

PROFESSIONAL PROVIDER AGREEMENT

This Professional Provider Agreement ("Agreement") is made and entered into by and between _____ ("Provider"), and Community First Health Plans, Inc. ("CFHP") to be effective the 1st day of _____.

RECITALS

- A. Provider is an individual practitioner who provides or arranges for the provision of professional medical services.
- B. CFHP is a Texas non-profit corporation licensed as a health maintenance organization under Article 20A, Texas Insurance Code, which has the legal authority to enter into this Agreement and to perform the obligations of CFHP hereunder with respect to the Benefit Programs identified on Addendum A.
- C. CFHP desires to enter into this Agreement to arrange for Provider to render Covered Services to Members of the various Benefit Programs identified on Addendum A.
- D. Provider desires to enter into this Agreement to render Covered Services to Members of the various Benefit Programs identified on Addendum A.

AGREEMENT

NOW, THEREFORE, in consideration of the above recitals and the covenants contained herein, the parties hereby agree as follows:

1. DEFINITIONS

Many words and terms are capitalized throughout this Agreement to indicate that they are defined as set forth in this Article 1.

- 1.1 Benefit Program.** Any group or individual health benefits plan operated, administered or insured, in whole or in part, by CFHP, with respect to which CFHP has contracted with Participating Providers to give Members access to Medically Necessary Covered Services. The Benefit Programs covered under this Agreement are listed on Addendum A hereto, as amended from time to time.
- 1.2 Benefit Program Requirements.** The rules, procedures, policies, protocols, and provisions required by state or federal law or adopted by CFHP or a regulatory or accrediting agency to be followed by Participating Providers and Members with respect to providing Medically Necessary Covered Services under a particular Benefit Program.
- 1.3 CFHP.** This term refers to Community First Health Plans, Inc., the sole party to this Agreement with Provider or any entity that has contracted with CFHP to administer a Benefit Program and to offer a network of Participating Providers.
- 1.4 CHIP.** The Children's Health Insurance Program, implemented by the State of Texas and HHSC pursuant to Title XXI of the Social Security Act and Senate Bill 445, 76th Texas Legislature.
- 1.5 Clean Claim.** A claim submitted by Provider for medical care or health care services rendered to a Member that contains the requirements set forth in Title 28, Chapter 21, Subchapter T, Texas Administrative Code ("Clean Claim Rules"), as amended from time to time, or in other applicable statutes, and any attachments or additional elements that

CFHP has notified the Provider, through the Provider Manual of the applicable Benefit Program or other written means, are necessary for processing a claim.

- 1.6 Covered Services.** All professional and other services covered in a particular Benefit Program, except Excluded Services, to be rendered by Provider to a Member in accordance with this Agreement.
- 1.7 Coordination of Benefits.** The allocation of financial responsibility between two or more payors of health care services, each with a legal duty to pay for or provide Medically Necessary Covered Services to a Member at the same time.
- 1.8 Copayment, Coinsurance and/or Deductible.** That portion of the cost of Medically Necessary Covered Services that a Member is obligated to pay under a particular Benefit Program. A Copayment, Coinsurance and/or Deductible may be either a fixed dollar amount or a percentage of the applicable Participating Provider contract rate. CFHP will advise Participating Providers of the amounts or methods by which Copayments, Coinsurance and/or Deductibles may be determined.
- 1.9 Credentialing.** The requirements adopted by CFHP in order for Provider and/or Providers to participate under this Agreement.
- 1.10 Emergency Care.** Health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions, including a behavioral health condition, 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 member'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. An Emergency continues as long as the Member is unable to be transferred to the appropriate CFHP Participating Provider because the nature of the illness or injury involved and/or the distance to the Participating Provider would make the transfer medically unreasonable.
- 1.11 Excluded Services.** Those health care services and supplies which are not Medically Necessary or which otherwise are not Covered Services under the applicable Benefit Program.
- 1.12 Facilities.** The hospitals, health care and/or other entities that contract with CFHP at which Covered Services may be provided under this Agreement.
- 1.13 Health Information.** Any information, whether oral or recorded in any form of medium, that: (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.
- 1.14 HHSC.** The Texas Health and Human Services Commission, the state agency responsible for administering the STAR Medicaid Managed Care and CHIP Programs.
- 1.15 HIPAA.** The Health Insurance Portability and Accountability Act of 1996.
- 1.16 Individually Identifiable Health Information.** Information that is a subset of health information, including demographic information collected from an individual; and: (1) Is created or received by a health care provider, health plan, employer, or health care

clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (3) that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

- 1.17 Medicaid.** A program of health care offered in accordance with Title XIX of the Federal Social Security Act and Chapter 32 of the Texas Human Resources Code or as otherwise allowed by HHSC and The Center for Medicare and Medicaid Services (“CMS”), and any waivers attendant thereto, including the STAR Program.
- 1.18 Medically Necessary.** Those Covered Services which are determined under the applicable Utilization Management Program to be:
- (a) Appropriate and necessary for the screening, prevention, symptoms, diagnosis or treatment of a medical condition;
 - (b) Provided for the screening, prevention, diagnosis, or direct care and treatment of a medical condition;
 - (c) Within standards of good medical practice within the organized medical community of the treating provider;
 - (d) Not primarily for the convenience of the Member or the treating provider;
 - (e) Consistent with the medical policy, the Utilization Management Program and Quality Management Program requirements and the Benefit Program Requirements applicable to the Benefit Program under which the Covered Services are rendered; and
 - (f) The most appropriate and cost effective service or supply consistent with generally accepted medical standards of care. For inpatient stays, this means that acute care as an inpatient is necessary due to the severity of the Member's condition, and that safe, cost effective and adequate care cannot be received as an outpatient or in a less intensive medical setting.
- 1.19 Medicare.** A program of health care offered by a Benefit Program in accordance with Title XVIII of the Social Security Act, including Medicare+Choice.
- 1.20 Member.** A person who is eligible to receive Medically Necessary Covered Services under a Benefit Program included in this Agreement.
- 1.21 Offset.** An adjustment of a payment owed by CFHP to Provider to deduct sums owed by the Provider to CFHP because of a previous claim overpayment or fraud and abuse.
- 1.22 Participating Provider.** A Facility, physician, physician organization or association, other health care practitioner or other organization that has a direct or indirect contractual relationship with CFHP or another Participating Provider to provide certain Medically Necessary Covered Services.
- 1.23 Pre-Authorization or Authorization.** The verbal or written approval by CFHP, or other permitted person or entity, obtained prior to providing certain Covered Services to a Member, when approval is required under the Utilization Management Program of the applicable Benefit Program.

- 1.24 Primary Care Provider or PCP.** A Participating Provider who is responsible pursuant to the applicable Benefit Program for coordinating and managing the delivery of Medically Necessary Covered Services to Members selecting, or assigned to, such provider. The following types of Participating Physicians shall be responsible for providing services as PCPs: General practice, general internal medicine, pediatrics, and family practice. A Specialty Care Physician may apply to be the PCP of Member who the Physician is currently treating and who is disabled or has chronic/complex conditions.
- 1.25 Privacy Requirements.** Includes the following provisions relating to the confidentiality of Individually Identifiable Health Information, and individuals' rights relating to their own Individually Identifiable Health Information: (1) Federal regulations promulgated by the Department of Health and Human Services pursuant to HIPAA and applicable to health plans, health care clearinghouses and providers who transmit Individually Identifiable Health Information electronically, adopted on December 28, 2000, 65 Fed. Reg. 82462, *et seq.*, modified by amendments adopted on August 14, 2002, 67 Fed. Reg. 53264, *et seq.*, and as may be further amended from time to time; (2) Senate Bill 11 passed by the 77th Texas Legislature, as such provision may be amended from time to time, and all applicable rules implementing Senate Bill 11; and (3) all other state or federal statutes or regulations governing privacy of, and access to, Individually Identifiable Health Information.
- 1.26 Protected Health Information.** Individually identifiable health information that is transmitted or maintained in any electronic, paper or other form or medium.
- 1.27 Provider Manual.** A Manual, as updated by CFHP from time to time, that contains administrative policies and procedures pertaining to such subject areas as Member eligibility; Member rights and responsibilities; CFHP's Utilization Management Program, CFHP's Quality Management Program, health promotion and wellness, billing and claims administration, appeals and other similar information and made part of this Agreement by reference.
- 1.28 Quality Improvement Committee.** CFHP Committee consisting of Participating Providers, responsible for developing, implementing, evaluating and revising the Quality Management and Improvement Program as delegated by the CEO and the Board of Directors of CFHP.
- 1.29 Quality Management Program.** The functions required by CFHP or a regulatory or accrediting agency, including, but not limited to, Credentialing and Recredentialing and certification of providers, review and audit of medical and other records, outcome rate reviews, peer review and provider complaints and appeals procedures performed or required by CFHP, or any other permitted person or entity, to review the quality of Medically Necessary Covered Services rendered to Members.
- 1.30 Recredentialing.** The process by which CFHP reviews the current credentials and past clinical and service practices of Participating Providers currently under contract with CFHP to determine if a Participating Provider is qualified to continue as a Participating Provider.
- 1.31 Referral.** A written or verbal approval by a Member's PCP, usually for a specified number of visits, treatments, or period of time, that is required under the Utilization Management Program for a Member to receive Medically Necessary Covered Services from another Participating Provider (usually a Specialty Care Provider) or other health care professional or organization. CFHP's Utilization Management Program may allow Members to directly access certain types of Specialty Care Providers without a referral. CFHP's Utilization Management Program also may require Pre-Authorization for certain

types of services. Referral to a non-Participating Provider always requires Pre-Authorization.

- 1.32 Service Area.** The geographic area(s), specified by counties and/or other descriptive boundaries, which are described in Addendum A to this Agreement.
- 1.33 Specialty Care Provider.** A Participating Physician or Provider other than a PCP who provides Medically Necessary Covered Services to a Member within the Participating Provider's specialized field of medicine. Access by a Member to a Specialty Care Provider usually requires a referral from the Member's PCP. However, CFHP's Utilization Management Program may allow Members to directly access certain types of Specialty Care Providers without a referral. A Specialty Care Physician may apply to be the PCP of Member who the Physician is currently treating and who is disabled or has chronic/complex conditions.
- 1.34 State.** The State of Texas.
- 1.35 Utilization Management Program.** The functions required by CFHP or a regulatory or accrediting agency, including, but not limited to Pre-Authorization, Referral and prospective, concurrent and retrospective review, performed or required by CFHP or any other permitted person or entity, to review and determine whether medical services or supplies which have been or will be provided to Members are covered under a Benefit Program and meet the criteria as Medically Necessary. CFHP's Utilization Management Program is described in the Provider Manual.

2. PERFORMANCE PROVISIONS

- 2.1 Provider Representations and Warranties.** Provider represents and warrants throughout the term of this Agreement, for himself or herself, that Provider:
- (a) is licensed by the State or otherwise legally permitted under the laws of the State to operate and provide Covered Services;
 - (b) complies 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.
 - (c) holds active staff privileges on the medical staff(s) of one or more Facilities that are Participating Providers, if applicable;
 - (d) holds a current DEA and DPS narcotic registration certificate, if applicable;
 - (e) maintains all required professional credentials and meets all continuing education requirements pursuant to CFHP's Credentialing and Recredentialing standards;
 - (f) is eligible and will remain eligible to participate in Medicare and Medicaid.
 - (g) Network Acute Care Providers serving Medicaid Members must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Texas Provider Identification Number (TPIN). All Network Providers, both CHIP and Medicaid, must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.)

2.2 Provision of Covered Services.

2.2.1 Generally. Provider agrees to provide Medically Necessary Covered Services to Members of the Benefit Programs covered under this Agreement, in accordance with:

- (a) the terms and conditions of this Agreement, and any Addenda or Exhibits attached to, and incorporated into, this Agreement;
- (b) the Provider Manual(s) applicable to the Benefit Program(s) in which Provider participates;
- (c) all laws, rules and regulations applicable to Provider and CFHP;
- (d) the Utilization Management Program, Quality Management Program, Benefit Program Requirements and complaints, appeals and other policies and procedures of the particular Benefit Program under which the Medically Necessary Covered Services are rendered;
- (e) the manner Provider renders services to his or her other members; and
- (f) the minimum clinical quality of care and performance standards that are professionally recognized and/or adopted, accepted or established by CFHP.

2.2.2 Emergency Care. When a Member seeks Emergency Care from Provider and Provider is not the Member's PCP, Provider will perform any medical screening evaluation or other evaluation required by State or federal law which is needed to determine if an Emergency exists. If Provider determines that an Emergency does not exist, Provider will instruct Member to contact his or her PCP to obtain an appropriate level of care. If a Member chooses to use the emergency room or other similar setting for care that does not meet the definition of Emergency Care, the member will be responsible for all billed charges. However, if an Emergency is determined to exist, Provider will provide Emergency Care services to the Member. Furthermore, once Member is considered to be stabilized in accordance with the criteria set forth in the definition of Emergency Care, Provider will contact CFHP for the approval and coordination of post-stabilization services. CFHP or its appointed representative(s) will approve or deny coverage of post-stabilization care within the time frame appropriate to the circumstances but in no case to exceed one (1) hour.

