

April 07, 2016

Board of County Commissioner
Clackamas County

Members of the Board:

**Approval of a Medicaid Group Provider Agreement with
FamilyCare, Inc. for Primary Care and Mental Health Services.**

Purpose/Outcomes	This Agreement combines primary care and mental health services from the CCHCD for Oregon Health Plan (OHP) members enrolled with FamilyCare. This agreement will replace the 2 existing provider agreements in effect from 2012.
Dollar Amount and Fiscal Impact	The total amount of the agreement is unknown, because the number of clients who will be enrolled with FamilyCare, Inc. cannot be projected with certainty. No County General funds are involved.
Funding Source	FamilyCare
Duration	Effective January 1, 2016 and continues until terminated.
Previous Board Action	No previous Board actions have been taken on this agreement. This agreement combines 2 existing agreements that were previously seen by the Board in 2012.
Strategic Plan Alignment	1. Individuals and families in need are healthy and safe 2. Ensure safe, healthy and secure communities
Contact Person	Deborah Cockrell 503-742-5495
Contract No.	7517

BACKGROUND:

Clackamas County Health Centers Division (CCHCD) of the Health, Housing and Human Services Department (H3S) requests the approval of a Medicaid Group Provider Agreement with FamilyCare, Inc. for the purchase of primary care and mental health services from the CCHCD for Oregon Health Plan (OHP) members.

The OHP members covered by this agreement are residents of Clackamas County who have access to physical health services at county clinics and are capitated to Family Care, Inc. for provision of physical and mental health services.

This is a revenue agreement for CCHCD. The total amount of the agreement is unknown, because the number of clients who will be enrolled with FamilyCare, Inc. cannot be projected with certainty. No County General funds are involved. The agreement is effective upon signature by both parties and shall continue until either or both parties terminate the agreement. This contract has been reviewed by County Counsel on January 20, 2016.

This contract is effective January 1, 2016 and continues until terminated. The agreement is retro-active due to language negotiations with contractor.

RECOMMENDATION:

Staff recommends the Board approval of this contract and authorizes Richard Swift, H3S Director to sign on behalf of Clackamas County.

Respectfully submitted,

Richard Swift, Director
Health, Housing & Human Services



**MEDICAID
GROUP PROVIDER AGREEMENT**

between

FAMILYCARE, INC.,

an Oregon non-profit corporation

and

**CLACKAMAS COUNTY
Acting by and through its Health, Housing and Human Services Department,
Health Centers Division**

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MEDICAID GROUP PROVIDER AGREEMENT

THIS MEDICAID GROUP PROVIDER AGREEMENT (“Agreement”) is made and entered into by and between FamilyCare, Inc. (hereinafter referred to as “FamilyCare”), an Oregon non-profit corporation operating in Oregon as a coordinated care organization, and Clackamas County, acting by and through its Health, Housing and Human Services Department, Health Centers Division (hereinafter referred to as “Group”).

RECITALS

WHEREAS, FamilyCare 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 plans; and

WHEREAS, Group is an individual lawfully qualified to provide medical services and/or behavioral health care services (mental health and/or addiction treatment), or employs or contracts with providers who are lawfully qualified to provide behavioral health care and/or medical services, and is willing to provide such services to Members of FamilyCare health benefit plans; and

WHEREAS, the health benefit plan(s) covered by this Agreement include: the Oregon Health Plan administered by the Oregon Health Authority pursuant to the Health Plan Services Contract, Coordinated Care Organization contract and, if applicable, the MHS Special Contract pursuant to the Personal/Professional Service Contract between FamilyCare and The Oregon Health Authority, Addictions and Mental Health Division (“AMH”), as well as any other Plans added to this Agreement as provided in this Agreement.

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

AGREEMENT

1. **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:

1.1 **Capitation Fee.** A predetermined monthly payment to Group or Group Practitioners, if applicable, for Covered Services to be provided to each Member assigned to Group or Group Practitioners.

1.2 **Care Management.** A program of care coordination and case management developed to manage high cost and at-risk Members with complex medical needs.

1.3 **Clean Claim.** A bill for services, line item of service or all services for one Member on a bill, on a claim form acceptable to FamilyCare that can be processed without obtaining additional information from the provider of the services or from a third party. A Clean Claim does not include a claim from a provider under investigation for fraud or abuse, or a claim under review for Medical Necessity.

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

1.5 Copayment or Copay. The fixed dollar amount that a Member may be obligated to pay for a Covered Service.

1.6 Covered Service. Medically Necessary health care services and supplies rendered or furnished to Member by Group or Group Practitioner for which benefits are available under a Member's Plan.

