Texas Medicaid Provider Enrollment Application Ordering and Referring Providers Only

A STATE MEDICAID CONTRACTOR

Rev. VII

Introduction

Dear Health-care Professional:

Thank you for your interest in becoming a Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program ordering/referring provider. Participation by providers in Texas Medicaid and the CSHCN Services Program is vital to the successful delivery of Medicaid and CSHCN Services Program services, and we welcome your application for enrollment.

This application is for individual providers who are not currently enrolled in Texas Medicaid or the CSHCN Services Program and who do not currently have an active Texas Medicaid or CSHCN Services Program billing Texas Provider Identifier (TPI).

Note: *Individual providers who are currently enrolled in Texas Medicaid or the CSHCN Services Program and who currently have an active Texas Medicaid or CSHCN Services Program billing provider TPI can use their current TPI for ordering/referring services and do not need to obtain an ordering/referring TPI.*

Providers are encouraged to review the current *Texas Medicaid Provider Procedures Manual* for information about provider responsibilities and much more. The *Texas Medicaid Provider Procedures Manual* and the *CSHCN Services Program Provider Manual* are updated monthly, and the current and archived provider manuals can be accessed on the TMHP website at www.tmhp.com.

Privacy Statement

With a few exceptions, Texas privacy laws and the Public Information Act entitle you to ask about the information collected on this form, to receive and review this information, and to request corrections of inaccurate information. The Health and Human Services Commission's (HHSC) procedures for requesting corrections are in Title 1 of the Texas Administrative Code, sections 351.17 through 351.23.

For questions concerning this notice or to request information or corrections, please call the TMHP Contact Center at 1-800-925-9126. TMHP customer service representatives are available Monday through Friday from 7 a.m. to 7 p.m. central standard time.

Affordable Care Act (ACA) Requirement for Ordering/Referring Providers

In compliance with the Affordable Care Act of 2010 (ACA), all ordering and referring providers are required to be enrolled in Texas Medicaid if they order or refer services for Texas Medicaid clients. This enrollment application is for providers whose only relationship with Texas Medicaid is ordering or referring services. This requirement is regulated by Title 42 Code of Federal Regulations (CFR) §455.410(b).

Providers whose applications are approved will receive an ordering/referring TPI that will be active for Medicaid and CSHCN Services Program ordering/referring services and cannot be used for billing claims.

Important: *In the future, if you wish to be reimbursed by Texas Medicaid for services you render to Medicaid clients, you must first complete a Texas Medicaid provider enrollment application. Enrolling with Texas Medicaid to be reimbursed for services rendered will result in your ordering or referring TPI to be deactivated.*

Application Correspondence

All correspondence related to this application (i.e., enrollment denials, deficiency letters) will also be mailed to the physical address listed on your application unless otherwise requested. Submit a cover letter listing the contact address and phone number to have deficiency letters mailed elsewhere.

Contact Information

For information about Medicaid provider identifier requirements, the status of your enrollment, or claims submission, call the TMHP Contact Center toll-free at 1-800-925-9126.

Thank you for applying to become a Texas Medicaid provider.

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Instructions

IMPORTANT: *This application is for individual providers who are not currently enrolled as a billing or performing provider in Texas Medicaid or the CSHCN Services Program and who do not currently have an active Texas Medicaid or CSHCN Services Program billing provider Texas Provider Identifier (TPI).*

Note: *Individual providers who are currently enrolled in Texas Medicaid or the CSHCN Services Program and who currently have an active Texas Medicaid or CSHCN Services Program billing provider TPI can use their current TPI for ordering/referring services and do not need to obtain an ordering/referring TPI.*

CHECKLIST – Forms and Attachments

To complete the Ordering/Referring Provider Enrollment Application process, the following forms must be completed and returned for processing:

☐ Ordering/Referring Provider Enrollment Application

☐ Ordering/Referring Provider Information Form (OR-PIF)

☐ HHSC Medicaid Ordering or Referring Provider Agreement

Important: *Retain a copy for your records of all documents submitted for enrollment.*

Mail your application to the following address:

Texas Medicaid & Healthcare Partnership
ATTN: Provider Enrollment
P.O. Box 200795
Austin, TX 78720-0795

