HHSC Provider Agreement

The provider (Provider) agrees to comply with all terms and conditions of this HHSC Provider Agreement (Agreement) as a condition for participation under the following programs (collectively referred to as "Program"):

Acute Care - Fee-for-Service, Children with Special Health Care Needs Services Program (CSHCN)

I LEGAL AUTHORITY

1.1.1 All Providers

1.1.1.1 This Agreement between Provider and the Texas Health and Human Services Commission (HHSC) is authorized by Texas Government Code Chapter 531 and Human Resources Code Chapter 32 and is in compliance with the provisions of the Code of Federal Regulations (CFR), including 42 CFR § 431.107, and the Texas Administrative Code (TAC), including 1 TAC § 352.5 and 352.7.

II TERMS, CONDITIONS, AND REQUIREMENTS

2.1 Availability of Funding.

2.1.1 All Providers

2.1.1.1 This Agreement is contingent upon the availability of funding. If funds become unavailable through lack of appropriations, budget cuts, transfer of funds between programs or Health and Human Services agencies, amendments to the General Appropriations Act, Health and Human Services agency consolidation, or any other disruptions of current appropriated funding for this Agreement, HHSC may restrict, reduce, or terminate funding under this Agreement, without penalty to HHSC. Notice of any restriction, reduction, or termination will include detailed information on the services and/or goods to be covered by any restriction, reduction, or termination of funds.

2.2 Agreement and documents constituting Agreement.

2.2.1 All Providers

2.2.1.1 HHSC Program-specific provider procedures manuals (Provider Manual) and provider handbooks (Provider Handbook) may be accessed via the Internet at www.tmhp.com and https://hhs.texas.gov/. Provider agrees to comply with the requirements of each Provider Manual relating to each Program that the Provider enrolls in. Provider also agrees to comply with all state and federal laws governing or regulating each Program in which Provider is enrolled. This Agreement incorporates by reference all Program requirements and the Provider application, including all revisions thereto.

2.2.1.2 For purposes of this Agreement, “Subcontractor” means an individual or entity that that the Provider has contracted with or delegated some of its management functions or responsibilities for providing all or a part of the services that are required to be performed under this Agreement. Provider may not subcontract any or all of the work and/or obligations due under the contract without prior written approval of the HHSC. Provider must require all Subcontractors to execute documents that bind the Subcontractors to comply with the provisions of this Agreement. Provider expressly understands and acknowledges that in entering into any subcontract, HHSC is in no manner liable to any Subcontractor of Provider. In no event shall this term relieve Provider of the responsibility for ensuring that the services performed under all subcontracts are rendered in compliance with the Agreement.

2.3 State and federal requirements.

2.3.1 All Providers

2.3.1.1 **Disclosure of Information by Providers.** Provider agrees to disclose information on ownership and control, information related to business transactions, information on persons convicted of crimes, and information for each affiliation that has a disclosable event in accordance with 42 CFR Part 455, Subpart B, and timely provide such information to HHSC, Texas Attorney General’s Medicaid Fraud Control Unit, and the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Program current at all times by informing HHSC or its designee in writing of any changes to the information contained in its application, including, but not limited to changes to the following information: ownership or control; federal tax identification number; Provider licensure, certification, or accreditation; phone number; or Provider business address. All changes must be reported to HHSC or its designee within the appropriate timeframe defined under 1 TAC § 352.21.

Provider agrees to disclose all convictions of Provider or Provider’s principals within 10 business days of the date

of conviction.

For purposes of this disclosure, Provider must use the definition of the term, "Convicted," contained in 42 CFR § 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs. Provider shall send the information to the HHSC's Office of Inspector General, P.O. Box 85211 – Mail Code 1361, Austin, Texas 78708. Provider must fully explain the details, including the offense, the date, the state, and the county where the conviction occurred, and the cause number(s).

2.3.1.2 **Child Support.** Texas Family Code § 231.006 requires HHSC to withhold contract payments from any entity or individual who is at least 30 days delinquent in court-ordered child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25 percent ownership interest is delinquent in any child support obligation.

Under Texas Family Code § 231.006, the vendor or applicant certifies that the individual or business entity named in the applicable contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this Agreement may be terminated, and payment may be withheld, if this certification is inaccurate. A child support obligor who is more than 30 days delinquent in paying child support, or a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25 percent, is not eligible to receive the specified grant, loan, or payment.

If HHSC is informed, and verifies, that a child support obligor who is more than 30 days delinquent is a partner, shareholder, or owner with at least a 25 percent ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied.

2.3.1.3 **Child Abuse and Neglect.** Provider must comply with the provisions of state law as set forth in Chapter 261 of the Texas Family Code, which relates to reporting child abuse and neglect.

2.3.1.4 **Cost Report, Audit and Inspection.** Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records

2.3.1.5 **Electronic Visit Verification (EVV).** EVV is a computer-based system that electronically documents and verifies the occurrence of a visit by a service provider who provides certain services by electronically capturing the time the visit begins and ends. A provider must comply with the following EVV requirements to be reimbursed for a service requiring the use of EVV:

- 1 TAC Chapter 354, Subchapter O (relating to Electronic Visit Verification).
- HHSC EVV Policy Handbook – https://hhs.texas.gov/laws-regulations/handbooks/evvpph/electronic-visit-verification-provider-policy-handbook
- HHSC EVV Webpage – https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-careproviders/resources/electronic-visit-verification.
- HHSC provider communications, including provider letters, information letters and policy clarifications.

2.3.1.6 **Exclusion, Suspension, Debarment, Revocation or Other Action.** Provider certifies that the Provider and its principals have not been excluded, suspended, debarred, revoked, or any other synonymous action, from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), Title XX (Block Grants to States for Social Services), or Title XXI (CHIP). Provider also certifies that the Provider and its principals have not been excluded, suspended, debarred, revoked, or any other synonymous action, under the following CFR provisions: 2 CFR Part 180; 2 CFR Part 376; 48 CFR Part 9, Subpart 9.4; and 48 CFR Part 309, Subpart 309.4, relating to federal contracting. Provider further certifies that the Provider and its principals have also not been excluded, suspended, debarred, revoked, or any other synonymous action, from participation in any other state or federal health-care program. Provider must notify HHSC or its designee within 10 business days of the time the Provider receives notice that any action is being taken against Provider, or any person defined under the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), which could result in the Provider's exclusion from the Program. Provider agrees to fully comply with the requirements of 48 CFR, Chapter 3, relating to eligibility for federal contracts and grants.