2.2.3 Behavioral Health. Providers who are Primary Care Physicians (PCPs) must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Providers who provide inpatient psychiatric services to a Member must schedule the Member for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven days from the date of discharge. Behavioral health providers must contact members who have missed appointments within 24 hours to reschedule appointments.

2.3 Accessibility and Availability.

2.3.1 Location and Hours. Provider shall maintain such offices, equipment, service personnel and allied health personnel as may be necessary to provide Covered Services under this Agreement. Provider shall provide, or arrange for provision

of, Covered Services under this Agreement at Provider's offices during normal business hours, and shall be available to Members by telephone twenty-four (24) hours a day, seven (7) days a week for consultation and/or management of medical concerns.

2.3.2 Appointment Availability. Provider shall comply with the minimum standards for availability of appointments for urgent, routine and wellness or other types of care required by CFHP, as set forth in the appropriate Benefit Program Provider Manual and made part of this Agreement by this reference.

2.4 PCP Services.

2.4.1 Selection or assignment. CFHP shall afford all new Members the opportunity to select a PCP upon enrollment. If a Member does not select a PCP at enrollment, CFHP may assign a Member to a PCP. CFHP shall make such an assignment to a PCP located within the zip code nearest the Member's residence or place of employment. To the extent practicable given the zip code limitation, CFHP shall assign PCPs in a manner promoting the fair and equitable distribution of Members among PCPs. CFHP shall inform a Member of the name, address, and telephone number of the PCP assigned to the Member and of the Member's right under Texas law to reject the assignment and select a different PCP.

2.4.2 Notification to PCP of selection or assignment. CFHP shall notify a PCP, via membership rosters, of the Member's selection of, or assignment to, that PCP within 30 days of the selection or assignment. A Member who selects PCP or is assigned to PCP by CFHP remains on the PCP's panel until CFHP notifies PCP that the Member is no longer on the PCP's panel or the Member is no longer enrolled with CFHP.

2.4.3 Coverage Requirements. PCPs shall arrange for coverage by another physician, in the event of Provider's illness, vacation or other absence from his or her practice, and will ensure that such covering physician is a Participating Provider, unless Provider has received a written exception from CFHP. If such covering physician is not a Participating Provider, PCP shall use his or her best efforts to cause such covering physician to abide by the terms of this Agreement. Should PCP utilize a locum tenens to provide coverage during his/her absence, PCP must notify CFHP and ensure that the locum tenens abides by the terms of this Agreement. In no event shall a locum tenens be allowed to provide services to Members in excess of ninety (90) days.

2.4.4 PCP Referrals and Admissions. PCPs must assess the medical needs and behavioral health needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. PCPs shall refer Members only to Participating Providers, and admit Members only into Facilities that are Participating Providers, for Medically Necessary Covered Services, except

- in an Emergency;
- pursuant to a Pre-Authorization;
- as otherwise allowed in the applicable Benefit Program Requirements;
- as otherwise required by law; or
- for certain specialized procedures and services for which CFHP requires the utilization of a qualified non-Participating Provider for such care.

- 2.4.5 Tuberculosis (TB).** Providers must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The Providers must report to the Texas Department of State Health Services (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.
- 2.4.6 Women, Infants and Children (WIC).** Providers must coordinate with the WIC Special Supplemental Nutrition Program to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin.
- 2.4.7 Specialty Care Provider as PCP.** A Specialty Care Physician may apply to be the PCP of a Member who the Physician is currently treating and who is disabled or has chronic/complex conditions. If CFHP approves the Specialty Care Provider's application to act as the Member's PCP, Specialty Care Provider shall be obligated to accept and perform the responsibilities of a PCP as set forth in Section 2.4 of this Agreement and the appropriate Benefit Program Provider Manual.
- 2.4.8 Failure to Achieve Satisfactory Provider-Member Relationship.** CFHP and PCP recognize that a satisfactory provider-member relationship is important to effective health care services. Because of the personal nature of the relationship between the Member and the PCP, there may be circumstances where the relationship is or becomes unsatisfactory. In the event of an unsatisfactory relationship between a Provider and a member, and if PCP reasonably determines that a satisfactory provider-member relationship cannot be achieved, PCP shall notify CFHP in writing within five (5) business days of making such determination. CFHP will evaluate the situation, conferring with the PCP and Member, as necessary, and, if appropriate, shall take immediate steps to remove the member from the Provider's panel. CFHP retains the right to disenroll the Member from the Plan in accordance with applicable regulations and the Member's Certificate of Coverage. PCP will remain responsible for providing or arranging for care to be provided for the Member until transfer or disenrollment, which shall not exceed 60 days from Provider's written notice to CFHP.
- 2.5 Non-Discrimination.** Provider shall not discriminate against any Member in the provision of Covered Services hereunder, whether on the basis of the Member's sex, race, color, religion, ancestry, national origin, disability, health status, source of payment, utilization of medical or mental health services or supplies or other unlawful basis including, without limitation, the filing by such Member of any complaint, appeal or legal action against Provider or CFHP. Provider further agrees to comply with Title VI of the Civil Rights Act of 1964 (Public Law), Section 504 of the Rehabilitation Act of 1973 (Public Law), The Americans with Disabilities Act of 1990 (Public Law 101-336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these Acts.
- 2.6 Non-retaliation.** CFHP shall not retaliate against any Provider who has reasonably filed a complaint on behalf of a Member or has appealed a decision made by CFHP.
- 2.7 Subcontracting.** Except for entering into agreements with its Providers and to the extent otherwise authorized under this Agreement, Provider shall not subcontract for the performance of Covered Services under this Agreement without the prior written consent of CFHP.

2.8 Utilization Management Requirements. Provider agrees to participate in, cooperate with and comply with the requirements and decisions rendered in connection with CFHP's Utilization Management Program. Provider also agrees to provide such records, review data and other information or data elements as may be required or requested under the Utilization Management Program and/or CFHP's policies and procedures, including outcome reporting in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 3.0, or its successor. The Utilization Management Program for a particular Benefit Program is set forth in the Provider Manual for that Benefit Program.

2.8.1 Pre-Authorization Requirements. For Covered Services that require Pre-Authorization under the applicable Utilization Management Program, Provider agrees not to seek payment from CFHP for Covered Services rendered to a Member unless such Pre-Authorization was obtained prior to the rendering of such services. Failure to obtain Pre-Authorization is grounds for CFHP to deny a Provider's claim for reimbursement for Covered Services.

In the event that Medically Necessary Covered Services are not available through a Participating Provider(s), CFHP will, upon request of Provider allow Referral(s) to a non-Participating Provider. Furthermore, CFHP agrees that prior to denying any Referral(s) to a non-Participating Provider for Medically Necessary Covered Services, CFHP will provide for a review by a specialist of the same or similar specialty. Services performed by a Non-Participating Provider must be Pre-Authorized. Failure to obtain such Pre-Authorization is grounds for CFHP to deny a Provider's claim for reimbursement for Covered Services.

2.8.2 Privacy Requirements. Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Providers 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.

2.9 Quality Assessment and Performance and Improvement. Provider shall be solely responsible for the quality of Covered Services rendered to Members. The quality of Covered Services rendered to Members, including appropriateness, timeliness and necessity of services and claims submission, shall be monitored under the Quality Assessment and Performance and Improvement applicable to the particular Benefit Program, including all confidentiality requirements. Provider agrees to participate in, cooperate with and comply with all requirements and decisions rendered by CFHP in connection with a Quality Assessment and Performance and Improvement. Provider also agrees to provide such records, review data and other information or data elements as may be required or requested under the Quality Assessment and Performance and CFHP's policies and procedures, including outcome reporting in accordance with, but not limited to, the Health Plan Employer Data and Information Set (HEDIS), Version 3.0, or its successor.

2.10 Credentialing and Recredentialing of Provider. Provider shall submit to CFHP, or its designated CVO, the Texas Standardized Credentialing Application, as modified from time to time by CFHP. In no event will this Agreement become effective, nor will a Provider begin performing his or her obligations under this Agreement, until (1) this Agreement is executed by CFHP and Provider, (2) CFHP notifies Provider in writing that Provider has successfully completed CFHP's initial Credentialing or subsequent Recredentialing activity; **AND** (3) CFHP has notified Provider, in writing, of the effective date of the Agreement.

- 2.11 Preventive Care Services.** Provider shall abide by CFHP's policies and procedures regarding preventive care and health education. Providers shall render preventive care and health education to Members during each office visit and document such in the medical record. Provider shall prepare an annual preventive care and health education action plan documenting planned classes, educational materials and services provided if appropriate. Provider must provide preventative care to children under age 21 in accordance with AAP recommendations for CHIP Members and CHIP Perinatal Newborns, and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members; and to adults in accordance with the U.S. Preventative Task Force requirements.
- 2.12 Notice of Adverse Action.** Provider shall notify CFHP in writing, within five (5) days of receiving any written or oral notice of any adverse action, including, without limitation, any malpractice suit or arbitration action, or other suit or arbitration action naming or otherwise involving Provider or CFHP, and any other event, occurrence or situation which might materially interfere with, modify or alter performance of any of Provider's duties or obligations under this Agreement. Provider shall forward to CFHP any written complaint or appeal of a Member against Provider or CFHP within twenty-four (24) hours of receipt thereof. Provider shall maintain a written record of any Member complaint and provide such record to CFHP promptly upon request. Provider also shall notify CFHP promptly of any action against any license, certification under Title XVIII or Title XIX or other applicable statute of the Social Security Act or other State law, DEA and DPS narcotic registration certificate, or, if applicable, medical staff privileges, and of any material change in the ownership or business operations of Provider.
- 2.13 Professional Liability Insurance.** Provider shall maintain professional liability insurance in an amount equal to the greater of the highest amount required by law, or two hundred thousand dollars (\$200,000) per claim and six hundred thousand dollars (\$600,000) in the aggregate of all claims per policy year. Such professional liability coverage shall include "tail" coverage of the same limits as stated above for any "claims-made" policy as necessary to continue coverage until any applicable statute of limitations has expired. Provider agrees to provide CFHP with written evidence, acceptable to CFHP, of such insurance coverage within three (3) days of such request by CFHP. Provider also agrees to notify or to ensure that its insurance carriers notify CFHP at least thirty (30) days prior to any proposed termination, cancellation or material modification of any policy for all or any portion of the coverage provided for above.
- 2.14 Use of Name.** Neither CFHP nor Provider shall use each other's trademarks, name, or symbols without permission; provided, however, that Provider agrees that CFHP may use Provider's name, office address, telephone number, and specialty, and a factual description of the practice in directories and other promotional materials.
- 2.15 Non-Solicitation.** Neither Provider nor any employee, agent or contractor of Provider shall solicit or attempt to convince or otherwise persuade any Member to discontinue participation in any CFHP Benefit Program with respect to which Provider provides Covered Services under this Agreement.
- 2.16 New or Additional Benefit Programs.** Provider acknowledges that CFHP may develop new or additional Benefit Programs in Provider's geographic area(s), and Provider agrees to negotiate with CFHP in good faith to amend this Agreement to include such new or additional Benefit Programs as requested by CFHP.
- 2.17 Payment of Applicable Taxes.** Provider shall be solely responsible for the collection and payment of any sales, use or other applicable taxes on the sale or delivery of medical services.

- 2.18 Investigation and Resolution of Complaints.** Provider shall notify CFHP if an event has a high potential for liability or results in a ninety (90) day notice or legal claim being served. CFHP shall be notified of the event within forty-eight (48) hours.
- 2.19 Release.** Provider hereby releases from liability CFHP and their affiliates, directors, committees, officers, employees, or agents and agrees to waive all legal claims which Provider may now or hereafter have against such individuals or entities related to any and all actions taken in good faith in connection with evaluating Provider's professional qualifications. Provider further releases from liability any individual or entity who may have information bearing on Provider's professional qualifications who discloses in good faith such information in connection with evaluation by the above entities and individuals of Provider's professional qualifications. Provider further agrees that any act, communication, report recommendation, or disclosure made in connection with the evaluation of professional qualifications shall be privileged and confidential and shall not be subject to discovery, subpoena, or other means of legal compulsion for its release.
- 2.20 Posting of Complaint Notice.** Provider shall post, in Provider's offices, a notice to Members on the process for resolving complaints with CFHP. The notice shall include the Texas Department of Insurance (TDI) toll-free telephone number for filing complaints.
- 2.21 Complaints and Appeals.** The Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.
- 2.22 Change of Address Notification.** Provider shall provide CFHP with at least 30 days notice that the Provider is changing office address and/or service location or is no longer affiliated with a particular provider group.