INSTRUCTIONS – Completing the Application and Other Forms

Complete this Texas Medicaid Provider Enrollment Application using the following information:

Item	Instructions
Medical Identification	Identify your provider type. Check only the appropriate box to ensure proper enrollment. **Note:** *A license or certification is required for all of the provider types listed except opticians.*
Reason for enrollment request	Check the appropriate box to indicate the type of enrollment you are seeking: **Updating current ordering/referring information.** Check this box if you are currently an ordering/referring-only provider and you would like to update your demographic or other information provided on this form. **New enrollment.** Check this box if you are not currently enrolled as a Texas Medicaid provider and you would like to order/refer services for Texas Medicaid clients. Ordering/referring-only providers cannot bill Texas Medicaid or the CSHCN Services Program for ordering/referring services. **Withdrawing from Medicaid/CSHCN as a billing/performing provider to enroll as an ordering/referring provider only.** Check this box if you are currently enrolled as a Texas Medicaid or CSHCN Services Program provider and you would like to terminate your billing/performing TPIs in order to only order/refer services for Texas Medicaid and CSHCN Services Program clients. By checking this box, you are indicating that you will no longer be billing Texas Medicaid or the CSHCN Services Program for rendered services.
Reason for enrollment request (continued)	**Important:** *This application is for individual providers who are not currently enrolled in Texas Medicaid or the CSHCN Services Program and who do not currently have an active Texas Medicaid or CSHCN Services Program billing/performing provider Texas Provider Identifier (TPI).*

Item	Instructions
Section A – Provider of Service Information	Provider demographic information. Provide complete and correct information as required.
OR-PIF	Each Provider must complete the Ordering/Referring Provider Information Form (OR-PIF) before enrollment.
HHSC Medicaid Provider Agreement for Ordering/Referring Providers	Read and sign the HHSC Medicaid Provider Agreement for Ordering/Referring Providers to indicate that you have read and agree with the terms of enrollment as required by Texas Medicaid.

CONTACT INFORMATION – Point of Contact for this Application

Provide a point of contact for questions about this application, and include an alternate address if deficiency letters should be mailed somewhere other than the physical address where services are rendered as noted on this application.

Contact Name: *Last*	*First*	*Middle Initial*
Contact Telephone Number:	**Contact Fax** *(if applicable)*:	
Email Address *(if applicable)*:		

Address: *Number*	*Street*	*Suite No.*	*City*	*State*	*ZIP Code*

Ordering/Referring Provider Identification Form

All information must be completed and contain a valid signature to be processed, unless inapplicable. If a question or answer does not apply, enter "N/A".

- Original signatures only; copies or stamped signatures not accepted.
- Use blue or black ink.

MEDICAL IDENTIFICATION:

Please check only the appropriate boxes to ensure proper enrollment.

Note: *A license or certification is required for all of the provider types listed below except opticians.*

Select only one of the following options. Selecting more than one of the following options may result in a delay in processing this enrollment application.

- ☐ Certified Nurse Midwife (CNM)
- ☐ Certified Registered Nurse Anesthetist (CRNA)
- ☐ Chiropractor
- ☐ Dentist
- ☐ Family Planning (FP) Agencies
- ☐ Genetics
- ☐ Hearing Aid
- ☐ Licensed Midwife (LM)
- ☐ Nurse Practitioner/Clinical Nurse Specialist (NP/CNS)
- ☐ Optometrist (OD)
- ☐ Physician (MD, DO)
- ☐ Physician Assistant
- ☐ Podiatrist
- ☐ Psychologist

REASON FOR ENROLLMENT REQUEST:

☐ You are currently enrolled with Texas Medicaid and the CSHCN Services Program for the sole purpose of ordering or referring, and you are updating your information.

☐ You are *not* currently enrolled in Texas Medicaid or the CSHCN Services Program, and you are applying to enroll with Texas Medicaid and the CSHCN Services Program for the sole purpose of ordering or referring.

☐ **You are VOLUNTARILY WITHDRAWING your Medicaid and CSHCN Services Program billing provider enrollment to enroll for the sole purpose of ordering or referring.**

IMPORTANT: *Choose this option only if you will no longer be billing Texas Medicaid and the CSHCN Services Program for reimbursement, but you will continue to order/refer services for Texas Medicaid and CSHCN Services Program clients.*

Ordering/Referring Provider Information Form (OR-PIF)

Each Provider must complete this Ordering/Referring Provider Information Form (OR-PIF) before enrollment.

