3

Health, Housing & Human Services
CLACKAMAS COUNTY

Richard Swift
Interim Director

April 9, 2015

Board of County Commissioner
Clackamas County

Members of the Board:

Approval of a Revenue Provider Agreement with
Providence Health Plan to provide immunization services to assigned members at the
Clackamas County Health Centers

Purpose/Outcomes	Providence Health Plan is a health plan provider and assigns their members to Clackamas County Health Centers Division (CCHCD) for care. This agreement is to make immunization services available to assigned members.
Dollar Amount and Fiscal Impact	This is a No Maximum agreement. Revenue is determined by number of members assigned that receive immunizations.
Funding Source	Fee for service. No County General Funds are involved.
Safety Impact	None
Duration	Effective May 1, 2015 and terminates on December 31, 2015
Previous Board Action	No previous action
Contact Person	Deborah Cockrell, Health Center Director – 503-742-5495
Contract No.	6488

BACKGROUND:
Clackamas County Health Centers Division (CCHCD) of the Health, Housing & Human Services Department requests the approval of a Revenue Provider Agreement with Providence Health Plan to provide immunization services at the Clackamas County Health Centers

This agreement is intended to provide immunization services to assigned members and expand service in Clackamas County to increase the number of people receiving immunizations.

This is a No Maximum agreement as revenue will be determined by the number of assigned members and how many of them receive this service. The Agreement is effective May 1, 2015 and terminates December 31, 2015.

Recommendation
We recommend approval of this amendment and that Richard Swift be authorized to sign on behalf of the Board of County Commissioners.

Respectfully submitted

Richard Swift, Interim Director

PROVIDENCE HEALTH PLAN
PROVIDER AGREEMENT

THIS AGREEMENT ("Agreement") between **Providence Health Plan** (PHP), an Oregon non-profit corporation, operating in Oregon and Southwest Washington, **Providence Health Assurance** (PHA), an Oregon non-profit corporation, operating in Oregon (hereinafter referred to as "Health Plan") and **Clackamas County Community Health** (hereinafter referred to as "Provider") and any attachment(s), describes the terms and conditions under which Provider shall participate in PHP and/or PHA Provider Network(s).

RECITALS

WHEREAS, Health Plan operates as a health care service contractor under the laws of Oregon and Washington; and

WHEREAS, Health Plan offers or administers one or more health benefit plans and desires to enter into a written agreement to arrange for the provision of certain Covered Services to Members of such products or plans; and

WHEREAS, Provider is lawfully qualified to provide health care services and is willing to provide such services to Members of Health Plan; and

WHEREAS, Health Plan and Provider mutually desire to preserve and enhance patient dignity; and

WHEREAS, Health Plan and Provider desire to create a culture of health care safety; and

WHEREAS, Health Plan desires to advance the healing ministry of Jesus in the communities it serves;

NOW, THEREFORE, in consideration of the promises and mutual covenants herein stated, it is agreed by and between the parties as follows:

ARTICLE I.
DEFINITIONS

As used in this Agreement and its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein, except where the context makes it clear that such meaning is not intended.

Attachment(s) shall mean the documents that accompany this Agreement that may contain proprietary information and procedures produced by Health Plan. Each Attachment is incorporated herein by this reference. Such Attachment(s) may contain compensation and reimbursement information, fee schedules, medical management and quality of care guidelines and procedures, and such other matters that may be unique to the features of Health Plan.

Care Management shall mean a program of care coordination and case management developed to manage high cost and at-risk members with complex medical needs.

Chief Medical Officer (CMO) shall mean the physician so designated by Health Plan to supervise utilization and quality management activities and to be responsible for such other programs and activities as may be designated by Health Plan. Medical Directors may be utilized by the CMO to assist in these functions.

Clean Claim shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

Clinical Quality Improvement Studies are studies regarding the measurable outcome or end result of care.

CMS is the Centers for Medicare and Medicaid Services, the federal government agency that regulates the Medicare program.

Coinsurance is the percentage or portion of the cost of care that a Member may be obligated to pay for a Covered Service.

Copayment or Copay is the fixed dollar amount that a Member may be obligated to pay for a Covered Service at the time the care is provided.

Covered Services are Medically Indicated health care services and supplies rendered or furnished to Member by Provider for which benefits are available under a Member's health care contract or plan.

Credentialing is the initial process by which Health Plan, or its designee, verifies practitioner or facility qualifications for panel membership in accordance with criteria adopted by Health Plan.

Deductible is the amount of out-of-pocket expense that Member is responsible to pay for Covered Services prior to being eligible to receive Health Plan benefits.

Emergency shall mean the sudden and unexpected onset of a condition requiring medical or surgical care for which Member secures care immediately after the onset of the condition, or as soon thereafter as care can be available, but in any case no later than twenty-four (24) hours after the onset. An Emergency situation shall include, but not be limited to, suspected heart attack or stroke, poisoning, loss of consciousness, severe respiratory distress, hemorrhaging or convulsion. The State of Oregon defines an "Emergency medical condition" as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Health Plan may determine that other similarly acute conditions are Emergencies. The final determination of whether a condition is an Emergency rests with Health Plan and may be subject to the procedures for post treatment utilization review.

HIPAA is the Health Insurance Portability and Accountability Act of 1996 that contains federal regulations addressing standards for electronic transactions and other administrative issues for the health care and health insurance industries.

Individual Service Agreement or **Group Service Agreement** shall mean the agreement between Health Plan and Member, or between Health Plan and Member's employer group, which defines terms and conditions of Health Plan's obligation to provide, arrange for, and/or reimburse for medical care provided to Member.

Medical Directors shall mean physicians who are designated by the CMO and are responsible for quality management and utilization management review, including concurrent hospital review.

Medically Indicated shall mean a service or supply provided or ordered by a practitioner that is necessary in order to prevent, treat or care for symptoms of an illness or injury, or to diagnose an illness or condition that is harmful to life or health, and which is commonly and customarily recognized throughout the practitioner's profession as appropriate in the treatment. The decision whether a service or supply ordered by the practitioner was Medically Indicated for the purposes of qualifying for payment by Health Plan rests with Health Plan, subject to the procedures for reconsideration.

Member shall mean any person entitled to receive benefits for Covered Services underwritten or administered by Health Plan and with respect to whom the Member or another person has paid premium entitling such person to have claims paid by Health Plan, as evidenced by Health Plan's logo on a membership card presented to Provider. Members include all persons covered by plans underwritten by Health Plan, including entities for which Health Plan provides administrative or claims services only.

Participating Practitioner shall mean a physician or other health care professional who is contracted to provide Covered Services to Members of Health Plan under this Agreement or otherwise. Any Participating Practitioner who serves Health Plan Members under this Agreement will be bound by its terms. Participating status shall be contingent upon Health Plan's designation as such.

Participating Facility shall mean a hospital or other health care facility that is contracted to provide Covered Services to Members of Health Plan. Participating status shall be contingent upon Health Plan's designation as such.

Physician Advisor shall mean a physician who has entered into a separate agreement to advise Health Plan with respect to medical appropriateness.

Preventive and Clinical Practice Guidelines shall mean the statements systematically developed from time to time by Health Plan, which assist Participating Practitioners and their Member patients in deciding upon appropriate health care for specific clinical circumstances.

Recredentialing is the process by which continued eligibility to participate in Health Plan contracts is determined. Health Plan, or its designee, verifies practitioner or facility qualifications in accordance with criteria adopted by Health Plan. This process is completed at least every three years.

Rules and Regulations of Health Plan shall mean the criteria and procedures pertaining to credentialing and recredentialing, participation, compensation, payment rules, processing guidelines, medical policy, utilization management, quality improvement, Health Plan standards, and such other matters determined from time to time by Health Plan. The Rules and Regulations of Health Plan may be viewed on Health Plan's website.