2.3.1.7 **State Auditor's Office Authority**. In accordance with the requirements of Texas Government Code § 2262.154, the state auditor may conduct an audit or investigation of an entity receiving funds from the state directly under the contract or indirectly through a subcontract with the contract. Provider understands and agrees the acceptance of funds directly under this Agreement or indirectly through a subcontract under the Agreement acts as acceptance of the authority of the state auditor, under the direction of the legislative audit committee, to conduct an audit or investigation in connection with those funds. Under the direction of the legislative audit committee, an entity that is the subject of an audit or investigation by the state auditor must provide the state auditor with access to any information the state auditor considers relevant to the investigation or audit. The Provider will ensure the clause, concerning the authority to audit funds received indirectly by Subcontractors through Provider and the requirement to provide access to information, is included in any subcontract it awards.

2.3.1.8 Provider must comply with the requirements of the Immigration Reform and Control Act of 1986, including, but not limited to, employment verification and retention of verification forms for any individual hired on or after November 6, 1986, that will perform any labor or services under this Agreement.

2.3.1.9 Provider certifies that it utilizes, and will continue to utilize for the term of this Agreement, the U.S. Department

of Homeland Security's E-Verify system to determine the eligibility of:

1. all persons employed by Provider to perform duties within Texas; and

2. all persons, including contractors, assigned by Provider to perform work pursuant to the Agreement within the United States of America.

2.3.1.10 Provider must comply with applicable provisions of the Clean Air Act (42 U.S.C. § 7401-7671q) and the Federal Water Pollution Control Act (33 U.S.C. § 1251-1387), if funding for the Agreement exceeds $100,000.

2.3.1.11 In accordance with Texas Government Code § 2155.4441, Provider shall, in performing any service under this Agreement, purchase products and materials produced in Texas when they are available at a price and time comparable to products and materials produced outside of this state.

2.3.1.12 Provider must make a good faith effort to utilize historically underutilized businesses (HUBs) when subcontracting. Some methods for locating HUBs include using searchable HUB databases at the Texas Comptroller of Public Accounts' website, using websites or other minority/women directory listings maintained by local chambers of commerce, advertising subcontract work in local minority publications, or contacting HHSC for assistance in locating available HUBs.

2.3.1.13 Provider agrees that its media releases, public announcements, public disclosures, or promotional or marketing materials relating to this Agreement, must not refer to the HHSC or to the State of Texas in a manner that suggests HHSC, or the State of Texas endorses, recommends, sponsors, or is collaborating with the Provider.

2.3.1.14 **Civil Rights Anti-Discrimination Clause**.

a) Provider agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§ 6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§ 1681-1688);

(6) Food and Nutrition Act of 2008 (7 U.S.C. § 2011 et seq.); and

(7) The HHSC's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

b) Provider agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by federal or state funding, or otherwise be subjected to discrimination.

c) Provider agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 CFR Part 80 or 7 CFR Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. Provider agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. Provider also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

d) Provider agrees to comply with Executive Order 13279, and its implementing regulations at 45 CFR Part 87 or 7 CFR Part 16. This executive order and its implementing regulations provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

Upon request, Provider will provide HHSC Civil Rights Office with copies of all of the Provider's civil rights policies and procedures.

e) Provider must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

Civil Rights Office

701 W. 51st Street, Mail Code W206

Austin, Texas 78751

Phone Toll Free: (888) 388-6332

Phone: (512) 438-4313

TTY Toll Free: (877) 432-7232

Fax: (512) 438-5885

2.3.2 Medicaid/CHIP Providers

2.3.2.1 **Disclosure by Providers Regarding Subcontractors and Suppliers.** In accordance with 42 CFR § 455.105, Provider must submit, within 35 days of the date of a request by the Secretary of the United States Department of Health and Human Services (Secretary) or HHSC, full and complete information about the following:

a) ownership of any Subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b) any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and Subcontractor during the five-year period ending on the date of the request.

In accordance with 42 CFR Part 455, federal financial participation is not available for providers who fail to comply with a request made by the Secretary or HHSC.

2.3.2.2 This Agreement is subject to all state and federal laws and regulations relating to fraud, waste, and abuse in health care and the Program. As required by 42 CFR § 431.107, Provider agrees to create and maintain all records necessary to fully disclose the extent and medical necessity of services provided by the Provider to individuals in the Program, and any information relating to payments claimed by the Provider for furnishing Program-covered services. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's designee, the Texas Attorney General's Medicaid Fraud Control Unit, the Texas Department of Family and Protective Services, and the United States Department of Health and Human Services. The records must be retained in the form in which they are regularly kept by the Provider for the longer of the following three timeframes: (1) a minimum of five years from the date of service (six years for freestanding rural health clinics and ten years for hospital-based rural health clinics); (2) until all investigations are resolved and closed; or (3) until all audit exceptions are resolved. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud, waste, and abuse. Provider must also allow these agencies and their agents unconditional and unrestricted access to its records and premises, as required by 1 TAC § 371.1667. Provider understands and agrees that payment for goods and services under this Agreement is conditioned on the existence of all records required to be maintained under the Program, including all records necessary to fully disclose the extent and medical necessity of services provided, and the correctness of the claim amount paid. If Provider fails to create, maintain, or produce such records in full accordance with this Agreement, Provider acknowledges, agrees, and understands that the public monies paid to the Provider for the services are subject to 100 percent recoupment, and that Provider is ineligible for payment for the services under either this Agreement or any legal theory of equity.

