P8W878710

TEXAS DEPARTMENT OF HEALTH (TDH) - TEXAS MEDICAL ASSISTANCE PROGRAM (MEDICAID) PROVIDER AGREEMENT

Name of Provider Soren ~~Vindelidee~~ Vindelilde Medicaid Provider I.D. # P8W87871 0

(Doing Business As) City of Houston Health and Human services Medicare Provider I.D. # W87871

Physical Address 8615 Delano Mailing Address 8000 NStaduim Dr 7 thFl

Houston,Texas 77004 Houston, Texas 77054

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

I. ALL PROVIDERS

1.1 Agreement and documents constituting Agreement.

A copy of the current *Texas Medicaid Provider Procedures Manual* (Provider Manual) has been or will be furnished to the Provider. The Provider Manual, all revisions made to the Provider Manual through the bimonthly update entitled *Texas Medicaid Bulletin*, and written notices are incorporated into this Agreement by reference. Provider has a duty to become familiar with the contents and procedures contained in the Provider Manual. Provider agrees to comply with all of the requirements of the Provider Manual, as well as all state and federal laws and amendments, governing or regulating Medicaid. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the Provider Manual and all state and federal laws and amendments governing and regulating Medicaid.

1.2 State and Federal regulatory requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider has also not been excluded or debarred from participation in any other state or federal health care program. Provider must notify TDH or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program. Provider agrees to comply with 45 C.F.R. Part 76, "Governmentwide Debarment and

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Suspension (Nonprocurement) and Governmentwide Requirements for Drug-Free Workplace (Grants)." This regulation requires the Provider, in part, to: (a) execute the attached "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions" (Attachment I) upon execution of this Agreement; (b) provide written notice to TDH or its agent if at any time the Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances; and (c) require compliance with 45 C.F.R. Part 76 by participants in lower tier covered transactions.

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to TDH, the Texas Health and Human Services Commission, the Texas Department of Human Services, the Texas Department of Protective and Regulatory Services, the Texas Attorney General's Medicaid Fraud Control Unit, the Health Care Financing Administration, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing TDH or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least ten (10) days prior to making such changes. Provider also agrees to notify TDH or its agent within three (3) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services and Provider must provide to TDH complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. § 431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program. Provider also agrees to provide, on request, access to records and copies of records free of charge to TDH, TDH's agent, the Texas Health and Human Services Commission, the Texas Attorney General's Medicaid Fraud Control Unit, the Health Care Financing Administration, the Texas Department of Insurance, the Federal Bureau of Investigation, and/or 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 five (5) years from the date of service (six (6) years for freestanding rural health clinics); or, until all audit or audit exceptions are resolved; whichever time period is longest. Provider must cooperate and assist TDH 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/or their agents access to its premises.

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit and the Texas Health and

1.2.4 The Texas Attorney General's Medicaid Fraud Control Unit and the Texas Health and
Human Services Commission's Office of Investigations and Enforcement and internal and external auditors for the state/federal government and/or TDH may conduct private interviews of Provider personnel, subcontractors and their personnel, witnesses, and patients. 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 personnel and subcontractors cooperate fully in being available and making personnel and subcontractors available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process, including investigations at the Provider's and the subcontractor's own expense.

1.2.5 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 services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

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

1.2.7 Child Support. (1) The Texas Family Code §231.006 requires TDH to withhold contract payments from any entity or individual who is at least thirty (30) days delinquent in child support obligations. It is the Provider's responsibility to determine and verify that no owner, partner, or shareholder who has at least 25% ownership interest is delinquent in any child support obligation. Provider must attach a list of the names, social security numbers, and medical license numbers if applicable, of all shareholders, partners, or owners who have at least a 25% ownership interest in the Provider. (2) Under Section 231.006 of the Family Code, 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 thirty (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% is not eligible to receive the specified grant, loan or payment. (3) If TDH is informed and verifies that a child support obligor who is more than thirty (30) days delinquent is a partner, shareholder, or owner with at least a 25% ownership interest, it will withhold any payments due under this Agreement until it has received satisfactory evidence that the obligation has been satisfied or that the obligor has properly entered into a written repayment agreement.

1.2.8 Cost Reports, 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 relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by TDH, or other appropriate payor, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true and accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and federal laws.

1.3.2 Provider must submit encounter data required by TDH or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement by an HMO or IPA.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with TDH rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the Provider Manual, and within the time limits established by TDH for submission of claims. Claims for payment or encounter data submitted by the provider to an HMO or IPA are governed by the Provider's contract with the HMO or IPA. Provider understands and agrees that TDH is not liable or responsible for payment for any Medicaid-covered services provided under the HMO or IPA Provider contract, or any agreement other than this Medicaid Provider Agreement. Federal and state laws provide severe penalties for any provider who attempts to collect any payment from or bill a recipient for a covered service.

