

Contract between IPA and Insurers

IPA SERVICES AGREEMENT

This IPA Services Agreement (“**Agreement**”) is made and entered into by and between _____, an entity organized under the laws of the State of _____ (“**IPA**”), and _____, a _____ corporation, referred to herein as “**Health Plan**”), as of this ____ day of _____, 200_ (the “**Effective Date**”). Health Plan and Provider may be referred to as the “**Parties**” in this Agreement or the “**Party**.”

RECITALS

- A. IPA is a medical group, individual practice, association, professional association, corporation or other public or private entity that provides or arranges for the provision of professional medical services and medical products.
- B. Health Plan desires to enter into this Agreement to arrange for IPA Providers to render Covered Services to Members of various Benefit Programs.
- C. IPA desires to enter into this Agreement so that IPA Providers may render Covered Services to Members of various Benefit Programs.
- D. The Effective Date of this Agreement shall be the first day of the subsequent month following the later to occur of the: (i) the date on which Health Plan and IPA execute this Agreement, or (ii) the date Health Plan receives all licenses, certifications and regulatory approvals, and or execution of executed contract(s) required for Health Plan to offer or provide services in connection with this Agreement.

AGREEMENT

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

I. **DEFINITIONS.** For purposes of this Agreement, the following terms shall have the meanings, except that, for purposes of Benefit Program(s) under the Medicare Advantage Program, Commercial and/or the Medicaid Program, definitions in the governing statutes, rules and regulations will take precedence over the definitions in this Agreement.

1.1. **ADDENDUM.** The attachments to this Agreement which set forth additional terms and conditions under which IPA Providers shall provide or arrange for the provision of Covered Medical Services to Members pursuant to the Benefit Programs.

1.2. **AFFILIATE.** Any person that directly, or indirectly through one or more intermediaries, is controlled by, or is under common ownership or control with Health Plan.

1.3. **BENEFIT PROGRAM.** Any one of the various health plans or products Health Plan or its Affiliates administer or sponsor. Each Benefit Program is described in the applicable Schedule of Benefits.

1.4. **BENEFIT PROGRAM REQUIREMENTS.** The rules, procedures, policies, protocols and other conditions that a Provider, Participating Providers, and Members must follow when providing or receiving Covered Medical Services under a particular Benefit Program.

1.5. **CAPITATION COMPENSATION.** The per Member per month (“PMPM”) payment, indicated in the applicable Exhibit to this Agreement, payable monthly for each Member who has selected or been assigned to an IPA Provider requiring IPA to provide or arrange for the provision of IPA Risk Services.

1.6. CLAIM FORM. The standard billing format that Health Plan uses and that includes detailed and descriptive medical data, and Medicare Advantage Member data and identifying information on CMS 1500 or UB-92 and/or UB-04 CMS-1450 forms, as applicable, or any successor format.

1.7. CLEAN CLAIM

- a) A clean claim must satisfy the conditions set forth in 42 C.F.R. § 422.500(b).
- b) A non-electronic claim IPA or IPA Provider submits, other than an institutional provider, submits is a clean claim if the claim is on the CMS Form 1500 or, if adopted by the Commissioner by rule, a successor to that form developed by the National Uniform Claim Committee or its successor. An electronic claim a physician or provider, other than an institutional provider submits, is a clean claim if the claim is in the Professional 837 (ASC X12N 837) format or, if adopted by the Commissioner by rule, a successor to that format adopted by CMS or its successor and claim.
- c) A non-electronic claim an institutional provider submits is a clean claim if the claim is on the CMS Form UB-04 CMS-1450 or, if adopted by the Commissioner by rule, a successor to that form developed by the National Uniform Billing Committee or its successor. An electronic claim an institutional provider submits is a clean claim if the claim is in the Institutional 837 (ASC X12N 837) format or, if adopted by the Commissioner by rule, a successor to that format adopted by CMS or its successor and claim satisfies the conditions set forth in 42 C.F.R. § 422.500(b) or its successor.

1.8. CMS. The Centers for Medicare and Medicaid Services, an administrative agency of the United States Department of Health and Human Services responsible for administering the Medicare Advantage and Medicaid Programs.

1.9. CMS CONTRACT. The contract between Health Plan and CMS that allows the Health Plan to operate a Medicare Advantage Program(s).

1.10. COMMERCIAL POLICY. A policy which sets forth the terms and conditions governing the relationship between the Health Plan and Commercial Members.

1.11. CONTRACTED SERVICES. All professional medical and other Covered Medical Services, except Non-Covered Services, to be rendered by IPA or an IPA Provider to a Member in accordance with this Agreement. Where and when applicable, Contracted Services are defined as IPA Risk Services which are specified in an exhibit to the applicable Addendum.

1.12. COORDINATION OF BENEFITS. The allocation of financial responsibility between two or more payers of health care services, each with a legal duty to pay for or provide Covered Medical Services to a Member at the same time.

1.13. COPAYMENT, COINSURANCE AND DEDUCTIBLE. That portion of the cost of Covered Medical Services that a Member is obligated to pay under a particular Benefit Program, including a deductible and co-insurance. A Copayment, Coinsurance and Deductible may be either a fixed dollar amount or a percentage of the applicable Participating IPA contract rate. Participating Providers may learn of the amounts of Copayment, Coinsurance and Deductibles or methods by which Copayment, Coinsurance and Deductibles may be determined by referring to the Schedule of Benefits viewable on the Health Plans website:

1.14. COVERED MEDICAL SERVICES (COVERED SERVICES). The Medically Necessary health care services and supplies that a Member is entitled to receive in accordance with a Benefit Program as outlined in the Schedule of Benefits.

1.15. DELEGATED SERVICES. The administrative services, including but not limited to, services provided under the Utilization Management Program, the credentialing of IPA Providers, and claims processing and payment to IPA Providers performed by IPA or IPA's designee. IPA shall perform

Delegated Services on behalf of Health Plan as required to provide or arrange for the provision of Covered Medical Services in accordance with this Agreement, a delegated services agreement by and between Health Plan and IPA (the "Delegated Services Agreement"), as amended from time to time, and the HMO Laws.

1.16 EMERGENCY MEDICAL CONDITION. A medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; or (d) serious disfigurement. Health Plan or its designee shall make the final determination of whether Emergency Services were required, subject to appeal under the applicable Medicare Advantage Member appeals procedure.

1.17. EMERGENCY SERVICES AND CARE. Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists, and if it does, the provision of the care, treatment, or surgery for a Covered Service by a physician which is necessary to relieve or eliminate the Emergency Medical Condition, within the service capability of IPA or an IPA Provider.

1.18. GOVERNMENT AGENCY. Any local, State or federal government agency or entity with regulatory or other authority over Health Plan, IPA, this Agreement, any Benefit Program, or IPA Provider.

1.19. HHSC. The Health and Human Services Commission.

1.20. HMO LAWS. Any and all laws and regulations of the State of or of the United States and all orders and other requirements of any government agency that are applicable to Health Plan, this Agreement, Benefit Programs, or Provider.

1.21. IPA PROVIDER. The physicians or allied health professionals who contract with IPA, or are employed by those physicians or allied health professionals, to provide Covered Services to Members.

1.22. IPA RISK SERVICES. Contracted Services and such other Covered Medical Services as referenced in the applicable Exhibit to this Agreement for which IPA has accepted Capitation Compensation under the applicable Benefit Programs to which the Addendum applies.

1.23 IPA SERVICE AREA. The geographic area(s), specified by county, or a portion thereof, in which IPA or IPA Providers shall provide Contracted Services or arrange for the provision of Covered Medical Services for Members by Benefit Program which are described in the applicable Exhibit to this Agreement. The IPA Service Area may be amended as agreed upon between Health Plan and IPA in accordance with Section 6.1 below.

1.24. MEDICALLY NECESSARY. A health care service is medically necessary if it satisfies all of the following conditions:

- it is required for the diagnosis, treatment or prevention of an illness or injury, or a medical condition such as pregnancy;
- it could not be omitted without adversely affecting the Member's condition;
- it is not primarily for the convenience of the Member or the treating provider;
- it is generally accepted as safe and effective treatment under standard medical practice in the community where the service is rendered and;
- it is provided in the most cost-efficient manner that is consistent with an

appropriate level of care.

1.25. **MEDICARE ADVANTAGE PROGRAM.** The comprehensive managed care program established under the Medicare Modernization Act of 2003 as Part C of Title XVIII of the Social Security Act and the rules and regulations promulgated there under.

1.26. **MEMBER.** A person who is eligible to receive Covered Medical Services under a Benefit Program included in this Agreement.

1.27. **NON-COVERED SERVICES.** Those health care services and supplies that are not Medically Necessary or that are not listed as Covered Medical Services under the applicable Benefit Program.

1.28. **OUT-OF-AREA SERVICES.** Urgently Needed Services and/or Emergency Services that a Member receives when the Member is outside the Service Area, or in rare instances, when Health Plan's participating provider network is temporality unavailable or inaccessible.

1.29. **PARTICIPATING PROVIDER.** A physician, physician organization, other health care practitioner or other organization that has a direct or indirect contractual relationship with Health Plan or another Participating Provider to provide certain Covered Medical Services.

1.30. **PRIMARY CARE PHYSICIAN ("PCP").** The IPA Provider who is responsible pursuant to the applicable Benefit Program for coordinating and managing the delivery of Covered Medical Services to Members selected or assigned to such physician and for whom IPA receives Capitation Compensation.

1.31. **PRIOR AUTHORIZATION.** The written or telephonic approval, with written follow-up, that Health Plan delivers prior to (a) a Member's admission to a hospital, or (b) a Member's receipt of certain other Covered Medical Services, which approval is required under the Utilization Management Program of the applicable Benefit Program.

1.32. **PROVIDER MANUAL.** The manual setting forth and documenting the policies and procedures of the Health Plan applicable to IPA Providers.

1.33. **QUALITY IMPROVEMENT PROGRAM.** Programs that review the quality of Covered Medical Services rendered to Members. These include without limitations; credentialing and certification of IPA Providers, review or audit of medical and other records, outcome rate reviews, peer review, provider appeals, and grievance procedures performed or required by Health Plan.

1.34. **REFERRAL.** If required under a Benefit Program, the written approval from the Member's physician, which may specify the number of visits, the type and number of treatments, the period of time in relation to the diagnosis, that will constitute Covered Medical Services.

1.35. **SCHEDULE OF BENEFITS.** The schedule of Covered Services of a Benefit Plan. The Schedule of Benefits also lists certain items or services that are excluded from or limited by Health Plan.

1.36. **SERVICE AREA.** The geographical area in which Health Plan is authorized by law to serve, market, enroll and provide services to Members in accordance with the terms and conditions of this Agreement.

1.37. **STATE.** The State of .

1.38. **URGENTLY NEEDED SERVICES.** Covered Medical Services provided when (a) such services are Medically Necessary and required without delay in order to prevent the serious deterioration of a Member's condition or health as a result of an unforeseen illness, injury, or condition and (b) it was not reasonable given the circumstances to obtain the services through Health Plan.

1.39. **UTILIZATION MANAGEMENT PROGRAM.** The functions that the Health Plan performs and requires 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. These include without limitations: Prior Authorization, and prospective, concurrent and retrospective

review.

II. PERFORMANCE PROVISIONS/REPRESENTATIONS OF IPA

2.1. REPRESENTATIONS AND WARRANTIES.

- (a) IPA represents and warrants that it has the authority to enter into this Agreement and to be bound to all of the terms and provisions of this Agreement. Upon request, IPA will provide to Health Plan representative agreements or certified excerpts thereof demonstrating such authority.
- (b) IPA represents and warrants that the terms of this Agreement do not conflict with the terms of any of its agreements; in any event, IPA represents and warrants that the terms of this Agreement shall apply in any situation where there is an inconsistency or conflict (i) with the terms of any agreement of IPA or (ii) with respect to any matter which is not addressed expressly in any such agreement. IPA shall be responsible to Health Plan for any such inconsistency or conflict in terms.
- (c) IPA shall provide Health Plan with certain information, including, but not limited to, a list of the names, practice locations, federal tax identification numbers, medical practice license numbers, federal Drug Enforcement Agency (“DEA”) numbers, Department of Public Safety (“DPS”) numbers, Medicare certification numbers, professional practice names and legal partnerships and the business hours of all physicians and allied health professionals that contract with IPA in a format acceptable to Health Plan. Health Plan and IPA shall mutually agree upon the inclusion of specific physicians and allied health professionals as IPA Providers. IPA shall provide Health Plan with updated additions, deletions, status changes, and address changes to the list of IPA Providers in a format acceptable to Health Plan. Health Plan and IPA shall mutually agree when to include additional physicians and other providers of health care as IPA Providers under this Agreement. Health Plan and IPA shall come to mutual agreement over the inclusion of additional physicians and other providers of health care as IPA Providers within sixty (60) days following Health Plan’s receipt of IPA’s request.
- (d) IPA shall ensure that the obligations contained in Section 2, Section 3 and Section 5 of this Agreement are included in IPA’s agreements with IPA Providers and shall use commercially reasonable efforts to ensure that all IPA Providers comply with all applicable terms and conditions of this Agreement, including, without limitation, the obligations of IPA set forth in Section 2, Section 3 and Section 5 of this Agreement.
- (e) IPA shall notify Health Plan in writing at least sixty (60) days prior to any action by IPA to terminate an IPA Provider’s agreement with IPA. When sixty (60) days prior notice is not possible, IPA shall provide as much advance notice as possible. IPA shall immediately notify Health Plan whenever an IPA Provider fails to renew his or her agreement with IPA, whenever IPA has reason to believe an IPA Provider will fail to renew his or her agreement with IPA, and whenever IPA knows of an occurrence causing the immediate termination of an IPA Provider under Section 2.1(g) of this Agreement.
- (f) IPA shall terminate the participation of a particular IPA Provider under this Agreement immediately upon request of Health Plan, after appropriate notification to the Board of Directors of IPA, or equivalent governing body if the IPA is not a corporate entity, in the event of:
 - (1) any misrepresentation or fraud by an IPA Provider in the credentialing process;

or

(2) any action by an IPA Provider which, in the reasonable judgment of Health Plan, constitutes gross misconduct or may jeopardize the health and safety of a Member; or

(3) an IPA Provider's loss, suspension or restriction of his or her license to practice medicine or dentistry, narcotic registration certificate issued by the DEA, or certification to participate in Medicare or Medicaid.