All questions on this form must be answered by or on behalf of the Provider, by ALL provider types (all spaces must be completed either with the correct answer or a "NA" on the questions that do not apply to the Provider).

The Provider must personally review this completed form and certify to the validity and completeness of the information provided by signing the HHSC Medicaid Provider Agreement for Ordering/Referring Providers.

Name Last:	**First:**	**Middle Initial:**

List any other alias, name, or form of your name ever used:	**National Provider Identifier (NPI) and Primary Taxonomy:**

For additional names or addresses, attach pages as necessary.

Physical address:					
Number	Street	Suite	City	State	ZIP

Social Security Number:	**Federal Tax ID number:**

Driver's license number:	**State:**	**Driver's license expiration date:** MM/DD/YYYY

Date of birth: MM/DD/YYYY		**Gender:**	☐ Male ☐ Female

Do you have one or more professional licenses, accreditations, or certifications?	
☐ Yes ☐ No *If Yes, provide the following information.*	

1.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date:** MM/DD/YYYY
2.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date:** MM/DD/YYYY
3.	**Professional Licensing or Certification Board:**	**Licensing State:**
	License Accreditation Certification Issuer:	**License Accreditation Certification Number:**
	Issue Date: MM/DD/YYYY	**Expiration Date:** MM/DD/YYYY

4.	Professional Licensing or Certification Board:	Licensing State:
	License Accreditation Certification Issuer:	License Accreditation Certification Number:
	Issue Date: MM/DD/YYYY	Expiration Date: MM/DD/YYYY

"Sanction" is defined as recoupment, payment hold, imposition of penalties or damages, contract cancellations, exclusion, debarment, suspension, revocation, or any other synonymous action. **Have you ever been sanctioned (as defined above) in any state or federal program?**	☐ Yes ☐ No

If **Yes**, *fully explain the details, including date, the state where the incident occurred, the agency taking the action, and the program affected. (attach additional sheets if necessary)*

Is your professional license or certification currently revoked, suspended or otherwise restricted?	☐ Yes ☐ No
Have you ever had your professional license or certification revoked, suspended, or otherwise restricted?	☐ Yes ☐ No
Are you currently, or have you ever been, subject to a licensing or certification board order?	☐ Yes ☐ No
Have you voluntarily surrendered your professional license or certification in lieu of disciplinary action?	☐ Yes ☐ No
(You may be subject to a license or certification verification/status check with your licensing or certification board.)	

If **Yes** *was answered to any of these questions, fully explain the details, including date, the state where the incident occurred, name of the board or agency, and any adverse action against your license. (attach additional sheets if necessary)*

Have you ever enrolled in or applied to any other State's Medicaid or CHIP program?	☐ Yes ☐ No
Are you currently or have you ever been subject to the terms of a settlement agreement, corporate compliance agreement or corporate integrity agreement in relation to any State or Federally funded program?	☐ Yes ☐ No
Do you currently have any outstanding debt in relation to any State or Federally funded program?	☐ Yes ☐ No

If ***Yes*** *was answered to any of the questions, fully explain the details including date, and the state if applicable.*

"Convicted" means that: **(a) A judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:** **(1) There is a post-trial motion or an appeal pending, or** **(2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;** **(b) A Federal, State or local court has made a finding of guilt against an individual or entity;** **(c) A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity, or** **(d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.**	
Are you currently charged with or have you ever been convicted of a crime (excluding Class C misdemeanor traffic citations)? *To answer this question, use the federal Medicaid/Medicare definition of "Convicted" in 42 CFR. § 1001.2 as described above, and which includes deferred adjudications and all other types of pretrial diversion programs. You may be subject to a criminal history check.*	☐ Yes ☐ No
Have you been arrested for a crime but not yet charged?	☐ Yes ☐ No
Is there an outstanding warrant for your arrest?	☐ Yes ☐ No
If **Yes**, *fully explain the details, including date, the state and county where the conviction occurred, the cause number(s), and specifically what you were convicted of. (attach additional sheets if necessary)*	
Are you a citizen of the United States?	☐ Yes ☐ No
If **No**, *provide the country of which you are a citizen.*	
If you are not a citizen of the United States, do you have a legal right to work in the United States? *If* **Yes**, *attach a copy of your green card, visa, or other documentation demonstrating your right to reside and work in the United States.*	☐ Yes ☐ No