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

1.8 Emergency or Emergency Medical Condition. A medical and/or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. An "Emergency Medical Condition" is determined based on the presenting symptoms (not the final diagnosis) as perceived by a prudent layperson and includes cases in which the absence of immediate medical attention would not in fact have had the adverse results described in the previous sentence.

1.9 Medical Director. Physicians who are designated by FamilyCare or a Plan and are responsible for quality management and utilization management review, including concurrent hospital review and, if appropriate under a Plan, making all final medical and behavioral health decisions relating to coverage or payment.

1.10 Medically Necessary or Medical Necessity. The decision as to whether a service or supply ordered by the provider was Medically Necessary, or as to whether services or supplies are required by Medical Necessity, for the purposes of qualifying for payment by FamilyCare rests with FamilyCare, subject to the procedures for reconsideration. Services and medical supplies are Medically Necessary or required by Medical Necessity if required for prevention (including a relapse), diagnosis or treatment of a physical or behavioral health condition that encompasses physical or mental conditions, or injuries and are (a) consistent with the symptoms or treatment of a physical or behavioral health condition; (b) appropriate with regard to standards of good health practice and generally recognized by the relevant scientific community and professional standards of care as effective; (c) not solely for the convenience of a Member or a provider of the service or medical supplies; and (d) the most cost effective of the alternative levels of medical services or medical supplies that can be safely provided to a Member in FamilyCare's judgment. The fact that an item or service is Medically Necessary does not by itself mean that the item or service is eligible for payment by FamilyCare; to be eligible for payment, items and services must be Covered Services under the Plan and meet all requirements for eligibility for payment in addition to being Medically Necessary.

1.11 Member. A person who is enrolled in a FamilyCare Plan and is entitled to receive Covered Services.

1.12 Participating Hospital. A hospital that is contracted to provide Covered Services to Members. Participating status shall be contingent upon FamilyCare's designation as such.

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

1.14 Participating Practitioner Group. An independent practice association; corporation, limited liability company, or partnership of professional providers; or other entity that employs or contracts with providers of professional medical and/or behavioral health services and contracts with FamilyCare to provide services to Members under this Agreement. Participating status shall be contingent upon FamilyCare's designation as such.

1.15 Participating Provider. A Participating Practitioner, Participating Practitioner Group, Participating Hospital or other facility or provider of health care items or services designated as a Participating Provider by FamilyCare.

1.16 Plan. The contract or agreement with FamilyCare setting forth the Covered Services to which a Member is entitled and, if a government health benefit program, the federal and state statutes and regulations governing the program. The Plan initially covered by this Agreement is the Oregon Health Plan administered by the Oregon Health Authority pursuant to the Health Plan Services Contract, Coordinated Care Organization contract with FamilyCare and applicable rules and regulations and, if applicable, the MHS Special Contract pursuant to the Personal/Professional Service Contract between FamilyCare and AMH.

1.17 Policies and Procedures. The criteria and procedures pertaining to credentialing and recredentialing, participation, compensation, payment rules, processing guidelines, medical policy, utilization management, quality improvement, fraud and abuse, health benefit plan standards, and such other matters determined from time to time by FamilyCare.

1.18 Primary Care Provider. A Participating Practitioner deemed a Primary Care Provider by FamilyCare for the Plan.

1.19 Primary Care Services. Those Covered Services routinely provided by Primary Care Providers in their practice of medicine or other health care profession or as may be further defined in the Plan.

1.20 Prior Authorization or Preauthorization. Prior authorization or Preauthorization is approval given by FamilyCare in advance of a proposed hospitalization, treatment, supply purchase or other Covered Service, in accordance with FamilyCare Policies and Procedures.

1.21 Referral. The process required by this Agreement by which a provider directs a Member to seek and obtain Covered Services from a Participating Practitioner or any other provider of Covered Services.

1.22 Scope of Service. 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 Group or Group Practitioners are professionally qualified to render, or as otherwise defined in the Services and Compensation Attachment.

1.23 Services and Compensation Attachment. An Attachment to this Agreement setting forth payment and other terms applicable to a Plan in which Group is a Participating Practitioner Group, which Attachment is made part of this Agreement upon execution or thereafter pursuant to paragraph 7.1.

1.24 Specialty Services. Those Covered Services provided by providers professionally qualified to practice a designated specialty as determined by FamilyCare which are within the provider's recognized scope of practice

1.25 Standards of Care and Service. Standards which have been developed by FamilyCare, incorporating concepts from Centers for Medicaid and Medicaid Services ("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 Policies and Procedures.