3. COMPENSATION

- 3.1 Compensation Rates.** Provider shall accept as payment in full for Covered Services and all other services (including payment for any and all sales, use or other applicable taxes on the sale or delivery of medical services) rendered under this Agreement to Members the amounts payable by CFHP as set forth for a particular Benefit Program in the Addenda to this Agreement, less any Copayments, Coinsurance or Deductibles payable under that Benefit Program. Provider has the obligation to ensure receipt of appropriate compensation and the responsibility to notify CFHP of any overpayments or underpayments.
- 3.2 Provider Bonuses and Incentives.** Both Provider and CFHP understand and agree that any payments made directly or indirectly to Provider under any bonus or incentive provisions set forth in the applicable Addendum are not made as an inducement to reduce or limit Medically Necessary Covered Services to any Member. There is no guarantee that Provider will receive or be eligible to receive such bonuses or incentives.
- 3.3 Claims Billing and Payment Process.** The following provisions apply to all Benefit Programs except Medicaid Managed Care (STAR) and any employer-sponsored self-funded Benefit Program(s). If Provider participates in the STAR Benefit Program or an employer-sponsored self-funded Benefit Program, claims billing and payment processes contained in the Addendum to this Agreement that relate to such Benefit Program(s) will apply.
- 3.3.1 Claims Submission.** Provider shall submit to CFHP, electronically, Clean Claim(s) for Covered Services rendered to Member(s), **within ninety-five (95) calendar days after Provider renders such services.** In the event that Provider fails to timely submit a Clean Claim, such claim shall be denied and

CFHP shall make no payment under this Agreement. Provider shall not seek payment from any Member in the event CFHP fails to pay Provider for a claim not timely submitted or for any claim appropriately denied by CFHP.

3.3.2 Claims Adjudication. CFHP shall: (1) pay the contracted amount of the claim in accordance with this Agreement and as outlined in Article 20A.18B, Texas Insurance Code, as amended from time to time; or (2) pay the contracted amount of the claim in accordance with this Agreement and notify Provider in writing if CFHP intends to audit the claim as allowed under the Clean Claims Rules. CFHP may also retrospectively audit claims paid in full under the contracted rates as allowed under Article 20A.18B, Texas Insurance Code, as amended from time to time.

3.3.3 Appeal of Claims Adjudication. Provider has **90 calendar days** from the date on the original Explanation of Payment received by the Provider to appeal the adjudication of the claim by CFHP including but not limited to incorrect payment by CFHP. CFHP will not accept an appeal of a claim adjudication submitted after this deadline and Provider will have no right of appeal or payment. The Provider Manual contains additional information on appeals of claim adjudications as amended from time to time by CFHP and made part of this Agreement by this reference.

3.3.4 Penalty for Late Payment. If CFHP does not adjudicate a Clean Claim in a timely manner, or for any other reason triggers penalty provisions of the Clean Claims Rules, CFHP shall make payment to Provider in accordance with the penalty requirements specified in Article 20A.18B, Texas Insurance Code, as amended from time to time.

3.4 Eligibility. Except in an Emergency, Provider shall verify the eligibility of Members in accordance with CFHP policies and procedures before providing Covered Services. CFHP shall make a good faith effort to confirm the eligibility of any Member when such is in question

3.5 Collection of Copayments, Coinsurance and Deductibles. Provider shall use its best efforts to collect all Copayments due from Members, and shall not waive or fail to pursue collection of Copayments, Coinsurance and Deductibles from Members, without the prior written consent of CFHP.

3.6 No Surcharges. Provider shall not charge the Member any fees or surcharges for Covered Services rendered pursuant to this Agreement (except to the extent of authorized Copayment(s)). For example, a Provider may not charge a Member for after hours access, prescription refills or telephone consultations. In addition, Provider shall not collect a sales, use or other applicable tax from Members for the sale or delivery of medical services. If CFHP receives notice of any additional charge, Provider shall fully cooperate with CFHP to investigate such allegations, and shall promptly refund any payment deemed improper by CFHP to the party who made the payment.

3.7 Member Held Harmless.

(a) Provider agrees that in the event of CFHP's insolvency or other cessation of operations, Provider will continue to provide services to Members through the period for which premium has been paid, including Members who are in an inpatient facility.

(b) Provider hereby agrees that in no event, including, but not limited to, non-payment by CFHP, CFHP's insolvency or CFHP's breach of this Agreement,

shall Provider bill, charge, collect a deposit from, or have any recourse against Member or any party acting on Member's behalf for services provided pursuant to this Agreement. Subject to Section 3.9, this provision shall not prohibit the collection of charges for services that are not Covered Services under the applicable Benefit Program.

- (c) Provider agrees to hold harmless the State of Texas, all State officers and employees, and all Members in the event of nonpayment by CFHP to the Provider. Provider further agrees to indemnify and hold harmless the State and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the State or its agents, officers or employees, through the intentional conduct, negligence or omission of Provider, any shareholder, partner or any other individual or entity holding an equitable interest in the Provider its agents, officers, employees or contractors.
- (d) Provider further agrees that this section 3.7 of the Agreement shall (1) survive the termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Members, and (2) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or persons acting on a Member's behalf, insofar as such contrary agreement relates to liability for payment for continuation of Medically Necessary Covered Services provided under the terms and conditions of the provision.
- (e) Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the State regulatory agency has received written notice of such proposed change and has approved such change.
- (f) Community First will initiate and maintain any action necessary to stop a Network Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, and HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Network Provider from collecting allowable copayment and deductible amounts from CHIP Members.

3.8 Member Liability for Excluded Services. CFHP shall not be liable for the provision of Excluded Services to a Member. Provider also cannot bill Member for Excluded Services unless, prior to the provision of Excluded Services to the Member, Provider must obtain a signed Private Pay form from the Member that the Member understands and acknowledges that:

- He/she has been informed in writing of the services to be provided;
- the services to be provided are not covered under the Member's Benefit Program;
- CFHP will not pay for or be liable for such services;
- Member requests that Provider render the Excluded Services, and that such Member will be financially liable for such services.

3.9 Coordination of Benefits. Provider agrees to conduct Coordination of Benefits in accordance with Article 20A.18B, Texas Insurance Code, as amended from time to time, and the policies and procedures established by CFHP for the applicable Benefit Program.

Provider shall not bill Members for any portion of Covered Services not paid by the primary carrier when CFHP is the secondary carrier, but shall instead look to CFHP for such payment. When a Member has coverage which is primary through another carrier, then CFHP's compensation to Provider shall be limited to the difference between the amount paid by the primary carrier and the contract rates contained in the applicable Addendum to this Agreement, less applicable Copayments, Coinsurance, or Deductibles.

- 3.10 Third Party Recoveries.** When CFHP has compensated Provider, directly or indirectly, for Covered Services, then CFHP retains the right to recover from applicable third party carriers covering a Member, including self-insured, indemnity and liability plans, and to retain all such recoveries. Provider agrees to provide CFHP with such information as CFHP may require to pursue recoveries from such third party sources, and to promptly remit to CFHP any monies Provider may receive from or with respect to such sources of recovery. Provider understands and agrees that it may not interfere with or place any liens upon the state's right or CFHP's right, acting as the state's agent, to recovery from third party resources.
- 3.11 Offset.** Provider shall be notified in writing by CFHP of any monies Provider may owe CFHP, for any reason, and Provider shall have 45 days from receipt of such notification to refund monies owed to CFHP. If there is a dispute as to monies owed to CFHP, Provider shall provide a written response to CFHP outlining the specific nature of such dispute within such 45-day notice period. Upon receipt by CFHP of Provider's written response to the notice of offset, CFHP shall have 30 days to research, review and respond to Provider's appeal. Provider agrees to cooperate with CFHP in its efforts to resolve the dispute. If Provider fails to respond within 45 days, as provided above, CFHP will offset monies owed by Provider from any outstanding monies that CFHP, for any reason, may owe to Provider.

4. TERM AND TERMINATION

- 4.1 Term.** This Agreement shall continue in force unless terminated in accordance with the provisions of this Part 4 of the Agreement. Regardless of the effective date of this Agreement, Provider shall not begin providing Covered Services to Members and CFHP shall have no obligation to pay for such services until execution of this Agreement by CFHP and Provider and the successful completion of all necessary Credentialing and certification processes.
- 4.2 Termination by Either Party.** Either party may terminate this Agreement:
- 4.2.1** Whenever CFHP's authority to operate as an HMO under Article 20A.01, et seq. Texas Insurance Code, is lost or suspended by the Texas Department of Insurance.
- 4.2.2** As of any date, by giving written notice of such intent at least ninety (90) days in advance. In the event of termination pursuant to this section, the obligations of Provider and CFHP under this Agreement shall continue in full force and effect with respect to existing Members for a period not to exceed ninety (90) days from the date of notice of contract termination ("Notice Period"). The parties may, however, agree to an earlier termination date. The right to terminate this Agreement pursuant to this section shall not release Provider from its obligation to continue providing services under Section 4.5 of this Agreement. CFHP's right to terminate this Agreement shall be subject to Provider's Appeal rights under Section 4.7 of this Agreement.
- 4.2.3** In the event that either Provider or CFHP fails to cure a material breach of this Agreement, including, but not limited to, (a) either party's violation of any

applicable law, rule or regulation; (b) either party's failure to maintain the professional liability insurance coverage specified hereunder; or (c) either party's failure to comply with the terms, conditions or determinations of any Utilization Management Program or Quality Management Program or other Benefit Program Requirements. The terminating party shall give the breaching party 30 days to cure such breach. If the breach is not cured by the breaching party within 30 days, the Agreement will be terminated effective 90 days after the original notice of breach. If the breach is cured within such thirty (30) day period, or if the breach is one which cannot reasonably be corrected within thirty (30) days, and the noticed party makes substantial and diligent progress toward correction during such thirty (30) day period, this Agreement shall remain in full force and effect; provided, however, this Agreement shall terminate if such cure is not complete within ninety (90) days of the original notice of breach.

- 4.3 Immediate Termination.** CFHP may terminate this Agreement immediately upon notice to Provider, in the event of (i) imminent harm to member health, (ii) an action by a state medical board, a medical or other licensing board, or a government agency that effectively impairs Provider's ability to practice medicine or another profession, or (iii) fraud or malfeasance.
- 4.4 Right of Partial Termination.** Provider may only terminate this Agreement in its entirety in accordance with Section 4.2. CFHP may terminate this Agreement with respect to one or more Benefit Programs as CFHP indicates in the notice of termination to Provider. This Agreement shall remain in full force and effect with respect to all other Members and Benefit Programs.
- 4.5 Effect of Termination on Continuity of Care.** Following termination of this Agreement, other than for reasons of medical competence or professional behavior, Provider shall continue rendering Covered Services in accordance with the dictates of medical prudence to Members with special circumstances for a period up to ninety (90) days from effective date of termination or for up to nine (9) months in the case of a Member who at the time of termination has been diagnosed with a terminal illness, or through delivery of a child, immediate postpartum care, and a six-month follow-up checkup after delivery in the case of a Member past the twenty-fourth (24th) week of pregnancy. Special circumstances include, but are not limited to: (a) persons with disabilities, (b) persons with acute conditions, (c) persons with life threatening illnesses, or (d) persons past the twenty-fourth (24th) week of pregnancy. In turn Provider must identify the special circumstance to CFHP and agree not to seek compensation for Medically Necessary Covered Services from Member of any amount for which the Member would not be responsible if the Provider were still a Participating Provider under this Agreement. CFHP will compensate Provider for such Medically Necessary Covered Services at the contractual compensation rate effective with Provider at the time of termination of this Agreement. In the event that a dispute develops regarding the necessity for continued treatment both Provider and CFHP agree to resolve such issues in accordance with Section 6.4 ("Dispute Resolution") of this Agreement. CFHP shall provide at least 30 days notice of Provider's termination to a Member who is currently being treated by Provider; notification of termination for reasons related to imminent harm may be given to Members immediately.
- 4.6 Release of Records Upon Termination.** Upon the effective date of termination of this Agreement and, if applicable, upon the expiration of any continuation of care, Provider shall copy all Member medical files in Provider's possession and forward such files to another Participating Provider of medical services upon a request by such Participating Provider and the delivery of a properly executed release of records. Provider shall cooperate with requesting provider in maintaining the confidentiality of such medical files.

- 4.7 Appeal of Termination.** In the event this Agreement is terminated by CFHP, CFHP will make available to Provider any reason(s) for such termination. Except in a case in which there is (i) imminent harm to member's health, (ii) an action by a state medical board, a medical or other licensing board, or a government agency that effectively impairs Provider's ability to practice medicine or another profession, or (iii) fraud or malfeasance, Provider may, upon request and prior to the effective date of such termination, request to appeal CFHP's termination decision. Termination appeals must be submitted in accordance with Section 6.12. On request and before the effective date of the termination, but within a period not to exceed sixty (60) days, all such Provider termination appeals will be reviewed by CFHP's Quality Improvement Committee. When a Quality Improvement Committee review is requested, CFHP will ensure that at least one member of the Committee is of the same or similar specialty as Provider requesting review. CFHP will also make available to Provider, upon request, a copy of recommendations of the Quality Management Committee and CFHP's determination for such termination. The recommendations of the Quality Improvement Committee must be considered by CFHP but are not binding on CFHP.
- 4.8 Termination for Gifts or Gratuities.** 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. CFHP may terminate the Provider contract at any time for violation of this requirement.