Ordering/Referring Provider Enrollment Application

Section A: Provider of Service Information
Existing Texas Provider Identifiers (TPIs) to be deactivated *(List all TPIs associated with the individual enrolling. These TPIs will be deactivated.)* **Note:** *Complete this field if you are voluntarily withdrawing your Medicaid and CSHCN Services Program billing/referring provider enrollment to enroll for the sole purpose of ordering or referring. By completing this application, you are requesting TMHP to deactivate your Texas Medicaid and CSHCN Services Program TPIs.*
List NPI
List Provider's Primary Specialty and Sub-specialty

Personal Information *Your name must match your social security record.*			
Legal Name, Last *(Legal Name According to the IRS)*	**First**	**Middle Initial**	**Title/Degree**
Other Name, Last	**First**	**Middle Initial**	
Type of Other Name			
☐ Former or Maiden Name ☐ Professional Name ☐ Other (Describe):_____			

Provider business email: (f applicable)	**Provider website address: (if applicable)**
Telephone number (Including Area Code)	
Fax number (if applicable)	

Medicare Identification Number if issued	**Medicare certification date: MM/DD/YYYY (if applicable)**

HHSC Medicaid Ordering or Referring Provider Agreement

Name of provider enrolling:	
Medicaid TPI: *(if applicable)*	**Medicare provider ID number:** *(if applicable)*
Physical address (where health care is rendered): *Providers MUST enter the physical address where the services are rendered to clients. If the accounting, corporate, or mailing address is entered in this physical address field, the application may be denied.* Number Street Suite City State ZIP	
Accounting/billing address: *(if applicable)* Number Street Suite City State ZIP	

As a condition for participation as an ordering or referring Provider under the Texas Medical Assistance Program (Medicaid), the ordering or referring Provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. GOVERNING DOCUMENTS, LAWS, AND REGULATIONS

1.1 Agreement and documents constituting Agreement.

The current *Texas Medicaid Provider Procedures Manual* (Provider Manual) may be accessed via the internet at www.tmhp.com. Provider has a duty to become educated and knowledgeable with the contents and procedures contained in the Provider Manual specifically the Ordering- or Referring-Only Providers and the Ordering or Referring Provider NPI sections. Provider agrees to comply with all of the applicable requirements of the Provider Manual, as well as all state and federal laws governing or regulating Medicaid, and Provider further acknowledges and agrees that the Provider is responsible for ensuring that all employees and agents of the Provider also comply. Provider agrees to acknowledge HHSC's provision of enrollment processes and authority to make enrollment decisions as found in Title 1, Part 15, Chapter 352 of the Texas Administrative Code. Provider is specifically responsible for ensuring that the Provider and all employees and agents of the Provider comply with the requirements of Title 1, Part 15, Chapter 371 of the Texas Administrative Code, related to waste, abuse and fraud, and Provider acknowledges and agrees that the Provider will be held responsible for violations of this Agreement through any acts or omissions of the Provider, its employees, and its agents.

1.2 State and Federal regulatory requirements.

1.2.1 By signing this Agreement, Provider certifies that the Provider have not been excluded, suspended, debarred, revoked or any other synonymous action from participation in any program under Title XVIII (Medicare), Title XIX (Medicaid), or under the provisions of Executive Order 12549, relating to federal contracting. Provider further certifies that the Provider has 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 the Health and Human Services Commission (HHSC) or its agent within 10 business days of the time it receives notice that any action is being taken against Provider, which could result in exclusion from the Medicaid program. Provider agrees to fully comply at all times with the requirements of 48 CFR, Chapter 3, relating to eligibility for federal contracts and grants.