2. Group Services.

2.1 Group and Group Practitioner. If Group is a medical group or other employer of physical or behavioral health care professionals, Group shall require all of its employed and contracted professionals who provide services to Members to comply with all of the provisions of this Agreement. If Group contracts with individual health care providers who are not employed by Group, as a medical group, independent practice association, or otherwise, Group shall ensure that it maintains current, valid contracts with each such individual health care provider who provides services to Members. Such employed or contracted professionals are referred to herein as "Group Practitioners." If Group is an individual health care provider, the term "Group Practitioner" shall also include Group. Contracts with Group Practitioners shall (a) require Group Practitioner to comply with all of the provisions of this Agreement, (b) be in form acceptable to FamilyCare and (c) be available for inspection on request by FamilyCare. Group shall ensure that each Group Practitioner is credentialed by FamilyCare prior to providing services to Members, and continues to comply with FamilyCare's credentialing and recredentialing Policies and Procedures.

2.2 Covered Services. FamilyCare retains Group and Group Practitioners to render Covered Services to Members within Group Practitioner's Scope of Service. Group and Group Practitioner shall provide Medically Necessary Covered Services to Members in an amount, duration and scope that is no less than the amount, duration and scope for the same services provided by Group and Group Practitioners to individuals eligible to receive Oregon Health Plan

health services under fee-for-service or to other individuals who receive services equivalent to Covered Services and in a manner that is sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished and include the following: (a) the prevention, diagnosis, and treatment of health impairments, (b) the ability to achieve age appropriate growth and development, and (c) the ability to attain, maintain, or retain functional capacity. All services shall be rendered subject to the terms and conditions of this Agreement and in accordance with FamilyCare's Policies and Procedures, including referral and Preauthorization procedures.

2.3 Performance. Subject to practice protocols and utilization standards adopted by FamilyCare, Group and Group Practitioners will determine the method, details, and means of performing Covered Services within the Scope of Service pursuant to this Agreement. Covered Services rendered will be provided as promptly as practicable, consistent with sound medical practice and in accordance with accepted community professional standards. Group agrees at all times to maintain a sufficient number of Group Practitioners to guarantee FamilyCare Members prompt and adequate access to Covered Services with the Scope of Service. Group and Group Practitioners shall communicate to Members in a linguistically and culturally appropriate fashion in accordance with FamilyCare's Policies and Procedures.

2.4 Personnel, Equipment and Supplies. Group or Group Practitioners shall, at Group or Group Practitioner's sole cost and expense, arrange for the provision of Covered Services. Subject to practice protocols and utilization standards adopted by FamilyCare, FamilyCare may not control, direct, or supervise Group or Group Practitioners in the performance of Covered Services. Group or Group Practitioner will supply all necessary office personnel, equipment, instruments and supplies required to perform Covered Services and which are usual and customary for a medical and/or behavioral health practice in the community. Group or Group Practitioner shall be solely responsible for payment of all wages, salary, compensation, payroll and withholding taxes, unemployment insurance, workers' compensation coverage and all other compensation, insurance and benefits with respect to personnel employed or contracted by Group or Group Practitioner, as applicable.

2.5 Hours. Group and Group Practitioners will arrange for the provision of Covered Services within the Scope of Service during normal office hours or as otherwise necessary to provide reasonable access to services by Members. Group and Group Practitioners will arrange for call coverage for Medically Necessary services on a 24-hour per day, seven day per week basis.

2.6 Patient Centered Primary Care Homes. Group and Group Practitioners shall communicate and coordinate care with the patient centered primary care home, if applicable, in a timely manner using electronic health information technology in accordance with FamilyCare's Policies and Procedures.

2.7 Individualized Care Plans. Group and Group Practitioners shall maintain individualized care plans to the extent feasible for each Member to address the supportive and therapeutic needs of each Member, particularly those with intensive care coordination needs, in accordance with FamilyCare's Policies and Procedures.

2.8 Referral and Preauthorization Procedure. Group and Group Practitioners shall comply with Referral and Preauthorization procedures adopted by FamilyCare prior to referring a Member to any individual, institutional or ancillary health care provider. Except as permitted by FamilyCare Policies and Procedures, Group and Group Practitioners shall refer Members only to Participating Providers designated by FamilyCare to provide the service for which the Member is referred. Except as required by applicable law, failure of Group and Group Practitioners to follow such procedures may result in denial of payment for unauthorized treatment. Preauthorization is not required prior to provision of Covered Services in the event of an Emergency or Emergency Medical Condition.