1.3.4 Federal law prohibits Provider from charging a recipient, any family member of the recipient, or any other source of payment, except where a co-payment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20)

1.3.5 As a condition for eligibility for Medicaid benefits, the recipient has assigned all rights to recover from any third party or any other source of payment to TDH (42 C.F.R. §433.145 and Human Resources Code §32.033). Provider is prohibited from seeking to recover amounts from the recipient in excess of the Medicaid payable amount, or from interfering with a claim or lien against TDH's rights to recover from any liable third party. Provider must comply with TDH third party recovery rules (25 TAC Chapter 28).

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1.3.6 Provider must refund any overpayments, duplicate payments, and erroneous payments, which are paid to Provider by Medicaid or a third party as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by TDH

or its agent and implement an effective method to track submitted claims against payments made by TDH.
payments made by TDH.

1.3.8 TexMedNet and Electronic Claims Submission. Provider may subscribe to the TDH TexMedNet system which allows the provider the ability to electronically submit claims, claims appeals, verify recipient eligibility, and receive electronic claims status inquiries, remittance and status reports, and transfer of funds into a provider account. Provider understands and acknowledges that independent registration is required to receive the electronic funds or electronic remittance report. Provider agrees to comply with the provisions of the Provider Manual and the TexMedNet licensing agreement regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to TDH or its agent 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 TDH, 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.

II. ADVANCE DIRECTIVES - HOSPITAL AND HOME HEALTH PROVIDERS

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

2.1.1 the individual's right to self determination in making health care decisions;

2.1.2 the individual's rights under the Natural Death Act (Health and Safety Code, Chapter 672) 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;

2.1.3 the individual's rights under Health and Safety Code, Chapter 674, relating to written Out-of-Hospital Do-Not-Resuscitate Orders; and,

2.1.4 the individual's rights to execute a Durable Power of Attorney for Health Care under the Civil Practice and Remedies Code, Chapter 135, regarding their right to appoint an agent to make medical treatment decisions on their behalf in the event of incapacity.

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

2.3 The Provider must document whether or not the individual has executed an advance directive and ensure that the document is in the individual's medical record.

2.4 The Provider cannot condition giving services or otherwise discriminate against an individual based on whether or not the recipient has or has not executed an advance directive.

2.5 The Provider must provide written information to all adult recipients on the provider's policies concerning the recipient's rights.
policies concerning the recipient's rights.

2.6 The Provider must provide education for staff and the community regarding advance directives.

III. STATE FUND CERTIFICATION REQUIREMENT FOR PUBLIC ENTITY PROVIDERS

3.1 Public 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 TDH the amount of state matching funds expended for eligible services according to established TDH procedures:

school health and related services (SHARS)
case management for high risk pregnant women and infants (PWI)
case management for blind and visually impaired children (BVIC)
case management for early childhood intervention (ECI)
case management for mental retardation (MR)
case management for mental health (MH)
mental health rehabilitation (MHR)
tuberculosis clinics
state hospital physician

3.2 Public entity SHARS providers are also required to reimburse TDH, according to established TDH procedures, the non-federal share of expenditures made by TDH for SHARS provided by Medicaid approved non-school providers to children enrolled in their school district.

IV. RECIPIENT RIGHTS

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

4.2 The recipient must have the right to choose providers unless that right has been restricted by TDH or by waiver of this requirement from HCFA. The recipient's acceptance of any service must be voluntary.

4.3 The recipient must have the right to choose any qualified provider of family planning services.

V. TERM AND TERMINATION

V. TERM AND TERMINATION

This Agreement will be effective from the date finally executed until the date the Agreement is terminated by either party. Either party may terminate this Agreement by providing the other party with thirty (30) days advance notice of intent to terminate. TDH may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificate, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety or recipients at risk. TDH may terminate this Agreement without notice if the Provider has not submitted a claim to the Medicaid program for 12 months.

Provider Signature **[Required]** Ann Gail Vandeventer MD

Date 12/29/2000

Printed Name and Title of Person signing for Provider _____

Medicaid Provider Number **[Required]** P8W878710

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CERTIFICATION
REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS
Attachment I

Federal Executive Orders 12549 and 12689 require the Texas Health and Human Services Commission (HHSC) to screen each covered potential contractor to determine whether each has a right to obtain a contract in accordance with federal regulations on debarment, suspension, ineligibility, and voluntary exclusion. Each covered contractor must also screen each of its covered subcontractors.

In this certification "contractor" refers to both contractor and subcontractor; "contract" refers to both contract and subcontract.

By signing and submitting this certification the potential contractor accepts the following terms:

1. The certification herein below is a material representation of fact upon which reliance was placed when this contract was entered into. If it is later determined that the potential contractor knowingly rendered an erroneous certification, in addition to other remedies available to the federal government, the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, or the HHSC may pursue available remedies, including suspension and/or debarment.

2. The potential contractor will provide immediate written notice to the person to which this certification is submitted if at any time the potential contractor learns that the certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

3. The words "covered contract", "debarred", "suspended", "ineligible", "participant", "person", "principal", "proposal", and "voluntarily excluded", as used in this certification have meanings based upon materials in the Definitions and Coverage sections of federal rules implementing Executive Order 12549. Usage is as defined in the attachment.