5. RECORDS, REPORTS AND REGULATORY REQUIREMENTS

5.1 Maintenance of Records.

- 5.1.1 Administrative Records.** Provider shall maintain such financial, administrative, and other records as may be necessary to meet all applicable accrediting requirements and local, State, and federal laws, rules, and regulations. Provider agrees to maintain the confidentiality of all information related to fees, charges, expenses, and utilization derived from, through, or provided by CFHP and/or the Benefit Program.
- 5.1.2 Medical Records.** Provider shall maintain a complete medical record for each Member for which it provides Covered Services which includes the recording of Provider's services and such other records as may be required by law or an accrediting agency. Such records shall be maintained in accordance with all applicable accrediting requirements and local, State, and federal laws, rules, and regulations. All medical records shall be treated as confidential so as to comply with all State and federal laws, rules, and regulations regarding the confidentiality of Member records.

Subject to applicable local, State, or federal laws, rules or regulations, in the event of (i) termination of this Agreement, (ii) the selection by a Member of another Participating Provider in accordance with Benefit Program procedures, or (iii) the approval of a Provider's request to transfer a Member to another Provider, Provider agrees to ensure that Member's medical records, x-rays, or other documents and data are transferred when requested to do so by the Member, at no charge to the Member.

- 5.1.3 Records for Benefit Program.** In accordance with State and federal regulations regarding Medicaid and CHIP Members, Provider agrees to maintain fiscal,

medical, and special records that are accurate, complete, up-to-date, organized, and otherwise in conformance with good medical documentation guidelines and CFHP policies and in such format as necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement. These records shall be retained for a period of at least five (5) years from the last date of treatment, three years after the Member attains majority, or for such other period as may be required by law, or until the resolution of any ongoing audit occurs.

- 5.2 Access to Records.** The records referred to in Section 5.1, above, shall be and remain the property of Provider and shall not be removed or transferred from Provider except in accordance with applicable local, State, and federal laws, rules, and regulations, including the Privacy Requirements. Subject to applicable State or federal confidentiality laws and pursuant to written consent or authorization by Members, CFHP shall have access to Provider's office during normal business hours on request, to inspect, review, and make copies of such records. Such records shall be transferred from an agent of one peer review committee to the agent of another peer review committee. When requested by CFHP, or authorized representatives of local, State or federal regulatory agencies, Provider shall provide copies of any such records for which Provider shall charge no more than ten cents (\$0.10) per page. In no event, however, shall Provider charge for records requested for payment of a claim, for approval of a request for authorization, or for quality audits. Notwithstanding the foregoing, but subject to applicable local, State, or federal laws, rules or regulations, in the event of (i) termination of this Agreement, (ii) the selection by a Member of another Participating Provider in accordance with Benefit Program procedures, or (iii) the approval by the Benefit Program of Provider's request to transfer a Member to another Provider, Provider agrees to transfer copies of Member's medical records, x-rays, or other data to the Benefit Program when requested to do so by the Benefit Program or the Member, at no charge to the Member or the Benefit Program. Additionally, Provider agrees to permit any accrediting agency, CFHP or their designated representatives, and the designated representatives of local, State, and federal regulatory agencies having jurisdiction over CFHP or any Benefit Program, to conduct site evaluations and inspections of Provider's offices and service locations as may be needed to assure quality of care rendered to Members. Provider agrees to provide the Texas Health and Human Services Commission (HHSC) all information required under CFHP's managed care contract with HHSC, including but not limited to the reporting requirements and other information related to the Provider's performance of its obligations under the contract and any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations. All information must be provided in accordance with timelines, definitions, formats, and instructions specified by HHSC.
- 5.3 Continuing Obligation.** The obligations of Provider under this Section 5 shall not be terminated upon termination of this Agreement, whether by rescission or otherwise. After termination of this Agreement, CFHP shall continue to have access to Provider's records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules, and regulations.
- 5.4 Accreditation and Regulatory Compliance.** Provider agrees to comply with all applicable accreditation and licensure requirements and local, State, and Federal laws, rules and regulations, now or hereafter in effect, to the extent that they directly or indirectly affect Provider or CFHP and bear upon the subject matter of this Agreement. Provider agrees to give immediate notice to CFHP in the case of suspension or revocation, or initiation of any proceeding that could result in suspension or revocation, of licensure or of any circumstance that would cause Provider to be noncompliant with any such statutes, rules, regulations, standards, or directives.

5.5 Fraud and Abuse. The 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 Providers and their employees, agents, contractors, and patients;
- (b) requests for information from such entities must be complied with, in the form and language requested;
- (c) Providers and their employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pretrial conference, hearings, trials and any other process, including investigations at the Provider's own expense; and
- (d) compliance with these requirements will be at the [Network Provider's] own expense.
- (e) Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;
- (f) Providers 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;
- (e) Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
- (f) If the Network Provider places required records in another legal entity's records, such as a hospital, the Network Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
- (e) Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by CFHP or a Member to the HHSC Office of Inspector General.

6. GENERAL PROVISIONS

- 6.1 Amendments.** All amendments to this Agreement must be agreed to in writing by Provider and CFHP in advance of the effective date thereof. Except as otherwise provided in this subsection, any amendment to this Agreement, including any of its Addenda, proposed by CFHP shall be effective ninety (90) days after CFHP has given written notice to Provider of the amendment. Amendments necessitated by accreditation, legislative, regulatory or legal requirements, or interpretations or court holdings do not require the consent of Provider and will be considered effective as of the date of the change, requirement, interpretation or court holding. Any amendment to this Agreement requiring prior approval of or notice to any federal or State regulatory agency shall not become effective until all necessary approvals have been granted or all required notice periods have expired. CFHP shall amend this Agreement from time to time to include additional Benefit Programs.

- 6.2 Assignment.** Neither this Agreement, nor any of Provider's rights or obligations hereunder, is assignable by Provider without the prior written consent of CFHP.
- 6.3 Confidentiality.**
- 6.3.1 Member-Related Information.** Provider must treat all information that is obtained through the performance of the services included in this Provider contract 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. Also under the Privacy Requirements, the parties agree to keep confidential and not disclose member-identifiable information to any third party without the prior written consent of the Member.
- 6.3.2 Business Activities.** Except as required by law and for the purposes of implementing this Agreement, CFHP and Provider agree to keep confidential any information regarding the other's business activities that is not otherwise available to the general public, unless prior written consent for disclosure is obtained from the other party.
- 6.3.3 Proprietary Information.** All information and materials provided by CFHP to Provider shall remain proprietary to CFHP including, but not limited to, contracts, fee schedules, reimbursement rates and methodology, handbooks, and any other operations manuals. Provider shall not disclose any of such information or materials or use them except as may be required to perform Provider's obligations hereunder, and Provider shall return all information and materials immediately upon termination of this Agreement.
- 6.3.4 Survival of Obligations.** The obligations of the parties under this section shall survive termination of this Agreement.
- 6.3.5 Confidentiality-HIPAA.** Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Providers 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.
- 6.4 Dispute Resolution.** All disputes or controversies arising or related to this Agreement, other than disputes relating to compensation rates and termination without cause, shall be arbitrated. Provider and CFHP agree: (a) negotiation shall be a condition precedent to the filing of any arbitration demand by either party; (b) to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement; and (c) no arbitration demand may be filed until the exhaustion of CFHP's internal appeal procedures. In the event arbitration between Provider and CFHP becomes necessary, such arbitration shall be initiated by either party making a written demand for arbitration on the other party. Such arbitration shall be conducted under rules the same as or consistent with the rules of the American Arbitration Association Dispute Resolution Service, but need not necessarily be conducted by that organization, except where applicable federal or State law requires otherwise. The parties expressly agree to be bound by the decision of the arbitrator(s). During the arbitration, each party shall bear its own attorneys' fees. Upon an award of the arbitrator, the prevailing party shall be entitled to recover its share of arbitration costs expended, and all its other costs, including its attorneys' fees. In the event the arbitrator fails to render an award within ninety (90) days

after submission of the matter for decision, or such longer times as the parties may stipulate, then either party may elect to have all further arbitration proceedings terminated and the matter submitted for judicial resolution. All reasonable costs and fees incurred during the arbitration shall then be awarded by the court to the prevailing party. Venue for any arbitration proceeding shall be mandatory in Bexar County, Texas.

- 6.5 Reporting of False Claims.** If Provider receives information regarding misconduct from any source and has reasonable grounds to believe that the misconduct either: (1) violates criminal law, or (2) constitutes a material violation of the civil law or rules and regulations governing managed care programs, including, but not limited to, the submission of false claims for payment, Provider shall report the information to CFHP within ten (10) days after learning of the information. When reporting the information to CFHP, Provider shall give CFHP any information relating to the misconduct that Provider has, including any information disclosed from another source.
- 6.6 Entire Agreement.** This Agreement supersedes any and all other agreements, either oral or written, between the parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this Agreement shall be valid or binding.
- 6.7 Governing Law.** This Agreement shall be governed by and construed and enforced in accordance with the laws of the State, except to the extent such laws conflict with or are preempted by any federal law, in which case such federal law shall govern. Federal law shall also govern with respect to Benefit Programs of federal governmental Payors. This Agreement shall be performable in Bexar County, Texas.
- 6.8 Hold Harmless.** Except as otherwise expressly set out in this Agreement, neither Provider nor CFHP (nor any of their respective sponsors, directors, officers, shareholders, employees or agents) shall be liable to the other for any act or omission of the other party. To the extent not covered by insurance, Provider and CFHP each agree to indemnify and hold the other harmless from and against any and all liabilities, losses, damages, claims and expenses of any kind, including costs and attorneys' fees, incurred by the indemnified party and arising from or in connection with the indemnifying party's performance of, or failure to perform its duties and obligations under this Agreement.
- 6.9 Non-Exclusive Contract.** This Agreement is non-exclusive and shall not prohibit Provider or CFHP from entering into agreements with other health care providers or purchasers of health care services.
- 6.10 Notice to Members.** CFHP shall provide reasonable advance notice to Members of the impending termination of Provider.
- 6.11 No Third Party Beneficiary.** Nothing in this Agreement is intended to, or shall be deemed or construed to create any rights or remedies in any third party, including a Member. Nothing contained herein shall operate (or be construed to operate) in any manner whatsoever to increase the rights of any such Member or the duties or responsibilities of Provider or CFHP with respect to such Members.
- 6.12 Marketing.** Network Provider Agrees to comply with HHSC's marketing policies and procedures, as set forth in the HHSC/CFHP Managed Care Contract (which includes HHSC's Uniform Managed Care Manual). The Network Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Network Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

6.13 Audit or Investigation. The Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Provider contract and any records, books, documents, and papers that are related to the Provider contract and/or the Provider's performance of its responsibilities under this contract:

- (a) HHSC and CFHP Program personnel from HHSC;
- (b) U.S. Department of Health and Human Services;
- (c) Office of Inspector General and/or the Texas Medicaid Fraud Control Unit;
- (d) an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
- (e) state or federal law enforcement agency;
- (d) special or general investigation committee of Texas Legislature;
- (e) the U.S. Comptroller General;
- (f) the Office of the State Auditor of Texas; and
- (g) any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

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

[Network 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. [Network 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.

6.14 Notice. Any notice required or desired to be given under this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or overnight courier, or facsimile, addressed as follows:

CFHP: Patrina L. Fowler
 Vice-President/COO
 Community First Health Plans, Inc.
 12238 Silicon Dr., Ste. 100
 San Antonio, Texas 78249

Provider:

Notices given hereunder shall be deemed given upon documented receipt. The addresses to which notices are to be sent may be changed by written notice given in accordance with this section.

- 6.15 Regulations.** CFHP is subject to the requirements of various local, State, and federal laws, rules, and regulations. Any provision required to be in this Agreement by any of the above shall bind Provider and CFHP whether or not provided herein. 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 Provider Contract and CFHP's managed care contract with HHSC, the HMO Program, and all persons or entities receiving state and federal funds. The 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 Provider contract, or any violation CFHP's contract with HHSC could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
- 6.16 Member Communications.** Community First is prohibited from imposing restrictions upon the Network Provider's free communication with a Member about the Member's medical conditions, treatment options, Community First referral policies, and other Community First policies, including financial incentives or arrangements and all managed care plans with whom the Network Provider contracts.
- 6.17 Severability.** If any provision of this Agreement is rendered invalid or unenforceable by any local, State or federal law, rule or regulation, or declared null and void by any court of competent jurisdiction, the remainder of this Agreement shall remain in full force and effect.
- 6.18 Status as Independent Entities.** None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between Provider and CFHP other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither Provider nor CFHP, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other.
- 6.19 Addenda.** Each Addendum to this Agreement is made a part of this Agreement as though set forth fully herein. Any provision of an Addendum that is in conflict with any provision of this Agreement shall take precedence and supersede the conflicting provision of this Agreement.
- 6.20 Gag Clause.** CFHP is prohibited from imposing restrictions upon the Provider's free communication with Members about a Member's medical conditions, treatment options, CFHP referral policies, and other CFHP policies, including financial incentives or arrangements.
- 6.21 Independent Medical Judgment.** Nothing contained in this Agreement shall be construed to require Provider to recommend or withhold any procedure or course of treatment that is not consistent with Provider's best medical judgment. Eligibility, Pre-Authorization, case management, and Utilization Management Program activities are performed for the purpose of clearly defining financial responsibility and encouraging efficient use of resources and network services. Provider is free to make independent medical recommendations, and Members are free to choose to accept or reject any treatment course.
- 6.22 Authority of State and Federal Agencies.** The parties acknowledge and agree that the State and federal agencies, or such other authorized agency or entity, have final authority

over this Agreement and certain aspects of the administration of certain Benefit Plans including, but not limited to, determination of benefits or eligibility, termination of coverage, and the structure and operation of the grievance system.