Scope of Service shall mean those services which fall within the geographic and CPT code limits established in the Attachments. If no geographic or CPT code limits are established in the Attachments, Scope of Service shall refer to those services which Provider is professionally qualified to render.

Standards of Care and Service shall mean standards which have been developed by Health Plan incorporating concepts from OMAP, from CMS, from medical group practice accreditation programs, and from community standards. These standards include, but are not limited to, access, accommodations, panel size and medical record documentation, and are contained in the Rules and Regulations of Health Plan.

Urgent shall mean services that are needed right away but are not life threatening. These include, but are not limited to, high fevers, minor sprains, cuts and burns, and ear, nose and throat infections. Routine care that can be delayed until Member can be seen by Member's physician is not Urgent care. The final determination of whether a condition is Urgent rests with Health Plan and may be subject to the procedures for post-treatment utilization review.

ARTICLE II.
OBLIGATIONS OF HEALTH PLAN

Services. Health Plan agrees to provide the following services necessary to fulfill the terms of this Agreement including, but not limited to:

Claims processing services
Member services
Medical and quality management services
Credentialing services
Claims review process linked to peer review
Marketing, sales and public relations

Support. Health Plan may provide statistical support and assistance to Provider for quality assurance, peer review, and medical management review functions, through the development and operation of a medical management information system.

Orientation and Training. Health Plan agrees to provide orientation and training for Provider in the use of the administrative services described herein, and the Rules and Regulations of Health Plan.

Eligibility Verification. Health Plan agrees to provide eligibility verification and benefit information through its customer service department.

Documents Provided. Copies of any Health Plan documents referenced in this Agreement will be provided to, or made available for examination by, Provider.

ARTICLE III.
OBLIGATIONS OF PROVIDER

Provider Scope of Service. Health Plan retains Provider to render Covered Services to Health Plan Members within Provider's Scope of Service. All services shall be rendered subject to the terms and conditions of this Agreement and in accordance with the Rules and Regulations of Health Plan.

Provider/Patient Relationship. Provider may not terminate a relationship with a Member solely for inconvenience reasons. However, a Participating Practitioner may withdraw from the care of a Member when, in the professional judgment of the Participating Practitioner, it is in the best interest of the Member to do so. In terminating any patient relationship, the Participating Practitioner should give due regard to ethical considerations. This action may only occur after following the procedural steps identified in the Rules and Regulations of Health Plan.

Authorization. Provider agrees not to admit any Member to a hospital or other inpatient facility in a non-Emergency or elective situation without first receiving the necessary authorizations pursuant to the Rules and Regulations of Health Plan and Health Plan's Prior Authorization Program.

Prompt Service. Services rendered will be instituted as promptly as practicable, consistent with sound medical practice and in accordance with accepted community professional standards.

Sufficient Practitioners. Provider agrees at all times to maintain a sufficient number of Participating Practitioners to guarantee prompt and adequate access to Health Plan Members.

Utilization Management. Provider understands that the purpose of the utilization management program is to determine which services are Medically Indicated. Cooperation shall extend to provision of or access to medical records, on-site review and telephone review, at no additional cost to Health Plan. Health Plan will make every reasonable effort to meet Provider's needs when scheduling an on-site review.

Non-Discrimination. Provider agrees that in accordance with the provisions, spirit and intent of this Agreement, and within the limits of Provider's specialty, (A) not to discriminate in the provision of medical services to Members on the basis of membership in Health Plan, source of payment, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status or handicap, or any other category protected under State or Federal law, and (B) to render medical services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other patients.

Services To Practitioner's Family. Provider agrees not to seek compensation for Covered Services rendered by a Participating Practitioner to that Participating Practitioner's immediate family member, i.e., spouse, daughter, son, stepdaughter, stepson, grandchild.

Call/Non-Par Coverage. Provider agrees to make prior arrangements to provide coverage for Members on a 24-hour a day, 7-day a week basis with a Participating Practitioner of same or similar specialty. When Provider is unable to make prior arrangements to provide coverage with a Participating Practitioner of same or similar specialty due to the unavailability of Participating Practitioners in the Provider's geographic area, Provider agrees to provide such coverage through non-participating practitioners; such arrangements shall be determined by Provider, with notice to Health Plan, which has the right to disapprove. Notification of any permanent on-call changes are to be in writing thirty (30) days prior to the scheduled change. The same terms and conditions as agreed to by Provider shall be in effect and primary coverage may not be through a hospital emergency room or urgent care center.

Non-Par Coverage Compliance. Provider agrees that if arrangements are made with a non-participating provider to treat Members in the absence of Participating Practitioners, Provider agrees to ensure that such non-participating provider will comply with the obligations of this Agreement, including but not limited to (A) acceptance of the fee established by Health Plan as full payment for Covered Services rendered to Member; (B) acceptance of the peer and medical management procedures of Health Plan; (C) agreement not to bill Members directly under any circumstances except for Copayments, Coinsurance, Deductibles and non-Covered Services as defined in Individual and Group Service Agreements; (D) obtaining required authorization from Health Plan prior to hospitalizations; and (E) agreement to undergo credentialing by Health Plan.

Refer To In-Plan Providers. Provider agrees to, whenever possible, provide or arrange for care of Members with Participating Practitioners and/or Participating Facilities.

Prior Authorization. Except in cases requiring Emergency treatment, Provider will not be compensated for Covered Services rendered to Members which were not provided in compliance with the Rules and Regulations of Health Plan and/or which were not authorized by Health Plan, nor will such services be billable to Member. Provider will follow the Prior Authorization Requirements as described in the Attachments.

Change In Status. Provider agrees to provide Health Plan with an updated schedule of Participating Practitioners categorized by name, board status, facility status, hospital affiliation, and relationship to Provider, at Health Plan's request or when there is a change in Participating Practitioner status. Provider agrees that Health Plan may use Participating Practitioners' name, office address, office telephone number, type of practice and an indication of willingness to accept new patients, in Health Plan directories.

Appeals and Grievances. Provider agrees to cooperate with Health Plan in resolving any Member appeals or grievances related to the provision of Covered Services.

Subcontracting. Prior to services being provided, Health Plan must authorize the use of a subcontractor to perform services covered under the Agreement.

ARTICLE IV.
PROVIDER WARRANTIES / COMPLIANCE WITH RULES AND REGULATIONS

Initial and Periodic Appraisal. Provider agrees to cooperate with such programs of initial and periodic appraisal as may be established by Health Plan. Provider agrees to require its Participating Practitioners to permit Health Plan to obtain any utilization, peer review or other information regarding Participating Practitioner practice of medicine from any participating institution at which Participating Practitioner has practiced, provided that Provider is not prohibited from disclosing such information under state or federal law. Provider releases Health Plan and its employees or agents or any person furnishing information to Health Plan from liability for acts made in good faith and without malice in connection with this provision.

Conditional Credentialing. Initial and periodic appraisal may result in conditional credentialing. Whether to grant conditional credentialing is determined solely by Health Plan.

Rules and Regulations of Health Plan. Provider agrees to be bound by the Rules and Regulations of Health Plan as they may be amended from time to time. If Provider violates any of the provisions of the Rules and Regulations of Health Plan, or any of the principles of professional conduct adopted by Health Plan, or acts contrary to or in violation of any Health Plan agreements, all contractual rights under this Agreement which pertain to Provider may be terminated in accordance with the Term and Termination section of this Agreement. The Rules and Regulations of Health Plan are available for examination by Provider on Health Plan's website.

Physician Practitioner Requirements. Participating Practitioners covered by this Agreement agrees that he or she is now, and will remain as long as this Agreement remains in effect, (A) the holder of (i) a currently valid license to practice

medicine or osteopathy in the state of Oregon and/or Washington within his or her scope of practice, and (ii) a valid DEA or CDS certificate, as applicable, a copy of which shall be submitted to Health Plan, (B) certified as recognized by the Board of Medical Specialists or the American Osteopathic Association (unless Participating Practitioner graduated prior to 1980), and (C) a medical staff member, as appropriate, in good standing on the medical staff of a participating institution.