2.3.2.3 The Texas Attorney General's Medicaid Fraud Control Unit, the HHSC's Office of Inspector General, and internal and external auditors for the state and federal government may conduct interviews of Provider employees, agents, Subcontractors and their employees, witnesses, and clients without the Provider's representative or Provider's legal counsel present. Provider's employees, agents, Subcontractors and their employees, witnesses, and clients must not be coerced by Provider or Provider's representative to accept representation from or by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this Agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied within the form and the manner requested. Provider will ensure by contract or other means that its agents, employees, and Subcontractors cooperate fully in any investigation conducted by the Texas Attorney General's Medicaid Fraud Control Unit or the HHSC's Office of Inspector General, or their designees. Subcontractors include persons and entities that provide the following: (1) medical or dental goods or services for which the Provider bills the Program; and (2) billing, administrative, or management services in connection with Program-covered services.

2.3.2.4 **Site Visits.** Providers must permit Centers for Medicare and Medicaid Services (CMS), its agents, its designated contractors, or HHSC or its designees to conduct announced and unannounced inspections of any and all provider locations. A failure to permit a site visit by CMS, its agents, its designees or HHSC or its designees shall be grounds for termination of this Agreement.

2.3.2.5 **Nondiscrimination.** Provider must provide services to clients in the same manner, by the same methods, and at the same level and quality as provided to the general public. Provider agrees to grant Program clients all discounts and promotional offers provided to the general public. Provider agrees and understands that free services to the general public must not be billed to the Program for Medicaid recipients. Provider further agrees that discounted services to the general public must not be billed to Program for a Program recipient at full price, but rather the Provider agrees to bill only the discounted amount that would be billed to the general public.

2.3.2.6 **AIDS and HIV.** Provider must comply with the provisions of Chapter 85 of the Texas Health and Safety Code, and HHSC's rules relating to workplace and confidentiality guidelines regarding HIV and AIDS.

2.3.2.7 **Employee Education and False Claims Recoveries.** Provider must comply with Social Security Act § 1902(a)(68) (codified at 42 U.S.C. § 1396a(a)(68)).

A Provider subject to this section shall create detailed provisions regarding its policies, guidelines, or procedures for detecting fraud, waste, and abuse. The Provider shall include in its employee handbook a specific discussion of the laws discussed in this Agreement, the right of employees to be protected as whistleblowers, and the Provider's policies and procedures for detecting and preventing fraud, waste and abuse.

2.3.2.8 **Lobbying Certifications.** Provider certifies to the best of its knowledge and belief, that:

a) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a member

of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding any federal contract, the making of any federal grant, the making of any federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

b) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

c) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

d) This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Title 31, Section 1352, of the United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

2.3.2.9 **Advance Directives.**
Hospitals, Home Health Providers, Nursing Facilities, Personal Care Services Providers, and Hospices

a) The client must be informed of their right to refuse, withhold, or have medical treatment withdrawn under the following state and federal laws:

1. The client's right to self-determination in making health-care decisions;
2. The client's rights under the Advance Directives Act (Texas Health and Safety Code, Chapter 166, Subchapter B) to execute an advance written Directive to Physicians, or to make a non-written directive regarding their right to withhold or withdraw life-sustaining procedures in the event of a terminal condition;
3. The client's rights under Texas Health and Safety Code, Chapter 166, Subchapter C, relating to written out-of-hospital do-not-resuscitate orders; and,
4. The client's rights to execute a medical power of attorney under the Texas Health and Safety Code, Chapter 166, Subchapter D, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

b) The Provider must have a policy regarding the implementation of the client's rights and compliance with state and federal laws.

c) The Provider must document whether the client has executed an advance directive and ensure that the document is in the client's medical record.

d) The Provider cannot condition giving services or otherwise discriminate against a client based on whether the client has or has not executed an advance directive.

e) The Provider must provide written information to all adult clients regarding the Provider's policies concerning the client's rights.

f) The Provider must provide education for Provider's staff and the community regarding advance directives.

2.3.2.10 **State Fund Certification Requirement for Public Entity Providers.** Public entity providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality. Public entity providers of the following services are required to certify to HHSC the amount of state matching funds expended for eligible services according to established HHSC procedures:

a) School health and related services (SHARS);

b) Case management for blind and visually impaired children (BVIC);

c) Case management for early childhood intervention (ECI);

d) Service coordination for intellectual and developmental disabilities (IDD);

e) Service coordination for mental health (MH);

f) Mental health rehabilitation (MHR);

g) Tuberculosis clinics; and

h) State hospitals.

2.3.2.11 **Home and Community Service Support Services Agencies.** If Provider is a home and community support services agency (HCSSA), Provider must hire attendants chosen by the client or the client's legally authorized representative, if requested, and if the individual who will provide the services:

a) meets minimum requirements for the service;

b) is willing to be employed as an attendant by the Provider; and

c) is determined competent by the Provider to deliver attendant services according to the client's individual service plan.

2.3.3 Vendor Drug Program (VDP) Providers

2.3.3.1 The Provider must comply with Texas State Board of Pharmacy rules and regulations in effect at the time a prescription is serviced.

2.3.4 Children with Special Health Care Needs (CSHCN) Services Program Providers

2.3.4.1 Upon request by Program, Provider must provide free copies of all records pertaining to applications received and services rendered for submitted invoices or claims.

2.4 Claims and Payment Data

2.4.1 All Providers

2.4.1.1 No payments can be made for any items or services directed or prescribed by a physician or other person authorized to direct or prescribe items or services who is excluded from Medicare, Medicaid, or any federal or state health care program when the individual or entity furnishing the items or services either knew or should have known of the exclusion. This prohibition applies even when the payment itself is made to another provider, practitioner, or supplier who is not excluded.

2.4.1.2 The Provider assigns to HHSC all claims for overcharges associated with this Agreement arising under the anti-trust laws of the United States, 15 U.S.C. §§ 1-38, or the anti-trust laws of the State of Texas, Tex. Bus. & Com. Code §§ 15.01-.40.

Reporting Fraud, Waste, or Abuse. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors (including sub-contractors) regarding their obligation to report fraud, waste, or abuse. Individuals with knowledge about suspected fraud, waste, or abuse in any State of Texas Health and Human Services program must report the information to the HHSC's Office of Inspector General (OIG). To report fraud, waste, or abuse, go to **www.oig.hhsc.texas.gov** and select "Report Fraud." Individuals may also call the OIG hotline (1-800-436-6184) to report fraud, waste, or abuse if they do not have access to the Internet.