(g) IPA shall terminate the participation of a particular IPA Provider under this Agreement upon request of Health Plan, after appropriate notification to the Board of Directors of IPA, or equivalent governing body if the IPA is not a corporate entity, in the event of:

(1) an IPA Provider's failure to comply with Health Plan's or a Payor's Utilization Management Program, Quality Improvement Program and/or Health Plan's credentialing criteria; or

(2) an IPA Provider's failure to maintain professional liability insurance in accordance with this Agreement; or

(3) an IPA Provider's loss of medical staff privileges as a result of a quality or peer review investigation or finding by the facility having granted privileges.

(h) **PROCESS OF TERMINATION.** At least ninety (90) days prior to the termination of an IPA Provider's status as a Participating Provider, Health Plan shall provide written explanation to IPA Provider of the reasons for termination, except in the case of imminent harm to patient health, action against license to practice medicine or dentistry for fraud or malfeasance, in which case termination may be immediate. Not later than 30 days following receipt of the written notification of termination, IPA Provider may request a review by the Health Plan's advisory review panel. On request and before the effective date of the termination of an IPA Provider's status as a Participating Provider, but within a period not to exceed sixty (60) days, an IPA Provider shall be entitled to a review of Health Plan's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health or an action by a state medical or dental board, or other medical or dental licensing board, or other licensing board or Government Agency, that effectively impairs the IPA Provider's ability to practice medicine, dentistry, or another profession, or in a case of fraud or malfeasance. The advisory review panel shall be composed of Participating Providers who are appointed to serve on the Health Plan's standing quality assurance committee or utilization review committee, and include, if available, at least one representative of the IPA Provider's specialty or a similar specialty. The decision of the advisory review panel must be considered but is not binding. Health Plan shall provide to the affected IPA Provider, on request, a copy of the recommendation of the advisory review panel and Health Plan's determination. IPA Provider shall be entitled to an expedited review process by Health Plan on request of IPA Provider. Except for termination based on imminent harm to Members, Health Plan shall notify Members of the termination by Health Plan of IPA Provider's status as a Participating Provider upon the effective date of the termination or the date the advisory review panel makes a formal recommendation.

(h) Effect of Termination.

- (1) In the event that a Member is receiving Contracted Services at the time the IPA Provider's contract terminates, an IPA Provider shall continue to provide Contracted Services to the Member until: (a) treatment is completed; (b) the Member is assigned to another Participating Provider; or (c) Member ceases to be covered; provided, however, that an IPA Provider may be required by law to continue providing care beyond such termination period to a Member who (1) been diagnosed with a terminal illness or (2) been identified by an IPA Provider as having Special Circumstances including a Member who has: (1) a disability, (2) an acute condition, (3) a life-threatening illness, or (4) is past the 24th week of pregnancy. Compensation to IPA for such Contracted Services shall be at the rates contained in the Addendum that applies to the applicable Benefit Program. Compensation to the IPA Provider shall be in accordance with the contract between IPA and the IPA Provider, not to extend beyond (i) ninety (90) days from effective date of termination; (ii) nine (9) months in the case of a Member who at the time of termination has been diagnosed with a terminal illness or Special Circumstance; or (iii) delivery of the child, immediate postpartum and follow-up checkup within the first six weeks of delivery for a Member who at the time of termination is past the 24th week of pregnancy.
- (2) **Member Notification.** IPA and IPA Providers remain liable for any obligations or liabilities arising from their conduct prior to the effective termination date. Health Plan shall notify Members seeking professional services after the date of termination that the IPA Provider is no longer a Participating Provider. If an IPA Provider is terminated for reasons other than the IPA Provider's request, Members will not be notified until the effective date of the termination is known or until such time as the review panel makes a formal recommendation. If an IPA Provider is terminated for reasons related to imminent harm, Health Plan will notify Members immediately.
- (3) **Continuity of Treatment.** Health Plan will notify the Member within thirty (30) days of any impending termination of a PCP from Health Plan's network who is currently treating the Member. Health Plan will notify the Member within thirty (30) days of any impending termination of a specialist provider from Health Plan's network who is currently treating the Member or has treated the Member within the past six (6) months. If the IPA Provider's contract is terminated for any reason other than medical competence or professional behavior, IPA and IPA Provider shall continue the course of treatment of a Member that began prior to such termination or expiration until the Member can, without medically injurious consequences, be transferred to the care of another Participating Provider. IPA Provider shall be compensated for the aforementioned continued provision of ongoing treatment to a Member who is then receiving Medically Necessary treatment in accordance with the dictates of medical prudence for a Special Circumstance, such as treatment for a Member who has a disability, acute condition, or life-threatening illness, or is past the 24th week of pregnancy. In such cases, IPA will continue to reimburse the physician at no less than at the contract rate for the continued provision of ongoing treatment to a Member and neither IPA nor IPA Provider may seek payment from the Member of any amount for which the Member would not be responsible if the physician were

still in Health Plan's Participating Provider network. IPA Provider shall abide by the determination of the applicable Payor's Member Grievance Procedure, including, but not limited to, grievance procedures for resolving disputes regarding the necessity for continued treatment, as described in the Health Plan Member Grievance Procedures.

- (4) IPA shall secure and compensate its own Medical Director who shall oversee IPA's compliance with Health Plan's professional review programs and assist Health Plan in the development of medical policy guidelines. Such Medical Director shall interface with Health Plan's Medical Director to support Health Plan's Utilization and Quality Improvement Programs.

2.2. **INDIVIDUAL PROVIDER REPRESENTATIONS AND WARRANTIES.** IPA represents and warrants, for itself or for each IPA Provider, as applicable, that IPA or IPA Provider:

- (a) is licensed by the State(s) to provide Contracted Services;
- (b) provides Contracted Services in compliance with all applicable local, State, and federal laws, rules, regulations and professional standards of care;
- (c) is certified to participate in Medicare under Title XVIII of the Social Security Act, and in Medicaid under Title XIX of the Social Security Act or other applicable State law pertaining to Title XIX of the Social Security Act;
- (d) holds active staff privileges on the medical staff(s) of one or more hospital Participating Providers, where applicable, or works with the IPA hospital in-patient manager in lieu of holding such active staff privileges;
- (e) holds a current DEA narcotic registration certificate, where applicable, and current State narcotics license;
- (f) shall maintain such licensure, compliance, certification and registration throughout the term of this Agreement;
- (g) shall maintain all required professional credentials and meet all continuing education requirements necessary to retain certification as mandated by county, State or federal regulations; and
- (h) shall maintain a professional relationship with each Member for whom such IPA Provider has been selected as such Member's PCP and shall be solely responsible to such Member for that Member's treatment and medical care for.

2.3. **PROVISION OF SERVICES.** IPA and IPA Providers agree to render Covered Services to Members of the Benefit Programs covered under this Agreement, in accordance with:

- (a) The terms and conditions of this Agreement;
- (b) All laws, rules and regulations, policies and procedures applicable to IPA, IPA Providers and Health Plan;
- (c) The Utilization Management Program, Quality Improvement Program, Benefit Program Requirements and grievance, appeals and other policies and procedures of the particular Benefit Program under which the Covered Medical Services are rendered;

- (d) The same manner, and with the same availability, as services are rendered to other patients; and
- (e) The quality of care and performance standards that are professionally recognized and/or adopted accepted or established by Health Plan.

2.4. **FACILITIES AND HOURS.** In consideration for compensation as provided herein, IPA and IPA Providers agree to make available and, when requested by Health Plan, to provide, within the Service Area and at the sites described in Exhibit 2 of this Agreement, Covered Services to each Member, twenty-four (24) hours a day, seven (7) days a week, in a manner which (a) provides for the sharing of Member health records, (b) documents medical care during a particular period and during any subsequent periods, (c) protects the confidentiality of Member health information, including records, in accordance with law and privacy standards mandated by the federal government through the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA"), and (d) provides treatment, facilities and personnel in accordance with generally accepted standards of medical practice and IPA management, this Agreement, the Members' benefits agreements, Utilization Management Programs, and Health Plan's agreements. At all times during the term of this Agreement, IPA shall maintain facilities, equipment and staff adequate to provide Covered Services to Members in accordance with this Agreement and all applicable State and federal laws. If IPA relocates or expands the facilities in place on the effective date, IPA shall notify Health Plan within ten (10) days.

2.5. **PROVISION OF SERVICES IN THE EVENT OF UNAVAILABILITY OF IPA PROVIDER.** IPA and IPA Provider shall arrange for alternate provision of Covered Services in the event of IPA Provider's illness, vacation or other absence from his or her practice, and shall use his or her best efforts to ensure that such alternate provision is by a Participating Provider possessing the same or similar qualifications as the IPA Provider. If such alternate provision is not by a Participating Provider, IPA and IPA Provider shall use his or her and its commercially reasonable efforts to cause such alternate professional to abide by the terms of this Agreement.

2.6. **NON-DISCRIMINATION AND ACCEPTANCE OF MEMBERS.** IPA and IPA Providers shall not discriminate against any Member in the provision of Covered Services hereunder, whether on the basis of the Member's age, sex, race, color, religion, ancestry, national origin, disability, health status, genetic information, evidence of insurability, limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, source of payment, utilization of medical or mental health services or supplies or any other unlawful basis in accordance with the HMO Laws, and additional State, local, and federal laws and regulations. Furthermore, IPA and IPA Providers shall not discriminate against any Member in the provision of Covered Services because of such Member filing any complaint, grievance or legal action against IPA, and IPA Providers or Health Plan.

2.7. **UTILIZATION MANAGEMENT REQUIREMENTS.** IPA and IPA Providers agree to participate in, cooperate with and comply with all decisions rendered in connection with Health Plan's Utilization Management Program. IPA and IPA Providers also agrees to provide such records and other information as may be required or requested under such Utilization Management Program.

2.8. **PRIOR AUTHORIZATION AND REFERRALS.** Unless a particular Benefit Program or Utilization Management Program contains no such requirement, or except in the event of an Emergency Medical Condition, IPA agrees not to seek payment from Health Plan for Contracted Services rendered to a Member unless Prior Authorization or a Referral was obtained for the rendering of such services. Such Prior Authorization or Referral may be issued by Health Plan, IPA or the applicable Payor, as applicable according to the Member's Benefit Program. Other than in the event of an Emergency Medical Condition, IPA shall use commercially reasonable efforts to cause IPA Providers to agree to obtain Prior Authorization or a Referral, by telephone if necessary, before providing Contracted Services or ordering

other Covered Medical Services. When and where IPA, on behalf of IPA Providers, is not compensated on a Capitation Compensation basis, if Prior Authorization or a Referral cannot be obtained, IPA Provider agrees to notify Health Plan, as soon as possible, but no later than twenty-four (24) hours after providing the Contracted Services, or ordering the other Covered Medical Services, or on the next working day.

2.9. PARTICIPATING PROVIDERS/MENTAL HEALTH CARE PROVIDERS. Except in the event of Emergency Medical Condition, as otherwise described in the applicable Benefit Program Requirements, or as otherwise required by law, IPA shall refer Members only to Participating Providers for Covered Medical Services. For certain specialized procedures and services which cannot be rendered by the Participating Providers, Health Plan shall first agree with IPA upon the use of appropriate non-participating providers. Additionally, if so required under the applicable Benefit Program Requirements, IPA shall admit Members only to designated hospital Participating Providers. If Medically Necessary Covered Medical Services are not available through Health Plan's Participating Provider network, Health Plan will, upon request of a Participating Provider, within a reasonable time period, allow referral to a non-Participating Provider. In the event that a requested referral is denied, the request shall be reviewed by a specialist of the same or similar specialty or the type of physician or provider to whom a referral was requested if requested by the Member or the Member's PCP. IPA and IPA Providers shall be permitted to direct any Member who appears to be in need of mental health or chemical dependency services to the provider designated by Health Plan to provide or arrange for such mental, health and chemical dependency services without first obtaining a Referral. Health Plan will update IPA and IPA Providers in the event Health Plan alters its arrangements for such mental health and chemical dependency services.

2.10. CASE MANAGEMENT. Health Plan shall arrange for case management services to Members with complex medical conditions to ensure that care is provided in a manner which encourages quality and continuity of care. IPA and IPA Provider shall cooperate fully with Health Plan in such case management activities, including, without limitation, providing information that may be required for Health Plan to determine the need for case management and the transfer of Members to designated Participating Providers for cost effective care.

2.11. OUT-OF-AREA SERVICES. IPA and IPA Provider and Health Plan shall cooperate fully with each other in activities relating to management and coordination of Out-of-Area Services, including, without limitation: (a) providing information necessary to transfer a Member to a Participating Provider in the IPA Service Area; (b) immediately notifying Health Plan or IPA of known or suspected provision of Out-of-Area Services to a Member; and (c) accepting the transfer of a Member to the care of IPA or IPA Provider following such Member's receipt of Out-of-Area Services.

2.12. TREATMENT PLANS. IPA and IPA Providers agree to cooperate with Health Plan policies and procedures to: (a) identify Medicare Advantage Members with complex or severe medical conditions; (b) assess those conditions, and use medical procedures to diagnose and monitor them on an ongoing basis; and (c) establish and implement a treatment plan that is appropriate to those conditions, which includes an adequate number of direct access visits to specialists consistent with the treatment plan, and is time-specific and updated periodically.