Participating Practitioner agrees to notify Health Plan immediately of any change in licensure or hospital privileges status (whether or not such hospital is a participating institution).

Non-Physician Practitioner Requirements. Provider states as a material term of this Agreement that Provider and all professional employees of Provider are now and will remain, as long as this Agreement remains in effect, the holders of all currently required licenses, certificates and/or registrations by appropriate federal, state and local governmental agencies to provide health care services that Provider and professional employees of Provider undertake to provide to Health Plan Members under this Agreement.

Provider agrees to notify Health Plan immediately upon a change in status of such licensure, certification, or registration.

Specialty Education. Provider agrees to require all Participating Practitioners covered by this Agreement to have education and/or training and experience in the field in which they practice and to be Board Certified, or have completed an approved specialty education and/or training program.

Patient Advocate. Provider may act as a patient advocate regarding a decision, policy, or practice without being subject to termination or penalty for the sole reason of such advocacy. Provider can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Fraud and Abuse. Provider agrees to comply with Health Plan's Fraud and Abuse program and questionable billing practices policies and procedures.

Facility Certification. Provider warrants that its facilities are currently certified under Title XVIII (Medicare) of the Social Security Act, when applicable, and have appropriate state licensure. Provider warrants that should it provide services in exempt units (skilled nursing, psychiatric, swing, rehabilitation, etc.), the units will be certified under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act and have appropriate state licensure. Provider further warrants that it is currently accredited by a recognized accrediting organization, such as JCAHO, AAAHC or CARF, as applicable. State and/or CMS site surveys may satisfy Health Plan criteria, provided information is current. Provider agrees to maintain such licensure and certification during the term of this Agreement.

Liability Insurance. Provider agrees to ensure that its Participating Practitioners, Participating Facilities, and all persons and entities performing services under this Agreement, maintain such policies of general liability and professional liability insurance or such other program of liability coverage as may be customary and acceptable to Health Plan to insure Provider, its Participating Practitioners, its Participating Facilities, its employees, and agents against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or failure to perform, any health care service provided under this Agreement, the use of any property and facilities provided by Provider, and activities performed by Provider in connection with this Agreement. Such coverage may be provided via a self-insured program. The amounts and extent of such insurance coverage shall be subject to the approval of Health Plan, which approval shall not be unreasonably withheld. Certificates of Insurance for the above insurance policies shall be provided to Health Plan upon request and shall provide that Health Plan be given at least thirty (30) days prior written notice of reduction or cancellation of such coverage. Any declaration sheets, exclusions, endorsements, or information on any incident which might reasonably result or has resulted in a lawsuit or legal action may be requested by Health Plan as deemed necessary.

Liability Oregon Public Hospitals. Health Plan recognizes that if a Provider is a public entity its liability is limited pursuant to ORS 30.260 through 30.300, and the Oregon Constitution, Article XI, Section 7. In such event, Provider's obligations with respect to liability insurance are limited by those provisions.

Program Cooperation and Participation. Provider agrees to cooperate and participate in the following, as designated from time to time by Health Plan and/or as required by state or federal regulations:

A. Internal medical and quality management, quality improvement, and customer service activities;
B. Disease management programs;
C. External audit systems;
D. Rules and Regulations of Health Plan;
E. Development of evaluation criteria for new medical technologies or new applications of established technologies (including medical procedures, drugs and devices);
F. Such other systems, activities and procedures relating to Health Plan accreditation by external accrediting bodies as may be determined from time to time by Health Plan;

G. Clinical Quality Improvement and Outcome studies; and
H. Standards of Care and Service, all of which are set forth in Rules and Regulations of Health Plan and/or other Health Plan documents and communications.

Provider shall further agree to comply with any final determinations made pursuant to any of the review processes noted above, as such determination(s) relates to Provider's rights and responsibilities under this Agreement. Failure to comply with such final determinations may constitute grounds for termination in accordance with the Term and Termination section of the Agreement.

Facility Inpatient Admission. If Provider is a hospital Participating Facility it agrees to notify Health Plan within twenty four (24) hours after any Emergency-related inpatient hospital admission of a Member, or by the end of the next working day if the admission occurs on a weekend or holiday, and will permit review of the admission by a Health Plan physician reviewer or designated representative. The purpose of the review is to provide certification of the medical indications for the admission under Health Plan's utilization management program, which certification shall, for approved admissions, in no event be for a period shorter than the period between date of admission and receipt by Provider of notice of certification. Failure by such Provider to notify Health Plan of Member's admission and to substantiate the medical indication for the admission within the time period set forth above may result in forfeiture of Provider's right to compensation from either Health Plan or Member for services rendered to such Member during his or her stay.

ARTICLE V.
BILLING AND COMPENSATION

Payment for Covered Services. Health Plan agrees to pay Provider for Covered Services rendered by Provider to Members, within Provider's Scope of Service.

Compensation Terms. Provider will be compensated for Covered Services rendered in accord with the terms set forth in the Attachments.

Implementation of Member Benefits. Provider agrees to comply with all Health Plan Rules and Regulations relating to the delivery of Covered Services. Health Plan may consult with Provider regarding significant changes to existing Health Plan administrative policies and procedures prior to implementation. Provider agrees to cooperate with Health Plan in monitoring Member Coinsurance, Copayment and/or Deductible in order to ensure that payment limitations imposed by federal law are not exceeded.

Member Responsibility. Health Plan may require Members to pay a Coinsurance, Copayment, and/or Deductible for certain Covered Services as set forth in the Member's Individual or Group Service Agreement with Health Plan. Provider agrees to be responsible for the collection of such Coinsurance, Copayment, and/or Deductibles. Provider may not waive Member's responsibility as set forth in the Member's Individual or Group Service Agreement with Health Plan. Members will be responsible for the payment of such Coinsurance, Copayment, and/or Deductibles.

Coordination Of Benefits. Coordination of benefits (COB) refers to the rules for the order of benefit determination under which health benefit plans pay claims when a person is covered under more than one plan. Such coordination of benefits is intended to provide the covered person with the most allowable benefits available under the plans and to preclude the Provider from receiving an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary plan benefits are coordinated, determination of liability will be in accordance with the administrative rules adopted by Oregon Department of Consumer and Business Services and applicable state and federal regulation. For Providers residing outside the State of Oregon, applicable state laws will apply.

Contract Allowable. Health Plan will have no obligation to pay any amount that, together with all other Health Plan payments to and contractual adjustments made by the Provider, exceeds the amount allowable by Health Plan for the service as set forth in the Attachments.

Additional Fees Prohibited. Provider understands and agrees that any additional fees or surcharges for Covered Services charged to Members are prohibited. An additional fee shall mean any charge that is not previously approved by Health Plan. A surcharge is an additional fee which is charged to a Member for Covered Services but which is not provided for under the applicable enrollment agreement or disclosed in the evidence of the Member's coverage.

Claim Submission. Provider agrees to submit claims whether primary, secondary or other payor to Health Plan on industry accepted claim forms for all Covered Services rendered to Members. Such claim form shall include statistical and descriptive medical and patient data in a form specified by Health Plan. Diagnosis codes listed will note the highest level of specificity. Billings will be consistent with ethical and community standard billing practices, and shall include such "CMS compliant" encounter data or other information as may be required of Health Plan by CMS or by state agencies. Under usual circumstances, such claim form shall be submitted to Health Plan within sixty (60) days of the date of service, and in no case later than twelve (12) months from the date of service. Neither Member nor Health Plan shall be responsible for the payment

of bills submitted after the twelve (12) month period, except in cases where Provider submits the claim no later than 12 months after a different insurer (a) denied the claim in whole or in part; or (b) requested a refund of an erroneous payment made on the claim.