1.2.2 Provider agrees to keep its application for participation in the Medicaid program current at all times by informing HHSC or its agent in writing of any changes to the information contained in its application, including, but not limited to changes in Provider's federal tax identification number, provider licensure, certification, or accreditation, phone number, or business addresses. All changes must be reported to HHSC or its designee in writing within 90 days of the change.

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

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud, abuse and waste in health care and the Medicaid 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 or supplies ordered or referred by the Provider to individuals in the Medicaid program. On request, Provider also agrees to provide these records immediately and unconditionally to HHSC, HHSC's agent, the Texas Attorney General's Medicaid Fraud Control Unit, DARS, DADS, DFPS, DSHS 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 a minimum of five years from the date of service, or until all investigations are resolved and closed, whichever period is longest. Provider must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Provider must also allow these agencies and their agents unconditional and unrestricted access to its records and premises as required by Title 1 TAC, §371.1667. The Texas Attorney General's Medicaid Fraud Control Unit, Texas Health and Human Services Commission's Office of Inspector General (OIG), 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 with in 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 Texas Health and Human Services Commission's Office of Inspector General or its designee.

1.2.4 Nondiscrimination. Provider must not exclude or deny aid, care, service, or other benefits available under Medicaid or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide ordering or referral services to Medicaid clients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

II. ORDERING OR REFERRING PROVIDER PROVISIONS

2.1 Provider agrees that Provider is enrolling in the Texas Medicaid program only as a participating provider that orders or refers medical services or supplies for Texas Medicaid or the Children with Special Health Care Needs (CSHCN) Services Program clients in accordance with 42 C.F.R. §410(b), as amended.

2.2 Reporting Waste, Abuse, and Fraud. Provider agrees to inform and train all of Provider's employees, agents, and independent contractors regarding their obligation to report waste, abuse, and fraud. Individuals with knowledge about suspected waste, abuse, or fraud in any State of Texas health and human services program must report the information to the HHSC Office of Inspector General (OIG). To report waste, abuse or fraud, go to www.hhs.state.tx.us and select "Reporting Waste, Abuse, or Fraud." Individuals may also call the OIG hotline (1-800-436-6184) to report waste, abuse or fraud if they do not have access to the Internet

III. CLIENT RIGHTS

3.1 Provider must maintain the client's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

3.2 The client must have the right to choose providers unless that right has been restricted by HHSC or by waiver of this requirement from the Centers for Medicare and Medicaid Services (CMS). The client's acceptance of any service must be voluntary.

3.3 The client must have the right to choose any qualified provider of family planning services.

IV. TERM AND TERMINATION

4.1 Provider may terminate this Agreement by providing to HHSC at least 30 days written notice of intent to terminate.

4.2 HHSC has grounds for terminating this Agreement, including but not limited to, the circumstances listed below, and which may include the actions or circumstances involving the Provider or:

(a) the exclusion from participation in Medicare, Medicaid, or any other publically funded health-care program;
(b) the loss or suspension of professional license or certification;
(c) any failure to comply with the provisions of this Agreement or any applicable law, rule or policy of the Medicaid program;
(d) any circumstances indicating that the health or safety of clients is or may be at risk;
(e) the circumstances for termination listed in 42 C.F.R. § 455.416, as amended; and
(f) the circumstances for termination listed in 1 T.A.C. §371.1703, as amended.

The Provider will receive written notice of termination, which will include the detailed reasons for the termination. The written notice of termination will also inform the Provider its due process rights.

4.3 HHSC may also cancel this Agreement for reasons, including but not limited to, the following:

(a) upon further review of the Provider's application, at any time during the term of this Agreement, HHSC or its agent, determines Provider is ineligible to participate in the Medicaid program; and the errors or omission cannot be corrected; and
(b) any other circumstances resulting in Provider's ineligibility to participate in the Medicaid program.

The Provider will receive written notification of the cancellation of the Agreement and any rights to appeal HHSC's determination will be included.

V. ELECTRONIC SIGNATURES

5.1 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. Submitted documents with electronic signatures may be accepted by mail or fax when the sender has met the national and state standards for electronic signatures set by the Health and Human Services and the Texas Uniform Electronic Transactions Act (UETA).

5.2 Provider understands and agrees that both the Provider and the Provider's representative whose signature is on an electronic signature method bear the responsibility for the authenticity of the information being certified to.