2.13. QUALITY IMPROVEMENT PROGRAM. IPA and IPA Providers shall be solely responsible for the quality of Covered Services rendered to Members. The quality of Covered Services rendered to Members shall be monitored under the Quality Improvement Program applicable to the particular Benefit Program. IPA and IPA Providers agree to participate in, cooperate with and comply with all decisions rendered by Health Plan in connection with a Quality Improvement Program. IPA and IPA Providers also agree to provide to Health Plan, if Health Plan is given reasonable written notice, all medical and other records, all review data, and such other information as may be required or requested under a Quality Improvement Program, including without limitation outcome reporting. In the event that the standard or

quality of care furnished by IPA and IPA Providers is found to be unacceptable under any Quality Improvement Program, Health Plan shall give written notice to IPA to correct the specified deficiencies within the time period specified in the notice. IPA and IPA Providers shall correct such deficiencies within that time period. Failure to correct such deficiencies is grounds for termination of this Agreement pursuant to Section 4.3.

2.14. CREDENTIALING OF IPA AND/OR IPA PROVIDERS. IPA and IPA Providers shall be subject to and comply with the credentialing and re-credentialing policies and procedures of Health Plan. Prior to execution of this Agreement, IPA shall provide all credentialing information pertaining to IPA and IPA Providers that is requested by Health Plan. IPA and IPA Providers agree to provide Health Plan with any authorizations, consents or releases that Health Plan may require to obtain the information described above. If IPA performs credentialing of IPA Providers for Health Plan under the Delegation Agreement in Exhibit 3 of this Agreement, IPA shall perform such credentialing in accordance with the performance standards and criteria of Health Plan as outlined in the Delegated Services Agreement. Health Plan shall have the right to audit IPA's performance of its credentialing functions from time to time and to reassume the obligation for credentialing in the event Health Plan determines that IPA either does not have the capacity to perform, or is not effectively performing, credentialing of IPA Providers. IPA shall immediately inform Health Plan of any changes in credentialing information pertaining to IPA and IPA Providers. IPA and IPA Providers hereby release Health Plan, its employees and its authorized agents from any and all liability and expense that is incurred by IPA and IPA Providers, its employees or its authorized agents due to any action taken by Health Plan pursuant to this Section 2.14. The acts described in Section 2.14 are subject to federal and State laws governing confidentiality and peer review protections.

2.15. SUBCONTRACTS. If IPA or IPA Providers delegate any of the duties, or subcontract for any Covered Services, under this Agreement to any other entity, such entity must first be credentialed by Health Plan which Health Plan agrees not to unreasonably withhold. IPA or IPA Providers must enter into a written subcontract with the entity, which meets Health Plan requirements and is consistent with the terms of this Agreement. Any subcontracting IPA or provider must agree to be bound to the terms of this Agreement. All terms of this Agreement apply to such subcontracting providers.

2.16. NOTICE OF ADVERSE ACTION. IPA and IPA Providers shall notify Health Plan in writing, within three (3) 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 IPA or IPA Providers, or of any other event, occurrence or situation which might materially interfere with, adversely affect, modify or alter performance of any of IPA's or an IPA Provider's duties or obligations under this Agreement. IPA shall forward to Health Plan any written complaint or grievance or oral complaint or grievance, relating to quality of care, of a Member against IPA, IPA Providers or Health Plan within twenty-four (24) hours of receipt thereof. IPA shall maintain a written record of all Member complaints and provide such record to Health Plan promptly upon request. IPA also shall notify Health Plan promptly of any action against IPA or IPA Providers with respect to any license, certification under Title XVIII or Title XIX or other applicable statute of the Social Security Act or other State, federal or local law.

2.17. LIABILITY INSURANCE. IPA agrees to secure and maintain during the life of the Agreement, at no expense to Health Plan, such policies of comprehensive and general liability, professional liability and worker's compensation coverage, with such carriers and in such amounts as required by Health Plan and governmental authorities, insuring IPA, its members, employees, agents and Subcontractors (as applicable), against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the performance of medical services contemplated by this Agreement and/or the maintenance of IPA Provider's facilities and equipment.

Upon request, IPA Provider shall provide Health Plan with evidence of said coverage, and IPA shall require the carrier(s) to provide Health Plan with ten (10) days prior notice of any cancellations or modifications. This clause shall survive for a period of time following the termination of this Agreement not less than the statute of limitations applicable to personal injury in the State of . [NOTE: This provision will not apply if IPA is a state or federal unit of government or a municipality that is required to comply with, and is subject to, the provisions of the and/or Federal Tort Claims Act.]

2.18. LISTING OF IPA PROVIDERS. IPA agrees that Health Plan and Payors may list the name, address, telephone number and other factual information of IPA and all of IPA Providers, in its marketing and informational materials. IPA shall supply all printed materials and other information relating to its operations, description of services, or information necessary for Health Plan to complete a request for proposal within three (3) days of Health Plan's request.

2.19. NON-SOLICITATION. Neither IPA or IPA Providers, nor any employee, agent or subcontractor of Provider, shall solicit or attempt to convince or otherwise persuade any Member not to participate or to discontinue participation in any Benefit Program for which IPA renders Covered Services under this Agreement. Further, IPA and IPA Providers and employees and subcontractors, shall treat Members promptly, fairly and courteously. Health Plan, IPA, and IPA Providers agree that nothing in this Agreement shall be construed as a limitation of IPA's and IPA Provider's right or obligation to discuss in good faith with the Member, prospective enrollee, or former Member (collectively the "Patient") information regarding the Patient's health, including the Patient's medical condition, treatment options, or information regarding the provisions, terms, requirements or services of Health Plan as they relate to the medical needs of the Patient, all in accordance with HMO Laws.

2.20. ENCOUNTER REPORTING. For Members for which IPA receives Capitation Compensation under this Agreement, IPA shall provide Health Plan with the Member/IPA Provider encounter information, via personal computer diskette, magnetic tape or electronic transmission in a mutually agreed upon format for each encounter with a Member during a calendar month. Such electronic encounter information materials shall be complete, accurate and provided to Health Plan by the fifteenth (15th) day of the month following the month in which the encounter occurred. Additionally, IPA shall promptly provide to Health Plan all corrections to and revisions of such encounter data.

2.21. NEW PRODUCTS/PAYMENT MECHANISM. During the term of this Agreement, Health Plan may, from time to time, develop new products and/or payment mechanisms. IPA shall be provided with ninety (90) calendar days written notice prior to the implementation of such new products or payment mechanisms. If IPA does not object to the implementation of such new product or payment mechanism within such ninety (90) calendar day notice period, IPA shall be deemed to have accepted the new product or payment mechanism. In the event IPA objects to any such new product or payment mechanism, the parties shall confer in good faith to reach agreement. If they cannot reach an agreement, Health Plan may implement such new product and/or payment mechanism; and IPA shall have the right to terminate this Agreement pursuant to Section 4.2.

2.22. TIMELY ASSIGNMENT OF MEMBERS. Where required under a Benefit Program, Health Plan shall require Members to select specified Participating Providers at the time of enrollment. In the event a Member does not select a PCP or other Participating Providers within sixty (60) days, Health Plan shall automatically assign such Member (the "Undesignated Member") to the participating provider determined by Health Plan to receive all Undesignated Members. The Member shall be informed of the name, address, and telephone number of the assigned PCP or other Participating Providers. Upon automatic assignment of PCP, the Member may change to another PCP of choice in accordance with Benefit Program procedures. A change by a previously Undesignated Member shall not be counted as a change in providers for the purposes of limitation. Health Plan shall notify the selected PCP within thirty (30)

working days of Member assignment.

2.23. MEMBER GRIEVANCE PROCEDURES. IPA and IPA Providers shall abide by the determination of the Member grievance procedure, including but not limited to, grievance procedures for resolving disputes regarding the necessity for continued treatment, as described in the Health Plan Member grievance procedures. IPA and IPA Providers shall post a notice to Member(s) on the process for resolving complaints in the office of the Provider. The notice must include the Department of Insurance's toll free telephone number. In connection with the Benefit Program, Health Plan will not engage in any retaliatory action, including refusal to renew coverage or cancellation of coverage, against an employer or Member because the employer, Member or person acting on behalf of the employer or Member has filed a complaint against or appealed a decision of Health Plan. Health Plan will not engage in any retaliatory action, including termination or refusal to renew a contract, against IPA or an IPA Provider, because IPA or IPA Provider has, on behalf of a Member, filed a complaint against, or appealed a decision of Health Plan. In the event the Member submits an appeal to Health Plan, Health Plan shall provide IPA with the documentation of the Member's appeal. IPA shall review the documentation of the Member's appeal, performing any necessary research or investigation and providing a determination and response to Health Plan within three (3) days of receipt from Health Plan of a Member appeal, or in the time frame required by the Department of Insurance.

- (a) IPA and IPA Providers agree to comply with Health Plan's procedures for Medicare Advantage Member grievances, organization determinations, and Medicare Advantage Member appeals required by the Medicare Advantage Program.
- (b) Without limiting the generality of the foregoing, in the event the Medicare Advantage Member submits an appeal to Health Plan, Health Plan shall provide IPA with copies of Medicare Advantage Member's appeal. IPA shall review the Medicare Advantage Member appeal, performing any necessary research or investigation and providing a determination and response to Health Plan within twenty-four (24) hours of receipt from Health Plan for a Medicare Advantage Member, or as required by the then current CMS guidelines.

2.24. TERMINATION OF MEMBERS. IPA may request to terminate Members as patients of IPA or IPA Providers, as applicable, only as specified in this Section. Health Plan shall attempt to resolve the problem without termination of the Member and Health Plan will be solely responsible for notifying a Member in the event Health Plan grants IPA's request. Health Plan will address IPA's request to terminate a Member within thirty (30) days after receipt of the written request or within fifteen (15) days after receipt of any additional information requested by Health Plan. IPA and IPA Providers shall promptly provide Health Plan with any information they have pertaining to the proposed termination. The decision to terminate a Member shall be made by Health Plan in its sole discretion. IPA and IPA Providers shall cooperate with any terminated Member and Health Plan to arrange an orderly transfer of the Member's care to another Participating Provider including, without limitation, providing all medical information necessary for the transfer of the Member's care, subject to and in accordance with State and federal laws and regulations regarding the confidentiality of medical records. Health Plan's right to terminate a Member from a Benefit Program pursuant to the applicable Benefit Program Requirements are preserved and in no way altered by this Section.

The specific circumstances under which IPA or an IPA Provider may terminate a Member as a patient are as follows:

- (a) Failure to Pay Copayments. IPA and IPA Provider may request that Health Plan terminate a Member for failure to pay Copayments by giving Health Plan at least thirty (30) days written notice during which time the Member may avoid termination by paying the amount due.

- (b) Member Misconduct. IPA and IPA Providers may request Benefit Program terminate a Member who (a) harasses, threatens, or is unruly or abusive to a physician or any personnel of IPA or IPA Providers; (b) engages in conduct detrimental to the operation of IPA or IPA Provider's delivery of services to its other patients; or (c) refuses to follow any policy or procedure of IPA or IPA Provider.
- (c) Failure to Achieve Satisfactory Physician-Patient Relationship. Because of the personal nature of the relationship between the Member and the Primary Care Physician, a satisfactory physician patient relationship is important to delivery of effective health care services. In circumstances where the relationship is or becomes unsatisfactory, IPA shall permit the Member to select another Primary Care Physician. If the Member has had unsatisfactory relationships with at least three (3) Primary Care Physicians, after consultation between IPA and the Member, if IPA determines that a satisfactory physician-patient relationship cannot be achieved between the Member and any Primary Care Physician, IPA and IPA Contracted Providers may request Health Plan terminate such Member.
- (d) Fraud, Abuse or Misuse of Identification Card. IPA and IPA Providers may request Health Plan terminate a Member who commits fraud in the use of Covered Medical Services or permits the use of his or her Health Plan identification card by any other person, or misuses the card himself or herself or otherwise defrauds IPA or any IPA Provider.
- (e) Member's Health Plan Terminates. IPA and IPA Providers may request Health Plan terminate a Member if Health Plan has terminated the Member's Benefit Program.

2.25. CONTRACT AUTHORITY. IPA acknowledges Health Plan's authority to negotiate and enter into and amend its agreements with CMS and HHSC as otherwise set forth in this Agreement.

III. COMPENSATION

3.1 COMPENSATION RATES. Where IPA is compensated on a Capitation Compensation basis on behalf of IPA and IPA Providers, IPA shall accept as payment in full for Contracted 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 Health Plan as set forth in Exhibit 1 of this Agreement, plus Copayment amounts payable by Members in accordance with the applicable Benefit Program. Except where IPA on behalf of IPA Providers is compensated on a Capitation Compensation basis, IPA may require IPA Providers to bill and accept compensation directly from Health Plan, less Copayment amounts payable by Members in accordance with the applicable Benefit Program. In lieu of such arrangement, unless IPA is compensated on a Capitation Compensation basis, IPA shall bill and accept payment for Contracted Services rendered by IPA Providers, and be responsible for administering such funds and compensating IPA Providers. It is expressly understood that, in this context, IPA acknowledges its obligations are to provide care consistent with the professional standards of care generally accepted by the medical community.

3.2. BILLING AND PAYMENT. Health Plan agrees to comply with the prompt payment provisions set forth in 42 C.F.R. § 422.520(b); Tex. Ins. Code §§ 542.001-542.302, 843.336-353 and 1271.005; and Tex. Admin. Code §§ 11.901(8) and Chapter 21, Subchapter T.