Accepting Partial Member Payment. Provider may accept a partial or estimated payment on coinsurance and/or deductible obligations before Health Plan has adjudicated the amount of such obligations, but only if the following conditions have been met: (1) Provider has verified Member's eligibility and benefits, and (2) Provider has a reliable process in place for timely reconciliation and timely repayment to Member of any overpayments by Member.

Provider is expected to make extended payment options available to the patient when necessary. Provider may not redirect Member to another provider solely for the purpose of shifting financial risk to the other provider.

Third Party. In the event of a Member's illness or injury for which a third party other than Health Plan has accepted financial responsibility or has been judged to be liable by an entity empowered to assess liability (such as a court or similar adjudicative body), Provider will bill the third party for payment prior to billing Health Plan. Any remaining unpaid balance due after forty five (45) days from billing may be billed to Health Plan for payment consideration. The amount available for collection by Provider from the third party shall be applied to charges for medical care of a Member at Health Plan's contracted rates prior to accessing the resources of Health Plan. If such third party liability eliminates any financial obligation of Health Plan on a Member's behalf, Health Plan will have no liability under this Agreement with respect to such illness or injury. In the event the third party is not liable for the illness or injury of a Member or if recovery from the third party is less than Health Plan's obligation to Member in the absence of payment by a third party, Provider must comply with Health Plan's rules governing the provision of Covered Services and the terms of this Agreement in order for Health Plan to be financially responsible.

Electronic Claims. The parties agree to cooperate in electronic submission of claims whenever possible.

Pay Clean Claim. Health Plan agrees to pay a Clean Claim within the time period mandated by applicable state and federal law.

Refund Request by Health Plan. Except in cases of coordination of benefits, fraud or abuse of billing, Health Plan may not request refunds from Provider unless it is within 18 months of initial payment. The request must be in writing and must specify why the refund is being requested. Health Plan may not request that a contested refund be paid earlier than six months after the Provider receives the request. In the case of coordination of benefits, Health Plan may not request a refund unless it is within 30 months after the date of payment. The request must be in writing and must specify why the refund is being requested and include the name of the primary payor or entity. If Provider fails to contest the refund request within 30 days, the request is deemed accepted and Provider must pay within 30 days (60 days total). If Provider does not pay, Health Plan can recover through offset of a future claim. Health Plan may at any time request a refund if the third party or government entity is found responsible by law, or if the Health Plan is unable to recover directly from the third party because the third party already paid or will pay the Provider for the health care services covered by the claim.

Additional Payment Request by Provider. Except in cases of coordination of benefits, fraud or abuse of billing, Provider may not request additional payment unless the request is in writing and within 18 months of the date of a denial or partial payment. The request must be in writing and must specify why the additional payment is being requested. The Provider may not request that an additional payment be paid earlier than six months after Health Plan receives the request. In the case of coordination of benefits, Provider may not request additional payment unless it is within 30 months after the date the claim was denied or payment intended to satisfy the claim was made. The request must be in writing and must specify the reason for the request and must include the name and address of the primary payor or entity.

Once Per Case. A request for re-review will be performed by Health Plan only once per case.

Never Events. Neither Participating Practitioners nor Participating Facilities shall seek payment from Health Plan or from Member for costs associated with "never events". Health Plan will not provide payment for identified "never events". Health Plan will be guided by the recommendations of the National Quality Forum, the American Hospital Association, CMS, and other relevant sources.

ARTICLE VI.
RECORDS AND CONFIDENTIALITY

Record Sharing. Provider agrees to participate in any system established by Health Plan that will facilitate, to the extent feasible, the maximum sharing of records, subject to compliance by Health Plan with state and/or federal law regarding confidentiality. Provider agrees to retain records in accordance with other minimum requirements of state law. Such obligations continue despite the termination of this Agreement. Health Plan shall have access at reasonable times upon

demand to the records of Provider. Provider and Health Plan agree to treat all medical records of Members as confidential so as to comply with all federal and/or state laws and regulations regarding the confidentiality of patient records. Provider agrees to cooperate with Health Plan in maintaining and providing financial records, and medical histories, administrative and other records of Members as shall be requested. Requests for copies shall be reasonable in nature.

Record Copying. Provider agrees, upon reasonable request by Health Plan, to provide access to and/or copies of all records necessary (A) for purposes of assessing quality of care, medical indications and/or appropriateness of care, (B) for claims adjudication, and (C) to comply with the provisions of the Rules and Regulations of Health Plan and/or the utilization and quality management program, the re-appraisal process, and records requests from state and federal regulatory agencies and review organizations. Health Plan will allow Provider a reasonable length of time within which to provide the requested documents. The parties agree that such records shall maintain the same confidential nature they had while in the possession of Provider. Provider is responsible for costs associated with record copying.

Record Retention. All clinical records shall be retained for seven (7) years after the date of service for which claims are made. If an audit, litigation, or research and evaluation, or other action involving the records is started before the end of the seven (7) year period, the records must be retained until all issues are resolved.

Audit of Records. Provider agrees, at all reasonable times, to provide Health Plan and any state or federal regulatory agency, and their duly authorized representatives, access to its facilities and to its medical records for the purpose of making audit or examination; upon request, Provider agrees to provide a suitable work area and copying capabilities to facilitate such a review or audit. This right to inspect, evaluate, and audit extends through seven (7) years from expiration or termination of this Agreement or completion of audit, whichever is later, unless the regulator extends this period or asserts a right to inspect, evaluate, or audit at any other time on account of a special need to retain particular records or a dispute or possibility of dispute related to such records, in which case the regulator's determination shall govern. This provision shall continue in effect notwithstanding the termination of this Agreement.

Proprietary Information. Provider agrees to maintain the confidentiality of documents, terms, and conditions relating to reimbursement rates and methods and other proprietary information of Health Plan. Upon request, Provider agrees to return all copies of documents containing any of Health Plan's proprietary information upon termination of this Agreement.

Medical Record Availability. Subject to applicable confidentiality requirements, Provider agrees to provide for a system, to the extent feasible, which permits sharing of records by Participating Providers and other health care professionals providing service to Members. Medical records shall be made available to each Participating Provider and other health care professional treating Member. In addition, medical records shall be made available upon request by any proper committee of Provider or Health Plan to determine that content and quality are acceptable, as well as for peer review or grievance review.

ARTICLE VII.
AMENDMENTS

Amendment. Health Plan may amend this Agreement by providing 30 days' written notice to Provider. If no written objection is received within thirty (30) days, Provider shall be deemed to approve such amendment.

Regulatory Amendment. If state or federal law, government agency regulations or accrediting agency requirements change and affect any provisions of this Agreement, then this Agreement will be deemed amended to conform with such changes effective the date such changes become effective. Health Plan will give Provider written notice of such changes.

ARTICLE VIII.
TERM AND TERMINATION

Effective Date. Provider will be notified by Health Plan of the effective date of this Agreement. Signed Agreements received by Health Plan by the 18th day of the month will generally be effective the 1st day of the following month, subject to credentialing approval as noted below. (Example: Signed Agreement received by 1/18, effective date will be 2/1. Signed Agreement received 1/19 to 2/18, effective date will be 3/1.) This Agreement shall remain in effect until December 31st of the year of execution and thereafter to December 31st of each subsequent year, unless terminated pursuant to the terms of this Agreement.

Credentialing Required. Participating status for individual practitioners or facilities covered under this Agreement is contingent upon credentialing approval in advance by Health Plan. Provider will be notified by Health Plan of the effective date for each Participating Practitioner or Participating Facility.

Termination Without Cause. This Agreement may be terminated without cause by Provider or Health Plan upon sixty (60) days prior written notice. Upon such termination, the rights of Provider shall terminate, provided, however, that such action shall not release Provider from obligations to persons then receiving treatment. Provider agrees to be paid in accordance with this Agreement for Covered Services provided prior to termination of this Agreement.