2.9 Hospital Admission Authorization. Group and Group Practitioners shall admit Members for hospital services only to a Participating Hospital unless an appropriate bed or service is unavailable. Except as provided in paragraph 2.11 or otherwise required by applicable law, Group and Group Practitioners may not admit a Member to a hospital on a non-Emergency basis without first receiving Prior Authorization from FamilyCare, or its designated agent, in accordance with FamilyCare's Policies and Procedures.

2.10 Compliance With FamilyCare Pharmaceutical Formularies. Group and Group Practitioners shall comply with pharmaceutical formularies and pharmaceutical prior authorization requirements developed or adopted by FamilyCare, unless otherwise Medically Necessary. In prescribing medications for Members, Group Practitioners shall select the most cost-effective medication that is clinically appropriate for the Member, including, when appropriate and available, generic equivalents and therapeutic equivalents.

2.11 Provision of Non-Covered or Unauthorized Services or Referral Care. Group and Group Practitioners shall advise a Member of any service, treatment, or test that is Medically Necessary but not covered under this Agreement if an ordinary careful practitioner in the same or similar community would do so under the same or similar circumstances. Nothing in this Agreement is intended to or shall be construed to require Group or Group Practitioners to deny care to a Member for non-Covered Services or deny services or referral care not otherwise authorized under applicable procedures. The fact that FamilyCare does not or may not provide payment for a service shall not relieve Group or Group Practitioners of the duty to exercise independent professional skill and judgment in advising and treating Members. When referring Members to non-Participating Providers, Group and Group Practitioners shall inform Members of their potential responsibility for payment. When recommending or offering non-Covered Services to a Member, Group Practitioners shall comply with paragraph 5.3.4.

2.12 Nondiscrimination. Group and Group Practitioners agree that in accordance with the provisions of this Agreement, and within the limits of a Group Practitioner's specialty, not to discriminate in the provision of Covered Services to Members on the basis of membership in a health benefit plan, source of payment, race, color, national origin, ethnicity, ancestry, religion, sex, marital status, sexual orientation, mental or physical disability, medical condition or history, age, or any other category deemed protected under State or Federal law; and to provide Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other patients of Group and Group Practitioners.

3. Group Obligations.

3.1 Acceptance of Members. Group and Group Practitioners agree to accept assignment of Members by FamilyCare, subject only to Group Practitioner's Scope of Service. This paragraph does not prevent Group or Group Practitioner from limiting practice to a recognized specialty such as pediatrics, specialized behavioral health services, geriatrics or obstetrics and gynecology.

3.2 Practitioner Qualifications. Group will require each Group Practitioner to complete FamilyCare's credentialing process and be approved as a Participating Provider before providing services to Members. Group warrants and represents that each Group Practitioner is, and for the duration of this Agreement shall remain, duly licensed to practice Group Practitioner's health care profession in all states in which Group Practitioner provides services to Members and is, and for the duration of this Agreement shall remain, in good standing with the appropriate licensing board(s), a participating provider in Medicaid, and the holder of a valid DEA Certificate (if applicable). Group warrants that each Group Practitioner shall maintain medical staff membership and clinical privileges appropriate to Group Practitioner's professional practice at a Participating Hospital that is a hospital in good standing and without restriction or limitation unless such membership and privileges are not required under FamilyCare's credentialing Policies and Procedures. Group warrants that each Group Practitioner is currently, and for the duration of this Agreement shall remain, in compliance with FamilyCare's credentialing and recredentialing criteria. Group and Group Practitioner do not and will not during the term of this Agreement employ or contract with any person who is excluded from participation in Medicare or Medicaid.

3.3 Covering Provider. If Group or a Group Practitioner is, for any reason, from time to time unable to provide those Covered Services Group has agreed to render under this Agreement when and as needed, Group or Group Practitioner may secure the services of a qualified covering provider who shall render such Covered Services. The covering provider must be a provider approved by FamilyCare to provide the Covered Services to Members otherwise required of Group or Group Practitioner. Group or Group Practitioner shall be solely responsible for securing the services of such covering provider. Group or Group Practitioner shall ensure that the covering provider: (a) looks solely to Group or Group Practitioner, FamilyCare, or the Plan(s), as the case may be, for compensation; (b) accepts FamilyCare's credentialing and peer review procedures; (c) does not directly bill Members for Covered Services under any circumstances, unless expressly required by the Plan(s); (d) obtains authorization in accordance with FamilyCare's utilization management program prior to all elective hospitalizations; and (e) complies with the terms of this Agreement and policies, procedures, and rules adopted by FamilyCare related to performance of medical and behavioral health services under this Agreement.

