section 2.33.2, no later than 30 after completing the audit. The notice must specify the basis and specific reasons for the recovery. The Provider will have the right to appeal the MCO's decision in the manner described in the MCO's Provider Manual, and the MCO will not attempt to recover the payment until the Provider has exhausted its appeals rights.

2.34 Services Paid by the State. The Provider understands and agrees that the MCO is not responsible for payment of some Medicaid benefits, known as "carve-out" or "non-capitated" services, such as DADS hospice services and PASRR screenings, evaluations, and specialized services. The Provider must submit claim for these services to the State's administrative services contractor. Texas Medicaid Provider Procedures Manual includes a complete list of carve-out services for STAR+PLUS.

2.35 Severability. If a court or competent authority finds that any provision of the Agreement, or part of any provision, is invalid, illegal or unenforceable, that provision or part will, to the extent required, be deemed to be deleted, and the validity and enforceability of the other provisions of this Agreement will not be affected.

2.36 Significant Traditional Provider Status. Nursing facility providers who hold valid certifications and licenses and Medicaid provider agreements with DADS as of September 1, 2013 are considered significant traditional providers, as described in Texas Government Code § 533.006. The MCO will give these nursing facility providers the opportunity to participate in its Network through February 28, 2018, unless the MCO demonstrates, to the satisfaction of HHSC, good cause for earlier termination.

2.37 Term and Termination

2.37.1 This Agreement is effective on *[insert date]*.

2.37.2 Subject to the terms and conditions otherwise set forth in this Agreement, this Agreement will have an initial term of 3 years, commencing as of the effective date, and will renew automatically thereafter for successive 1 year terms, unless either party notifies the other of its intent not to renew at least 180 days prior to the end of the then current term.

2.37.3 This Agreement may be terminated by mutual written agreement of the parties. Additionally, either party may terminate this Agreement for Cause, defined as a material breach of this Agreement by the other party hereto, upon 90 days prior written notice to the other party. The notice will set forth the reasons for termination and provide the breaching party 90 days to cure such material breach or the termination becomes effective.

2.37.4 The MCO must follow the procedures outlined in §843.306 of the Texas Insurance Code if terminating this Agreement. At least 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. The MCO may immediately terminate this Agreement in a case involving:

- (1) imminent harm to patient health;
- (2) an action by a state licensing board or government agency against the Facility, or an action by a State Medical Board against the Provider's Medical Director, that effectively impairs the Provider's ability to provide services; or
- (3) Fraud or malfeasance.

No later than 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, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the provider's specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of the MCO. The MCO must consider the advisory review panel's decision, but is not binding on the MCO. Within 60 days following receipt of the 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 its decision to the provider. The MCO must provide to the affected provider, on request, a copy of the recommendation of the advisory review panel and the MCO's determination.

2.37.5 If the Provider is terminated, barred, suspended or otherwise excluded from participation in, or has voluntarily withdrawn as the result of a settlement agreement related to, any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, this Agreement will automatically and immediately terminate.

2.37.6 The Provider may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A "thing of value" means any item of tangible or intangible property that has a monetary value of more than \$50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and federal law. The MCO may terminate this Agreement at any time for violation of this requirement.

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

2.39 Tuberculosis. Provider must coordinate with the local tuberculosis control program to ensure that all Members with confirmed or suspected tuberculosis have a contact investigation and receive directly observed therapy. The Provider must report to DSHS or the local Tuberculosis control program any Member who is noncompliant, drug resistant, or who is or may be posing a public health threat.

ARTICLE III -- TDI REQUIREMENTS

3.1 Continuity of Treatment.

3.1.1 Unless this Agreement terminates for reasons of clinical competence or professional behavior, termination will not release the MCO of its obligation to compensate Provider for the continued care and treatment of any Member who is under Special Circumstances (as defined below).

3.1.2 As used in this section, "Special Circumstances" will mean a Member who has a disability, an acute condition, a life-threatening illness, who is past the 24th week of pregnancy, or who has a condition that Provider reasonably believes could cause harm to the Member if such care or treatment is discontinued.

3.1.3 To be reimbursed for providing continued care and treatment under this section, Provider must identify the Member's Special Circumstances to the MCO, request that the Member be permitted to continue treatment under Provider's care and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if this Agreement were not terminated.

3.1.4 Compensation to the Provider will be in accordance with the fee schedule in effect as of the termination date.

3.1.5 Treatment of Special Circumstances as described herein will be governed by the dictates of medical prudence and Medical Necessity.

3.1.6 The requirements of this section will not extend beyond 90 days from the effective date of termination, or beyond 9 months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness; provided, however, the obligation of the MCO for reimbursement to a Member will, for a pregnant Member who at the time of termination is past the 24th week of pregnancy, extend through delivery of the child, immediate postpartum care, and the follow-up check-up within the first 6 weeks of delivery.

3.1.7 In addition to the foregoing, termination will not release the Provider or MCO from liability to others with respect to services rendered to Members, monies paid, or other actions through the date of termination, nor will it relieve Provider of his or her obligation not to bill Members for Covered Services. This section will survive termination of this Agreement for any reason.