Termination Automatic With Cause.

The following provision applies to Participating Facilities:

This Agreement will automatically terminate upon the revocation, non-renewal, limitation or suspension of a Provider's license for any or part of its facilities or services.

The following provisions apply to Participating Practitioners:

This Agreement will automatically terminate upon the occurrence of any of the following events: if Participating Practitioner (i) dies, (ii) retires, (iii) is adjudicated incompetent, (iv) has his or her professional license revoked, restricted, suspended, or not renewed, (v) loses his or her hospital privileges, or (vi) voluntarily leaves active practice in Health Plan service area for a period of six (6) months or more.

Termination With Cause.

The following provisions apply to Participating Facilities and to Participating Practitioners:

This Agreement may be terminated with cause by either party by giving written notice to the other party at least thirty (30) days in advance of the effective date of termination in the event that the other party (i) fails to pay valid, past due debts, (ii) lacks the financial resources to pay its financial obligations, (iii) fails to maintain required professional liability insurance coverage, (iv) makes any intentional misrepresentation to Member regarding the provision of medical services or the payment thereof, (v) fails to accept the results of and comply with the requirements of the utilization and quality management committees of Health Plan, (vi) fails to participate in and accept the Rules and Regulations of Health Plan, (vii) is determined by Health Plan to no longer meet Health Plan's standards for credentialing, (viii) suffers limitation of a required license, or (ix) is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. Remedy of such breach within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for its remaining term, subject to any other provision of this Agreement.

The following provision also applies to Participating Practitioners:

At Health Plan's discretion, with thirty (30) days prior written notice, this Agreement may be terminated with cause if any Participating Practitioner suffers limitation of hospital medical staff privileges. If Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement and the notice of termination shall set forth the facts underlying the alleged breach.

Termination With Cause of Less Than Entire Agreement. Health Plan may, at its sole discretion, choose to terminate an individual practitioner or individual facility providing Covered Services under this Agreement whose conduct would otherwise give Health Plan cause to terminate this Agreement in its entirety. Upon such individual termination, the Agreement shall remain in effect as to all other practitioners or facilities covered by it.

Immediate Termination. Nothing herein shall be construed as limiting the right of Health Plan to terminate this Agreement, or an individual practitioner or facility providing Covered Services under this Agreement, immediately where Health Plan determines that the health, safety or welfare of any Member is jeopardized by failing to do so. If Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement.

Transitional Plan For Member. The parties recognize and agree that Member must not suffer or be exposed to avoidable risks to life and welfare due to circumstances related to termination of this Agreement. Therefore, upon receipt of termination notice by either party and under the supervision of the Chief Medical Officer, the parties agree to establish a written plan for transitional services for any affected Member. Such plan shall be completed within seven (7) working days of issuance of a termination notice. If Provider is a hospital, reimbursement for Covered Services provided after termination for any Member who is an inpatient of hospital as of the effective date of termination will continue to be governed by this Agreement until discharged from inpatient stay.

Coordination Of Member Communication. Health Plan and Provider agree to coordinate any communications to be made by Health Plan or Provider to other parties of the reasons for and circumstances surrounding any termination of this Agreement.

Obligations After Termination. The following obligations of the parties shall continue after any termination of this Agreement:

A. To indemnify and hold each other harmless as otherwise described in this Agreement;
B. To cooperate with each other in the event any action or other proceeding based on or related to the facts having to do with this Agreement is brought by any third party against either of them;
C. To maintain medical records and allow access to information as provided in this Agreement.
D. To maintain the confidentiality of records.

E. To resolve disputes under this Agreement in accord with its terms.
F. To hold members harmless with respect to billings for Covered Services provided during the term of this Agreement.
G. To accept payment under this Agreement for members hospitalized at the time of termination.
H. To coordinate member communications.

Participating Practitioner Rights Upon Termination or Other Disciplinary Action. The Rules and Regulations of Health Plan (Credentialing Policies and Procedures) are incorporated by reference into this Agreement, including but not limited to those related to:

1. The process by which improvements and corrections may be required with respect to a Participating Practitioner's or Participating Provider's performance.
2. The processes for identifying any need to take action with regard to limiting or terminating a Participating Practitioner or Participating Provider's credentialing occurs.
3. The Participating Practitioner or Participating Provider's rights to notice and opportunity to be heard when the Health Plan acts to remove or to limit participation in the Health Plan.

ARTICLE IX.
DISPUTE RESOLUTION AND ARBITRATION

Disputes/Arbitration. In the event of any dispute arising out of or relating to this Agreement, the parties shall first attempt in good faith mutually to resolve the dispute. If the parties are unable to resolve the dispute, then all matters in controversy shall be submitted to binding arbitration before a single arbitrator under the auspices, rules, and regulations of the United States Arbitration & Mediation Service in Portland, Oregon. The parties agree to be bound by the decision of the arbitrator, which shall be a final determination of the matter in dispute. The parties further agree to divide the cost of arbitration equally, including filing, administration, and arbitrator's fees, but to be responsible each for its own attorneys' fees.

Legal Fees in Matters Other than in Arbitration. In the event suit or legal action is instituted by any party seeking interpretation of the terms hereof seeking redress for a breach of this Agreement, or seeking to enforce or to invalidate an arbitration award, the prevailing party shall be entitled to all costs and attorneys' fees incurred at trial or on any appeal.

ARTICLE X.
HOLD HARMLESS

Hold Harmless. Provider may bill Member for non-Covered Services that Provider provides. Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than Health Plan) acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting Copayments, Coinsurance, Deductibles or fees for non-Covered Services delivered to Health Plan Members (subscribers/enrollees).

Provider agrees that this provision shall survive the termination of this Agreement, for Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This provision is not intended to apply to services provided after this Agreement has been terminated.

Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this Agreement.

Any modification, addition, or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the appropriate regulating entity has received written notification of proposed changes.

ARTICLE XI.
GOVERNING LAW & REGULATORY REQUIREMENT

Regulatory Amendment. If state or federal law changes, including government agency regulations and accrediting agency requirements, affect any provisions of this Agreement, then this Agreement will be deemed amended to conform with such changes effective the date such changes become effective. Health Plan will give Provider written notice of such changes.

Agree to Comply. The Parties agree to comply with all applicable state and/or federal laws and regulations, including HIPAA.

ARTICLE XII.
TRANSPARENCY

Data Sharing. Health Plan intends to collect objective measurements relating to Provider's practice and to make such measurements available to other Providers, to patients, and/or to the public, in detail or in summary format, subject only to protecting patients' state and/or federal confidentiality rights. Provider will have the opportunity to meet with Health Plan to discuss the methodology of data collection and will have the opportunity to review and correct Health Plan's source data prior to publishing. Provider hereby waives any claim that such measurements are privileged or confidential, under ORS 41.675 or otherwise, and consents to Health Plan's use and disclosure of such practice measurements.

ARTICLE XIII.
GENERAL PROVISIONS

Assignment. Provider may not assign rights, duties or obligations under this Agreement without the prior written consent of Health Plan. This Agreement shall survive the sale, merger or asset transfer of Health Plan, and bind any successor of Health Plan to its terms and conditions.

Behavioral Health Services. Covered mental health and chemical dependency benefits administered by United Behavioral Health, Inc. are not covered under this contract. Covered mental health and chemical dependency benefits administered by Health Plan are covered under this contract.

Entire Agreement. This Agreement, including its Attachments, Addendums or Exhibits, contains all of the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement and the Attachments, Addendums or Exhibits hereto, are null and void and of no further force or effect.

Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly or by implication limit or define or extend the specific terms of the section so designated.