- 6.23 Headings.** The headings contained in this Agreement are for the convenience of the parties only and shall not be deemed to affect the meaning of the provisions hereof.
- 6.24 Counterparts.** This Agreement may be executed in two counterparts, each of which shall be deemed an original and together shall constitute one and the same agreement, with one counterpart being delivered to the other party hereto.
- 6.25 Non-Assumption of Liabilities.** Unless specifically provided by this Agreement, Provider does not assume or become liable for any of the existing or future obligations, liabilities, or debts of CFHP, and CFHP does not assume or become liable for any of the existing or future obligations, liabilities, or debts of Provider.
- 6.26 No Waiver of Rights.** The failure of either party to insist upon the strict observation or performance of any provision of this Agreement or to exercise any right or remedy shall not impair or waive any such right or remedy. Every right and remedy given by this Agreement to the parties may be exercised from time to time and as often as appropriate.
- 6.27 Advance Directives.** Provider must comply with the requirements of state and federal laws, rules and regulations relating to advanced directives. An advance directive is, for example, a living will or a durable power of attorney in which an individual makes decisions concerning medical care in advance of incapacity, including the right to accept or refuse future medical or surgical treatment.
- 6.28 Attorneys' Fees.** If any action at law or in equity is brought to enforce or interpret the provisions of this Agreement, the prevailing party shall be entitled to reasonable attorneys' fees in addition to any other relief to which the party may be entitled.
- 6.29 Force Majeure.** Either party's breach of this Agreement shall be excused, to the extent reasonably necessary, because of an act of God, war, civil commotion, fire, explosion, or other force majeure event that occurs without the fault or negligence of the non-performing party and prevents performance under this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement to be effective as of the date first written above.

Provider:

Community First Health Plans, Inc.:

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

Federal Tax Identification Number

Addendum A

Benefit Programs and Service Area

This Agreement applies to Benefit Programs where a check mark appears in the "Fee for Service" box.

Benefit Programs	FEE-FOR-SERVICE
HMO Standard Commercial/ASO Program. <i>See Addendum B.</i>	
STAR Program (Medicaid Managed Care) <i>See Addendum C.</i>	
Children's Health Insurance Program (CHIP) <i>See Addendum D.</i>	
Children's Health Insurance Program (CHIP) Perinatal Program <i>See Addendum E.</i>	
University Family Care Plan (UFCP) <i>See Addendum F.</i>	
Business Associate Addendum <i>See Addendum G</i>	

Service Area includes the following Texas counties:

HMO/ASO

Atascosa
Bexar
Comal
Guadalupe
Kendall
Medina
Wilson

STAR

Atascosa
Bandera (eff 09/01/2011)
Bexar
Comal
Guadalupe
Kendall
Medina
Wilson

CHIP

Atascosa
Bexar
Comal
Guadalupe
Kendall
Medina
Wilson

Optional Service Area

Bandera (CHIP)

Addendum B

HMO Standard Commercial

A. General Program Requirements

1. Provider understands and agrees that CFHP has the sole responsibility for the payment of Covered Services rendered to Members by Provider under this Agreement. In the event of CFHP's insolvency or cessation of operations, Provider's sole recourse is against CFHP through the bankruptcy, conservatorship, or receivership estate of CFHP.
2. Provider understands and agrees that it shall comply with the minimum standards for availability of appointments for urgent, routine, wellness or other types of care required by CFHP, as set forth in the Commercial Provider Manual as amended from time to time by CFHP and made a part of this Agreement by this reference.
3. Provider understands and agrees that for Covered Services that require Pre-Authorization, Provider will not seek payment from CFHP for Covered Services rendered to a member unless such Pre-Authorization was obtained prior to the rendering of such services. Failure to obtain Pre-Authorization is grounds for CFHP to deny Provider's claim for reimbursement for Covered Services.
4. Provider understands and agrees to accept as payment in full for Covered Services and all other services (including payment for any sales, use or other applicable taxes on the sale or delivery of medical services) rendered under this Agreement to Members the amounts payable by CFHP as set forth in the Compensation section of this Addendum, less any applicable Co-payments, deductibles and/or co-insurance amounts payable by Member.
5. Provider understands and agrees that Provider shall submit to CFHP electronically a Clean Claim for Covered Services rendered to Member(s), within ninety-five (95) calendar days after Provider renders such services. In the event Provider submits an inaccurate or incomplete claim to CFHP, Provider shall have until the end of the 95-day filing period to correct such claim and submit a Clean Claim to CFHP. Provider must clearly identify the corrected claim as such when submitting the corrected claim to CFHP. CFHP shall not be under any obligation to pay Provider on any claim not timely submitted. Provider shall not seek payment from any Member in the event CFHP fails to pay Provider for a claim not timely submitted.
6. Provider understands and agrees that Provider has sixty (60) days from the date on the original Explanation of Payment received by Provider to appeal the adjudication of the claim by CFHP including but not limited to incorrect payment by CFHP. CFHP will not accept an appeal after this deadline and Provider will have no right of appeal or payment. The Commercial Provider Manual contains additional information on appeals of claim adjudication and is made part of this Agreement by this reference.
7. Provider understands and agrees that it must submit claims that comply with nationally accepted billing practices and in a format consistent with HIPAA national codes and requirements.
8. Provider understands and agrees that CFHP is free to seek repayment of any monies identified as the result of its Fraud and Abuse program and that the 180 day audit limitation contained in Article 20A.18B, Texas Insurance Code, as amended from time to time, does not apply in these instances.

9. Provider understands and agrees that CFHP will adjudicate claims in accordance and consistent with standard claim editing rules and guidelines, as amended from time to time. As required, CFHP will provide notice to Providers of any significant changes implemented prior to the effective date of the changes.
10. Provider understands and agrees that CFHP shall: (1) pay the contracted amount of the claim in accordance with the Compensation section of this Addendum; (2) if CFHP does not adjudicate a Clean Claim in accordance with Article 20A.18B, Texas Insurance Code, CFHP shall pay a penalty as outlined in the provisions of Article 20A.18B, Texas Insurance Code, as amended from time to time.

B. Compensation

1. Provider shall accept as payment in full from CFHP for Covered Services the lesser of CFHP's current Commercial Fee Schedule or Provider's billed charges, less applicable co-payments, deductibles or coinsurance amounts due from Member.
2. For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

Addendum C

Medicaid Managed Care (STAR) Benefit Program

A. General Program Requirements

1. Provider is being contracted to deliver Medicaid managed care under the HHSC STAR Program. Community First must provide copies of the HHSC/Community First contract to Provider upon request. Provider understands that services provided under this contract are funded by state and federal funds under the Medicaid program. Provider is subject to all state and federal laws, rules, and regulations that apply to all persons or entities receiving state and federal funds. Provider understands that any violation by Provider of a state or federal law relating to the delivery of services by Provider under this Agreement, or any violation of the HHSC/Community First contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.
2. Provider understands and agrees that CFHP has the sole responsibility for payment of Covered Services rendered to STAR Members by Provider under this Agreement, subject to Coordination of Benefits and third-party liability rules. In the event of CFHP insolvency or cessation of operations, Provider's sole recourse is against CFHP through the bankruptcy, conservatorship, or receivership estate of CFHP. The Provider understands and agrees that CFHP Members may not be held liable for CFHP's debts in the event of the entity's insolvency. The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, CFHP, its employees, agents or subcontractor. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against CFHP. 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.).
3. Provider understands and agrees HHSC is not liable or responsible for payment for any Medicaid Covered Services provided to STAR Members under this Agreement. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a Medicaid recipient for a Covered Service.
4. Provider agrees that any modification, addition, or deletion of the provisions of this Agreement will become effective no earlier than 30 days after Community First notifies HHSC of the change in writing. If HHSC does not provide written approval within 30 days from receipt of notification from Community First, changes can be considered provisionally approved, and will become effective. Modifications, additions, or deletions, which are required by HHSC or by changes in state or federal law, are effective immediately.
5. The Provider understands and agrees to the following:
 - a. Providers are subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs as applicable:
 - b. Providers 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. Providers must provide originals and/or copies of any and all information, allow access to premises, and provide records to the office of Inspector General, HHSC,

the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;

- d. If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
 - e. Providers must report any suspected fraud or abuse including any suspected fraud and abuse committed by CFHP or a Member to the HHSC Office of Inspector General.
6. Provider is required to submit proxy claims forms to Community First for services provided to all STAR Members that are capitated by Community First in accordance with the encounter data submissions requirements established by Community First and HHSC.
 7. All provider clean claims pertaining to STAR Members must be adjudicated within 30 days. For those services rendered to a STAR Member, Community First must pay provider interest on all clean claims that are not paid within 30 days at a rate of 1.5% per month (18% annual) for each month the claim remains unadjudicated.
 8. The Network Provider is prohibited from billing or collecting any amount from a Medicaid Member for Health Care Services provided pursuant to this Network Provider contract. 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.
 9. CFHP will provide the Provider at least 90 days notice prior to implementing a change in claims guidelines, unless the change is required by statute or regulation in a shorter time frame.
 10. CFHP must notify Providers 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 CFHP is unable to provide 30 days notice, CFHP must give Providers a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.
 11. Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting established in the IFSP.
 12. If a Member requests contraceptive services or family planning services, the Providers must also provide the Member counseling and education about family planning and available family planning services.
 13. Providers cannot require parental consent for Members who are minors to receive family planning services.
 14. Providers must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

15. The Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Provider contract:
- a. environmental protection laws:
 - (1) Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*) regarding the provision of smoke –free workplace and promoting the non-use of all tobacco products;
 - (2) 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;
 - (3) 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”);
 - (4) 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
 - (5) 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;
 - b. state and federal anti-discrimination laws:
 - (1) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
 - (2) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
 - (3) Americans with Disabilities Act of 1990 (Public Law 101-336); and
 - (4) Title 40, Texas Administrative Code, Chapter 73;
 - c. the Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.*) regarding employment verification and retention of verification forms; and
 - d. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).

C. THSteps Requirements for PCPs

- 1. CFHP is required by its STAR Agreement with HHSC to develop effective methods to ensure that children under the age of 21 receive THSteps services when due and according to the recommendations established by the American Academy of Pediatrics and the THSteps periodicity schedule for children. The STAR Agreement requires CFHP to arrange for THSteps services to be provided to all eligible Members except when a Member knowingly and voluntarily declines or refuses services after the Member has been provided information upon which to make an informed decision.
- 2. Information and training on THSteps is included in the STAR Provider Manual as amended from time to time by CFHP and made part of this Agreement by this reference.
- 3. If Provider is a PCP or a Specialty Care Provider acting as a PCP (e.g., OB-GYN for pregnant Member), Provider agrees to provide the THSteps services to children under

age 21 in accordance with paragraph B.1 of this Addendum. Such services include the following procedures and responsibilities:

- a. All newly enrolled Members assigned to PCP shall receive a THSteps checkup within 90 days from enrollment, if one is due according to the American Academy of Pediatrics periodicity schedule, or if there is uncertainty regarding whether one is due. Provider should make THSteps checkups a priority to all newly enrolled Members.
 - b. Cooperate and coordinate with CFHP, HHSC or Texas Department of Health (TDH) outreach programs and THSteps regional program staff and agents to provide prompt delivery of services to children of migrant farm workers and other migrant populations who are assigned to PCP.
 - c. All laboratory specimens collected as a required component of a THSteps checkup (see Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the HHSC/ TDH Laboratory for analysis.
 - d. Providers must submit claims for services paid (either on a capitated or fee-for service basis) on the HCFA 1500 claim form and use the unique procedure coding required by HHSC, or use such other claim form and procedure coding hereafter required by HHSC and the Standard Transactions and Code Sets regulations adopted under HIPAA.
 - e. If Provider is providing primary care for a newborn:
 - (1) Provider shall ensure that all newborn Members have an initial newborn checkup before discharge from the hospital and again within two weeks from the time of birth.
 - (2) Providers must send all THSteps newborn screens to the Texas Department of State Health Services (DSHS), formerly the Texas Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. Providers must include detailed identifying information for all screened newborn Members and each Member's mother to allow HHSC to link the screens performed at the hospital with screens performed at the two-week follow-up.
4. Provider shall comply with the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the Vaccine Information Statement.
 5. Provider shall comply with performance benchmarks for THSteps established by HHSC or TDH. HHSC or TDH will establish performance benchmarks against which HMO's full compliance with the THSteps periodicity schedule will be measured. The performance benchmarks will establish minimum compliance measures, which will increase over time. Provider must cooperate with HMO to meet all performance benchmarks required by HHSC or TDH for THSteps services.
 6. Provider shall allow HHSC or TDH, or persons appointed by such agencies, to perform chart reviews to validate that all THSteps screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted encounter data could result in HMO and/or Provider being investigated by state or federal agencies for potential fraud and abuse without notice to HMO or the provider

C. STAR Program Compensation Schedule

1. **Fee Schedule.** Provider shall accept as payment in full from CFHP for Covered Medical Services the following fee-for-service arrangement:
 - One hundred percent (100%) of the current State of Texas Medicaid Fee Schedule, less any applicable Copayments.
 - For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.
2. **Revisions based on State's Adjustments to Fee Schedule.** Any adjustments to the Medicaid Fee Schedule, as established by the State of Texas, will be effective the first of the following month in which CFHP receives official written notification from the State of Texas or its contracted claims processor for fee-for-service Medicaid.
3. **Revisions to the Terms of the Contract Between CFHP and HHSC.** Should the terms of the contract between CFHP and HHSC be altered by HHSC or as the legislative, regulatory or legal requirements including but not limited to a reduction in premiums from appropriation or state agency decision, CFHP will provide written notice to Provider and the Agreement will be adjusted accordingly.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

Addendum D

Children's Health Insurance Program (CHIP) Benefits Program

A. General Program Requirements

1. Provider understands and agrees that CFHP has the sole responsibility for payment of Covered Services rendered by Provider under this Agreement, subject to Coordination of Benefits rules and third-party liability, and in the event that CFHP becomes insolvent or ceases operations, Provider's sole recourse is against CFHP through CFHP's bankruptcy, conservatorship, or receivership estate.