3.4 Withdrawal from Care. Prior to withdrawing from a Member's care, Group or Group Practitioner shall contact FamilyCare to enlist assistance with resolution of issues giving rise to the proposed withdrawal. Group or Group Practitioner will cooperate with FamilyCare to attempt to resolve the issues for 30 days. In the event the issues cannot be resolved satisfactorily, Group or Group Practitioner shall give FamilyCare and the affected Member(s) at least 30 days' prior written notice of intent to withdraw from care of Member(s), shall cooperate fully with FamilyCare in transferring care of the Member(s) to another Participating Practitioner, and shall continue provision of care for urgent needs and prescriptions for at least 30 days from the date of

notice of withdrawal. Notwithstanding the foregoing, if a Member has exhibited behavior that is verbally or physically threatening or if other unusual circumstances require prompt action for the protection of Group, Group Practitioners, the Member or others, Group may withdraw from the care of a Member on such written notice to the Member and FamilyCare as is reasonable and consistent with accepted standards of professional practice considering the circumstances, and shall thereafter cooperate fully with FamilyCare in transferring care of the Member to another Participating Provider.

3.5 Compliance with Law and Ethical Standards.

3.5.1 Group and Group Practitioner shall at all times during the term of this Agreement comply with all applicable federal, state, and municipal laws, statutes, and ordinances, and any regulations promulgated thereunder; all applicable rules and regulations of each Group Practitioner's licensing board(s); and the ethical standards of the applicable professional association.

3.5.2 In particular, and not to the exclusion of any other applicable law or regulation, Group and FamilyCare acknowledge that in the course of performing under this Agreement, they may use or disclose to each other or to outside parties certain confidential health information that may be subject to protection under state and/or federal law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations promulgated thereunder with respect to privacy and security of health information, and agree that each will comply with all applicable state and federal privacy laws. If requested to do so by FamilyCare, Group will execute a Business Associate Agreement in a form acceptable to FamilyCare.

3.5.3 Group will cooperate with and participate in FamilyCare's compliance plans, including provision of information, cooperation with auditing and monitoring activities, participation in training and education, and implementation of compliance initiatives and programs as reasonably requested by FamilyCare from time to time.

3.6 Compliance With FamilyCare Policies and Procedures. Group agrees to be bound by the Policies and Procedures of FamilyCare as they may be amended from time to time. If Group or Group Practitioner violates any of the provisions of such Policies and Procedures, or any of the principles of professional conduct adopted by FamilyCare, or acts contrary to or in violation of any Medicaid laws or regulations, all contractual rights under this Agreement which pertain to Group or Group Practitioner may be terminated in accordance with the Term and Termination section of this Agreement and applicable law. FamilyCare shall monitor Group's and Group Practitioner's compliance with FamilyCare's Policies and Procedures and Group and Group Practitioners agree to be subject to corrective action determined necessary by FamilyCare to ensure Group and Group Practitioner compliance.

3.7 Utilization Management and Quality Assurance Programs. FamilyCare has and will maintain utilization management and quality assurance and other operational programs and policies to guide and review individual and aggregate performance of Participating Providers in the delivery of Covered Services. Review may include but not be limited to Medical Necessity and compliance with clinical protocols, referral requirements, Preauthorization standards, and the evaluation of the results of care. Group and Group Practitioners shall cooperate fully with

FamilyCare in any inquiries FamilyCare may make with respect to such programs. Group and Group Practitioners agree to comply with and, subject to Participating Provider rights of appeal or reconsideration, shall be bound by such policies and programs. Group and Group Practitioners agree that decisions of FamilyCare's utilization management or quality assurance committees may include denial of payment for Covered Services provided to a Member when services are provided in a manner inconsistent with FamilyCare's Policies and Procedures or, in appropriate situations, termination of this Agreement as provided herein.

3.8 Fraud and Abuse Programs. Group and Group Practitioners agree to comply with FamilyCare's fraud and abuse program and questionable or inappropriate billing practices Policies and Procedures.

3.9 Grievance Procedures. FamilyCare will have Policies and Procedures for appealing Member disputes related to prior authorization and referral procedures. Group and Group Practitioners shall comply with both Member and Participating Provider grievance and appeal procedures and shall be bound by such procedures.

3.10 Patient Advocate. Group Practitioners practicing in conformity with ORS 677.095 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. Group Practitioners can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations. When communicating about Non-Covered Services, Group Practitioners shall comply with paragraph 2.11 and paragraph 5.3.4 of this Agreement.