Indemnification. Within the limits of its insurance policies and to the extent not otherwise inconsistent with the laws of the State of Oregon and/or Washington, the parties mutually agree to indemnify and to hold each other (including their officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party, including reasonable attorney fees, arising out of or in connection with, either directly or indirectly, the breach of this Agreement by or willful misconduct of the indemnifying party or its employees or agents. The fact that a physician or other provider is a Participating Practitioner does not make such person an agent of Health Plan unless the person's agreement with Health Plan explicitly so provides. The principles of comparative fault shall govern the interpretation and enforcement of this indemnity provision.

Independent Parties. None of the provisions of this Agreement is intended to create, nor shall any be deemed or construed to create, any relationship between the parties other than that of independent entities contracting with each other under this Agreement solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be deemed to be the agent, employer, partner, joint venture, or representative of the other, except as specifically provided herein.

Invalid Provisions. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other term or provision.

Liaison. The parties agree to maintain an effective liaison and close cooperation with each other to provide maximum benefits to each Member at the most reasonable cost consistent with quality standards of medical practice.

Notices. Notices required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent to Health Plan or Provider at their respective places of business.

Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach.

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PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
PROVIDER AGREEMENT
SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

CLACKAMAS COUNTY COMMUNITY HEALTH	**PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE**
Signature	*Signature*
	Jeff Butcher
Print Name	*Print Name*
	Chief Financial Officer
Title	*Title*
	March 27, 2015
Date	*Date*

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
COMMERCIAL (EPO) LINE OF BUSINESS
ATTACHMENT EPO
EXCLUSIVE PROVIDER ORGANIZATION

Exclusive Provider Organization (EPO) is a closed network of Providers contracted to provide services on a fee-for-service basis with no risk borne by Providers. The network is available to Health Plan Members enrolled in an EPO product. EPO products include Providence Administrative Services Only (ASO) products where Member's employer bears risk. Employers who select a Providence ASO product may at their discretion elect to exclude one or more Participating Practitioners or Participating Facilities from their designated network.

To the extent the Exclusive Provider Organization (EPO) provisions in this Attachment are in conflict with or not addressed in the Agreement, the EPO provisions in this Attachment supersede the provisions of the Agreement for EPO.

DEFINITIONS

Member shall mean any person who is enrolled in Health Plan's EPO and for whom required premium or other payments have been made to Health Plan by Member or by Member's employer.

Open Option Member shall mean a Member of Health Plan's EPO who, in addition to benefits for Covered Services provided by Participating Practitioners and Participating Facilities, also has benefits covering services by non-participating practitioners or facilities These benefits may require additional Member cost sharing.

Personal Option Member shall mean a Member of Health Plan's EPO who has benefits for Covered Services provided by Participating Practitioners and Participating Facilities and has no coverage for non emergent services provided by non-participating practitioners or facilities unless prior authorized by Health Plan.

Personal Physician shall mean a Participating Practitioner specializing in Internal Medicine, Family Practice, General Practice, Pediatrics or Obstetrics/Gynecology who has contracted with Health Plan and is (A) the case manager who acts as a Member's point of entry to the delivery system, and (B) manages/oversees all services for the Member including office care, preventive health Maintenance, and referral management. A Personal Physician may not be a Personal Physician for immediate family members under this Agreement.

OBLIGATIONS OF PROVIDER

Accepting Members. If Provider is a Personal Physician, Provider agrees to accept newly enrolled Members and Members who transfer from another Personal Physician. A Personal Physician shall provide Covered Services for a reasonable number of Members, as defined in the Rules and Regulations of Health Plan. Upon prior approval of Health Plan, Provider may limit his or her practice to existing patients who are or become Members. A Personal Physician with an open practice may not refuse to be a Personal Physician for a Member who chooses them.

PROVIDENCE CHOICE PLAN

Providence Choice Plan Member shall mean a Member of Health Plan's EPO who is enrolled in the Providence Choice Plan and for whom required premium payments have been made to Health Plan. Benefits are covered under Providence Health Plan's Medical Home Program.

Providence Choice Plan. Providence Choice Plan is a Providence Health Plan EPO point of service product with a primary medical home benefit design.

Referral Provider shall mean a Participating Practitioner or a Participating Facility who is contracted with Health Plan to provide Covered Services to Providence Choice Plan Members upon a referral from the Providence Choice Plan Member's designated medical home. A Referral Provider will provide coordinated Covered Services based upon Providence Choice Plan Member's proposed plan of treatment as directed by the designated medical home.

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Providence Choice Plan Out of Plan Benefits. Participating Practitioners who see a Providence Choice Plan Member without a referral from the Providence Choice Plan Member's designated Medical Home will be reimbursed in accordance with the terms of this Agreement at the Providence Choice Plan Member's out-of-plan benefit.

Plan Of Treatment. Providence Choice Plan Member's designated medical home and Referral Provider shall agree on the proposed plan of treatment prior to implementation of such treatment by Referral Provider. Should the Referral Provider desire to refer Providence Choice Plan Member to another Referral Provider, such referral must be obtained from Member's designated medical home in advance. Referral Provider will send a copy of Member's record to Member's designated medical home after all approved visits or after any urgent or emergent care visits.

Referral Systems. Referral Providers shall participate in the referral system to facilitate appropriate referral services for Providence Choice Plan Members.

Hold Harmless. Except in cases where Providence Choice Plan utilizes their opt-out benefit, Provider hereby agrees that Provider will not be compensated by Health Plan or Providence Choice Plan Member for Covered Services rendered to Providence Choice Plan Member that have not been referred by Providence Choice Plan Member's designated medical home unless such Providence Choice Plan Member requires Emergency treatment.

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PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
ATTACHMENT A
COMPENSATION STRUCTURE

SCOPE OF SERVICES

Provider is engaged only to provide Covered Services from sites within the limits of the following counties: Washington, Multnomah, Clackamas, and Yamhill counties in Oregon and Clark County in Washington

Provider is engaged only to provide Covered Services which Provider is professionally qualified to render.

The rates in Attachment A-1 are premised on services offered by Provider as of the inception of this Agreement. In the event Provider adds new services, Provider agrees to notify Health Plan within a reasonable time, 1) in order for Health Plan to determine if services will be incorporated into current Agreement, and 2) to negotiate in good faith to establish rates applicable to such new services should they be incorporated into current Agreement.

PAYMENT FOR MEDICAL SERVICES

Health Plan will pay Covered Services at 100% of the allowed compensation, less any applicable copayment, coinsurance and deductibles, in accordance with the fee schedule in the Attachments. Member coinsurance and deductibles are calculated using the allowed compensation, not billed charges. No withhold is applied.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
COMMERCIAL (EPO) LINE OF BUSINESS
ATTACHMENT A-1
FEE SCHEDULE

RATE EFFECTIVE DATE: JANUARY 1, 2015

PHYSICIAN/PRACTITIONER
(MD, DO, DPM, NP, PA, CNMW, DDS, DMD)

Provider is only contracted to provide Immunizations to Health Plan Members

Service Type	Codes	Payment Source	Rate
RBRVS	90460, 90461, 90471-90474 (CPT)	2014 CMS RBRVS RVUs (available as of 12/31/2013)	$ 62.00
Immunizations	9XXXX (CPT)	Immunizations priced using Oregon Immunization Program (OIP), if no OIP priced at Wholesale Acquisition Cost (WAC), if no WAC priced at CMS Average Sales Price (ASP) or Average Wholesale Price (AWP)	100% OIP 110 % WAC, ASP, AWP

- Reimbursement will be at the allowed amount or billed charges, whichever is less.
- New codes not included in the existing fee schedules may be evaluated and priced by Health Plan applying the most current published fee schedule rates, weights or RVUs. Service codes not encompassed by fee schedules may be priced at Health Plan's discretion by applying a most comparable rate. The most current code sets will be recognized by Health Plan in accordance with HIPAA regulations
- Specific services within the code ranges listed above may be excluded from this Agreement. For example, Provider may not be contracted to provide the technical component for MRI, CT or other high tech services.
- If there is no separate Providence Connect Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule, at the Providence Connect Member's out-of-plan benefit.
- If there is no separate Providence Connected Care Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule and the Providence Connected Care Member's benefits.
- For any other commercial network, if there is no separate Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule and the Member's benefits.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
ATTACHMENT C
QUALITY AND MEDICAL MANAGEMENT
QUALITY AND MEDICAL MANAGEMENT PROGRAM

Health Plan oversees the quality, cost and utilization of services rendered to Members through its Quality and Medical Management Program. The Quality and Medical Management Program adheres to state and regulatory rules and regulations, Health Plan policy and quality management measures. Provider, Participating Practitioners and Participating Facilities support the administration of the Quality and Medical Management Program.