VI. INTERNAL REVIEW REQUIREMENT

6.1 Provider, in accordance with TAC 352.5 (b)(1), has conducted an internal review to confirm that neither the applicant Provider or the re-enrolling Provider, nor any of its employees, or subcontractors (as applicable), have been excluded from participation in a program under Title XVIII, XIX, or XXI of the Social Security Act.

I attest that an internal review was conducted to confirm that neither I, the applicant Provider nor the re-enrolling Provider, nor any of my employees, or subcontractors have been excluded from participation in a program under the Title XVIII, XIX, or XXI of the Social Security Act."

☐ Yes ☐ No

VII. PRIVACY, SECURITY, AND BREACH NOTIFICATION

7.1 "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 follwoing:

(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 section 521.002);

(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;

(f) 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.

7.2 Any 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) The relevant portions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. Chapter 7, Subchapter XI, Part C;

(b) 42 CFR Part 2 and 45 CFR Parts 160 and 164;

(c) The relevant portions of The Social Security Act, 42 U.S.C. Chapter 7;

(d) The Privacy Act of 1974, as amended by the Computer Matching and Privacy Protection Act of 1988, 5 U.S.C. § 552a;

(e) Internal Revenue Code, Title 26 of the United States Code, including IRS Publication 1075;

(f) OMB Memorandum M-07-16;

(g) Texas Business and Commerce Code Chapter 521;

(h) Texas Health and Safety Code, Chapters 181 and 611;

(i) Texas Government Code, Chapter 552, as applicable; and

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

7.3 The Provider further certifies that the Provider will comply with all amendments, regulations, and guidance relating to those laws, to the extent applicable.

7.4 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.

VIII. PROVIDER'S BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

8.1 For purposes of this section:

Breach has the meaning of the term as defined in 45 C.F.R. §164.402, and as amended.

Discovery/Discovered has the meaning of the terms as defined in 45 C.F.R. §164.410, and as amended.

8.2 Notification to HHSC.

(a) Provider will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any unauthorized disclosure or suspected disclosure of HHSC Confidential Information to the extent and in the manner determined by HHSC.

(b) Provider's obligation begins at discovery of unauthorized disclosure or suspected disclosure and continues as long as related activity continues, until all effects of the incident are mitigated to HHSC's satisfaction (the "incident response period").

(c) Provider will require that its employees, contractors or subcontractors (as applicable), comply with all of the following breach notice requirements.

8.3 Breach Notice.

1. Initial Notice.

(a) For federal information, including without limitation, Federal Tax Information, Social Security Administration Data, and Medicaid Member Information, within the first, consecutive clock hour of discovery, and for all other types of Confidential Information not more than 24 hours

after discovery, or in a timeframe otherwise approved by HHSC in writing, initially report to HHSC's Privacy and Security Officers via email at: privacy@hhsc.state.tx.us and to the HHSC division responsible for this UMCC;

(b) Report all information reasonably available to Provider about the privacy or security incident; and

(c) Name, and provide contact information to HHSC for, Provider's single point of contact who will communicate with HHSC both on and off business hours during the incident response period.

8.4 48-Hour Formal Notice.

No later than 48 consecutive clock hours after discovery, or a time within which discovery reasonably should have been made by Provider, provide formal notification to HHSC, including all reasonably available information about the incident or breach, and Provider's investigation, including without limitation and to the extent available:

(a) The date the incident or breach occurred;

(b) The date of Provider's and, if applicable, its employees, contractors or subcontractors (as applicable) discovery;

(c) A brief description of the incident or breach; including how it occurred and who is responsible (or hypotheses, if not yet determined);

(d) A brief description of Provider's investigation and the status of the investigation;

(e) A description of the types and amount of Confidential Information involved;

(f) Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual and if applicable the, legally authorized representative, last known address, age, telephone number, and email address if it is a preferred contact method, to the extent known or can be reasonably determined by Provider at that time;

(g) Provider's initial risk assessment of the incident or breach demonstrating whether individual or other notices are required by applicable law or this DUA for HHSC approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

(h) Provider's recommendation for HHSC's approval as to the steps individuals and/or Provider on behalf of Individuals, should take to protect the Individuals from potential harm, including without limitation Provider's provision of notifications, credit protection, claims monitoring, and any specific protections for a legally authorized representative to take on behalf of an Individual with special capacity or circumstances;