2.4.2 Medicaid/CHIP Providers

2.4.2.1 Provider agrees to submit claims, including electronic claims, for payment in accordance with billing guidelines and procedures promulgated by HHSC, its designee, or other appropriate payer. Provider certifies that information submitted regarding claims data will be true, accurate, and complete, and that the Provider's records and documents are both accessible and validate the services and the need for services billed and represented as provided. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

2.4.2.2 Provider must submit claims data required by HHSC, its designee, or other appropriate payer to document services provided, even if the Provider is paid under a capitated fee arrangement by a Managed Care Organization (MCO), Health Maintenance Organization (HMO), or Insurance Payment Assistance (IPA).

2.4.2.3 All claims submitted by Provider must include the Provider's NPI or, as applicable, Atypical Provider Identifier (API), and be for services actually rendered by Provider, with the exception that physician providers must submit claims for services rendered by another in accordance with HHSC rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, as applicable, and within the time limits established by HHSC for the submission of claims. The manner and form by which the claims for payment data submitted by the Provider to a MCO, HMO, or IPA are governed by the Provider's contract with the MCO, HMO, or IPA. HHSC is not liable or responsible for payment for any Program-covered services provided under the MCO, HMO, or IPA Provider contract, or any agreement other than this Agreement. Provider understands that payment and satisfaction of claims will be from federal and/or state funds, and that any false claims or statements, any falsified documents, or any concealment of a material fact may be prosecuted under applicable federal and/or state laws.

2.4.2.4 Federal and state law prohibits Provider from charging a client, or any financially responsible relative or representative of the client, for Program-covered services, except where a co-payment is authorized under the Medicaid State Plan (42 CFR § 447.20). Provider must not bill the client, or any financially responsible relative or representative of the client, for the cost of any charges not paid for by the Program due to the Provider's failure to request the required authorization or its failure to submit a claim for reimbursement by the appropriate submission deadline. Provider must not charge the client, or any financially responsible relative or representative of the client, any pre–admission or pre-treatment charges or deposits if services are reimbursable by the Program. Provider agrees to refund the client, or any financially responsible relative or representative of the client, any pre–admission or pre-treatment charges when services are authorized, and collection of funds occurred prior to Program application and eligibility determination.

2.4.2.5 Provider agrees to obtain authorization from the Program, before the date of service, for all services requiring prior authorization.

2.4.2.6 Except as provided by HHSC's third-party recovery rules (Title 1, Part 15, Chapter 354, Subchapter J of TAC), Provider agrees to accept the amounts paid under Medicaid as payment in full for all covered services, excluding amounts paid under the prescription drug plan (42 CFR § 447.15).

2.4.2.7 Provider has an affirmative duty to verify that claims submitted for payment are true and correct and are received by HHSC or its designee. Provider also has an affirmative duty to implement an effective method to track submitted claims against payments made by HHSC or its designee.

2.4.2.8 Provider has an affirmative duty to verify that payments received are for actual services rendered and that those services rendered were medically necessary. Provider must refund any overpayments, duplicate payments, and erroneous payments that are paid to Provider by HHSC, its designee, or a third party as soon as any such payment is discovered or reasonably should have been known.

2.4.2.9 Provider agrees that HHSC may make proper adjustments to the Provider's payments from month to month to compensate for prior overpayments, underpayments, or payments not made in accordance with the requirements of this Agreement. Provider further agrees HHSC may withhold Provider's payments, in whole or in part, due to any disagreements between Provider and HHSC, until such disagreements are resolved. Provider is responsible for payment of any valid audit exceptions found by HHSC, HHS, or the Texas Office of the Attorney General's Medicaid Fraud Control Unit.

2.4.2.10 **Texas Medicaid and Healthcare Partnership (TMHP) EDI and Electronic Claims Submission.** Provider may subscribe to the TMHP Electronic Data Interchange (EDI) system, which allows the Provider the ability to electronically submit claims and claims appeals, verify client eligibility, receive electronic claim status inquiries, remittance and status (R&S) reports, and transfer of funds into a provider account. Provider shall register in order to receive the electronic funds or electronic R&S reports. Provider agrees to comply with the provisions of the Provider Manual and the TMHP EDI licensing agreement regarding the transmission and receipt of electronic claims and/or eligibility verification data. Provider must verify that all claims submitted to HHSC or its designee are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detecting and correcting all claims errors. If Provider contracts with third-parties to provide claims and/or eligibility verification data from HHSC, the Provider remains responsible for verifying and validating all transactions and claims and ensuring that the third party adheres to all client data confidentiality requirements.

2.4.3 . Vendor Drug Program (VDP) Providers

2.4.3.1 HHSC or another state or federal agency may, consistent with due process, assess a remedy, sanction, penalty, or other action authorized by law, including, but not limited to, payment hold, recoupment, administrative penalties, debarment, suspension, cancellation of contract, or exclusion from participation in the VDP.

2.4.3.2 HHSC reserves the right to suspend all or part of the payments under this Agreement if a review or audit indicates the Provider is not substantially complying with all program requirements, statutes, or procedures. HHSC will provide the Provider written notice of the specific instances of substantial non-compliance prior to suspending payment.

2.4.3.3 Provider is under a permanent obligation to notify HHSC of Texas Deceptive Trade Practices Act and to inform HHSC of all instances whereby the Provider or its officers, while serving the Provider or as officers of another entity, are found liable of violating the Texas Deceptive Trade Practices Act.

2.4.3.4 Provider agrees to refund the VDP for any overpayment, duplicate payment, or erroneous payment made by the VDP to which the Provider is not entitled. Provider authorizes HHSC to recoup from any source of payment flowing from HHSC to the Provider.