PROGRAM SUMMARY

A description of the Quality and Medical Management Program may be viewed on Health Plan's website.

Key features:

Quality and Medical Management Program Committees that review and monitor medical management and quality management activities.

Continuous quality of care and service improvements.

Program oversight by Medical Directors and experienced Quality and Medical Management Program staff.

Medical Policy and Payment Rule development process.

Technology Assessment Program.

Formal appeal and complaint resolution process.

Ethics Committee participation.

Medical Management Activities:

Preauthorization of selected inpatient admissions, day surgery, selected outpatient services and drugs. A complete list of these procedures is available on Health Plan's website. This list is subject to periodic modification.

Second opinions.

Concurrent review of inpatient admissions, continued stays, and discharge planning.

Identification of patients needing individualized care management, case management, and exceptional needs care coordination (ENCC).

Review of urgent and emergent claims for appropriateness of level of care.

Specialized maternity management program, Providence Beginnings.

Mental Health/Chemical Dependency Program.

Organ Transplant Program.

Pharmacy Management Program.

PRIOR AUTHORIZATION

Prior Authorization. Prior authorization is required for certain health care services. A list of inpatient, outpatient and short-stay services that require prior authorization is available on Health Plan's website.

Periodic Modification. The list of services requiring prior authorization is subject to periodic modification by Health Plan.

Benefit Guarantee. Authorization does not guarantee benefits or payment. Benefits are based on eligibility at the time the service is rendered and are subject to any applicable contract terms.

Questions. Questions regarding materials posted on the Health Plan website should be directed to the appropriate Health Plan Provider Relations Representative.

Denied Services. Provider may request a re-review of a service denied for lack of medical indications within one hundred and eighty (180) days of the initial denial. The request must be in writing and must include additional information that was not available at the time of the original determination.

Review. Professional medical staff will review all of the available information submitted with the request for re-review. At the discretion of the Chief Medical Officer or designated medical Director, a review by a physician advisor or independent third party may be requested.

Time to Complete Review. Health Plan will complete the review within twenty (20) business days of receipt of all information necessary to process the request. If Health Plan cannot make a determination within twenty (20) business days, Member and/or Provider will be notified of the reason for the delay. Health Plan will make a decision and notify Member and/or Provider within ten (10) additional business days.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
COMMERCIAL (EPO) LINE OF BUSINESS
ATTACHMENT W
WASHINGTON STATE ADMINISTRATIVE CODE REQUIREMENTS

Governed By. All insurance and insurance transactions in the State of Washington, or affecting subjects located wholly or in part, or to be performed within this state, and all persons having to do therewith are governed by this code. RCW 48.01.020 , RCW 48.43.545

Supersede. For commercial insured business this Attachment contains contract provisions required by the State of Washington Administrative Codes (WAC) applicable to this Agreement. To the extent the Washington Administrative Codes are in conflict with or not addressed in the Agreement, the Washington Administrative Codes supersede the provisions of the Agreement for services provided by Washington State Participating Practitioners and Participating Facilities.

DEFINITIONS

Terms. The following terms shall have the meaning attributed below for purposes of this Attachment. Capitalized terms not otherwise defined herein shall have the meaning assigned to them in the Agreement.

Clean Claim shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment in accordance with WAC 284-43-321.

Emergency. An Emergency medical condition is defined as the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment of bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. RCW 48.43.005(11)

HEALTH PLAN OBLIGATIONS

Eligibility Verification. Health Plan will provide eligibility verification and benefit information through its customer service department and Health Plan website. WAC 284-43-320(1)

AUDIT GUIDELINES

Health Plan Right. Health Plan has the right to ask for and receive information relating to the ability of Provider to deliver health care services that meet the accepted standards of medical care prevalent in the community. Health Plan may not have access to other similar records unrelated to Members. WAC 284-43-324(1)

Record Retention. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members subject to applicable state and federal laws related to confidentiality of medical or health records. WAC 284-43-320(6)

Access to Records. Access to Provider medical records by Health Plan for audit purposes must be limited to only that necessary to perform the audit. WAC 284-43-324(2)

Audit Reciprocity. If Health Plan elects to audit Provider, Provider has reciprocity to audit Health Plan. WAC 284-43-324(3)

CLAIMS

Expedited Claims. Provider has the right to expedited claims payment. WAC 284-43-321(2)(a)

Explanation of Denials. Provider has the right to an explanation when their claims are denied. Provider shall be provided a specific explanation when their claims are denied. WAC 284-43-321(4)

Timely Payments/Interest Payments. Health Plan shall administer claims payment in a manner that complies with WAC 284-43-321 and any additional applicable regulatory requirements to ensure timely and accurate processing and

payment. The receipt date of a claim is the date the Health Plan receives either written or electronic notice of the claim. Health Plan shall confirm the receipt of claims and will respond to provider or facility inquiries about claims. Health Plan shall calculate and pay interest charges in accordance with applicable state laws and regulations applicable to delayed claims payment. WAC 284-51-100(2)(b)(c)

Claims Payment. Health Plan shall pay ninety-five percent (95%) of Clean Claims within thirty (30) days of receipt. Ninety-five percent (95%) of all claims shall be paid or denied within sixty (60) days of receipt. Interest accruement of one percent (1%) per month will be paid for Clean Claims not paid or denied within sixty one (61) days. Health Plan shall add interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the Health Plan to a Members deductible, copayment, coinsurance, or any similar obligation of Member. WAC 284-43-321(2)(d)

Claim Standards. Claim payment standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities or Member, or instances where Health Plan has not been granted reasonable access to information under the provider or facilities control. Health Plan, providers, or facilities, are not required to comply with these provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute. WAC 284-43-321(6)(7)

COMPENSATION AND NOTIFICATION

Notification. Health Plan will provide Provider at least sixty (60) days notice of changes that affect compensation and health care service delivery, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state requirements, unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, provider or facility may terminate the contract without penalty if provider or facility does not agree with the changes. No change to the Agreement may be made retroactive without the consent of provider or facility. WAC 284-43-320(4)

Provider Overpayment and Recovery. Except in cases of fraud, Provider may not request payment from Health Plan to satisfy a claim unless it does so in writing to Health Plan within twenty four (24) months after the date the claim was denied or payment intended to satisfy the claim was made. Provider must request any additional balances from Health Plan within thirty (30) months after original payment was made. This does not apply to subrogation claims. RCW 48.43.005(16), RCW 48.43.600, Title 18 RCW 70.127

Health Plan Overpayment and Recovery. Except in cases of fraud, Health Plan may not request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to the Provider within twenty four (24) months after the date payment was made. Health Plan must request a refund from Provider of payment previously made to satisfy a claim within thirty (30) months after the date payment was made. This is not applicable to subrogation claims. RCW 48.43.005(16), RCW 48.43.600, Title 18 RCW 70.127

CREDENTIALING AND UNFAIR DISCRIMINATION

Credentialing Standards. Health Plan credentialing standards for providers or facilities practicing in the State of Washington will adhere to State of Washington Administrative Code. RCW 18.130.040, WAC 284.43.310(1)

Unfair Discrimination. Health Plan will not exclude providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations. WAC 284-43-310(1)(a)(b)