- (a) BILLING. Where IPA is not compensated on a Capitation Compensation basis on behalf of IPA and IPA Providers, IPA and IPA Providers shall submit to Health Plan, via Health Plan's electronic claims submission program or hardcopy format, clean, complete and accurate claims in a format approved by Health Plan for Covered Services rendered to a Member, within ninety-five (95) days after such services are rendered. Where Health Plan is

the secondary payer under Coordination of Benefits, such ninety (95) day period shall commence once the primary payer has made payment on or has denied the claim. Health Plan shall not be under any obligation to pay IPA and IPA Providers on any claim not timely submitted. IPA and IPA Providers shall not seek payment from any Member in the event Health Plan fails to pay IPA or IPA Provider for a claim not timely submitted. IPA and IPA Providers may not submit a duplicate claim for payment before the forty-sixth (46th) day after the date the original claim is submitted.

(b) **PAYMENT AND CLAIMS PROCESSING.** Unless the claim is disputed, Health Plan shall make payment on each of IPA's, and IPA Provider's Clean Claims timely submitted for Covered Services rendered to a Member, within the thirtieth (30th) day after the date Health Plan receives a Clean Claim from IPA or an IPA Provider.

1. If Health Plan determines that the claim is not payable, Health Plan shall notify IPA or IPA Provider in writing within thirty (30) days of receipt of the claim, as to why the claim will not be paid.
2. If Health Plan determines a portion of the claim is payable, Health Plan shall pay the portion of the claim that is not in dispute within thirty (30) days of receipt of the claim, and notify the IPA or IPA Provider in writing why the remaining portion of the claim will not be paid.
3. If Health Plan needs additional information from the IPA or an IPA Provider to determine payment, Health Plan, not later than the thirtieth (30th) calendar day after the date Health Plan receives a Clean Claim, shall request in writing that the IPA provide relevant and necessary information for clarification of the claim.
4. If Health Plan has requested additional information under this section, Health Plan shall determine whether the claim is payable on the fifteenth (15th) day after the date Health Plan receives requested information.
5. Provider will provide a National Provider Identification (NPI) number upon credentialing and will submit with all claims.
6. Health Plan may not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

(c) **AVAILABILITY OF CODING GUIDELINES.**

1. IPA and IPA Providers may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the IPA and IPA Providers will receive under the contract.
2. Health Plan will provide the coding guidelines and fee schedules not later than the thirtieth (30th) day after the date Health Plan receives the request.
3. Health Plan will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the IPA and IPA Providers not later than the ninetieth (90th) calendar day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules, unless the change is required by statute or regulation in a shorter timeframe.
4. IPA or IPA Provider may terminate Agreement on or before the thirtieth (30th) day after the date the IPA or IPA Provider receives the information requested, without penalty or discrimination in participation in other health care products or plans.
5. IPA and IPA Providers may only use or disclose information received under this Subsection (c) for the purpose of practice management, billing activities, and other

business operations, or IPA may disclose the information to a governmental agency involved in the regulation of health care or insurance.

6. Health Plan shall, on request of the IPA and IPA Providers, provide the name, edition, and model version of the software that Health Plan uses to determine bundling and unbundling of claims.

- (d) APPEALS. IPA and IPA Providers shall abide by Health Plan's appeal process for disputes regarding denial of coverage as outlined in the Provider Manual.
- (e) MEDICARE AS SECONDARY PAYER. IPA and IPA Providers shall not be entitled to payment by Health Plan for the provision of Covered Medical Services to the extent that the Medicare program is not the primary payer, as determined in accordance with the relevant provisions of section 1862(b) of the Social Security Act and 42 C.F.R. Part 411, except as set forth in this Section. IPA agrees to assist Health Plan in identifying payers that are primary to the Medicare program, determining the amounts payable by those payers and coordinating Covered Medical Services with the benefits of the primary payer in accordance with Health Plan policies and procedures relating to coordination of benefits. IPA is authorized to charge other individuals or entities for Covered Medical Services provided to a Medicare Advantage Member for which Medicare is not the primary payer, as follows: if such Covered Medical Services are also covered under (a) State or federal workers' compensation, any no-fault insurance or any liability insurance policy or plan, including a self-insured plan, IPA may charge: (i) the insurance carrier, (ii) employer, (iii) any other entity that is liable for payment for the Covered Medical Services as a primary payer, or (iv) the Medicare Advantage Member (to the extent such Medicare Advantage Member has been paid by the carrier, employer, or entity for such Covered Medical Services); and (b) a group health plan or large group health plan. IPA may charge: (i) the group health plan or large group health plan; or (ii) the Medicare Advantage Member, to the extent that such Medicare Advantage Member has been paid by either such plan.

3.3. CAPITATED COMPENSATION

- (a) Where IPA is compensated on a Capitation Compensation basis on behalf of IPA and IPA Providers, IPA shall accept as payment in full for Contracted 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 Health Plan as set forth in the applicable Exhibit to this Agreement, plus Copayment amounts payable by Members in accordance with the applicable Benefit Program.
- (b) Health Plan shall begin payment of capitated amounts to IPA for Member's PCP, computed from the date of enrollment, not later than the sixty (60) days after the date the Member selects or is assigned a PCP.
- (c) If selection or assignment of a PCP or primary care provider does not occur at enrollment, capitated amounts that would have been paid to or on behalf of a selected or assigned PCP or primary care provider, if a selection or assignment had been made, shall be reserved as a capitated amount payable until the Member makes a selection or the Health Plan assigns a PCP or primary care provider. A PCP automatically assigned by Health Plan must be located within the zip code nearest the Member's residence or place of employment.
- (d) Health Plan shall notify IPA and IPA Provider of a Member's selection of that person as the PCP or primary care provider, or of the assignment of the Member to that physician or provider by the Health Plan, not later than the 30th working day after the date of the selection or assignment.

- 3.4. ELIGIBILITY. Except in an Emergency, IPA shall verify the eligibility of Members before

providing Covered Services. Health Plan shall confirm the eligibility of any Member.

3.5. **COLLECTION OF COPAYMENT, COINSURANCE AND DEDUCTIBLES.** IPA and IPA Providers shall use commercially reasonable efforts to collect all Copayment, Coinsurance and Deductibles due from Members, and shall not waive or fail to pursue collection of Copayment, Coinsurance and Deductibles from Members, without the prior written consent of Health Plan.

- (a) IPA and IPA Providers agree to refund any amounts incorrectly collected from a Medicare Advantage Member (or from others on behalf of a Medicare Advantage Member), and to pay any other amounts due to a Medicare Advantage Member (or others on a Medicare Advantage Member's behalf), in accordance with the provisions of 42 C.F.R. § 422.270, as amended from time to time. IPA and IPA Providers further agree to notify Health Plan of any amounts IPA owes under this Section. IPA further agrees to indemnify and hold harmless Health Plan for any loss, cost, or liability incurred by Health Plan as a result of (i) any amounts incorrectly collected from a Medicare Advantage Member by IPA or any of its employees or contractors; and/or (ii) the failure by IPA or any of its employees or contractors to pay any amounts due under this section. This indemnity shall not be construed to limit health plan's rights, if any, to common law indemnity.
- (b) **NO SURCHARGES.** IPA and IPA Providers shall not charge the Member any fees or surcharges in addition to authorized Copayment, Coinsurance and Deductibles for Covered Services rendered pursuant to this Agreement. In addition, IPA and IPA Providers shall not collect sales, use or other applicable tax from Members for the sale or delivery of medical services. If Health Plan receives notice that IPA has asked a Member to pay any additional charge, IPA shall fully cooperate with Health Plan to investigate such allegations, and shall promptly refund any payment deemed improper by Health Plan to the Member who made the payment.

3.6. **MEMBER HELD HARMLESS.** IPA and IPA Providers hereby agree that in no event, including, but not limited to, nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall IPA and IPA Providers bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Health Plan, IPA or persons acting on Member's behalf for Covered Services provided pursuant to this Agreement.

This Section 3.6 shall not prohibit collection of supplemental charges or Copayment, Coinsurance and Deductibles made in accordance with the terms of the applicable Benefit Program or fees for non-Covered Medical Services delivered on a fee-for-service basis to a Member. IPA and IPA Providers further agree that (i) this Section 3.6 shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and (ii) this Section 3.6 supersedes any oral or written contrary agreement now existing or hereafter entered into between IPA and Members or persons acting on their behalf.

Providers shall accept as payment in full for Covered Medical Services provided to Members the compensation arrangements specified in Exhibit I of this Agreement. IPA and IPA Providers acknowledge that in the event of Health Plan's insolvency or other cessation of operations, benefits to Medicare Advantage Members will continue through the period for which payment from CMS to Health Plan has been paid. No changes in the insolvency protection or continuation of benefits provisions under this Section shall be made without prior written approval of CMS, if applicable. 42 C.F.R. §§ 422.504(g)(1)(i)-(ii), and (3). Any modification, addition, or deletion to this Section 3.7 shall be effective on a date no earlier than fifteen (15) days after the appropriate Government Agencies have received written notice of such proposed changes.

3.7. **CONDITIONS FOR REIMBURSEMENT FOR NON-COVERED SERVICES.** IPA and IPA Providers may bill a Member for Non-Covered Medical Services only if the Member is notified in

advance that the services to be provided are Non-Covered Medical Services under the Member's Benefit Program, and the Member requests that the IPA or IPA Providers render the Non-Covered Medical Services prior to IPA rendering of such services. Neither a Member, nor Health Plan shall be liable to pay IPA or IPA Providers for any Covered Service IPA or IPA Providers render to a Member which is determined under a Utilization Management Program not to be Medically Necessary.

3.8. **COORDINATION OF BENEFITS.** IPA and IPA Providers agree to conduct Coordination of Benefits in accordance with the policies and procedures established by Health Plan for the applicable Benefit Program. IPA shall not bill Members for any portion of Covered Services not paid by the primary carrier when Health Plan is the secondary carrier, but shall instead look to Health Plan for such payment. When a Member has coverage which is primary through another carrier, then the compensation (as described in Exhibit 1) that Health Plan will pay to IPA shall be limited to the difference between the amount paid by the primary payer and the contract rates, including Copayment, Coinsurance and Deductibles.

3.9. **THIRD PARTY RECOVERIES.** When Health Plan has compensated IPA or IPA Providers for Covered Services, then Health Plan retains the right to recover from applicable third party carriers covering a Member, including self-insured plans, and to retain all such recoveries. IPA agrees to provide Health Plan with such information as Health Plan may require to pursue recoveries from such third party sources and to promptly remit to Health Plan any monies IPA may receive from or with respect to such sources of recovery.

3.10. **FINANCIAL INCENTIVE PLANS.** Health Plan and IPA agree that any financial incentive (as defined under the applicable HMO Laws) received from Health Plan related to the performance of IPA's or IPA Provider's duties under this Agreement shall comply with the applicable HMO Laws and that no payments shall be made directly or indirectly to IPA or IPA Providers as an inducement to reduce or limit Medically Necessary services. This includes without limitations compliance as defined in 42 C.F.R. § 422.208 and governed by 42 C.F.R. § 417.479, 42 C.F.R. § 438.6(h), and 42 C.F.R. § 422.210. IPA and IPA Providers further agree to cooperate with Health Plan's efforts to comply with federal and State regulations, including disclosure requirements related to physician incentive plans.

IV. TERM AND TERMINATION

4.1. **VOLUNTARY TERMINATION AND AUTOMATIC RENEWAL.** In accordance with 42 CFR 422.505, and whether or not this regulation applies to a particular benefit proper, either Party may terminate this Agreement without cause by giving the other Party written notice of termination at any time at least ninety (90) days prior to the effective date of termination. This Agreement shall automatically renew for successive one (1) year periods after this Agreement has been in effect for one (1) year.

4.2. **RENEWAL AND TERMINATION OF A BENEFIT PROGRAM.** Either Party may voluntarily terminate this Agreement and any Addendum(s) specific to any Benefit Program subject to the ninety (90) day notice period described in Section 4.1 above. In the event Health Plan does not renew its CMS Contract for Medicare Advantage, Health Plan will notify CMS and IPA simultaneously of its intention not to renew in accordance with the terms and conditions of the CMS Contract. In the event CMS terminates the CMS Contract, Health Plan will notify IPA of the termination of the applicable Benefit Program upon receiving notice from CMS. In the event Health Plan does not renew the HHSC Agreement for the Medicaid Program, Health Plan will notify HHSC and IPA simultaneously of its intention not to renew in accordance with the terms and conditions of the HHSC Agreement. In the event HHSC terminates the HHSC Agreement, Health Plan will notify IPA of the termination of the applicable Benefit Program upon receiving notice from HHSC. The termination of any Benefit Program shall not require the termination of this Agreement in its entirety. Upon the termination of any Benefit Program any and all

other Benefit Programs shall remain in full force and effect unless a Benefit Program is otherwise individually terminated or the entire Agreement is terminated in accordance with its terms.

4.3 TERMINATION DUE TO MATERIAL BREACH. The following events shall constitute a "Material Breach" of this Agreement by the IPA and shall be subject to the terms set forth in Sections 4.4 of this Agreement: (a) IPA's violation of any applicable law, rule or regulations; (b) the IPA's failure to maintain the professional liability insurance coverage specified hereunder; (c) IPA's failure to comply with the terms, conditions or determinations of any Utilization Management Program or Quality Improvement Program or other Benefit Program requirements; (d) Health Plan's determination that the IPA's new or additional offices/facilities are not satisfactory; or (e) IPA's breach of any section of this Agreement.