3.2 Disclosure of Claims Processing Information.

3.2.1 Upon the Provider's request, the MCO will provide information to assist the Provider in determining that he or she is being compensated in accordance with this Agreement. The information will 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 the Provider for Covered Services rendered pursuant to this Agreement. The information will include a summary and explanation of the payment and reimbursement methodologies that the MCO will use to pay Clean Claims submitted by the Provider, including but not limited to fee schedules, coding methodologies, bundling processes, downcoding policies, descriptions of any other applicable policy or procedure used by the MCO that may affect payment to the Provider, and any addenda, schedules, exhibits or policies used by the MCO in carrying out the payment of Clean Claims submitted by the Provider. If source information outside the control of the MCO, such as State Medicaid or federal Medicare fee schedules, is the basis for fee computation under this Agreement, the MCO will identify such source and explain the procedures by which the Provider may readily access the source electronically, telephonically, or as otherwise agree to be the parties.

3.2.2 In complying with this section, the MCO will not be required to provide specific information that would violate any applicable copyright law or licensing agreement. In such circumstances, the MCO will 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.

3.2.3 The MCO may provide the information by any reasonable method, including by email, computer disks, paper copies, or access to an electronic database, and will provide the information within 30 days after the MCO receives the Provider's request.

3.2.4 The MCO will provide the Provider with 90 days prior written notice of any amendments, revisions, or substitutions of the information required to be provided by the MCO under this section.

3.2.5 The Provider is prohibited by law and by this Agreement from using or disclosing the information provided to the MCO pursuant to this section for any purpose other than the Provider's practice management, billing activities, other business operations, or communications with a governmental agency involved in the regulation of health care or insurance. The 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 Member or to misrepresent any aspect of the services. The Provider may not rely upon information provided by MCO pursuant to this section about a service as a representation that a Member is covered for that service under the terms of the Member's MCO Coverage Plan.

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

3.3 Member Hold Harmless.

3.3.1 The Provider will look only to the applicable MCO and agree to hold Members harmless for compensation for all Covered Services provided to Members during the term of this Agreement.

3.3.2 Under no circumstances, including but not limited to, nonpayment by MCO, MCO insolvency, or breach of this Agreement or an Attachment, will the Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against, Medicare, Medicaid, Members or persons (other than MCO) acting on the Members' behalf (including but not limited to the MCO) for Covered Services provided pursuant to this Agreement.

3.3.3 This provision will not prohibit collection of Applied Income or of Copayments on the MCO's behalf made in accordance with the terms of the applicable MCO coverage plan, nor does this provision affect the right of the Provider to collect fees for services provided to Members that do not constitute Covered Services (unless the MCO denied payment on the basis of the Provider's failure to comply with the terms and conditions of this Agreement or any Attachment) or for which Member has specifically otherwise assumed financial responsibility, in writing, prior to the time that services were rendered.

3.3.4 Provider further agrees that this section will:

- (1) survive the termination of this Agreement or any Attachment, regardless of the reason for termination;
- (2) supersede any oral or written agreement now existing or hereafter entered into between the Provider and a Member, persons acting on the Members' behalf (other than MCO), and the MCO; and
- (3) be construed to be for the benefit of Members, persons acting on the Member's behalf (other than MCO), and the MCO.

3.3.5 Any modifications, additions, or deletions to this provision will be effective no earlier than 15 days after the Texas Commissioner of Insurance has received written notice of such changes.

3.4 No Retaliation. The MCO will not terminate, refuse to renew this Agreement or take any retaliatory action against the Provider as a result of any complaints filed by the Provider on behalf of a Member, against the MCO or due to an appeal of a decision made by the MCO.

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

3.6 Pre-termination Review.

3.6.1 Prior to the termination of this Agreement by the MCO, the MCO will provide a written explanation to the Provider of the reasons for termination.

3.6.2 No later than 30 days following receipt of the termination notice, and to the extent required by the laws and regulations applicable to health maintenance organizations, the Provider may request a review of MCO's proposed termination, to be held within a period not to exceed 60 days of the Provider's request.

3.6.3 At the Provider's request, the review will be conducted on an expedited basis.

3.6.4 Such review will be conducted by the physicians and providers, including at least one provider in the Provider's specialty or a similar specialty, if available, appointed to serve on the MCO's standing Quality Improvement Committee or utilization review committee.

3.6.5 The MCO will consider, but will not be bound by, the decision reached by the advisory review panel.

3.6.6 Upon the Provider's request, the MCO will provide the Provider with a copy of this decision and of the MCO's determination with respect to termination of this Agreement.

3.6.7 This review will not be required for termination under circumstances involving "Imminent Harm" as follows:

- (1) imminent harm to a Member's health; or
- (2) fraud or misfeasance.

3.6.8 The MCO will not notify Members 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.

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

3.8 Records relating to Other Insurance. The Provider will retain in the Provider's records updated information concerning a Member's other health benefit plan coverage.