4. The potential contractor agrees by submitting this certification that, should the proposed covered contract be entered into, it will not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the Department of Health and Human Services, United States Department of Agriculture or other federal department or agency, and/or the HHSC, as applicable.

Do you have or do you anticipate having subcontractors under this proposed contract? [x] Yes [ ] No **[REQUIRED]**

5. The potential contractor further agrees by submitting this certification that it will include this certification titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion for Covered Contracts" without modification, in all covered subcontracts and in solicitations for all covered subcontracts.

6. A contractor may rely upon a certification of a potential subcontractor that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered contract, unless it knows that the certification is erroneous. A contractor must, at a minimum, obtain certifications from its covered subcontractors upon each subcontract's initiation and upon each renewal.

7. Nothing contained in all the foregoing will be construed to require establishment of a system of records in order to render in good faith the certification required by this certification document. The knowledge and information of a contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

8. Except for contracts authorized under paragraph 4 of these terms, if a contractor in a covered contract knowingly enters into a covered subcontract with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the federal government, Department of Health and Human Services, United States Department of Agriculture, or other federal department or agency, as applicable, and/or the HHSC may pursue available remedies, including suspension and/or debarment.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Indicate in the appropriate box which statement applies to the covered potential contractor:

[REQUIRED]

[x] The potential contractor certifies, by submission of this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded form participation in this contract by any federal department or agency or by the State of Texas.

[ ] The potential contractor is unable to certify to one or more of the terms in this certification. In this instance, the potential contractor must attach an explanation for each of the above terms to which he is unable to make certification. Attach the explanation(s) to this certification.

Name of Potential Contractor	Vendor ID No. Or Social Security No.	HHSC Contract No. (if applicable)

Soren Vindekildee MD 12/29/2000

Signature of Authorized Representative **[REQUIRED]** Date **[REQUIRED]**

Printed Typed Name and Title of Authorized Representative
Soren Vindekildee

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CERTIFICATION

REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION FOR COVERED CONTRACTS

Attachment I

Attachment I

DEFINITIONS

Covered Contracts/Subcontract.

(1) Any nonprocurement transaction which involves federal funds (regardless of amount and including such arrangements as subgrant and are between HHSC or its agents and another entity.

(2) Any procurement contract for goods or services between a participant and a person, regardless of type, expected to equal or exceed the federal procurement small purchase threshold fixed at 10 U.S.C. 2304(g) and 41 U.S.C. 253(g) (currently $25,000) under a grant or subgrant.

(3) Any procurement contract for goods or services between a participant and a person under a covered grant, subgrant, contract or subcontract, regardless of amount, under which that person will have a critical influence on or substantive control over that covered transaction:
   a. Principal investigators.
   b. Providers of audit services required by the HHSC or federal funding source.
   c. Researchers.

Debarment. An action taken by a debarring official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) to exclude a person from participating in covered contracts. A person so excluded is "debarred".

Grant. An award of financial assistance, including cooperative agreements, in the form of money, or property in lieu of money, by the federal government to an eligible grantee.

Ineligible. Excluded from participation in federal nonprocurement programs pursuant to a determination of ineligibility under statutory, executive order, or regulatory authority, other than Executive Order 12549 and its agency implementing regulations; for example, excluded pursuant to the Davis-Bacon Act and its implement regulations, the equal employment opportunity acts and executive orders, or the environmental protection acts and executive orders. A person is ineligible where the determination of ineligibility affects such person's eligibility to participate in more than one covered transaction.

Participant. Any person who submits a proposal for, enters into, or reasonably may be expected to enter into a covered contract. This term also includes any person who acts on behalf of or is authorized to commit a participant in a covered contract as an agent or representative of another participant.

Person. Any individual, corporation, partnership, association, unit of government, or legal entity, however organized, except: foreign governments or foreign governmental entities, public international organizations, foreign government owned (in whole or in part) or controlled entities, and entities consisting wholly or partially of foreign governments or foreign governmental entities.

Principal. Officer, director, owner, partner, key employee, or other person within a participant with primary management or supervisory responsibilities; or a person who has a critical influence on or substantive control over a covered contract whether or not the person is employed by the participant. Persons who have a critical influence on or substantive control over a covered transaction are:
(1) Principal investigators.
(2) Providers of audit services required by the HHSC or federal funding source.
(3) Researchers.

Proposal. A solicited or unsolicited bid, application, request, invitation to consider or similar communication by or on behalf of a person seeking to receive a covered contract.

Suspension. An action taken by a suspending official in accordance with 45 C.F.R. Part 76 (or comparable federal regulations) that immediately excludes a person from participating in covered contracts for a temporary period, pending completion of an investigation and such legal, debarment, or Program Fraud Civil Remedies Act proceedings as may ensue. A person so excluded is "suspended".

Voluntary exclusion or voluntarily excluded. A status of nonparticipation or limited participation in covered transactions assumed by a person pursuant to the terms of a settlement.