- (a) In the event that IPA fails to cure a Material Breach of this Agreement within thirty (30) days of receipt of written notice to cure from Health Plan, then Health Plan may terminate this Agreement, effective as of the expiration of said thirty (30) day period. 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 IPA makes substantial and diligent progress toward correction during such thirty (30) day period, this Agreement shall remain in full force and effect.
- (b) Either Party may terminate this Agreement immediately by giving written notice to the other Party upon (a) the filing by or against a Party in a court of competent jurisdiction of a petition for bankruptcy, reorganization, dissolution, liquidation, or receivership; or (b) the inability of a Party to pay its debts as they mature or an assignment of assets by a Party for the benefit of its creditors. Health Plan may immediately terminate the Agreement if it gives written notice in the case of imminent harm to patient health, the existence of an action against IPA's license to practice or fraud or malfeasance by IPA. If Health Plan determines that termination due to Material Breach is required, then before terminating the Agreement, Health Plan shall provide written explanation to IPA of the reasons for termination.

4.4. PROCESS OF TERMINATION. At least ninety (90) days prior to the effective date of termination of this Agreement, Health Plan shall provide written explanation to IPA of the reasons for termination and the following process, except in the case of imminent harm to patient health, the existence of an action against IPA's license or fraud or malfeasance by IPA, in which case termination may be immediate and without the process. On request and before the effective date of the termination of this Agreement, but within a period not to exceed sixty (60) days, IPA shall be entitled to a review of Health Plan's proposed termination by an advisory review panel. The advisory review panel shall be composed of Participating Providers appointed to serve on the standing quality improvement committee or utilization review committee of Health. The decision of the advisory review panel must be considered but is not binding. Health Plan shall provide to IPA, on request, a copy of the recommendation of the advisory review panel and Health Plan's determination. IPA shall be entitled to an expedited review process by Health Plan on request of IPA. Health Plan shall notify Members of the termination by Health Plan of IPA's status as a Participating IPA upon the effective date of the termination or the date the advisory review panel makes a formal recommendation.

4.5. EFFECT OF TERMINATION. In the event that a Member is receiving Covered Services at the time this Agreement terminates, IPA and IPA Providers shall continue to provide Covered Services to the Member until: (a) treatment is completed; (b) the Member chooses another Participating Provider, or (c) Member ceases to be covered. Compensation for such Covered Services shall be at the Health Plan fee for service fee schedule in effect at the time of termination. With respect to Benefit Programs under the Medicare Advantage Program, IPA acknowledges and agrees that in the event of Health Plan's insolvency or other cessation of operations, benefits to Members will continue through the period for which payment from CMS to Health Plan has been made. Any modification, addition, or deletion to the

provisions of this Section shall be effective on a date no earlier than fifteen (15) days after the appropriate Government Agency has received written notice of such proposed change and has approved such change.

4.6. CONTINUING OBLIGATIONS/MEMBER NOTIFICATION. IPA and Health Plan remain liable for any obligations or liabilities arising from conduct prior to the effective termination date. Health Plan shall notify Members seeking professional services from IPA and IPA Providers after the date of termination that IPA is no longer a Participating IPA. If this Agreement is terminated for reasons other than IPA's request, Members will not be notified until the effective date of the termination or until such time as the Health Plan advisory review panel makes a formal recommendation. If the Agreement is terminated for reasons related to imminent harm or IPA's request Health Plan will notify Members immediately. A Member currently being treated by the IPA or an IPA, Provider shall be given reasonable advance notice of the impending termination of the IPA from the Health Plan.

4.7. CONTINUITY OF TREATMENT. If IPA's participation under this Agreement is terminated for any reason other than medical competence or professional behavior, violation of any applicable law, rule or regulation, the revocation or suspension of any of IPA's accreditations or certifications; or Health Plan's determination that the health and/or safety of any Member is or may be jeopardized, IPA will, at the request of the treating IPA Provider physician, provide for continuity of care for a Member then receiving medically necessary treatment who has "special circumstances", such as a disability, an acute condition, or a life-threatening illness, or for a member who is past the 24th week of pregnancy. "Special circumstances" means a condition such that the treating IPA Provider physician reasonably believes that discontinuing care by the treating physician or Hospital could cause harm to the Member. The special circumstance shall be identified by the treating physician, who must request that the Member be permitted to continue treatment under the treating physician's care. In such cases, Health Plan will continue to reimburse the IPA or IPA Provider at no less than at the Health Plan fee for service fee schedule, as may be amended from time to time, for the continued provision of ongoing treatment to a Member. IPA or IPA Provider may not seek payment from the Member of any amount for which the Member would not be responsible if the IPA were still in Health Plan's Participating IPA network. IPA agrees to abide by the determination of the applicable Member grievance procedure, including but not limited to grievance procedures for resolving disputes regarding the necessity for continued treatment, as described in the Health Plan Member grievance procedures.

V. RECORDS, AUDITS AND REGULATORY REQUIREMENTS

5.1. MEDICAL AND OTHER RECORDS.

- (a) IPA and IPA Providers agree to prepare and maintain all medical and other records required by law. IPA and IPA Providers shall use commercially reasonable efforts to maintain such records for at least ten (10) years after the rendering of Covered Services (records of a minor child shall be kept for at least one (1) year after the minor has reached the age of eighteen (18), but in no event less than ten (10) years). Additionally, IPA shall maintain such financial, administrative and other records as may be necessary for compliance by Health Plan with all applicable local, State, and federal laws, rules and regulations. IPA and IPA Providers shall abide by all federal and State laws regarding confidentiality, accuracy, and disclosure of medical records and other health and enrollee information. IPA and IPA Providers shall assure their own compliance and that of any business associates with all the privacy and security provisions of HIPAA regulations and in accordance with 42 C.F.R., Part 431, Subpart F, as they become effective. IPA and IPA Providers agree to provide all documents and information necessary for Health Plan to comply with Health Plan's requirements for submitting information under the CMS Contract, including but not limited to 42 C.F.R. §422.516, 42 C.F.R. §422.257, and 42 C.F.R. §422.504(a)(8) as determined in the sole

discretion of Health Plan. IPA and IPA Providers agree, as a condition to receiving payment under this Agreement to provide a certification certifying, to the best of IPA's knowledge, information, and belief, the accuracy, completeness, and truthfulness of the encounter data IPA submits to Health Plan under this Section and in accordance with the provisions of 42 C.F.R. § 422.504(1), as may be amended from time to time.

- (b) HEALTH PLAN RECORDS. Health Plan shall maintain such records (electronic or otherwise) as shall be reasonably necessary to accurately account for processing IPA and IPA Providers' bills and the incidence of use by Members of IPA pursuant to this Agreement.

5.2. ADVANCE DIRECTIVES. IPA and IPA Providers agree to: (a) document in a prominent part of each Medicare Advantage Member's medical record whether or not the Medicare Advantage Member has executed an advance directive; (b) not condition the provision of care or otherwise discriminate against a Medicare Advantage Member based on whether or not the individual has executed an advance directive; (c) comply with Health Plan's policies and procedures regarding advance directives; and (d) comply with requirements of State and federal law regarding advance directives, including without limitation the rules and regulations under the Medicare Advantage Program.

5.3. ACCESS TO RECORDS; AUDITS. The records referred to in Section 5.1 shall be and remain the property of IPA, and shall not be removed or transferred from IPA except in accordance with applicable local, State, and federal laws, rules and regulations. Subject to applicable State or federal confidentiality or privacy laws, IPA and IPA Providers hereby agree to the following: Health Plan or its designated representatives, the Department of Health and Human Services (DHHS), the Comptroller General, or their designee may evaluate, inspect and review such records for: (i) the quality, appropriateness, and timeliness of services furnished to Medicare Advantage Members; (ii) the facilities; and (iii) enrollment and disenrollment. The evaluation may be through inspection or other means during normal business hours or request, and the inspector may make copies of the records. IPA and IPA Providers further agree that DHHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of IPA (or its assignee) that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under CMS Contract, or as the Secretary of the federal Department of Health and Human Services may deem necessary to enforce the CMS Contract. IPA and IPA Providers agree to make available, for the purposes specified in this Section, the premises, physical facilities and equipment, records relating to Medicare Advantage Members, and any additional relevant information that CMS may require. IPA and IPA Providers further agree that DHHS, the Comptroller General, or their designees have a right to inspect, evaluate, and audit that extends through ten (10) years from the final date of the contract period of the CMS Contract or completion of any audit, whichever is later. 42 C.F.R. § 422.504(e)(2); 42 C.F.R. § 422.504(e)(3); 42 C.F.R. § 422.504(i)(2)(ii); and 42 C.F.R. § 422.504(e)(4). Additionally, IPA and IPA Providers shall obtain from a Member a signed authorization that provides an appropriate consent for disclosure of information for permitted purposes. This consent shall be maintained as part of the Member's permanent medical records.

5.4. CONTINUING OBLIGATION. The obligations of IPA and IPA Providers under Sections 5.1, 5.2 and 5.3 shall not be terminated upon termination of this Agreement, whether by rescission or otherwise. After termination of this Agreement, Health Plan and any Government Agency shall continue to have access to IPA's and IPA Providers' records as necessary to fulfill the requirements of this Agreement and to comply with all applicable laws, rules and regulations.

5.5. REGULATORY COMPLIANCE/EXCLUDING PROVIDERS AND MARKETING.

- (a) IPA and IPA Providers agree to comply with HMO Laws and all applicable local, State, and federal laws, rules and regulations, and Health Plan policy and procedure, now or

hereafter in effect, to the extent that they directly or indirectly affect IPA or Health Plan, and bear upon the subject matter of this Agreement. IPA agrees to submit to Health Plan such reports and financial information as is necessary for Health Plan to comply with regulatory requirements to monitor the financial and administrative viability of IPA. IPA and IPA Providers shall be financially responsible, hold harmless and indemnify Health Plan for payment of any interests or fines which are accrued or imposed as a result of any such non-compliance, in accordance with CFR 422.504(i)(4)(v).

- (b) IPA and IPA Providers and Health Plan agree to comply with: (i) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 C.F.R Part 84; (ii) The Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. Part 91; (iii) The Rehabilitation Act of 1973; (iv) The Americans With Disabilities Act; and (v) all other applicable laws and rules, including, without limitation, all applicable Medicare rules and regulations and CMS instruction. IPA and IPA Providers acknowledge that Health Plan receives federal funds and that, as an independent contractor of Health Plan; the payments IPA and IPA Providers receive under this Agreement are, in whole or in part, from federal funds. IPA and IPA Providers agree to comply with all laws, rules, and regulations applicable to entities receiving federal funds.
- (c) IPA acknowledges that it is prohibited from employing or contracting with an individual who is excluded from participation in the Medicare program (or with an entity that employs or contracts with such an individual) for the provision of any of the following: (i) health care; (ii) utilization review; (iii) medical social work; or (iv) administrative services. IPA agrees to immediately notify Health Plan in the event IPA, or any of its employees or contractors, is excluded from participation in the Medicare program or any administrative or regulatory proceeding is initiated that could lead to the exclusion of IPA or any of its employees or contractors from the Medicare program. In such event, Health Plan may immediately terminate this Agreement pertaining to the Benefit Program for the Medicare Advantage Program.
- (d) IPA and IPA Providers acknowledge and agree that all marketing activities related to a Benefit Program under the Medicare Advantage Program must conform to the requirements of the Medicare Advantage Program, codified at 42 C.F.R. § 422.80, as amended from time to time. IPA and IPA Providers agree not to engage in any such marketing activities, directly or indirectly, without first obtaining Health Plan's and CMS's approval.

VI. GENERAL PROVISIONS

6.1. **AMENDMENTS.** Except for amendments affecting coding guidelines and fee schedules that will result in a change of payment to the IPA as provided in Section 3.3(c)(3), Health Plan may amend this agreement as follows: (1) Health Plan may at any time amend this Agreement by giving sixty (60) days' advance written notice to IPA, (2) Health Plan may at any time without advance notice send amendments to the Agreement to comply with CMS regulatory requirements as required by law, (3) Health Plan may amend this Agreement at any time by written agreement of both Parties. If IPA objects to any amendment under subsection (1) or (2), IPA may give notice of such objection and submit its intent to terminate the Agreement using the termination process outlined in the Agreement. Health Plan may at its discretion accept the IPA's termination at an earlier time than the sixty (60) day notice time period and remove the IPA from the network, or may in the case of subsection (1), withdraw or modify its amendment.

6.2. **ASSIGNMENT.** Neither this Agreement or applicable amendments, nor any of IPA's rights or obligations hereunder, is assignable, delegable or transferable by IPA without the prior written consent of Health Plan, which shall not be unreasonably withheld or delayed. Notwithstanding the foregoing, Health Plan may, without IPA's consent, validly assign this Agreement to any Affiliate or successor in interest of Health Plan.

6.3. CONFIDENTIALITY.

- (a) Health Plan and IPA and IPA Providers agree to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated herein, and not for any other purpose. Specifically, IPA and IPA Providers, as well as Health Plan, shall keep strictly confidential all compensation rates set forth in this Agreement and Exhibit 1, except that this provision does not preclude disclosure of the method of compensation, e.g., fee-for-service, capitation, shared risk pool, or per diem or disclose to third parties for the purpose of claims audit or utilization reviews.
- (b) CONFIDENTIALITY OF RECORDS. For any medical records or other information IPA and IPA Providers maintain with respect to Members, IPA and IPA Providers must establish procedures to: (a) safeguard the privacy of any information that identifies a Member; (b) release information from, or copies of, records only to authorized individuals; (c) ensure that unauthorized individuals cannot gain access to or alter Member records; (d) release original medical records only in accordance with federal and State laws, court orders, or subpoenas; (e) maintain the records and information in an accurate and timely manner; (f) ensure timely access by Members to the records and information that pertain to them; and (g) abide by all State and federal laws regarding confidentiality and disclosure for mental health records, medical records, other health information and Member information in accordance with 42 C.F.R. § 422.504(a)(13), 42 C.F.R. § 422.504(h)(2) and 42 C.F.R. § 422.118.