2.4.4 Medical Transportation Providers (MTP)

2.4.4.1 Warrants may be held by the State Comptroller when there is a tax liability and/or restitutions due on payments to the provider. It will be the responsibility of the facility to resolve these issues with the Comptroller of Public Accounts (CPA)

2.5 Third Party Billing Vendor Provisions

2.5.1 Medicaid/CHIP Providers

2.5.1.1 Provider agrees to submit notice of the initiation and termination of a contract with any person or entity covenanted to bill Provider's claims (Biller), unless the person is submitting claims as an employee of the Provider and the Provider is submitting an IRS Form W-2 for that person. This notice must be submitted within five business days of the initiation and termination of the contract and must be submitted in accordance with Program requirements pertaining to third-party billing vendors. Provider understands that any delay in timely submitting the notice or failure to submit the notice may result in delayed payments to the Provider and/or recoupment from the Provider for any overpayments resulting from the Provider's failure to provide timely notice.

2.5.1.2 Provider must have a written contract with any person or entity covenanted to bill Provider's claims, unless the person is submitting claims as an employee of the Provider and the Provider is submitting an IRS Form W-2 for that person. The contract must be signed and dated by a principal of the Provider and the Biller. It must also be retained in the Provider's and the Biller's files according with the Program records retention policy. The contract between the Provider and Biller may contain any provisions they deem necessary, but, at a minimum, must contain the following provisions:

a) Biller agrees they will not alter or add procedures, services, codes, or diagnoses to the billing information received from the Provider, when billing the Program;

b) Biller understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings;

c) Provider agrees to submit to Biller true and correct claim information that contains only those services, supplies, or equipment that Provider has actually provided to recipients;

d) Provider understands that they may be criminally convicted and subject to recoupment of overpayments and imposed penalties for submittal of false, fraudulent, or abusive billings, directly or indirectly, to the Biller or to Program or its designee;

e) Provider and Biller agree to establish a reimbursement methodology to Biller that does not contain any type of incentive, directly or indirectly, for inappropriately inflating, in any way, claims billed to the Program;

f) Biller agrees to register and be approved by the Program as a third-party billing vendor prior to submitting claims to the Program on behalf of the Provider; and

g) Biller and Provider agree to notify the Medicaid program within five business days of the initiation and termination, by either party, of the contract between the Biller and the Provider.

2.6 Client Rights

2.6.1 All Providers

2.6.1.1 Provider may not request or accept payment from client, any financially responsible relative or representative of the client, or client's designee for completing any Program forms.

2.6.2 Medicaid/CHIP Providers

2.6.2.1 The client must have the right to choose providers, unless that right has been restricted by HHSC or waived by CMS. The client's acceptance of any service must be voluntary.

2.7 Signatures

2.7.1 All Providers

2.7.1.1 Provider understands and agrees that any signature on a submitted document certifies, to the best of the Provider's knowledge, the information in the document is true, accurate, and complete.

2.7.1.2 Provider understands and agrees that both the Provider and the Provider's representative who utilizes an electronic signature bear the responsibility for the authenticity of the information being certified to.

2.8 Privacy, Security, and Breach Notification

2.8.1 All Providers

2.8.1.1 **Definitions**

a) "Breach" means the acquisition, access, use, or disclosure of HHSC Confidential Information in an unauthorized manner which compromises the security or privacy of the HHSC Confidential Information.

b) "HHSC Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to the Provider electronically or through any other means that consists of or includes any or all of the following:

a) Protected Health Information in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information (as defined in 45 CFR § 160.103 and 45 CFR § 164.402);

b) Sensitive Personal Information (as defined in Texas Business and Commerce Code § 521.002(2));

c) Federal Tax Information (as defined in IRS Publication 1075);

d) Personally Identifiable Information (as defined in OMB Memorandum M-07-16);

e) Social Security Administration Data (defined as information received from a Social Security Administration federal agency system of records), including, without limitation, Medicare or Medicaid information (defined as information relating to an applicant or recipient of Medicare or Medicaid benefits);

All information designated as confidential under the constitution and laws of the State of Texas and of the United States, including the Texas Health & Safety Code and the Texas Public Information Act, Texas Government Code, Chapter 552.

2.8.1.2 **HHSC Confidential Information.**

Any HHSC Confidential Information received by the Provider under this Agreement may be disclosed only in accordance with applicable law. By signing this Agreement, the Provider certifies that the Provider is, and intends to remain for the term of this Agreement, in compliance with all applicable state and federal laws and regulations with respect to privacy, security, and Breach notification, including without limitation the following:

a) Title 5 U.S.C. Part I, Chapter 5, Subchapter II, Section552a, Records Maintained on Individuals, The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988;

b) Title 26 U.S.C., Internal Revenue Code;

c) Title 42 U.S.C. Chapter 7, Subchapter XI, Part C, Administrative Simplification, the relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

d) Title 42 U.S.C. Chapter 7, the relevant portions of the Social Security Act;

e) Title 42 U.S.C. Chapter I, Subchapter A, Part 2, Confidentiality of Substance Use Disorder Patient Records;

f) Title 45 CFR Chapter A, Subchapter C, Part 160, General Administrative Requirements;

g) Title 45 CFR Chapter A, Subchapter C, Part 164, Security and Privacy;

h) Internal Revenue Service Publication 1075, Tax Information Security Guidelines for Federal, State and Local Agencies, Safeguards for Protecting Federal Tax Returns and Return Information;

i) Office of Management and Budget Memorandum 17-12, Preparing for and Responding to a Breach of Personally Identifiable Information;

j) Texas Business and Commerce Code, Title 11, Subtitle B, Chapter 521, Unauthorized Use of Identifying Information;

k) Texas Government Code, Title 5, Subtitle A, Chapter 552, Public Information, as applicable;

l) Texas Health and Safety Code, Title 2, Subtitle D, Chapter 81, Section 81.006, Funds;

m) Texas Health and Safety Code, Title 2, Subtitle I, Chapter 181, Medical Records Privacy;

n) Texas Health and Safety Code, Title 7, Subtitle E, Chapter 611, Mental Health Records;

o) Texas Human Resources Code, Title 2, Subtitle A, Chapter 12, Section 12.003, Disclosure of Information Prohibited (VDP);

p) Texas Occupations Code, Title 3, Health Professions (ICF/IID), as applicable;

q) Constitutional and common law privacy (VDP); and

r) Any other applicable law controlling the release of information created or obtained in the course of providing the services described in this Agreement.