3.11 Provider Directory. Group and Group Practitioner agree that FamilyCare may use the name, specialty, board certification, professional school(s), addresses, phone numbers, languages spoken other than English, prescription drug formularies used, and type of practice of Group and Group Practitioners with regard to access and acceptance of new patients, in the FamilyCare directory of Participating Providers.

3.12 Patient Consents. Group and Group Practitioners shall obtain the consent of Members to allow Group and Group Practitioners to use and disclose to FamilyCare and Participating Providers the Member's Protected Health Information (as defined by HIPAA) for purposes contemplated by this Agreement.

3.13 Medical Records. Group or Group Practitioners shall maintain with respect to each Member receiving Covered Services hereunder a single standard medical or treatment record in such form, containing such information, and preserved for such time period(s), as are required by state and federal law, accepted standards of practice and FamilyCare Policies and Procedures. Subject to confidentiality laws, and upon receipt of three business days' prior written notice from FamilyCare, Group and Group Practitioners shall share such records with Participating Providers in accordance with FamilyCare's Policies and Procedures, and permit FamilyCare, and its designated representatives, to review or inspect such records in accordance with payment, utilization management, quality assurance, peer review and other Policies and Procedures of FamilyCare. Copies of such records shall be made available to FamilyCare upon request without charge.

3.14 Required Information. Group and Group Practitioners shall provide FamilyCare with information necessary for FamilyCare to fulfill its obligations with and to comply with state and federal law. Group and Group Practitioners authorize FamilyCare to release information as required by state and federal law and shall promptly procure such additional consents as may be necessary from time to time for purposes of this paragraph.

3.15 Cooperation with Plan and FamilyCare Medical Directors. Group and Group Practitioners acknowledge that contracting Plans will place certain obligations upon FamilyCare regarding the quality of care received by Members and that contracting Plans in certain instances will have the right to oversee and review the quality of care administered to Members. Group and Group Practitioners agree to cooperate with FamilyCare's Medical Directors and the medical directors of contracting Plans in their review of the quality of care administered to Members and to submit information as requested.

3.16 Notice to FamilyCare. Group and Group Practitioners will notify FamilyCare, in writing, within three working days, of any of the following events affecting Group or Group Practitioner: loss of licensure, accreditation or participating provider status in Medicaid; notice of any claim, demand or complaint involving a Member; termination, suspension, restriction or non-renewal of a Group Practitioner's clinical privileges or staff membership with any hospital, health plan or provider organization; loss of insurance coverage required by this Agreement.

4. FamilyCare Obligations.

4.1 Eligibility Determinations and Reports. FamilyCare will make eligibility information available to Group and Group Practitioner by telephone or by electronic means.

4.2 Authorizations. FamilyCare will provide authorization for non-Emergency Covered Services in the form of a Preauthorization and shall certify or recertify lengths of stay if required by telephone contact or other mutually agreeable form of communication between Group or Group Practitioner, the Member's Primary Care Provider or referral provider and/or FamilyCare personnel, according to FamilyCare's Quality Improvement and Utilization Management Policies and Procedures.

4.3 Claims Processing. FamilyCare shall be responsible for adjudicating and paying claims for Covered Services consistent with the terms of this Agreement and FamilyCare's Policies and Procedures.

4.4 Policies and Procedures. FamilyCare will make its Policies and Procedures available to Group and Group Practitioner in accordance with applicable laws and regulations.

4.5 Compliance with Law. FamilyCare shall at all times during the term of this Agreement comply with all applicable federal, state, and local laws, statutes and ordinances, and any regulations promulgated thereunder.

5. Services and Compensation.

5.1 Compensation. FamilyCare agrees to pay Group or Group Practitioner for Covered Services rendered by Group or Group Practitioner to Members, within Group or Group

Practitioner's Scope of Service, at the lesser of Group or Group Practitioner's billed charges or the rate determined in accordance with the terms of the Services and Compensation Attachment, which is attached hereto as Attachment A and as attached made a part of this Agreement. Compensation amounts, methodologies or formulas may vary for other providers.