Provider agrees that in the event of CFHP's or HHSC's insolvency or other cessation of operations, Provider will continue to provide services to CHIP Members through the period for which premium has been paid, including CHIP Members who are in an inpatient facility.

Provider hereby agrees that in no event, including, but not limited to non-payment by CFHP or HHSC, CFHP's or HHSC's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or have any recourse against a CHIP Member or another party acting on their behalf for Contracted Services provided pursuant to this Agreement. This provision shall not prohibit the collection of charges for Excluded Services rendered by Provider if Provider has followed Section 3.8 of the Agreement.

Provider agrees to hold harmless the State of Texas, all State officers and employees, and all CHIP Members in the event of nonpayment by CFHP or HHSC to the Provider. Provider further agrees to indemnify and hold harmless the State and its agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the State or its agents, officers or employees, through the intentional conduct, negligence or omission of Provider, any shareholder, partner or any other individual or entity holding an equitable interest in the Provider its agents, officers, employees or contractors.

Provider further agrees that (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of CHIP Members, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the CHIP Member or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for continuation of Covered Medical Services provided under the terms and conditions of the provision.

Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the State regulatory agency has received written notice of such proposed change and has approved such change.

Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, CFHP, its employees, agents or subcontractors. Further, the Provider understands and agrees that there is not right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by CFHP or any judgment rendered against CFHP. 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. If Provider initiates any action to collect payment from HHSC or any CHIP Member over and above allowable Copayments, excluding payment for Excluded Services, CFHP will initiate and maintain such necessary action to stop Provider or his or her employees, agents, assigns, trustees, or successors in interest from maintaining that action against HHSC or any CHIP Member.

Provider will make reasonable efforts to stop a health care provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC or any CHIP Member to collect payment from HHSC or any CHIP Members over and above allowable Copayments, excluding payment for services not covered under CHIP.

3. Provider is responsible for collecting at the time of service any applicable CHIP co-payments or deductibles in accordance with CHIP cost-sharing limitations. Provider shall not charge cost-sharing or deductibles to CHIP Members of Native American Tribes or Alaskan Natives; co-payments or deductibles to a CHIP Member with an ID card that indicates the Member has met his or her cost-sharing obligation for the balance of their term of coverage; and co-payments for well-child or well baby visits or immunizations. Co-payments are the only amounts that a Provider may collect from CHIP Members, except for costs associated with unauthorized non-emergency services provided to a Member by out-of-network providers for non-covered services.
4. The Network Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Network Provider contract.
5. Provider and CFHP acknowledge that HHSC maintains the right to review this Agreement and any arrangement between Provider and CFHP.
6. CFHP will defend, indemnify and hold harmless CHIP Members and HHSC against any and all claims, costs, damages, or expenses (including attorneys' fees) of any type or nature arising from the failure, inability, or refusal of CFHP to pay Provider for Contracted Services.
7. Unless prohibited or limited by applicable law, at least 30 days prior to the effective date of CFHP's termination of the Agreement without cause, CFHP will notify the CHIP administrative contractor and will notify any affected CHIP Members in writing. Upon a termination of the Agreement with cause, CFHP will notify the CHIP administrative contractor in writing on the next working day and will notify affected CHIP Members in writing. If Provider initiates termination of the Agreement, CFHP will notify the CHIP administrative contractor and will make reasonable efforts to notify affected CHIP Members in writing.
8. Provider is prohibited from engaging in direct marketing to CHIP Members that is designed to increase enrollment in a particular health plan. Such prohibition does not prevent Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance. Provider is responsible for collecting any applicable CHIP Copayments and the limitations on those Copayments.
9. A Provider incentive plan, if any, contained in the Agreement will meet requirements of the Texas Insurance Code and the Texas Administrative Code.
10. The Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Provider contract:
 - a. environmental protection laws:

- (1) Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*) regarding the provision of smoke –free workplace and promoting the non-use of all tobacco products;
 - (2) 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;
 - (3) 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”);
 - (4) 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
 - (5) 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;
- b. state and federal anti-discrimination laws:
- (1) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
 - (2) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
 - (3) Americans with Disabilities Act of 1990 (Public Law 101-336); and
 - (4) Title 40, Texas Administrative Code, Chapter 73;
- c. the Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.*) regarding employment verification and retention of verification forms; and
- d. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).
11. CFHP will provide the Provider at least 90 days notice prior to implementing a change in claims guidelines, unless the change is required by statute or regulation in a shorter time frame.
 12. CFHP must notify Providers 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 CFHP is unable to provide 30 days notice, CFHP must give Providers a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.
 13. CFHP shall adjudicate (finalize as paid or denied adjudicated) clean claims within 30 days from the date the claim is received by CFHP. CFHP will pay Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within 30 days.
 14. Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Provider understands and agrees that any Medically Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting established in the IFSP.

B. CHIP Program Compensation Schedule

1. Fee Schedule. Provider shall accept as payment in full from CFHP for Covered Services:

- ♦ One hundred percent (100%) of the current CFHP CHIP Fee Schedule, less any applicable Copayments.
- ♦ For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

2. Revisions to the Terms of the Contract Between CFHP and HHSC. Should the terms of the current contract between CFHP and HHSC be altered by HHSC or as the result of legislative action, regulatory or legal requirements including but not limited to a reduction in the premiums from appropriation or state agency decision, CFHP will provide Provider with notice to the Provider and the Agreement will be adjusted accordingly.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

Addendum E

Children's Health Insurance Program (CHIP) Perinatal Program

A. General Program Requirements.

1. DEFINITIONS

Adverse Determination: A decision that is made by CFHP that the health care services furnished or proposed to be furnished to the CHIP Perinate Member and/or the CHIP Perinate Newborn are not medically necessary.

CHIP Perinate Member: This means the eligible Mother of the UNBORN CHIP Perinate Newborn who is eligible to receive Medically Necessary Covered Services related to pre-partum care, labor and delivery services and two post partum visits.

CHIP Perinate Newborn: This means the Newborn child of a CHIP Perinate Member who is eligible to receive Medically Necessary Covered Services through the CHIP Perinatal Benefit Program for the remainder of the twelve-month eligibility period established by HHSC or its designee.

CHIP Perinatal Program: The Children's Health Insurance Program (CHIP) Perinatal Program, which provides Coverage to both the CHIP Perinate Member and the CHIP Perinate Newborn in accordance with the Agreement between Community First Health Plans, Inc. (CFHP) and the Health and Human Services Commission of the State of Texas (HHSC).

CHIP Administrator: The contractor with the state that administers enrollment functions for CHIP health plans.

Covered Health Services/Covered Services/Coverage: Those Medically Necessary Services that are listed in **Section VIII, SCHEDULE OF BENEFITS, EXCLUDED SERVICES AND COVERED HEALTH SERVICES**, of the Evidence of Coverage for the CHIP Perinatal Program.

Disability: A physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Emergency and Emergency Condition: A medical condition of 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 the condition, sickness, or injury is of such nature that failure to get immediate care could result in:

- Placing the CHIP Perinate's health in serious jeopardy;
- Serious impairment to bodily functions as related to the CHIP Perinate;
- Serious dysfunction of any bodily organ or part that would effect the UNBORN CHIP Perinate; or
- Serious disfigurement to the UNBORN CHIP Perinate.

Emergency Services and Emergency Care: Health care services provided in an in-network or out-of-network Hospital emergency department or other comparable facility by in-network or out-of-network Physicians, Providers, or facility staff to evaluate and stabilize medical conditions. Emergency Services also include, but are not limited to, any medical screening examination or other evaluation required by state or federal law that is

necessary to determine whether an Emergency Condition related to the labor and/or delivery of the covered CHIP Perinate Member exists.

Health Benefit Plan or Plan: The Coverage provided to the CHIP Perinate Member issued by CFHP providing Covered Health Services.

Medically Necessary Services: Health services that are:

Physical:

- Reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical malformations or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of an CHIP Perinate Member, or endanger the life of the CHIP Perinate Member;
- Provided at appropriate facilities and at the appropriate levels of care for the treatment of an CHIP Perinate Member's medical conditions;
- Consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;
- Consistent with diagnosis of the condition; and
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

Medically Necessary Services must be furnished in the most appropriate and least restrictive setting in which services can be safely provided and must be provided at the most appropriate level or supply of service which can safely be provided and which could not be omitted without adversely affecting the CHIP Perinate Member's physical health and/or the quality of care provided.

Member: Any covered CHIP Perinate Member who is eligible for benefits and who is enrolled in the Texas CHIP Perinatal Program.

UNBORN CHIP Perinate: Any child from conception to birth whom the **CHIP Perinatal Program** has determined to be eligible for Coverage and who is enrolled in the Plan.

2. Provider understands and agrees that for the CHIP Perinate Member in families with **income at or below** 185% of the Federal Poverty Level, the **facility charges** are **not** a covered benefit and are not the responsibility of CFHP. In order for the facility to receive payment for facility services related to labor with delivery, the facility must assist the CHIP Perinate Member in applying for Emergency Medicaid. Professional service charges for the CHIP Perinate Member in families with **income at or below** 185% of the Federal Poverty Level are limited to prenatal care, labor with delivery and postpartum care. Payment for such services are the responsibility of CFHP.

Provider understands and agrees that for the CHIP Perinate Member in families between 186% and 200% of the Federal Poverty Level, the benefit is limited to prenatal care, labor with delivery and postpartum care. The facility charges are limited to labor with delivery and are the responsibility of CFHP. Professional service charges for the CHIP Perinate Member in families between 186% and 200% of the Federal Poverty Level associated with labor with delivery are a covered benefit and payment for such services is the responsibility of CFHP. The CHIP Perinate Newborn benefits are the same as those available in the standard CHIP Benefit Program.

Provider understands and agrees that Coverage of the CHIP Perinate Member begins on the first day of the month in which the CHIP Perinate Member is determined eligible for the CHIP Perinatal Program and continues for a period of 12 months. The CHIP Perinate Member may lose CHIP Perinatal Program eligibility for the following reasons:

- Change in health insurance status, i.e., parent of an CHIP Perinate Member enrolls in an employer sponsored health plan;
- Death of an UNBORN CHIP Perinate;
- Mother of CHIP Perinate Newborn permanently moves out of state;

Provider understands and agrees that a CHIP Perinate Member may be disenrolled by CFHP, subject to the approval of HHSC, for the following reasons:

- Fraud or intentional material misrepresentation made by Mother or Authorized Representative after 15 days written notice from HHSC;
- Fraud in the use of services or facilities after 15 days written notice to by HHSC;
- Misconduct that is detrimental to the safe operations of CFHP and the delivery of services;
- Failure by UNBORN CHIP Perinates' Mother and a Participating Physician to establish a satisfactory patient-physician relationship so long as CFHP has, in good faith, provided UNBORN CHIP Perinates' Mother with the opportunity to select an alternative Participating Provider;
- Mother of the CHIP Perinate Member no longer lives or resides in CFHP's Service Area.

Provider agrees that in the event of CFHP's or HHSC's insolvency or other cessation of operations, Provider will continue to provide services to CHIP Perinate Members through the period for which premium has been paid, including CHIP Perinate Members who are in an inpatient facility only for those CHIP Perinate Members in families between 186% and 200% of the Federal Poverty Level.