The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to the laws listed herein under section 2.8.1.2, to the extent applicable.

Provider must not perform any work or maintain any information relating or obtained pursuant to this Agreement outside of the United States.

2.8.1.3 **Cybersecurity Training.**

All of Provider's authorized users, workforce, and Subcontractors with access to a state computer system or database will complete a cybersecurity training program certified under Texas Government Code, Title 10, Subtitle B, Chapter 2054, Section 2054.5192, Cybersecurity Training Required: Certain State Contractors, by the Texas Department of Information Resources.

2.8.1.4 **Business Associate Agreement.**

Provider will ensure that any Subcontractor of Provider who has access to HHSC Confidential Information will sign a HIPAA-compliant Business Associate Agreement with Provider, and Provider will submit a copy of that Business Associate Agreement to HHSC upon request.

2.9 Provider's Incident Notice, Reporting and Mitigation

2.9.1 All Providers

2.9.1.1 The Provider's obligation begins at discovery of any unauthorized disclosure of HHSC Confidential Information or any privacy or security incident that may compromise HHSC Confidential Information. "Incident" is defined as an attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. The Provider's obligation continues until all effects of the Incident are resolved to HHSC's satisfaction, hereafter referred to as the "Incident Response Period."

2.9.1.2 **Notification to HHSC.**

a) The Provider must notify HHSC within the timeframes set forth in Section (c) below.

b) The Provider must require that its Subcontractors and contractors take the necessary steps to assure that the Provider can comply with all of the following Incident notice requirements.

c) Incident Notice:

1. Initial Notice.
   Within twenty-four (24) hours of discovery, or in a timeframe otherwise approved by HHSC in writing, the Provider must preliminarily report on the occurrence of an Incident to the HHSC Privacy and Security Officers via email at: privacy@HHSC.state.tx.us.

2. This initial notice must, at a minimum, contain:
   (i) all information reasonably available to Provider about the Incident;
   (ii) confirmation that the Provider has met any applicable federal Breach notification requirements; and
   (iii) the identity of Provider's single point of contact for communication with HHSC, both during and outside of business hours during the Incident Response Period.
3. Formal Notice.
   No later than three (3) Business Days after discovery of an Incident, or when the Provider should have reasonably discovered the Incident, the Provider must provide written formal notification to HHSC using the Potential Privacy/Security Incident Form, which is available on the HHSC website at . The formal notification must include all available information about the Incident and Provider's investigation of the Incident.

2.9.1.3 Provider Investigation, Response, and Mitigation.

The Provider must fully investigate and mitigate any Incident to the extent practicable and as soon as possible. At a minimum, the Provider agrees it will:

a) Immediately commence a full and complete investigation;

b) Cooperate fully with HHSC in its response to the Incident;

c) Complete or participate in an initial risk assessment;

d) Provide a final risk assessment;

e) Submit proposed corrective actions to HHSC for review and approval;

f) Commit necessary and appropriate staff and resources to expeditiously respond;

g) Report to HHSC as required by HHSC and all applicable federal and state laws for Incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC;

h) Fully cooperate with HHSC to respond to inquiries and/or proceedings by federal and state authorities about the Incident;

i) Fully cooperate with HHSC's efforts to seek appropriate injunctive relief or to otherwise prevent or curtail such Incidents;

j) Recover, or assure destruction of, any HHSC Confidential Information impermissibly disclosed during or as a result of the Incident;

k) Comply with reasonable corrective action or measures, as specified by HHSC in a corrective action plan if directed by HHSC; and

l) Provide HHSC with a final report on the Incident, including an explanation of the Incident's resolution.

2.9.1.4 Breach Notification to Individuals and Reporting to Authorities.

a) In addition to the notices required in this section, the Provider must comply with all applicable legal and regulatory requirements in the time, manner, and content of any notification to individuals, regulators, or third-parties, or any notice required by other state or federal authorities, including without limitation, notifications required in Title 45 CFR Chapter A, Subchapter C, Part 164, Subpart D, Notification in the Case of Breach of Unsecured Protected Health Information and Texas Business and Commerce Code, Title 11, Subtitle B, Chapter 521, Section 521.053(b), Notification Required Following Breach of Security of Computerized Data, or as specified by HHSC following an Incident.

b) The Provider must assure that the time, manner, and content of any Breach notification required by this section meets all federal and state regulatory requirements.

c) Breach notice letters must be in the Provider's name, on the Provider's letterhead, and must contain contact information to obtain additional information, including the name and title of the Provider's representative, an email address, and a toll-free telephone number.

d) The Provider must provide HHSC with copies of all distributed communications related to the Breach notification at the same time the Provider distributes the communications.

e) The Provider must demonstrate to the satisfaction of HHSC that any Breach notification required by applicable law was timely made. If there are delays outside of the Provider's control, the Provider must provide written documentation to HHSC of the reasons for the delay

III TERM AND TERMINATION

3.1 Agreement Term

3.1.1 All Providers

3.1.1.1 The effective date of this Agreement is the date stated in the provider enrollment notification sent by HHSC or its

designee to Provider. The Agreement will end on the date stated in the provider enrollment notification, with or without other advance notice of the Agreement's termination date, unless the Agreement is amended, renewed, or terminated at an earlier date in accordance with any of the terms relating to termination within Section III of this agreement. Provider must revalidate its enrollment in Medicaid and complete a new Medicaid Provider Agreement.

3.2 Provider Termination

3.2.1 Medicaid/CHIP Providers

3.2.1.1 Provider may terminate this Agreement by providing written notice of intent to terminate to HHSC or its designee at least 30 calendar days in advance of its intended termination date.

3.2.2 Long-term-Care Providers

3.2.2.1 Provider may terminate this Agreement by providing written notice of intent to terminate to HHSC or its designee at least 60 calendar days in advance of its intended termination, when Provider's services include long-term care, as stated under 26 TAC § 554.2310 and 40 TAC § 49.551.