6.4. VENUE. The Parties agree that any action arising out of this Agreement shall be venued in the federal, State or local courts located in Travis County, and the parties hereby consent to personal jurisdiction in such courts and waive any objection based on the defense of an inconvenient forum and any objection to jurisdiction or venue of any action instituted hereunder. Each Party hereby irrevocably consents to the service of process of any of the aforementioned courts in any such suit, action or proceeding by the mailing of copies thereof by registered or certified mail, postage prepaid, to the addresses set forth in Section 6.8. The prevailing Party shall be entitled to recover from the non-prevailing Party all costs and other expenses it has incurred in connection with any litigation, including, without limitation, fees and expenses of attorneys and any other experts.

6.5. 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.

6.6. GOVERNING LAW. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of , 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 payers.

6.7. 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 or Participating Provider, other than the Provider. 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 IPA and IPA Providers or Health Plan with respect to such Members.

6.8. 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, addressed as follows:

Attention: Vice President, Provider Operations

IPA
Address
Facsimile
Telephone number
Attention: President

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

6.9. REGULATION. Health Plan 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 IPA, IPA Providers and Health Plan whether or not provided herein.

6.10. 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.

6.11. STATUS AS INDEPENDENT ENTITIES. The relationship between Health Plan and IPA and IPA Providers shall be that of independent contractors. None of the provisions of this Agreement is intended to create or shall be deemed or construed to create any relationship between IPA and Health Plan other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither IPA nor Health Plan, nor any of their respective agents, employees, or representatives shall be construed to be the agent, employee or representative of the other. This Agreement shall not create, and shall not be construed as creating, any partnership, joint venture, agency relationship or employer-employee relationship, or any other relationship except that of independent contractors. Nothing contained in this Agreement shall cause either Health Plan or IPA and IPA Providers to be liable or responsible for any debt, liability or obligation of the other Party or any third party unless such liability or responsibility is expressly assumed by the Party sought to be charged therewith.

6.12. ADDENDA. Each Addendum to this Agreement and the Exhibits thereto are 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.

6.13. SEPARATE OBLIGATIONS. The rights and obligations of Health Plan under this Agreement shall apply to each Affiliate only with respect to the Benefit Programs of such Affiliate. No such Affiliate shall be responsible for the obligations of any other Affiliate under this Agreement with respect to the other Affiliate's Benefit Programs. The person executing this Agreement on behalf of Health Plan has been duly authorized by each Affiliate to execute this Agreement on such Affiliate's behalf.

6.14. FORCE MAJEURE. Health Plan and IPA shall each be excused, discharged and released from performance under this Agreement to the extent that all or part of this Agreement cannot be performed due to causes which are outside the control of Health Plan and IPA, and could not be avoided by the exercise of due care, including but not limited to, any acts of God, war, epidemic or by any enforceable law, regulation or order. The foregoing shall not be considered to be a waiver of any continuing

obligations under this Agreement, and as soon as such conditions cease, the Party affected thereby shall fulfill its obligations as set forth under this Agreement.

6.15. REMEDIES. All rights, powers, and remedies granted to either Party by any particular term of this Agreement are in addition to, and not in limitation of, any rights, powers, or remedies which it has under any other term of this Agreement, at common law, in equity, by statute, or otherwise, and all such rights, powers, and remedies may be exercised separately or concurrently, in such order and as often as may be deemed expedient by either Party. A waiver by either Party of any breach or default hereunder shall not constitute a waiver of any subsequent breach or default of either the same or any other provision of this Agreement.

6.16. DELEGATED ADMINISTRATIVE FUNCTIONS. Health Plan shall delegate those administrative functions that may be outlined in Exhibit 3, Delegation Agreement. Initial delegation and delegation renewal will be subject to review, on an ongoing basis, and approval of IPA's performance of delegated administrative functions and compliance by IPA of all Health Plan and regulatory guidelines. Health Plan retains the right to approve, suspend, or terminate delegated functions. Failure of IPA to perform delegated administrative functions in compliance with Health Plan's policies and procedures shall result in revocation of delegation for one or all of the administrative functions that have been delegated. IPA acknowledges and agrees that its Agreements with Subcontractors are subject to review and approval by Health Plan, CMS, AHCA, and other applicable regulatory agencies. Any services or other activity performed by related entity, contractor, subcontractor, or first-tier or downstream entity of the Provider, in accordance with this contract is consistent and complies with the Health Plan's contractual obligations. Delegated functions shall comply with all requirements under section 70.18 of the Medicaid HMO contract and with 42 CFR 422.504(i)(1), 42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(3)(ii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

IN WITNESS WHEREOF, the Parties have executed this Agreement to be effective as of the Effective Date.

HEALTH PLAN:

IPA :

By: _____
Name:
Title:
Date:

By: _____
Name:
Title:
Date:
IPA Tax ID:

EXHIBIT 1
COMPENSATION SCHEDULE

For purposes of this Agreement, **the IPA acknowledges by initialing below**, the lines of business in which the Provider will participate: **(If none initialed all will apply.)**

- _____ Commercial Members (Exhibit 1-1 fee schedule)
- _____ Medicaid (Exhibit 1-2 fee schedule)
- _____ Medicare Advantage HMO (Exhibit 1-3 fee schedule)
- _____ Medicare PPO (Exhibit 1-4 fee schedule)

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EXHIBIT 1-1
PHYSICIAN/PROVIDER PAYMENT ARRANGEMENT- COMMERCIAL

The parties acknowledge and agree that the description of Covered Services set forth in this Agreement product line are subject to the terms and conditions of the applicable Subscriber Contract.

The IPA Provider is responsible for collection of applicable co-payments, co-insurance, deductibles, and amounts due for non-covered services. Fee-for-service reimbursement will be less any applicable co-payments, co-insurance, deductibles, or amounts due for non-covered services. Payment to IPA Provider will be at the lesser of billed charges or the contracted rates.

- 1) IPA Provider will be reimbursed on a fee-for-service basis at 110% of prevailing Medicare Allowable Charge (MAC).
- 2) Covered codes that do not have a MAC and are covered by the plan will be reimbursed at 150% of prevailing Medicaid rates.
- 3) Diagnostic Services (excluding Laboratory Services with the exception of allowable in office labs) will be reimbursed at 80% of the prevailing MAC.
- 4) Immunizations and Injectables will be reimbursed at 100% of the prevailing ASP Medicare fee schedule at the time of service. (Uncoded items must be billed with NDC numbers along with amount administered and will be paid at 90% of AWP at time of service, according to the Red Book Pricer. Invoices may be requested)

**EXHIBIT 1-2
PHYSICIAN/PROVIDER PAYMENT ARRANGEMENT- MEDICAID**

The parties acknowledge and agree that the description of Covered Services set forth in this Agreement product line are subject to the terms and conditions of the applicable Subscriber Contract.

The IPA Provider is responsible for collection of applicable co-payments, co-insurance, deductibles, and amounts due for non-covered services. Fee-for-service reimbursement will be less any applicable co-payments, co-insurance, deductibles, or amounts due for non-covered services. Payment to Provider will be at the lesser of billed charges or the contracted rates.

- 1) IPA Provider will be reimbursed on a fee-for-service basis at 100% of Medicaid prevailing rates.
- 2) Diagnostic Services (excluding Laboratory Services with the exception of allowable in office labs) will be reimbursed at 100% of Medicaid prevailing rate.
- 3) Immunizations will be covered under the VFC program (Vaccinations for Children) per Medicaid guidelines. Plan will reimburse a vaccination administration fee of \$10.00 per administration for Members assigned to a physician and \$8.00 per administration for Members assigned to an Advanced Nurse Practitioner or Physician Assistant. Plan will reimburse immunizations covered by Medicaid but not provided through VFC at 100% of Medicaid prevailing rates.

**EXHIBIT 1-3
IPA PROVIDER PAYMENT ARRANGEMENT- MEDICARE HMO**

The parties acknowledge and agree that the description of Covered Services set forth in this Agreement product line are subject to the terms and conditions of the applicable Subscriber Contract.

See attached Physician Practice Management (PPM) Agreement

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**EXHIBIT 1-4
IPA PROVIDER PAYMENT ARRANGEMENT- MEDICARE PPO**

The parties acknowledge and agree that the description of Covered Services set forth in this Agreement product line are subject to the terms and conditions of the applicable Subscriber Contract.

The IPA Provider is responsible for collection of applicable co-payments, co-insurance, deductibles, and amounts due for non-covered services. Fee-for-service reimbursement will be less any applicable co-payments, co-insurance, deductibles, or amounts due for non-covered services. Payment to Provider will be at the lesser of billed charges or the contracted rates.

- 1) IPA Provider will be reimbursed on a fee-for-service basis at 100% of prevailing Medicare Allowable Charge (MAC).
- 2) Diagnostic Services (excluding Laboratory Services with the exception of allowable in office labs) will be reimbursed at 80% of the prevailing MAC.
- 3) **FOR PCPS & OB/GYNS:** Well Woman and Preventive Check-ups will be paid as follows:

CPT Code	Description	Fee
99384	Preventive visit, 12-17 years - New	\$90.00
99385	Preventive visit, 18-39 years - New	\$110.00
99386	Preventive visit, 40-64 years - New	\$110.00
99387	Preventive visit, 65+ years - New	\$110.00
99394	Preventive visit, 12-17 years - Established	\$80.00
99395	Preventive visit, 18-39 years - Established	\$90.00
99396	Preventive visit, 40-64 years - Established	\$90.00
99397	Preventive visit, 65+ years - Established	\$110.00

- 4) Immunizations and Injectables will be reimbursed at 100% of the prevailing ASP Medicare fee schedule at the time of service. (Uncoded items must be billed with NDC numbers along with amount administered and will be paid at 90% of AWP at time of service, according to the Red Book Pricer. Invoices may be requested)

EXHIBIT 2
IPA SITES/SERVICES

IPA agrees to provide _____ services to Members.
(Type of Specialty or Primary Care Service)

For Primary Care Physicians:

The PCP shall provide the following minimum set of primary care services to assigned Members, unless waived by the Health Plan in writing with an appropriate adjustment in compensation.

- ✓ Care for common medical conditions.
- ✓ Periodic health evaluations or routine physical exams – except exams for employment, school or immigration purposes.
- ✓ Venipuncture and other specimen collection.
- ✓ Preventive care and education.
- ✓ Routine gynecological examinations including Pap smears.
- ✓ Family planning and nutritional counseling.
- ✓ Administration of injections including subcutaneous, intramuscular, intravenous, and intra-articular injections.
- ✓ Provision of routine immunizations.
- ✓ Hospital and Skilled Nursing Facility inpatient visits.
- ✓ Well baby and child care for Physicians accepting pediatric patients.
- ✓ Early and periodic screening, diagnosis and treatment (CHCU) services and therapy services.
- ✓ Healthy Start screenings and referrals.

*EXHIBIT 3
DELEGATION AGREEMENT (IF APPLICABLE)*

This section is required if Provider has delegated credentialing, subcontracts or “downstream” arrangements with other providers/organizations.

The following Health Plan “Delegation Agreements” are incorporated as part of the Primary Care IPA Provider Agreement:

Delegation Agreement: _____

Delegation Agreement: _____

Delegation Agreement: _____

PHYSICIAN SERVICES AGREEMENT

MEDICAID ADDENDUM

This Addendum supplements the Agreement between _____, a _____ corporation [d/b/a Universal Health Care referred to herein as "**Health Plan**"] and _____ ("**IPA**") effective (Date) ("the Agreement") and will run concurrently with the terms of the Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid enrollees who are covered under the following Medicaid benefit programs: Children's Health Insurance Program ("CHIP") Health Maintenance Organization ("HMO"); CHIP Perinatal HMO; State of _____ Access Reform ("STAR") HMO; STAR+PLUS HMO; and STAR Health Managed Care Organization ("MCO").

ADDENDUM DEFINITIONS

The following section defines the capitalized terms identified in this Addendum. Any terms that are not identified in the Agreement or in this Addendum may be found in governing statutes, rules, and regulations.

1. **CHIP HMO.** A Medicaid managed care program designed to provide Health Insurance to families who do not qualify for Medicaid or cannot afford to buy private health insurance.
2. **CHIP PERINATAL.** A Medicaid managed care program designed to provide prenatal and delivery services to unborn children of Low-income pregnant women who do not qualify for Medicaid.
3. **HEALTH PASSPORT.** An electronic health information system for the medical information of children in the care or custody of the Department of Family and Protective Services (DFPS).
4. **MCP.** Managed Care Plan.
5. **MEDICAID.** Medical assistance provided under state plan approved under Title XIX of the Social Security Act.
6. **MEMBER.** A Medicaid consumer who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services and is subsequently enrolled in the MCP.
7. **STAR HMO.** The State of _____ Access Reform program that provides a Medicaid managed care program for children who are in the state's foster care program.
8. **STAR+PLUS.** A Medicaid managed care program designed to provide health care, acute and long-term services and support through a managed care system.
9. **STAR HEALTH MCO.** A Medicaid managed care program.
10. **HEALTH STEPS ("THSteps").** A children's program under Medicaid that provides medical and dental preventive care and treatment to Medicaid-enrolled children from birth to 21 years of age.

ADDENDUM PROVISIONS

The provisions of this Medicaid Addendum are intended to supplement the Agreement to include requirements identified in the HHSC Uniform Managed Care Manual Provider Checklist. In the event of a conflict between a provision in this Addendum and one in the Agreement, the Parties shall make every effort to read both documents in harmony and reconcile the language in this Addendum with the Agreement. In the event of a conflict that cannot be reconciled, the language in this Addendum shall control interpretation or implementation of the Medicaid program(s) which are the subject of this addendum.

IPA and IPA Providers agree to abide by all of the following terms and conditions applicable to that specific Medicaid Benefit Program:

1.0 AUDIT AND INVESTIGATION

1.1 INFORMATION PROVIDED TO HHSC. IPA and IPA Providers agree to provide to HHSC:

1. all information required under the Health Plan's managed care contract with HHSC, including but not limited to the reporting requirements and other information related to IPA and IPA Provider's performance of its obligations under the contract; and
2. any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by HHSC.

