

## ATTACHMENT X

### **MANDATORY PROVIDER CONTRACT PROVISIONS** **EFFECTIVE 12/1/11 (PER CHAPTER 8.1, UMCM)**

#### **1. Access to Records**

Upon receipt of a record review request from the Health and Human Services Commission Office of Inspector General (OIG) or another state or federal agency authorized to conduct compliance, regulatory, or program integrity functions, Provider must provide, at no cost to the requesting state or federal agency, the records request within three (3) business days of the request. If the OIG or another state or federal agency representative reasonably believes that the requested records are about to be altered or destroyed or that the request may be completed at the time of the request and/or in less than 24 hours, Provider must provide the records requested at the time of the request and/or in less than 24 hours. The request for record review includes, but is not limited to clinical medical or dental Member records; other records pertaining to the Member; any other records of services provided to Medicaid or other health and human services program recipients and payments made for those services; documents related to diagnosis, treatment, service, lab results, charting; billing records, invoices, documentation of delivery items, equipment, or supplies; radiographs and study models related to orthodontia services; business and accounting records with backup support documentation; statistical documentation; computer records and data; and/or contracts with providers and subcontractors. Failure to produce the records or make the records available for the purpose of reviewing, examining and securing custody of the records may result in OIG imposing sanctions against Provider as described in Title 1 Tex. Admin. Code, Chapter 371 Subchapter G.

#### **2. Updates to Contact Information.**

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

#### **3. Audit or Investigation**

Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to the Agreement [Provider Agreement with HMO] and any records, books, documents, and papers that are related to the Agreement and/or the Provider's performance of its responsibilities under the State Contracts:

- a) HMO program Personnel from HHSC or its designee;
- b) The U.S. Department of Health and Human Services or its designee;
- c) The Office of Inspector General;
- d) The Texas Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

- e) Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of HHSC;
- f) A state or federal law enforcement agency;
- g) A special or general investigating committee of the Texas Legislature or its designee;
- h) The U.S. Comptroller General or its designee;
- i) The Office of the State Auditor of Texas or its designee; and
- j) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

#### **4. Claims Payment**

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

#### **5. Fraud and Abuse**

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

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

#### **6. Laws, Rules, and Regulations**

Provider understands and agrees that, in addition to the laws, rules and regulations specifically listed in its Provider Agreement, the following laws, rules and regulations, and all amendments or modifications thereto, apply to such Agreement:

- (i) state and federal anti-discrimination laws:

- (a) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and as applicable 45 C.F.R. Part 80 or 7 C.F.R. Part 15 (29 U.S.C. § 794),;
  - (b) Section 504 of the Rehabilitation Act of 1973 (42 U.S. Code § 12101 et seq.);
  - (c) Americans with Disabilities Act of 1990 (42 U.S.C. §§ 6101-6107);
  - (d) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);
  - (e) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);
  - (f) Food Stamp Act of 1977 (7 U.S.C. § 200 et seq.);
  - (g) Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16); and
  - (h) the HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.
- (ii) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (Public Law 104-191) and,
  - (iii) the Health Information Technology Act for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. § 17931 et seq.

## **7. Termination of Provider Agreement**

HMO must follow the procedures outlined in Section 843.306 of the Texas Insurance Code if terminating the Agreement with Provider. At least ninety (90) days before the effective date of the proposed termination of this Agreement, HMO must provide a written explanation to Provider of the reasons for termination. HMO may immediately terminate this Agreement in a case involving (a) imminent harm to patient health; (b) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs Provider's ability to practice medicine, dentistry, or another profession; or (c) fraud or malfeasance.

Not later than thirty (30) days following receipt of the termination notice, Provider may request a review of the HMO's proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a license, or fraud or malfeasance. The advisory review panel must be composed of physicians and providers, including at least one representative in Provider's specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of HMO. The decision of the advisory review panel must be considered by HMO but is not binding on HMO. Within 60 days following receipt of Provider's request for review and before the effective date of the termination, the advisory review panel must make its formal recommendation, and the HMO must communicate the HMO's decision to Provider. HMO must provide to Provider, on request, a copy of the recommendation of the advisory review panel and HMO's determination.

**8. For STAR Health Providers only:**

**Coordination Between Behavioral Health Services Provider and PCP**

The Provider must comply with the *Psychotropic Medication Utilization Parameters for Foster Children* found at

[http://www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/guide-  
psychotropic.asp](http://www.dfps.state.tx.us/Child_Protection/Medical_Services/guide-<br/>psychotropic.asp), as amended or modified from time to time.