In the event CFHP becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against CFHP will be through CFHP's bankruptcy, conservatorship, or receivership estate. The Provider understands and agrees that CFHP's Members may not be held liable for CFHP's debts in the event of the entity's insolvency. The Provider understands and agrees that the Texas Health and Human Services Commission (HHSC) does not assume liability for the actions of, or judgments rendered against, CFHP, 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, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq).

Provider further agrees that (1) this provision shall survive the termination of the Agreement regardless of the cause giving rise to the termination and shall be construed to be for the benefit of CHIP Perinate Members, and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the CHIP Perinate Member or persons acting on their behalf, insofar as

such contrary agreement relates to liability for payment for continuation of Covered Medical Services provided under the terms and conditions of the provision.

Any modification, addition, or deletion of or to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the State regulatory agency has received written notice of such proposed change and has approved such change.

3. If Provider initiates any action to collect payment from HHSC or any CHIP Perinate Member excluding payment for Excluded Services, CFHP will initiate and maintain such necessary action to stop Provider or his or her employees, agents, assigns, trustees, or successors in interest from maintaining that action against HHSC or any CHIP Perinate Member.

Provider will make reasonable efforts to stop a health care provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC or any CHIP Perinate Member to collect payment from HHSC or any CHIP Perinate Members over and above allowable Co-payments, excluding payment for services not covered under CHIP.

4. Provider and CFHP acknowledge that HHSC maintains the right to review this Agreement and any arrangement between Provider and CFHP.
5. The Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Provider contract.
6. CFHP will defend, indemnify and hold harmless CHIP Perinate Members and HHSC against any and all claims, costs, damages, or expenses (including attorneys' fees) of any type or nature arising from the failure, inability, or refusal of CFHP to pay Provider for Contracted Services.
7. Unless prohibited or limited by applicable law, at least 30 days prior to the effective date of CFHP's termination of the Agreement without cause, CFHP will notify the CHIP administrative contractor and will notify any affected CHIP Perinate Members in writing. Upon a termination of the Agreement with cause, CFHP will notify the CHIP administrative contractor in writing on the next working day and will notify affected CHIP Perinate Members in writing. If Provider initiates termination of the Agreement, CFHP will notify the CHIP administrative contractor and will make reasonable efforts to notify affected CHIP Perinate Members in writing of Provider's termination.
Provider understands and agrees that, except for reasons of medical competence or professional behavior, termination of his/her agreement with CFHP does not release CFHP from its obligation to reimburse Provider who is treating the CHIP Perinate Member with special circumstances, such as an CHIP Perinate Member who has a disability, an acute condition or a life-threatening illness, or is past the twenty-fourth week of gestation, at no less than the contract rate for the ongoing medically necessary treatment in accordance with the dictates of medical prudence.
8. Provider is prohibited from engaging in direct marketing to CHIP Perinate Members that is designed to increase enrollment in a particular health plan. Such prohibition does not prevent Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
9. A Provider incentive plan, if any, contained in the Agreement will meet requirements of the Texas Insurance Code and the Texas Administrative Code.
10. The Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Provider contract:

- a. environmental protection laws:
 - (1) Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*) regarding the provision of smoke –free workplace and promoting the non-use of all tobacco products;
 - (2) 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;
 - (3) 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”);
 - (4) 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
 - (5) 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;
 - b. state and federal anti-discrimination laws:
 - (1) Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
 - (2) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
 - (3) Americans with Disabilities Act of 1990 (Public Law 101-336); and
 - (4) Title 40, Texas Administrative Code, Chapter 73;
 - c. the Immigration Reform and Control Act of 1986 (8 U.S.C. §1101 *et seq.*) and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq.*) regarding employment verification and retention of verification forms; and
 - d. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).
11. CFHP will provide the Provider at least 90 days notice prior to implementing a change in claims guidelines, unless the change is required by statute or regulation in a shorter time frame.
12. CFHP must notify Providers 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 CFHP is unable to provide 30 days notice, CFHP must give Providers a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.
13. CFHP shall adjudicate (finalize as paid or denied adjudicated) clean claims within 30 days from the date the claim is received by CFHP. CFHP will pay Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within 30 days.
14. Providers must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). Provider understands and agrees that any Medically

Necessary Health and Behavioral Health Services contained in an IFSP must be provided to the Member in the amount, duration, scope and setting established in the IFSP.

B. CHIP Perinatal Program Compensation Schedule.

1. Fee Schedule. Provider shall accept as payment in full from CFHP for Covered Services:

- One hundred and five (100%) of the current Medicaid fee schedule as amended from time to time by HHSC and/or its designee.
- For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

2. Revisions to the Terms of the Contract Between CFHP and HHSC. Should the terms of the current contract between CFHP and HHSC be altered by HHSC, as the result of legislative action, and/or regulatory or legal requirements including but not limited to a reduction in the premiums from appropriation or state agency decision or reimbursement levels, CFHP will provide Provider with written notice to the Provider and the Agreement will be amended accordingly.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

Addendum F

University Family Care Plan (UFCP) Benefits Program

A. General Program Requirements.

1. Provider understands and agrees that CFHP is the "ASO" (Administrative Services Only) Administrator for the University Family Care Plan/University Health Plan Benefit Programs and is responsible for administering payment of Covered Services and performing utilization management functions for Covered Services rendered to Members by Provider under this Addendum to the ***Behavioral Health Professional Provider Agreement*** as outlined in the ***Summary of Benefits*** for the University Family Care Plan/University Health Plan Benefit Programs and/or as directed by the Plan Sponsor. For the purposes of this Addendum, the Plan Sponsor is the Bexar County Hospital District, d/b/a University Health System, a political subdivision of the State of Texas, hereinafter called UHS. In the event of CFHP's insolvency or cessation of operations, Provider's sole recourse is against the Plan Sponsor.
2. Provider understands and agrees that it shall comply with the minimum standards for access/availability of appointments for urgent, routine, wellness, specialty care or other types of care as set forth in ***Attachment 1 to Addendum E, University Family Care Plan, Performance Standards***, to this Addendum, as amended from time to time by mutual agreement among Provider Group, Plan Sponsor and CFHP and made a part of the Agreement by this reference. Provider understands and agrees that a quarterly review will be conducted of Provider's performance as outlined in Section III, ***Performance Review Matrix***, of this Addendum, and appropriate Corrective Action Plan(s) will be developed and initiated by Provider to address identified access/availability issues.
3. Provider agrees and understands that requests for services requiring pre-authorization must be routed in a timely manner from the Provider's office directly to CFHP but no later than twenty-four (24) hours prior to the delivery of services in a format and method outlined by CFHP. Provider agrees to actively assist Member in scheduling an initial appointment within the minimum standards for access/availability.
4. Provider understands and agrees that for Covered Services that require Pre-Authorization, Provider will not seek payment from CFHP for Covered Services rendered to a Member unless such Pre-Authorization was obtained prior to the rendering of such services. Provider also understands and agrees that neither the Member nor Plan Sponsor will be billed for these services. Provider understands and agrees that all ancillary services including diagnostic laboratory services, diagnostic radiology services and DME will be provided through network providers designated by the Plan Sponsor and communicated to Provider in the usual manner. Provider understands and agrees that referrals made to external and/or non-participating providers due to the lack of access/appointment availability within the limited provider network require pre-authorization and Provider will obtain required pre-authorization from CFHP.
5. Provider understands and agrees to accept as payment in full for Covered Services and all other services (including payment for any sales, use or other applicable taxes on the sale or delivery of medical services) rendered under this Agreement to Members the amounts payable by CFHP as set forth in the Section II, ***Compensation***, of this Addendum, less any applicable Co-payments, deductibles and/or co-insurance amounts payable by Member.

- Provider understands and agrees that Provider shall electronically submit claims to CFHP (Clean Claims) for Covered Services rendered to eligible Members in accordance with national billing standards, recognized billing protocols and in compliance with the regulations promulgated pursuant to Title 28, Chapter 21, Subchapter T (Submission of Clean Claims), Texas Administrative Code, as amended from time to time, as maybe applicable. Provider understands and agrees that claims must be submitted within ninety (90) days from the date services were provided to an eligible Member.
6. Provider understands and agrees that Provider has ninety (90) calendar days from the date on the original Explanation of Payment received by Provider to appeal the adjudication of the claim by CFHP including but not limited to incorrect payment by CFHP. CFHP will not accept an appeal after this deadline and Provider will have no right of appeal or payment after this deadline. Provider must clearly identify the corrected claim as such when submitting the corrected claim to CFHP. Appeals may not be submitted electronically. CFHP shall not be under any obligation to pay Provider on any claim not timely submitted. Provider shall not seek payment from any Member or Plan Sponsor in the event CFHP fails to pay Provider for a claim not timely submitted. The appropriate Benefit Program Provider Manual contains additional information on appeals of claim adjudication and is made part of this Agreement by this reference.
 7. Provider understands and agrees that it must submit claims that comply with nationally accepted billing practices and in a format consistent with HIPAA national codes and requirements as amended from time to time.
 8. Provider understands and agrees that CFHP is free to seek repayment of any monies identified as the result of its Fraud and Abuse program and that the 180 day audit limitation contained in Article 20A.18B, Texas Insurance Code, as amended from time to time, does not apply in these instances. Provider also understands and agrees that CFHP may recoup any monies due as the result of its Fraud and Abuse program should Provider fail to respond within the time frame outlined in any written communication provided by CFHP to Provider regarding repayment from any monies due the Provider for the specific Benefit Program in question.
 9. Provider understands and agrees that CFHP will adjudicate claims in accordance and consistent with standard claim editing rules and guidelines as disclosed to Provider Group and if applicable in accordance with Chapter 843, Subchapter J (Payment of Claims To Physicians and Providers), Texas Insurance Code requirements, as amended from time to time. As required, CFHP will provide notice to Provider of any significant changes implemented prior to the effective date of the changes.
 10. Provider will utilize Bexar County Hospital District, d/b/a University Health System facilities for all diagnostic laboratory and radiology services and be responsible for obtaining pre-authorization for all service requiring pre-authorization.

B. Compensation

1. Provider shall accept as payment in full from CFHP for Covered Services the lesser of CFHP's current Commercial Fee Schedule or Provider's billed charges, less applicable co-payments, deductibles or coinsurance amounts due from Member.

2. For those Covered Services for which an allowable has not been determined, Provider shall be reimbursed at (1) the lesser of CFHP's usual and customary rate; or (2) the interim rate established by CFHP based on a rate analysis completed at the time the claims is received; Once CFHP establishes a reimbursement rate, all future claims will be paid at that rate.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date

ADDENDUM G
BUSINESS ASSOCIATE ADDENDUM

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Part I

PREAMBLE

- A. Effective Date: The effective date of this Business Associate Addendum ("Addendum") is the same as the effective date of the underlying Agreement.
- B. Parties: The parties to this Addendum are **Community First Health Plans, Inc.**, a Texas health maintenance organization ("Community First"), and _____ ("Business Associate"). Community First and Business Associate agree that there shall be no third party beneficiaries to the underlying Agreement or this Addendum, including but not limited to individuals whose protected health information is created, received, used, and/or disclosed by Business Associate in its role as business associate.
- C. Purpose: The parties intend that this Addendum comply with the business associate contract requirements set forth in the Standards for Privacy and Security of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy and Security Rule"), The Health Information Technology for Economic and Clinical Health ("HITECH") Act, and applicable state law requirements regarding the privacy of protected health information.
- D. In connection with the Business Associate's creation, receipt, use, and/or disclosure of protected health information (defined below), the parties agree as follows.

Part II

GENERAL TERMINOLOGY

- A. The following terms shall have the same meaning in this Addendum as is set forth in the HIPAA Privacy and Security Rule: business associate, data aggregation, designated record set, individual, Notice of Privacy Practices, required by law, use, individually identifiable health information, health information, disclose or disclosure, administrative safeguards, physical safeguards, technical safeguards, facility, confidentiality, availability, security, security incident, and Secretary. Protected health information ("PHI") shall have the same meaning as the term "protected health information" in 45 C.F.R. § 164.501. Electronic Protected Health Information ("ePHI") shall mean PHI in electronic media as that term is defined in 45 C.F.R. § 162.103. Unless otherwise indicated in this Addendum, both PHI and ePHI will be referred to collectively as PHI.
- B. In the event of an inconsistency between the provisions of this Addendum and the mandatory terms of the HIPAA Privacy and Security Rule or HITECH, as may be expressly amended from time to time by the U.S. Department of Health and Human Services ("HHS") or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties, the interpretation of HHS, such court, or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.
- C. Where provisions of this Addendum are different from those mandated by the HIPAA Privacy and Security Rule or HITECH, but are nonetheless permitted by the Rule, the provisions of the Addendum shall control.