1.2 ACCESS TO RECORDS. IPA and IPA Providers agree to provide the following entities or their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that are related to the Agreement and/or the IPA and IPA Provider's performance of its responsibilities under this contract:

- 1) HHSC and Managed Care Organization Program personnel from HHSC;
- 2) U.S. Department of Health and Human Services;
- 3) Office of Inspector General and/or the Medicaid Fraud Control Unit;
- 4) an independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;
- 5) state or federal law enforcement agency;
- 6) special or general investigation committee of the Legislature;
- 7) the U.S. Comptroller General;
- 8) the Office of the State Auditor of ; and
- 9) any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

IPA and IPA Providers must provide access wherever it maintains such records, books, documents, and papers. IPA and IPA Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to, the following purposes:

- 1) examination;
- 2) audit;
- 3) investigation;

- 4) contract administration;
- 5) the making of copies, excerpts, or transcripts; or
- 6) any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

1.3 **AUTHORITY OF STATE AUDITOR'S OFFICE.** *IPA and IPA Providers understand 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. IPA and IPA 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.*

2.0 BEHAVIORAL HEALTH

2.1 **OUTPATIENT FOLLOW-UP.** If IPA Provider provides inpatient psychiatric services to a Member, IPA Provider 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.

2.2 **BEHAVIORAL HEALTH PROVIDER OBLIGATIONS.** This subsection applies only to Health Plan's STAR Health MCO. IPA Provider agrees to submit information for the Health Passport. If IPA Provider is a behavioral health provider, it must:

- 1) Submit to the Health Plan for inclusion into the Health Passport treatment plans and referrals to other providers.
- 2) Evaluate each Member's progress using a standardized outcome measurement instrument, to be provided by the Health Plan, at intake, quarterly at a minimum, and at termination of the Health Care Service Plan, or as significant changes are made in the treatment plan.
- 3) Document the outcome measurement scores in the Health Passport.
- 4) Function as a member of the PCP Team by coordinating with the PCP and service manager as appropriate.
- 5) Testify in court as needed for child protection litigation.

2.3 **HEALTH PASSPORT INFORMATION.** This subsection applies only to Health Plan's STAR Health MCO. If IPA Provider is a behavioral health provider, it must provide the following information for the Health Passport:

- 1) Primary and secondary (if present) diagnosis.
- 2) Assessment information, including results of a mental status exam.
- 3) Brief narrative summary of each clinical session.
- 4) Scores on each outcome rating form(s).
- 5) Referrals to other providers or community resources.
- 6) Health Care Service Plans and referrals to other providers.
- 7) Any other relevant care information.

2.4 **COORDINATION BETWEEN BEHAVIORAL HEALTH SERVICES.** This subsection applies only to Health Plan's STAR Health MCO. IPA Provider must comply with the *Psychotropic Medication Utilization Parameters for Foster Children*, as amended or modified from time to time, and found at:

2.5 An IPA Provider who is a Primary Care Physician (“PCP”) must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders.

2.6 The subsection applies only to Health Plan’s STAR Health MCO. An IPA Provider who is a PCP must use the Health Steps behavioral health forms, at a minimum, for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. Members must be screened for behavioral health problems, including possible substance abuse or chemical dependency. The PCP must submit completed Health Steps screening and evaluation results to Health Plan to include in the Health Passport.

3.0 CLAIMS PAYMENT

3.1 NOTICE OF CHANGES IN CLAIMS GUIDELINES. Health Plan will provide IPA at least ninety (90) days notice prior to implementing a change in the above-referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

3.2 IPA or IPA Provider must submit claims for processing and/or adjudication to the following entity/entities:

Telephone:

Fax:

3.3 CHANGES IN CLAIMS PROCESSING OR ADJUDICATION ENTITIES. The Health Plan must notify IPA in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If the Health Plan is unable to provide thirty (30) days notice of a change, Health Plan shall give IPA a thirty (30) day extension on the claims filing deadline to ensure claims are routed to the correct processing center.

3.4 ADJUDICATION OF CLAIMS. The Health Plan shall adjudicate (finalize as paid or denied adjudicated) Clean Claims within thirty (30) days from the date the claim is received by the Health Plan. The Health Plan will pay IPA or IPA Provider interest (%) at a rate of 1.5% per month (18% per annum) on all Clean Claims that are not adjudicated within thirty (30) days.

4.0 HHSC INQUIRY

4.1. APPEAL OF PROVIDER CLAIMS. Health Plan will develop, implement, and maintain a system for tracking and resolving all IPA or IPA Provider appeals related to claims payment. Health Plan’s processes will comply with the requirements of 42 C.F.R. §438.414. For CHIP and CHIP Perinatal Program providers, Health Plan’s processes will comply with the requirements of Chapter 843, Subchapter G of the Insurance Code. Within this process, the Health Plan must respond fully and completely to each IPA or IPA Provider claims payment appeal within thirty (30) days of receipt by Health Plan and establish a tracking mechanism to document the status and final disposition of each IPA or IPA Provider claims payment appeal. Health Plan will contract with physicians who are not IPA or IPA Providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to an IPA or IPA Provider appeal. The determination of the physician resolving the dispute must be binding on Health Plan, the IPA, and the IPA Provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing IPA Provider.

4.2 INQUIRY AND INVESTIGATIONS. IPA and IPA Provider understand and agree that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into IPA Provider and Member complaints.

5.0 CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

5.1 COLLECTION OF CHIP HMO CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES. This subsection applies to the following Health Plan program: CHIP HMO. IPA Provider is responsible for collecting at the time of service any applicable CHIP co-payments, co-insurance or deductibles in accordance with CHIP cost-sharing limitations.

5.2 PROHIBITED CHARGES. This subsection applies to the following Health Plan program: CHIP HMO. IPA and IPA Provider shall not charge:

- 1) cost-sharing or deductibles to CHIP Members of Native American Tribes or Alaskan Natives;
- 2) co-payments, co-insurance 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
- 3) co-payments, co-insurance and deductibles for well-child or well-baby visits or immunizations.

5.3 LIMIT ON AMOUNTS COLLECTED FROM CHIP MEMBERS. This section applies to the following Health Plan program: CHIP HMO. Co-payments, co-insurance and deductibles are the only amounts that IPA and IPA 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.

6.0 NON-COVERED SERVICES.

6.1 IPA Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay form from such a Member.

7.0 FRAUD AND ABUSE

7.1 FRAUD INVESTIGATION. IPA and IPA Provider understand and agree to the following:

- 1) HHSC Office of Inspector General ("OIG") and/or the Medicaid Fraud Control Unit must be allowed to conduct private interviews of IPA Provider, IPA and its employees, agents, contractors, and patients;
- 2) requests for information from such entities must be complied with, in the form and language requested;
- 3) IPA Provider, IPA and its employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at IPA and IPA Provider's own expense; and
- 4) compliance with these requirements will be at IPA and IPA Provider's own expense.

7.2 IPA AND IPA PROVIDER'S OBLIGATIONS. IPA and IPA Provider understand and agree to the following:

- 1) IPA and IPA Provider is 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;

- 2) IPA and IPA provider must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;
- 3) IPA and IPA Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Attorney General's Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
- 4) IPA and IPA Provider place required records in another legal entity's records, IPA and IPA Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and
- 5) IPA and IPA Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by the Health Plan or a Member to the HHSC Office of Inspector General.

8.0 INSURANCE.

8.1 IPA and IPA Provider shall maintain, during the term of the Agreement, insurance as required in Section 2.17 of the Agreement.

9.0 LAWS, RULES, AND REGULATIONS

9.1 **APPLICABLE LAWS.** IPA and IPA Provider understand and agree they are subject to all State and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and the Health Plan's managed care contract with HHSC, and all persons or entities receiving state and federal funds. IPA and IPA Provider further agree that any violation of a State or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the Health Plan'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.

9.2 **ENVIRONMENTAL AND ANTI-DISCRIMINATION LAWS.** IPA and IPA Provider understand and agree that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement:

1. Environmental protection laws:
 - a. Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;
 - b. National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality") relating to the institution of environmental quality control measures;
 - c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");
 - d. State Clean Air Implementation Plan (42 U.S.C. §740 *et seq.*) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and
 - e. Safe Drinking Water Act of 1974 (21 U.S.C. §349; 42 U.S.C. §300f to 300j-9) relating to the protection of underground sources of drinking water;
2. State and federal anti-discrimination laws:

- a. Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352);
 - b. Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);
 - c. Americans with Disabilities Act of 1990 (Public Law 101-336); and
 - d. Title 40, Administrative Code, Chapter 73;
3. 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
 4. the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191).

10.0 LIABILITY

10.1 **LIABILITY IN THE EVENT OF HEALTH PLAN'S INSOLVENCY OR CESSATION OF OPERATIONS.** In the event the Health Plan becomes insolvent or ceases operations, IPA and IPA Provider understand and agree that their sole recourse against the Health Plan will be through the Health Plan's bankruptcy, conservatorship, or receivership estate. IPA and IPA Provider understand and agree that Health Plan's Members may not be held liable for Health Plan's debts in the event of Health Plan's insolvency.

10.2 **HHSC LIABILITY.** IPA and IPA Provider understand and agree that HHSC does not assume liability for the actions of, or judgments rendered against, the MCO, its employees, agents or subcontractors. Further, IPA and IPA Provider understand and agree that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to IPA and IPA Provider by the Health Plan or any judgment rendered against the Health Plan. HHSC's liability to IPA and IPA Provider, if any, will be governed by the Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 *et seq.*).

11.0 HEALTH PLAN'S OBLIGATION TO PREVENT HOSPITAL FROM COLLECTING PAYMENTS.

11.1 The Health Plan will initiate and maintain any action necessary to stop IPA and IPA Provider or its employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHS Agency, or any Member, excluding payment for non-covered services. This provision does not restrict a CHIP Network Provider from collecting allowable co-payment and deductible amounts from CHIP Members.

12.0 PROVIDER NETWORK REQUIREMENTS, MEDICAID AGREEMENTS, TPI AND NPI.

12.1 If IPA Provider is a Network Acute Care Provider serving Medicaid Members, IPA Provider must enter into and maintain a Medicaid Hospital agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Provider Identification Number (TPIN). IPA Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

13.0 MEDICAL CONSENT REQUIREMENTS.

13.1 This section applies to the following Health Plan program: STAR Health MCO. IPA and IPA

Provider must comply with medical consent requirements in Family Code §266.004, which require the Member's Medical Consenter to consent to the provision of medical care.

14.0 NOTIFICATION OF PROVISION OF EMERGENCY SERVICES.

14.1 This section applies to the following Health Plan program: STAR Health MCO. IPA and IPA Provider must notify the Medical Consenter about the provision of Emergency Services no later than the second Business Day after providing Emergency Services, as required by Family Code §266.009.

15.0 MEMBER COMMUNICATIONS.

15.1 The Health Plan is prohibited from imposing restrictions upon IPA Provider's free communication with a Member about the Member's medical conditions, treatment options, Health Plan referral policies, and other Health Plan policies, including financial incentives or arrangements and all managed care plans with whom IPA Provider contracts.

16.0 PAYMENT FOR SERVICES

16.1 BILLING OF MEMBERS FOR COVERED SERVICES PROHIBITED. This subsection applies to the following Health Plan programs: STAR HMO, STAR-PLUS HMO, and STAR Health MCO. IPA and IPA Provider is prohibited from billing or collecting any amount from a Medicaid Member for Health Care Services provided pursuant to this Agreement. Federal and state laws provide severe penalties for any provider who attempts to bill or collect any payment from a Medicaid recipient for a Covered Service.

16.2 LIABILITY OF HHSC FOR PAYMENT OF COVERED SERVICES. IPA and IPA Provider understand and agree that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Agreement.

17.0 PROVIDER RESPONSIBILITIES.

17.1 This section applies to the following Health Plan program: STAR Health MCO. At the request of HHSC for DFPS, IPA and/or IPA Provider must testify in court as needed for child protection litigation.

18.0 PROFESSIONAL CONDUCT.

18.1 While performing the services described in the Agreement, IPA and IPA Provider agrees to:

- 1) comply with applicable state laws, rules, and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and
- 2) otherwise conduct itself in a businesslike and professional manner.

19.0 THIRD PARTY RECOVERY.

19.1 IPA and IPA Provider understand and agree that they may not interfere with or place any liens upon the state's right or the Health Plan's right, acting as the state's agent, to recovery from third party resources.

20.0 CONFIDENTIALITY

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

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

20.2 IPA and IPA Provider must treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs.

20.3 IPA and IPA Provider shall protect the confidentiality of Member Protected Health Information (“PHI”), including all patient records. IPA and IPA Provider must comply with all Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

21.0 LIMITATIONS ON MARKETING

This section applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, and STAR-PLUS HMO.

21.1 IPA and IPA Provider agree to comply with HHSC’s marketing policies and procedures, as set forth in the HHSC/Health Plan Managed Care Contract (which includes HHSC’s Uniform Managed Care Manual).

21.2 IPA and IPA Provider are prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain IPA or IPA Provider from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

22.0 TERMINATION FOR GIFTS OR GRATUITIES

22.1 This subsection applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, STAR-PLUS HMO, and STAR Health MCO. IPA and IPA Provider may not offer or give anything of value to an officer or employee of HHSC or the State of 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. The Health Plan may terminate this Agreement at any time for violation of this requirement.

23.0 COORDINATION WITH OTHER PROGRAMS

23.1 EARLY CHILDHOOD INTERVENTION (ECI). This subsection applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, STAR+PLUS HMO, and STAR Health MCO. IPA and IPA Provider must cooperate and coordinate with local ECI programs to comply with federal and state requirements relating to the development, review and evaluation of Individual Family Service Plans (IFSP). IPA and IPA Provider understand and agree 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.