Selection. Health Plan may decline to select a provider or facility who fails to meet other legitimate selection criteria of Health Plan. Health Plan is not required to employ, to contract with, or retain more providers or facilities than are necessary to comply with network adequacy. Health Plan selection standards for participating providers and facilities is available for review upon request of the commissioner of the State of Washington. WAC 284-43-310(2)(3)(4)

CONTRACT TERMINATION

Termination Without Cause. Sixty (60) days written prior notification is required when either Health Plan or Provider terminates the Agreement without cause. Upon notice of termination Health Plan will develop a plan to coordinate the transition of care for affected Member(s) and will notify Member(s) in a timely manner of receipt or issuance of the notice of termination. Provider will be paid in accordance with the Agreement for covered Services for at least 60 days following notice of termination. RCW 48.43.515(7), WAC-284-43-320(7)

Report to State. Health Plan will not penalize Provider who, while acting in good faith, reports to state or federal authorities any act or practice by Health Plan that jeopardizes patient health or welfare or that may violate state or federal law. WAC-284-43-320 (9)

CONTRACTING OUTSIDE THE PLAN

Citizens Right to Contract. Washington citizens have the right to freely contract outside of their health plan on any terms or conditions the citizens choose. RCW 48.43.085, WAC-284-43-320(10)

ENROLLEE COVERAGE / EMERGENCY CARE / UTILIZATION REVIEW

Emergency Care. Health Plan shall cover emergency services necessary to screen and stabilize a Member if a prudent layperson acting reasonably would have believed that an emergency medical condition existed. RCW 48.43.093(1)(a)

Prior Authorization. Health Plan shall not retrospectively deny coverage for emergency and non-emergency care that had prior authorization at the time the care was rendered. RCW 48.43.520, WAC 284-43-410, WAC 284-43-320(1)

Utilization Review. Retrospective review determinations must be based solely on the medical information available to Provider at time the service was provided. Retrospective review must be completed within thirty (30) days of receipt of the necessary information. RCW 48.43.520, WAC 282-43-410

GRIEVANCE PROCEDURES / DISPUTE RESOLUTION

Dispute Resolution. In the event of any dispute between Provider and Health Plan arising out of or relating to the Agreement between the two parties, Provider and Health Plan may first attempt in good faith to resolve the dispute mutually between themselves. Health Plan shall allow not less than thirty (30) days after the action giving rise to a dispute for Provider to complain and initiate the dispute resolution process. Health Plan will render a decision on a Provider complaint within a reasonable time for the type of dispute. In the case of billing disputes, Health Plan will render a decision within sixty (60) days of the complaint. In order to initiate the resolution process, Provider shall contact Health Plan in writing. RCW 48.43.055, WAC 284-43-320(11), WAC 284-43-322

Non Binding Arbitration. If Provider and Health Plan are unable to resolve the dispute by mutual agreement, including but not limited to, utilizing all available levels of Health Plan's grievance and appeals processes, unless otherwise prohibited by state law, then all matters in controversy may be submitted, upon the motion of either party, to non-binding arbitration under the auspices, rules and regulations of United States Arbitration & Mediation (USAM) in Portland, Oregon. All such arbitration proceedings shall be administered by USAM in the state in which Provider is duly licensed and providing services; however, the arbitrator shall be bound by applicable state and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The arbitrator must have experience in resolving matters of the same type under dispute in the same jurisdiction. If agreed by Health Plan and Provider in advance, the decision of the arbitrator shall be final and binding as to each of them. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days after the entry of judgment. Utilizing these grievance procedures does not prohibit any potential judicial remedies that may be available to Provider. Alternative dispute resolutions, such as mediation and arbitration, are not binding and are not required to the exclusion of judicial remedies. WAC 284-43-322(1)(2)(3)(4)(5)

Administrative Fees. In all cases submitted to USAM, Provider and Health Plan agree to share equally the USAM administrative fee as well as the arbitrator's fees and expenses, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party, subject to final apportionment by the arbitrator. WAC 284-43-322

Cost of Filing. Provider and Health Plan agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing to have an award enforced may be recovered by the party which brings such action. WAC 284-43-322

Mediation. Should Provider or Health Plan, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to USAM, or the parties may initiate such other procedures as they may mutually agree upon at such time. WAC 284-43-322

HOLD HARMLESS

Hold Harmless. Provider hereby agrees that in no event, including, but not limited to, nonpayment by Health Plan, its insolvency, or its breach of contract, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or person, other than Health Plan acting on Member's behalf, for services provided pursuant to the Agreement. This provision shall not prohibit collection of deductibles, copayments, co-insurance, or amounts owed for noncovered services which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Member in accordance with the terms of the Member subscriber agreement. WAC 284-43-320 (2)(a)

Continuity of Care. In the event of Health Plan's insolvency, Provider agrees to continue to provide the services promised in the Agreement to Members of Health Plan for the duration of the period for which premiums were, on behalf of the Member, paid to Health Plan, or until Member's discharge from inpatient facilities, whichever time is greater. RCW 48.43.515(7), WAC 284-43-320(2)(c)

Rights of Member. Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in Member agreement. WAC 284-43-320(2)(f)

May Not Bill Member. Provider may not bill Member for covered services except for deductibles, copayment or coinsurance in cases where Health Plan denies payments because Provider has failed to comply with the terms of the Agreement. WAC 284-43-320(2)(b)

Provision Supersedes. Provider further agrees that provisions noted in the Hold Harmless section of this Attachment shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members and that this provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf. WAC 284-43-320(2)(d)

Abide By Provisions. If Provider contracts with other health care providers who agree to provide covered services to Members of Health Plan with the expectation of receiving payment directly or indirectly from Health Plan, such provider must agree to abide by the Hold Harmless section of this agreement. WAC 284-43-320 (2)(e)

Class C Felony. Providers willfully collecting or attempting to collect an amount from a Member while knowing that collection to be in violation of the Agreement constitutes a class C felony. RCW 48.80.030(5)(6), WAC 284-43-320(3)

PROVIDER / PATIENT CARE

Non Discrimination. Providers shall furnish covered services to Members without regard to Member's enrollment in the plan as a private purchaser of the plan or as a participant in the publicly financed programs of health care services. WAC 284-43-320(8)

Patient Advocate. Providers shall inform Member of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Member's service agreement with Health Plan. Nor will Providers be prohibited, discouraged or penalized for advocating on behalf of a Member with Health Plan. RCW 48.43.510(6)(7), WAC-284-43-320 (5)(a)

Discuss Comparative Merits. Members, or those paying for their coverage, are not precluded or discouraged from discussing the comparative merits of different health carriers with their providers. Providers are not precluded, discouraged, or limited from participating in these discussions. WAC-284-43-320(5)(b)

SUBCONTRACTORS

Downstream Contracts. Health Plan requires that all downstream or subcontracted providers comply with all applicable laws contained in the State of Washington Administrative Codes including but not limited to billing and claim payment standards. WAC 284-43-300 Subchapter C, WAC 284-42-321(5)

Notification of Downstream Contracts. Health Plan must be notified when Provider initiates any new downstream or subcontract agreement and the template of such contract will be forwarded to Health Plan for review. Health Plan is required to ensure that downstream or subcontracts are compliant with the State of Washington Administrative Codes. WAC 284-43-300, Subchapter C

PHARMACY

Pharmacy Standard. The following rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

Pharmacy Data Submission. The pharmacy identification card or other technology must include the data element consistent with the "BIN number," "IIN/BIN number" or "RxBIN" which is ANSI assigned international identification number, identified in the National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card Implementation Guide. Other data elements of the NCPDP Guide must be included on the card only if they are required for the processing of claims. This rule does not compel the issuance of a separate pharmacy identification card provided that the Member identification card contains the required data elements. All health plans that use a card or other technology for prescription claims processing that are delivered, issued for delivery or renewed on or after July 1, 2003, will comply with the requirements of this rule. WAC 284-43-323