3.3 HHSC Termination

3.3.1 All Providers

3.3.1.1 HHSC may terminate this Agreement at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas.

3.3.1.2 HHSC has grounds for terminating this Agreement for circumstances including, but not limited to, those listed below, and which may include the actions or circumstances involving the Provider or any person or entity with an affiliate relationship to the Provider:

a) the exclusion from participation in Medicare, Medicaid, or any other publicly funded health-care program;

b) the loss or suspension of a professional license or certification;

c) any failure to comply with the provisions of this Agreement or any applicable law, rule, or policy of the Program;

d) HHSC or the OIG determine that the Provider has, or may be placing the health or safety of clients at risk, including abuse, neglect, or exploitation;

e) if upon further review of the Provider's application, or at any time during the term of this Agreement, HHSC or its designee, determines Provider is ineligible to participate in the Program;

f) any other circumstances resulting in Provider's ineligibility to participate in the Program;

g) the circumstances for termination listed in 42 CFR § 455.416, as amended;

h) the circumstances for termination listed in 1 TAC § 371.1703, as amended;

i) the Provider has not submitted a claim to the Program for at least 24 months;

j) the Provider has not provided services for 12 months or longer; and

k) any other circumstances resulting in Provider's ineligibility to participate in the Program.

3.3.1.3 HHSC will provide written notification of the termination of the Agreement, and any rights to appeal will be included with the notice of termination.

3.3.2 Medicaid/CHIP providers

3.3.2.1 Pursuant to 42 CFR § 455.23, HHSC shall suspend all Medicaid payments to the Provider upon notification by HHSC or the OIG that a credible allegation of fraud under the Medicaid Program is pending against the Provider, unless HHSC has good cause not to suspend the payments or to suspend the payments only in part.

3.3.3 Long-term-Care Providers

3.3.3.1 If the Provider fails to comply with any provision of the Agreement, HHSC may apply sanctions at its discretion, including, but not limited to, the following:

a) recouping overpayments;

b) suspending the Provider's payments; and

c) initiating termination of the Agreement.

3.3.3.2 HHSC may suspend payments to Provider under the Agreement during the pendency of a hearing on either the Agreement's termination or a facility's Medicaid certification of noncompliance. HHSC may withhold payments until a final decision is issued and all appeals are exhausted.

IV ACKNOWLEDGEMENTS AND CERTIFICATIONS

4.1 HHSC Agrees:

4.1.1 Vendor Drug Program (VDP) Providers

4.1.1.1 HHSC agrees to pay clean claims for covered drugs paid for by VDP. HHSC will make payments to providers, in

amounts and under conditions determined by HHSC and established by administrative rule (see e.g., Title 1, Part 15, Chapter 354, Subchapter F of TAC, titled "Pharmacy Services," and Title 1, Part 15, Chapter 355, Subchapter J, Division 28 of TAC, titled "Pharmacy Services: Reimbursement"). VDP is not responsible for claims billed to, or paid by, a MCO contracted with HHSC or the MCO's subcontractor.

4.1.1.2 HHSC agrees to pay clean claims in accordance with applicable federal and state laws, and regulations (see e.g., 42 U.S.C. § 1396a(a)(37) and 42 CFR § 447.45). However, HHSC will attempt to pay clean claims submitted electronically or on the VDP Pharmacy Claims Billing Request based on a weekly payment cycle, as described in the "Claims Payment" provisions of the Provider Manual. HHSC is not required to pay Provider claims that are under investigation for fraud, waste, or abuse, or that are on vendor hold. HHSC may place irregular or erroneous claims on vendor hold until the provider can adjust such irregularities or errors.

4.1.1.3 HHSC agrees to provide reasonable notice of any impending change in the Provider's status as a participating provider of pharmaceutical services, including notice of cancellation of this Agreement, if no claims are processed in a 12-month period.

4.2 Provider Agrees:

By signing below, Provider acknowledges and certifies to all of the following:

4.2.1 All Providers

4.2.1.1 Provider must comply with the enrollment requirements established under Title 1, Part 15, Chapter 352 of TAC. Provider is responsible for ensuring that the Provider, its employees, and its agents comply with the requirements of Title 1, Part 15, Chapter 371 of TAC, relating to fraud, waste, and abuse program integrity. Provider and its principals will be held responsible for violations of this Agreement through any acts or omissions of the Provider, its employees, and its agents.

4.2.1.2 Provider agrees to notify HHSC or its designee if Provider files bankruptcy or is the subject of a bankruptcy petition. The Provider must provide HHSC or its designee with notice of the bankruptcy within 10 calendar days after the case is filed. Provider must also provide HHSC or its designee the notice pleadings in the case upon request.

4.2.1.3 Provider has carefully read and understands the requirements of this Agreement and will comply with the Agreement and its amendments.

4.2.1.4 Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Program and Provider certifies that this information is current, complete, and correct.

4.2.1.5 Provider agrees and understands that HHSC or its designee may review Provider's application any time after the application has been accepted and for the term of this Agreement. Upon review, HHSC or its designee may determine that the information contained therein does not meet the Program enrollment requirements and Provider may no longer be eligible to participate in the Program. Provider will have the opportunity to correct any errors or omissions as determined by HHSC or its designee. Provider agrees and understands that any errors or omissions that are not corrected or cannot be corrected will result in termination of this Agreement.

4.2.1.6 Provider understands that falsifying entries, concealment of a material fact, or pertinent omissions may constitute fraud and may be prosecuted under applicable federal and state law.

4.2.1.7 Provider understands that any breach or violation of any of the provisions of this Agreement or state or federal regulations shall make this entire Agreement, at HHSC's option, subject to termination.

4.2.1.8 Provider understands and agrees that any falsification, omission, or misrepresentation in connection with the application for enrollment or with claims filed may result in all paid services declared as an overpayment and subject to recoupment. Any falsification, omission, or misrepresentation may also result in other administrative sanctions that include payment hold, exclusion, debarment, termination of this Agreement, and monetary penalties.

4.2.1.9 Provider agrees to abide by all Program laws, Program regulations, and Program instructions. The Program laws, Program regulations, and Program instructions are available through HHSC or its designee. Provider understands that payment of a claim by Program is conditioned upon the claim and the underlying transaction complying with such Program laws, Program regulations, and Program instructions (including, but not limited to, the Federal anti-kickback statute (42 U.S.C. § 1320a-7b) and the Stark law (42 U.S.C. §1395nn), and on the Provider's compliance with all applicable conditions of participation in Program.