23.2 TUBERCULOSIS (TB). This subsection applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, STAR+PLUS HMO, and STAR Health MCO. IPA and IPA Provider 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). IPA and IPA Provider must report to the 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.

23.3 WOMEN, INFANTS, AND CHILDREN (WIC). This subsection applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, STAR+PLUS HMO, and STAR Health MCO. IPA and IPA Provider 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.

23.4 THSTEPS. This subsection applies to the following Health Plan programs: STAR HMO, STAR+PLUS HMO, and STAR Health MCO. IPA and IPA Provider must send all THSteps newborn screens to the Department of State Health Services (DSHS), formerly the Department of Health, Bureau of Laboratories or a DSHS-certified laboratory. IPA and IPA Provider 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.

24.0 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)

24.1 IPA and IPA Provider agree to comply with Health Plan's QAPI Program requirements.

25.0 PROVIDER NETWORK REQUIREMENTS, MEDICAID AGREEMENTS, TPI AND NPI

25.1 This subsection applies to the following Health Plan programs: CHIP HMO, CHIP Perinatal HMO, STAR HMO, STAR-PLUS HMO, and STAR Health MCO. If IPA Provider is a Network Acute Care Provider serving Medicaid Members, it must enter into and maintain a Medicaid provider agreement with HHSC or its agent to participate in the Medicaid Program, and must have a Provider Identification Number (TPIN). IPA Provider must have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D.

26.0 FAMILY PLANNING

26.1 MEMBER COUNSELING AND EDUCATION ABOUT FAMILY PLANNING. This subsection applies to the following Health Plan programs: STAR HMO, STAR-PLUS HMO, and STAR Health MCO. If a Member requests contraceptive services or family planning services, IPA Provider must also provide the Member counseling and education about family planning and available family planning services.

26.2 PARENTAL CONSENT. This subsection applies to the following Health Plan programs: STAR HMO, STAR-PLUS HMO, and STAR Health MCO. IPA Provider cannot require parental consent for Members who are minors to receive family planning services.

26.3 CONFIDENTIALITY OF FAMILY PLANNING SERVICES. This subsection applies to the following Health Plan programs: STAR HMO, STAR-PLUS HMO, and STAR Health MCO. IPA and IPA Provider must comply with state and federal laws and regulations governing Member confidentiality (including minors) when providing information on family planning services to Members.

27.0 PRIMARY CARE PHYSICIANS (PCPs)

27.1 ACCESSABILITY. PCPs must be accessible to Members 24 hours per day, 7 days per week.

27.2 PREVENTATIVE CARE. PCPs must provide preventative care:

1. to children under at 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
2. to adults in accordance with the U.S. Preventative Task Force requirements.

27.3 ASSESSMENTS. 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.

27.4 THSTEPS. This subsection applies to the following Health Plan programs: STAR Health MCO. PCPs must:

1. either be enrolled as THSteps providers or refer Members due for a THSteps check-up to a THSteps provider;
2. refer Members for follow-up assessments or interventions clinically indicated as a result of the THSteps check-up, including the developmental and behavioral components of the screening;
3. submit information from the THSteps forms and documents to the Medical Passport.

**PHYSICIAN PRACTICE MANAGEMENT (PPM) PARTICIPATION ADDENDUM TO
AGREEMENT BETWEEN**

_____ herein as “Health Plan”), and
_____ (the “IPA”)

**[Percentage of Premium]
IPA REIMBURSEMENT**

A. DEFINED TERMS

Capitalized terms have the same meaning as set forth in the IPA Services Agreement (the “Agreement”).

B. PAYMENT AND FUNDING ARRANGEMENTS

Health Plan agrees to pay IPA for Covered Services provided to Members who have been assigned to IPA Physicians who have been designated to be Primary Care Physicians according to the payment arrangement set forth below. IPA agrees that the payment arrangements identified below shall apply for Covered Services rendered to Health Plan Members.

C. COMPENSATION FOR MEMBERS ASSIGNED TO IPA

1. PPM Medicare Operating Fund: Health Plan shall establish a PPM Medicare Operating Fund in a subsidiary ledger at the Financial Records of Health Plan, from which all covered services, shall be paid for all Medicare Masterpiece Members assigned to IPA Providers. PPO, Medicare Masterpiece Plus, and Medicaid Members are excluded from this PPM Medicare Operating Fund. The PPM Medicare Operating Fund and the calculation, transaction and distributions described below will exclude premium revenue and expenses associated with any of their PPO, Medicare Masterpiece Plus, and Medicaid beneficiaries.

2. Funding the Medicare PPM Operating Fund: The following monies will be placed into the Medicare PPM Operating Fund by Health Plan as described in Section C(1) above:

i. PPM Medicare Operating Fund Revenues. Health Plan will assign as described in C.1 above, on a monthly basis, into the PPM Medicare Operating Fund the following percentage of the revenues that Health Plan received for Medicare Masterpiece Members with both Part A and Part B, Part D, and any other additional benefits provided by Health Plan for services that Health Plan provides to Members assigned to PPM. Revenue enhancement services Health Plan engages in to qualify members for additional benefits, eligibility programs or data/encounter reporting accuracy will offset the gross funding by the funding percentage.

<u>Description</u>	<u>Reimbursement Rate</u>
Medicare Operating Fund	Eighty-five Percent (85%) of Medicare Monthly Premium
Commercial Operating Fund	Eighty-five Percent (85%) of Plan Monthly Premium

ii. Third Party Collections. Health Plan has the responsibility for collecting money related to Medicare Secondary Payer and Third Party Liability involving but not limited to Auto Insurance

Carriers and subrogation (litigation) cases and Workers' Compensation, and any and all rights whatsoever for Coordination of Benefits with another Group Health Insurance provider. Upon recovery by Health Plan of any amount from such claims of third party liabilities, Health Plan shall (a) account to IPA for such amounts, (b) contribute such amounts after deduction of reasonable cost of collection, if any, to the PPM Medicare Operating Fund.

3. Deductions from the PPM Medicare Operating Fund. The following monies will be deducted from PPM Medicare Operating Fund by Health Plan:

i. Plan shall pay for Primary Care Services and Specialty Care Services rendered to IPA Members by IPA Providers at 100% of the prevailing Medicare Allowable Charge (MAC) and for Commercial Plans at 125% of the MAC. IPA Provider agrees to collect all Copayments, Deductibles, Coinsurance, and cost-sharing amounts directly from Health Plan Members. IPA shall not waive, discount, or rebate such amounts.

ii. Plan shall pay IPA for administrative fees in the amount of \$12.00 per member per month (PMPM) based on the Members assigned to IPA Providers who are primary care physicians for all IPA services including provider contracting, provider relations, credentialing, and other general administrative services.

iii. Reinsurance. Health Plan will be responsible for purchasing Stop-loss Reinsurance coverage. Health Plan will negotiate for and acquire on IPA's behalf a policy or policies of Stop-Loss Reinsurance at such level as would be appropriate for the IPA's risk contracts and patient panels pursuant to 42 CFR § 417.489 and 42 CFR 422.208. In determining an appropriate level of Stop-Loss Reinsurance for the IPA, Health Plan will rely exclusively on information reported by the IPA under Section C below regarding its downstream risk arrangements and the patient panel sizes of its downstream Affiliates. If Health Plan purchases Stop-Loss Reinsurance on behalf of the IPA, the premium or premiums for such policy or policies shall be deducted from the PPM Medicare Operating Fund. An additional \$2 PMPM will also be deducted from the PPM Medicare Operating Fund and paid to Health Plan in consideration of Health Plan's costs in determining requirements for and negotiations to acquire such policies and the administration of such policies.

iv. Health Plan shall pay all covered services and expenses, including reinsurance payments, from the remaining funds in the PPM Medicare Operating Fund. This includes payment for any sub-capitated services.

v. Prior to distribution of monies from any of the Operating Funds, reserve for incurred but not reported or paid (IBNR) claims costs will be calculated by Health Plan and such IBNR amounts will be held in the Funds during the "Claims Run out period." This period is currently the most recent 14 months and may be subject to change. IBNR Completion Factors are subject to change by Health Plan in accordance with actuarial standards and Health Plan will notify IPA thirty (30) days prior to such change. The following completion factor schedule will be used in the calculation of IBNR (the three most current months are calculated with a medical loss ratio (MLR) of 100%):

Months	CF (same for Part A and Part B)
14	0.9950
13	0.9900
12	0.9850
11	0.9850
10	0.9800
9	0.9700
8	0.9600
7	0.9500
6	0.9390
5	0.8990
4	0.8480
3	100% MLR
2	100% MLR
1	100% MLR

E

vi. Deficit Reserve Requirement. Health Plan shall establish a reserve in a subsidiary ledger of the financial records of the Health Plan (the "Deficit Reserve"). The monthly allocation from the Fund to the Deficit Reserve shall be equal to five percent (5%) of the total revenue that Health Plan receives from (i) Members and (ii) CMS, for Members. The purpose of the Deficit Reserve is to secure Group's obligations to pay any Group Deficit. The establishment of the initial amount of the Deficit Reserve and its subsequent annual recalculation is not a warranty or representation by Health Plan that Group has or will have the right to serve any specific number of Medicare Members. The funding of the Deficit Reserve shall be recalculated for each calendar year, based upon the number of Medicare Members existing on each yearly anniversary of this Addendum. Health Plan may combine any amounts held for the Fund and Deficit Reserve with its other funds. No interest shall be paid on the Fund, including the amount of the IBNR and the Deficit Reserve.

4. Calculation and Payment of Operating Fund Surpluses and Deficits. The calculation of the Operating Fund will commence after enrollment with IPA reaches one hundred (100) Members and will be calculated from the first Member enrolled with IPA Physicians. Within the first ninety (90) days thereafter, PPM will receive a preliminary reconciliation report with utilization data and claim reports.

Within thirty (30) days after an initial four (4) month period, Health Plan will determine Surpluses and Deficits for the first month. Subsequent reconciliation shall be completed monthly thereafter. Surpluses are defined as any positive balance remaining in the PPM Operating Fund. PPM will receive 50% of any Surpluses or be responsible for 50% of Deficits in the PPM Medicare Operating Fund. Health Plan shall issue payment to IPA for any surplus amount within thirty (30) days of the reconciliation date. IPA will issue payment to Plan for any Deficit within thirty (30) days of request by Plan. Plan may elect to recover the Deficit from future payments of the Surplus and/or reduction in the primary care capitation.

D. REPORTING, RIGHT TO AUDIT, AND REQUIRED DOCUMENTATION

1. Reports from Health Plan to IPA. Health Plan shall provide IPA with monthly statements (including monthly data listings for claims pertaining to Medicare Masterpiece members assigned to IPA Providers) with respect to the financial arrangements set forth in this Addendum. Health Plan shall also provide IPA with Utilization Management Program reports and Utilization Management and Quality Improvement Program descriptions.

2. Reports from IPA to Health Plan. IPA shall provide Health Plan with quarterly reports to UHC detailing the nature of its downstream arrangements and the stop-loss reinsurance in place to ensure IPA Provider/provider groups are not placed at substantial financial risk for Referrals without adequate stop loss protection. These reports will be signed and submitted using Health Plan's Physician Incentive Plan report form (attached as Exhibit A to this Addendum) by October 15, January 15, April 15, and July 15 of each year. These reports will disclose:

i. Whether IPA Providers are paid in whole or in part based on the cost of services not provided by IPA Providers to IPA's Medicare Masterpiece Members.

ii. The type of incentive plan, including bonus structure, under which each of IPA's Providers receive compensation from IPA, including the amount of any bonus, identified as a percentage of premium received by IPA.

iii. The patient panel sizes of IPA's Providers, including any pooled patient populations. In accordance with 42 CFR 422.208, a provider or physician group's patient panel can only be pooled if the following criteria are met:

- a. Pooling of patients is consistent with the relevant contracts governing the compensation arrangements for the IPA.
- b. The IPA Providers being pooled must be at risk for Referral services with respect to each of the categories of patients being pooled.
- c. The terms of the compensation arrangements permit the IPA to spread the risk across the categories of patients being pooled (i.e. payments must be held in a common risk pool).
- d. The distribution of payments to IPA/IPA Providers from the risk pool is not calculated separated by patient category (either by MCO or by Medicare, Medicaid, or Commercial Policy), and
- e. The terms of the risk borne by the IPA/IPA Providers are comparable for all categories of patients being pooled.

iv. The amount and type of any stop-loss reinsurance in place to cover each of IPA's Providers, if not provided by and purchased through Health Plan.

3. Right to Audit. Health Plan shall have the right to review all documents, records, and contracts of the IPA in order to ensure IPA's compliance with the physician incentive plan regulations in Paragraph C(3)(iii) above, including, but not limited to: all of IPA's downstream agreements with physicians or other providers; any policies of stop-loss reinsurance or other insurance held by IPA or downstream physicians or providers, and any documents evidencing whether the pooling conditions of the regulations cited in Paragraph C(3)(iii) above can be met, including but not limited to, IPA's contracts with other group, old-age retirement, or Commercial Policy health plans, or documents demonstrating enrollment by members of other group, old-age retirement, or Commercial Policy health plans.

E. REPRESENTATIONS AND WARRANTIES

IPA warrants and represents that IPA and all IPA Providers and other providers agree to abide by all terms and conditions of this PPM Participation Addendum and the IPA Agreement to which this Addendum is attached. This Addendum shall not be effective until IPA shall obtain acknowledgement of such agreement by IPA Providers.

F. TERM

The term of this Addendum shall coincide with IPA's current IPA Provider Agreement. In any event, this Agreement may not be terminated for any reason for one year from the effective date. In addition, IPA and IPA Providers agree not to encourage Members to disenroll from Health Plan or switch to competing plans during the term of this Agreement or for any period thereafter.