5.2 Payment of Compensation by FamilyCare.

5.2.1 To be considered for payment, Group or Group Practitioner shall submit to FamilyCare a Clean Claim on a completed CMS 1500 statement, CMS 1450 or HIPAA ANSI, or successor forms, within four months following the provision of Covered Services, including services reimbursed under a Capitation Fee. FamilyCare in its sole discretion may allow exceptions for maternity claims, claims requiring coordination with a third-party resource or a delay in billing due to eligibility issues. Group and Group Practitioners will submit such additional encounter data as FamilyCare may request, including accurate and specific data describing the services rendered. Group and Group Practitioners will follow Medicare Correct Coding guidelines, or other industry standard coding guidelines approved by FamilyCare in coding services in all claims and data submitted to FamilyCare. Claims for payment must reflect Co-payments, Coinsurance and Deductibles collected or to be collected. Claims submitted for payment beyond twelve months (or any shorter period established by applicable law or regulation) from the date Covered Services were provided may be denied in FamilyCare's sole discretion. FamilyCare agrees to pay a Clean Claim within the time required by applicable state and federal law.

5.2.2 FamilyCare shall not be obligated to make payment to Group or Group Practitioner if Group or Group Practitioner fails to obtain a referral in accordance with FamilyCare Policies and Procedures, if the patient is not a Member at the time of service, if information provided to FamilyCare is materially inaccurate, or if the delivery of service does not comply with applicable FamilyCare Policies and Procedures.

5.2.3 Nothing herein requires FamilyCare to adopt, or prevents FamilyCare from adopting, different billing and payment policies with respect to workers' compensation cases or other situations in which FamilyCare is or could be a secondary or conditional source of reimbursement for Covered Services.

5.3 Patient Billing.

5.3.1 Group and Group Practitioners shall look only to FamilyCare for compensation for Covered Services and shall at no time seek compensation from Members or persons acting on their behalf for Covered Services. In the event of non-payment by FamilyCare for any reason, Group and Group Practitioners shall not bill or otherwise attempt to collect from Members any amounts owed by FamilyCare and shall continue providing services to Members for the duration of the period for which premium payment has been made by or on behalf of the Member and until Member is discharged from the hospital (if applicable) or until the Member's Primary Care Provider determines that care in the hospital is no longer Medically Necessary (if applicable). No surcharge to any Member shall be permitted. A surcharge shall, for purposes of this Agreement, be deemed to be any additional fee not provided for in the Plan.

5.3.2 Group and Group Practitioners shall bill and make reasonable efforts to collect all Co-payments, Coinsurance and Deductibles from Members as specifically permitted in the Plan, if such amounts have not been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits.

5.3.3 Group and Group Practitioners shall not bill a Member for otherwise Covered Services denied as a result of utilization management, Medical Necessity determination, or audit activity.

5.3.4 Group and Group Practitioners shall not bill Member for any non-Covered Services unless Group or Group Practitioner has obtained prior written agreement from the Member and such billing is permitted under the Plan or otherwise permitted by CMS or the Oregon Health Plan. Group or Group Practitioner shall not bill Member for missed appointments.

5.3.5 Group and Group Practitioners agree the provisions of this Section 5 shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members.

5.4 Coordination of Benefits and Third Party Liability.

5.4.1 Coordination of Benefits (COB) refers to the determination of which two or more health benefit plans will apply, either as primary or secondary coverage, for the rendition of hospital, surgical, medical or behavioral health services to a Member. Such coordination is intended to preclude the Member from receiving an aggregate of more than 100 percent of covered charges from all coverage. When the primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures employed by the Oregon Department of Consumer and Business Services and applicable state and federal regulations.

5.4.2 Group and Group Practitioners shall maintain records to identify any third party or payor responsible for payment for services provided to Members. Group and Group Practitioners shall notify FamilyCare within 30 days of any potential responsible third party and shall provide FamilyCare with all relevant identifying information concerning the Member, the claim and the third party resource available to Group or Group Practitioners.

5.4.3 Group or Group Practitioners agree to coordinate with FamilyCare for proper determination of COB and third party liability, and to bill and collect from other payors those charges for which the other payor is responsible. Group and Group Practitioners shall report all collections received in accordance with this paragraph to FamilyCare. FamilyCare shall not be obligated to pay Group or Group Practitioners any amounts which, when added to the amounts paid to Group or Group Practitioners in accordance with this paragraph by other payors, would exceed the reimbursement for which FamilyCare would be obligated in the absence of such payments from other payors.

5.5 Overpayments. FamilyCare will conduct retrospective reviews of claims and reimbursements to Group or Group Practitioners. Group and Group Practitioners will refund to FamilyCare all overpayment amounts paid to Group or Group Practitioners, whether not properly payable under paragraph 5.2, due to clerical error, failure to apply or follow applicable Policies and Procedures, third party recovery or other reason. Overpayments shall be refunded to

FamilyCare within 30 days of notification to Group or Group Practitioners that a refund is due or within 60 days of identification of an overpayment by Group or Group Practitioners, whichever is earlier. If Group or Group Practitioner fails to refund an overpayment within thirty days after FamilyCare's notification, FamilyCare may withhold any overpayment amount from future payments for services rendered by Group or Group Practitioners. If a refund is not timely received, FamilyCare may initiate a collection or legal proceeding to recover overpayment amounts; in a collection or legal proceeding to recover overpayment, FamilyCare shall be entitled to recover its reasonable attorneys' fees and costs incurred in such proceeding.