(i) The steps Provider has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

(j) The steps Provider has taken, or will take, to prevent or reduce the likelihood of recurrence;

(k) Identify, describe or estimate of the persons, workforce, subcontractor, or individuals and any law enforcement that may be involved in the incident or breach;

(l) A reasonable schedule for Provider to provide regular updates to the foregoing in the future for response to the incident or breach, but no less than every three (3) business days or as otherwise directed by HHSC, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

(m) Any reasonably available, pertinent information, documents or reports related to an incident or breach that HHSC requests following discovery.

8.5 Investigation, Response and Mitigation.

(a) Provider will immediately conduct a full and complete investigation, respond to the incident or breach, commit necessary and appropriate staff and resources to expeditiously respond, and report as required to and by HHSC for incident response purposes and for purposes of HHSC's compliance with report and notification requirements, to the satisfaction of HHSC.

(b) Provider will complete or participate in a risk assessment as directed by HHSC following an incident or breach, and provide the final assessment, corrective actions and mitigations to HHSC for review and approval.

(c) Provider will fully cooperate with HHSC to respond to inquiries and/or proceedings by state and federal authorities, persons and/or incident about the incident or breach.

(d) Provider will fully cooperate with HHSC's efforts to seek appropriate injunctive relief or otherwise prevent or curtail such incident or breach, or to recover or protect any HHSC Confidential including complying with reasonable corrective action or measures, as specified by HHSC in a Corrective Action Plan if directed by HHSC.

8.6. Breach Notification to Individuals and Reporting to Authorities.

(a) HHSC may direct Provider to provide breach notification to individuals, regulators or third-parties, as specified by HHSC following a breach.

(b) Provider must obtain HHSC's prior written approval of the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in Provider's name and on Provider's letterhead, unless otherwise directed by HHSC, and will contain contact information, including the name and title of Provider's representative, an email address and a toll-free telephone number, for the Individual to obtain additional information.

(c) Provider will provide HHSC with copies of distributed and approved communications.

(d) Provider will have the burden of demonstrating to the satisfaction of HHSC that any notification required by HHSC was timely made. If there are delays outside of Provider's control, Provider will provide written documentation of the reasons for the delay.

(e) If HHSC delegates notice requirements to Provider, HHSC shall, in the time and manner reasonably requested by Provider, cooperate and assist with Provider's information requests in order to make such notifications and reports.

IX ACKNOWLEDGEMENTS AND CERTIFICATIONS

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

(a) Provider agrees to notify TMHP if the Provider files or is the subject of a bankruptcy petition. The Provider must provide TMHP and HHSC with notice of the bankruptcy no later than ten days after the case is filed. TMHP and HHSC also request notice of pleadings in the case.

(b) Provider has carefully read and understands the requirements of this Agreement, and will comply.

(c) Provider has carefully reviewed all of the information submitted in connection with its application to participate in the Medicaid program, including the Ordering/Referring Provider Information Form (OR-PIF), and Provider certifies that this information is current, complete, and correct.

(d) Provider agrees to review and update any information in the application to maintain compliance with and eligibility in the Medicaid program and continued participation therein.

(e) Provider agrees to inform HHSC or its designee in writing of any changes to the information contained in the application, whether such changes occur before or after enrollment. The written notification must be within 90 days of all changes to the information previously submitted.

(f) Provider agrees and understands that HHSC or its agent may review Provider's application any time after the application has been accepted and throughout the term of this Agreement. Provider agrees and understands that upon review, HHSC or its designee may determine that the information contained therein does not meet the Medicaid 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 agent. Provider agrees and understands that any errors or omissions that are not corrected or cannot be corrected will result in termination of this Agreement.

(g) 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 and may also result in other administrative sanctions that include, exclusion, debarment, termination of this Agreement, and monetary penalties.

(h) Provider agrees to abide by all Medicaid regulations, program instructions, and Title XIX of the Social Security Act. The Medicaid laws, regulations, and program instructions are available through the Medicaid contractor.

Name of Provider Enrolling: _____

Applicant's Signature: _____ Date: _____