Part III

PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

- A.** Except as otherwise provided in this Addendum, Business Associate may use or disclose PHI on behalf of, or to provide services to, Community First for those functions, activities, and/or services relating to mining of pharmacy data activities if such use or disclosure of PHI would not violate the HIPAA Privacy and Security Rule or HITECH if done by Community First.
- B.** As part of providing functions, activities, and/or services to Community First as identified in Part III.A., Business Associate may disclose information, including PHI, to other business associates of Community First and may use and disclose information, including PHI, received from other business associates of Community First as if this information was received from, or originated with, Community First as long as all such Business Associates have executed an Addendum or Agreement providing reasonable assurances that they will comply with the provisions of this Addendum.
- C.** Business Associate agrees not to use or further disclose PHI, and to ensure that its directors, officers, employees, contractors, and agents, do not use or further disclose PHI other than as permitted or required by this Addendum or as required by law. Except as otherwise limited in this Addendum, Business Associate may use PHI for the proper management and administration of Business Associate's business or to carry out the legal responsibilities of Business Associate.
- D.** Except as otherwise limited in this Addendum, Business Associate may use PHI to provide data aggregation services to Community First as permitted by 42 C.F.R. § 164.504(e)(2)(i)(B).
- E.** If the use or disclosure of PHI in this Agreement is based upon an individual's specific consent or authorization and the individual revokes such consent or authorization in writing, or the effective date of such authorization has expired, or the consent or authorization is found to be defective in any manner that renders it invalid, Business Associate agrees that, upon notice of such revocation or invalidity, Business Associate will cease the use and disclosure of any such individual's PHI except where an exception under the HIPAA Privacy and Security Rule expressly applies. Any prior use or disclosure undertaken by Business Associate in reliance on such consent or authorization will not be affected.
- F.** If Business Associate becomes aware of any use or disclosure of PHI that is not provided for in this Addendum, Business Associate will report that use or disclosure to Community First as soon as reasonably possible.
- G.** Business Associate acknowledges that should Community First or one of its Business Associates Use or Disclose PHI improperly in violation of this Addendum ("Improper Use/Disclosure"), Community First is required to take reasonable steps to mitigate harmful effects of the Improper Use/Disclosure. Should Business Associate or an agent of Business Associate make an Improper Use/Disclosure, Business Associate shall notify Community First immediately and consult with Community First on the steps necessary to mitigate the harmful effects of such Disclosure, which steps may include:

 - 1. Identifying the source(s) of the Improper Use/Disclosure and taking appropriate corrective action;
 - 2. Contacting the recipient of the information that was disclosed by the Improper Use/Disclosure and instructing such recipient to either destroy or return the information and to make no further use or disclosure of such information;
 - 3. Notifying the individual whose PHI was the subject of the Improper Act; and/or

4. Reviewing, and correcting where appropriate, any policy or procedure of Business Associate that directly caused or contributed to the Improper Use/Disclosure.
- H. Upon receiving a written request from Community First or an individual whose PHI is in Business Associate's possession, Business Associate shall provide the individual access to his or her PHI in a designated record set in accordance with 45 C.F.R. § 164.524. Business Associate may require the individual to pay certain fees, as delineated in 45 C.F.R. § 164.524(c)(4), for it to provide copies or summaries of PHI.
- I. Upon receiving written notification from Community First that it has directed or agreed, pursuant to 45 C.F.R. § 164.526, to amend PHI in a designated record set, Business Associate agrees to make available such PHI for amendment and incorporate any such amendments to such PHI as directed by Community First.
- J. Upon receiving written notification from Community First that it has agreed, pursuant to 45 CFR §164.522, to honor an individual's reasonable request for confidential communications to the individual (e.g., by using alternative means or sending information to an alternative location), Business Associate shall cooperate with Community First in processing and honoring such requests for confidential communications and will disclose information to the individual only through the alternative means or location agreed to by Community First.
- K. Upon receiving written notification from Community First that it has agreed, pursuant to 45 CFR §164.522, to honor an individual's request that Community First restrict, in a manner that exceeds restrictions required by law, uses and disclosures of PHI to carry out payment or health care operations or to disclose PHI to a relative, personal friend or other person identified by the individual and involved in the care of the person or payment of the person's health care, Business Associate shall cooperate with Community First in processing and honoring such requests for restrictions and shall comply with any restriction agreed to by Community First of which Business Associate has notice.
- L. Business Associate agrees, at the written request of Community First, to make available to Community First the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.
- M. For the purpose of Community First or the Secretary determining Community First's compliance with the HIPAA Privacy and Security Rule, Business Associate shall make available to Community First or the Secretary the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI. No legal privilege, if any, will be deemed to have been waived by Business Associate by virtue of disclosure under this provision of the Addendum.

Part IV

SAFEGUARDS TO SECURE PHI

- A. Business Associate agrees to, and assures Community First that it will, use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Addendum or as required by law. Specifically, Business Associate agrees to:
 1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Community First and to allow Community First to review such safeguards upon request; and
 2. Secure ePHI (including data in motion, data at rest, data in use and data disposed), created by Community First, or accessed, maintained, retained, modified, recorded, stored, destroyed, or otherwise held, used, or disclosed by Business Associate on behalf of Community First, by encrypting such ePHI in accordance with the Department of

Health and Human Services Guidance at <http://www.hhs.gov/ocr/privacy> ("HHS Guidance") and the National Institute of Standards and Technologies ("NIST") at <http://www.csrc.nist.gov/> to ensure that such information is unusable, unreadable, or indecipherable to unauthorized individuals. Business Associate understands and agrees that ePHI is encrypted as specified in the HIPAA Security Rule by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools shall be stored by Business Associate on a device or at a location separate from the data that are used to encrypt or decrypt.

Part V

BREACH NOTIFICATION

- A.** Business Associate agrees to report to Community First any security incident involving PHI of which it becomes aware.
- B.** In the event that Business Associate uses a method other than encryption or an encryption algorithm that is not specified in the Guidance or NIST Standards and Technologies to secure the ePHI as referenced in Part IV, Section A.2. of this Addendum, such ePHI shall be considered to be "unsecured" in accordance with HITECH. If unsecured ePHI is breached, Business Associate agrees to assume full responsibility, including all costs and expenses, incurred to assess the risk of harm caused by the breach and to provide notification to the individuals whose PHI was breached, the media and HHS as required by HITECH.
- C.** For the purposes of this Part V, a breach occurs when there is an unauthorized acquisition, access, use or disclosure of unsecured PHI/ePHI which compromises the security or privacy of the PHI/ePHI. A breach compromises the security or privacy of PHI/ePHI if it poses a significant risk of financial, reputational, or other harm to the individual whose PHI/ePHI was compromised. Business Associate agrees to:
 - 1. Implement a system to detect breaches of PHI/ePHI within Business Associate's business; maintain written documentation with respect to all suspected and confirmed breaches for six (6) years; provide access to such documentation to Community First upon request; and to submit documentation on breaches to HHS as required by HITECH on an annual basis; to develop breach notification policies and procedures; to train workforce members on, and have sanctions for failure to comply with, these policies and procedures; to allow workforce members to file complaints regarding these policies and procedures or a failure to comply with them, and refrain from intimidating or retaliatory acts towards its workforce members;
 - 2. Notify Community First on the first day that a breach is known to Business Associate, or by exercising reasonable diligence, would have been known to Business Associate;
 - 3. Provide Community First, to the extent possible, with the identity of each individual whose unsecured PHI/ePHI has been, or is reasonably believed to have been, breached;
 - 4. Conduct a risk assessment, as instructed by and in collaboration with Community First, to determine whether the privacy or security of individuals' PHI/ePHI was compromised as a result of the breach and to provide Community First the results of the assessment and any other available information, in writing, that is required to evaluate what information shall be included in notification of the breach;
 - 5. Provide Community First any supplemental information relevant to the assessment and/or determination of whether the breach compromises the security and privacy of the PHI/ePHI, even if that information becomes available after notification;

6. In consultation with Community First, implement mutually agreed upon action(s) to mitigate any harm to individuals whose PHI/ePHI has been breached;
 7. Upon agreement by Community First that a breach compromises the privacy and security of PHI/ePHI, send notification to individuals whose PHI/ePHI has been compromised, the media and HHS as required by HITECH, as soon as possible, without reasonable delay but no later than sixty (60) calendar days after the date the breach was discovered by Business Associate, on the form and in the manner approved by Community First. Business Associate shall maintain documentation of all notifications and risk assessments;
 8. In those instances where Community First determines that a breach does not compromise the privacy and security of PHI/ePHI, Business Associate shall maintain documentation of the reason for this conclusion for six (6) years from the date of the determination unless a longer retention period is required by state or federal law. Such documentation shall include the application of any exceptions to the breach notification requirements provided in HITECH.
- D. In the event Business Associate, as of September 23, 2009, uses a method of encryption or an encryption algorithm in compliance with the HIPAA Security Rule, and as specified in the HHS Guidance and NIST Standards and Technologies to secure ePHI under this Addendum, and subsequently discovers a breach of encrypted information, Business Associate is not required to provide the breach notification in the Part V, Section C.7. above. Business Associate must, however, comply with the provisions of Part III of this Agreement that relate to unauthorized use and disclosures of PHI, including Part III, Sections F, G, K, and M.

Part VI

DESTRUCTION OF PHI/EPHI

Business Associate shall destroy all paper, film, or other hard copy media by shredding or destruction, and destroy electronic media by clearing, purging or destruction consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.

Part VII

SUBCONTRACTORS

- A. Business Associate agrees [and shall provide that its directors, officers, employees, subcontractors, and agents, agree] not to disclose PHI to any other person (other than members of their respective workforce as specified in Section B of this Part VII), unless disclosure is required by law or authorized by the person whose PHI is to be disclosed. Any such disclosure other than as specifically permitted in the immediately preceding sentences shall be made only if such disclosee has previously signed a written agreement that:
1. Binds the disclosee to the provisions of this Addendum pertaining to PHI, for the express benefit of Community First and, if disclosee is other Community First, the disclosee;
 2. Contains reasonable assurances from disclosee that the PHI will be held confidential as provided in this Addendum, and only disclosed as required by law for the purposes for which it was disclosed to disclosee; and
 3. Obligates disclosee to immediately notify Community First of any breaches of the confidentiality or security of the PHI, to the extent disclosee has obtained knowledge of such breach.

- B. Business Associate shall not disclose PHI to any member of its workforce and shall provide that its subcontractors and agents do not disclose PHI to any member of their respective workforces, unless Business Associate or such subcontractor or agent has advised such person of Business Associates' obligations under this Addendum, and of the consequences for such person and for Business Associate or such subcontractor or agent of violating them. Business Associate shall take and shall provide that each of its subcontractors and agents take appropriate disciplinary action against any member of its respective workforce who uses or discloses PHI in contravention of this Agreement.

Part VIII

OBLIGATIONS OF COMMUNITY FIRST

- A. Community First shall provide Business Associate with the Notice of Privacy Practices that Community First produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice. The Notice of Privacy Practices currently in effect for the insurance or benefit products being provided or administered through Community First is attached to the Agreement as Exhibit B.
- B. Community First shall provide Business Associate with any changes in, or revocation of, permission by any individual to use or disclose his/her PHI if such changes affect Business Associate's permitted or required uses and disclosures. Community First shall notify Business Associate in writing of such change made by an individual.
- C. Community First shall notify Business Associate, of any restriction to the use or disclosure of PHI that Community First has agreed to in accordance with 45 C.F.R. § 164.522.

Part IX

INDEMNIFICATION

Business Associate hereby agrees to indemnify and hold harmless Community First and its officers, directors, employees, and agents, from and against any and all claims, actions or proceedings of any kind and any losses, costs, damages, liabilities or expenses (including, but not limited to, attorneys' fees at all levels of trial and appeal) incurred by, imposed upon or asserted against any separate party and its officers, directors, employees, and agents, resulting from or in connection with (i) the negligent acts or omissions of any party, or any of its shareholders, officers, directors, employees, contractors, or agents, (ii) any misrepresentation or breach of any warranty made by Business Associate under this Agreement, or (iii) the breach of any covenant, agreement, or obligation of Business Associate under this Agreement or applicable law.

Part X

MISCELLANEOUS

- A. Upon termination of this Agreement, Business Associate agrees, at Community First's option, to either return or destroy all PHI received from Community First that Business Associate maintains in any form. Business Associate also agrees to comply with federal and state laws as they may be amended from time to time governing the maintenance or retention of PHI. If the return or destruction of PHI is not feasible, Business Associate agrees to extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- B. If it is believed that Business Associate breached any provision in this Addendum, Community First may, at its option:
 - 1. Access and audit the records of Business Associate related to Business Associate's use and disclosure of PHI;

2. Require Business Associate to submit to monitoring and reporting, and such other conditions as Community First may determine are necessary, to ensure compliance with this Addendum, including mitigation of harmful effects of an Improper Use/Disclosure under Section III.J of this Agreement;
3. Require any action or inaction necessary of Business Associate to remedy the breach and comply with the HIPAA Privacy and Security Rules and, if such steps were unsuccessful;
4. Terminate this Agreement; or
5. Report the infraction to the Secretary.

IN WITNESS WHEREOF, the undersigned have executed this Addendum, effective on the date of the underlying agreement.

Provider

Community First Health Plans, Inc.

Signature

Patrina L. Fowler, Vice-President/COO

Title

Date

Date