4.2.1.10 Nothing in this Agreement, or any conduct by a representative of HHSC relating to this Agreement, shall be construed as a waiver of the state's sovereign immunity to suit.

4.2.1.11 Neither party to this Agreement waives its right to enforce a right under this Agreement by failing to enforce or delaying the enforcement of any other right under this Agreement.

4.2.1.12 Provider is not an employee of HHSC for any purpose. The Provider and HHSC agree that:

a) HHSC will not withhold or pay any sums for income tax, unemployment insurance, Social Security, or any other withholding, or make available to the Agreement any of the benefits, including workers' compensation insurance coverage and health and retirement benefits, afforded to HHSC employees; and

b) Provider will indemnify, defend, and hold harmless HHSC, its officers, agents, designees, and employees from any loss, damage, claim, liability, or expense arising out of Provider's performance as

a Program Provider under the Agreement. Provider's performance as a Program Provider under the Agreement includes the actions of its employees, Subcontractors, joint venture participants, or agents. Provider will not be liable for the negligence or willful misconduct of HHSC.

4.2.1.13 Provider understands that nothing in this Agreement is intended to create a joint venture, a partnership, or a principal-agent relationship.

4.2.1.14 Provider may not assign, transfer, or convey this Agreement, in whole or in part, without the prior written consent of HHSC, and HHSC's consent may be withheld or granted at the sole discretion of HHSC. Except where otherwise agreed in writing by HHSC, assignment will not release Provider from its obligations under the Agreement.

4.2.1.15 This Agreement shall be governed and construed in accordance with the laws of the State of Texas without reference to its conflicts of law provisions. Provider consents to personal jurisdiction in the State of Texas.

4.2.1.16 The venue for any lawsuit between HHSC and the Provider shall be Travis County, Texas.

4.2.1.17 Provider is, and will be, an independent contractor without authorization, express or implied, to bind HHSC or the State of Texas to any agreement, settlement, liability, or understanding.

4.2.1.18 Upon its effective date, this Agreement supersedes and replaces any existing agreements or contracts previously executed by Provider and HHSC related to the Program. This Agreement does not impair Provider's obligation to repay HHSC any money owed to HHSC pursuant to prior agreements or contracts with HHSC or the ability of HHSC to recoup such amounts from payment made pursuant to this Agreement.

4.2.1.19 This Agreement may be amended by notice from HHSC or its designee by any medium of HHSC or its designee's choice.

4.2.1.20 Provider agrees that the Provider enrollment notification letter is incorporated by reference into this Agreement.

4.2.1.21 Provider affirms, without exception, as follows:

a) Provider affirms that it will not boycott Israel during the term of this Agreement.

b) Provider affirms that it is not engaged in business with Iran, Sudan, or any foreign terrorist organization.

4.2.1.22 Parties agree to rely upon the procedures described in Texas Government Code Chapter 2260 to resolve any dispute that may arise out of this Agreement.

4.2.1.23 In the event any provision of this Agreement becomes unenforceable or void, all other provisions of this Agreement will remain in effect.

4.2.2 Medicaid/CHIP Providers

4.2.2.1 **Compliance Program Requirement.** Provider certifies that in accordance with requirement 1 TAC § 352.5(b)(11), Provider has a compliance program containing the core elements established by the Secretary of Health and Human Services under § 1866(j)(9) of the Social Security Act (42 U.S.C. § 1395cc(j)(9)), as applicable.

4.2.2.2 **Internal Review Requirement.** Provider certifies that in accordance with 1 TAC § 352.5(b)(1), Provider has conducted an internal review to confirm that neither the applicant or the re-enrolling provider, nor any of its employees, owners, managing partners, or contractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act. If the applicant is enrolling as a performing provider, the applicant need only attest to the applicant's own status.

4.2.3 Vendor Drug Program (VDP) Providers

4.2.3.1 **Authority to Dispense Covered Drugs.** Provider is authorized to dispense covered drugs to clients of VDP.

Full name of Provider: HARRIS COUNTY TAX OFFICE

Provider's Signature: _____

For Providers that are entities, facilities, groups, or organizations, and whose authorized representative is completing this application with authority to sign on the Provider's behalf, the authorized representative must sign above and print their name and title where indicated below.

Representative's Full Name: Radie Said

Representative's Position/Title: Associate Director

HARRIS COUNTY

By: _____
Lina Hidalgo
County Judge

Approved as to Form
Christian D. Menefee
County Attorney

By: Shannon Fleming
Shannon Fleming
Senior Assistant County Attorney
CAO File No. 25GEN0289

ORDER OF COMMISSIONERS COURT
Authorizing execution of an Agreement

The Commissioners Court of Harris County, Texas, convened at a meeting of said Court at the Harris County Administration Building in the City of Houston, Texas, on _____, 2025, with all members present except _____.

A quorum was present. Among other business, the following was transacted:

ORDER AUTHORIZING EXECUTION OF AN AGREEMENT BETWEEN HARRIS COUNTY AND THE HEALTH AND HUMAN SERVICES COMMISSION

Commissioner _____ introduced an order and moved that Commissioners Court adopt the order. Commissioner _____ seconded the motion for adoption of the order. The motion, carrying with it the adoption of the order, prevailed by the following vote:

Vote of the Court	Yes	No	Abstain
Judge Hidalgo	□	□	□
Comm. Ellis	□	□	□
Comm. Garcia	□	□	□
Comm. Ramsey, P.E.	□	□	□
Comm. Briones	□	□	□

The County Judge thereupon announced that the motion had duly and lawfully carried and that the order had been duly and lawfully adopted. The order adopted follows:

IT IS ORDERED that County Judge is hereby authorized to execute for and on behalf of Harris County an Agreement with the Health and Human Services Commission for a Provider Agreement. Agreement is incorporated herein as though fully set forth word for word.

All Harris County officials and employees are authorized to do any and all things necessary or convenient to accomplish the purposes of this order.