5.6 Accounting and Reports. To the extent that payments to Group or Group Practitioners for Covered Service include financial risk withholds, FamilyCare shall provide an accounting of risk withhold funds on an annual basis or as required by law. Requests for information under this paragraph concerning such accounting must be made within two years after the end of the agreement term pertaining to the requested information.

5.7 Tax Obligations. Group and Group Practitioners shall be responsible for appropriate management of all federal and state tax obligations applicable to compensation or payments paid to Group and Group Practitioners, respectively, under this Agreement.

6. Term and Termination.

6.1 Term of Agreement. This Agreement will become effective on the Effective Date set forth on the signature page and will continue until terminated in accordance with this Section 6.

6.2 Immediate Termination. This Agreement may be immediately terminated upon delivery of written notice to the other party, or at such later date as may be set forth in the written notice, if any of the following occurs.

6.2.1 Federal or state regulations or guidelines are modified or changed in such a way that Covered Services are no longer allowable or appropriate for purchase under this Agreement;

6.2.2 Group or Group Practitioner or FamilyCare is found to be in violation of any state or federal law or regulation;

6.2.3 Any license, certification, or privilege required by law or regulation to fulfill obligations under this Agreement is for any reason revoked, restricted, limited, suspended or not renewed;

6.2.4 Group or Group Practitioner or FamilyCare is suspended or excluded from participating in the Medicaid program;

6.2.5 Group or Group Practitioner fails to maintain insurance required by this Agreement; or

6.2.6 Group or Group Practitioner is convicted of a felony; dies; retires; is adjudicated incompetent; loses his or her hospital privileges (unless such privileges are not

required under FamilyCare's credentialing Policies and Procedures); or voluntarily leaves active practice in FamilyCare's service area for a period of 6 months or more.

6.3 Termination by FamilyCare. FamilyCare may terminate this Agreement immediately on written notice to Group if FamilyCare reasonably determines that the health, safety or welfare of Members may be jeopardized by continuation of this Agreement or if Group has failed to meet objective patient care quality standards.

6.4 Termination Without Cause. This Agreement may be terminated without cause by Group or FamilyCare upon 90 days prior written notice. Upon such termination, the rights of Group and Group Practitioners shall terminate; provided, however, that such action shall not release Group and Group Practitioners from obligations to persons then receiving treatment. If this Agreement is terminated under this paragraph 6.4, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement.

6.5 Termination for Breach. If either party commits a material breach of this Agreement, the other party may commence to terminate the Agreement by giving written notice to the party committing the breach stating its intention to terminate and starting with particularity the alleged breach. If the breach is not cured within 30 days after the notice is given, the other party may terminate this Agreement immediately upon written notice. This right of termination shall be in addition to all other rights and remedies.

6.6 Responsibility for Members at Termination. Group or Group Practitioners shall continue to provide Covered Services to a Member who is receiving Covered Services from Group or Group Practitioners on the effective termination date of this Agreement, until the Covered Services being rendered to the Member by Group or Group Practitioners are completed (consistent with existing professional ethical/legal requirements for providing continuity of care to a patient), unless FamilyCare makes reasonable and medically appropriate provision for the assumption of such Covered Services by another Participating Provider. Group or Group Practitioner shall be compensated for those Covered Services provided to a Member pursuant to this paragraph (prior to and following the effective termination date) in accordance with compensation provisions stated in the applicable Services and Compensation Attachment or by mutual agreement.

6.7 Effect of Termination. Termination of this Agreement shall have no effect upon the rights and obligations of the parties arising under this Agreement prior to the effective date of termination or upon those provisions which are specifically identified as surviving termination.

6.8 Termination With Cause of Less Than Entire Agreement. FamilyCare may, at its sole discretion, choose to terminate an individual Group Practitioner providing Covered Services under this Agreement whose conduct would otherwise give FamilyCare cause to terminate this Agreement in its entirety, who does not meet FamilyCare's credentialing requirements, who fails to meet objective patient care quality standards, as applicable, or on request of a Plan. Upon such individual termination, the Agreement shall remain in effect as to Group and all other Group Practitioners.

6.9 Credentialing and Hearings Process. Group and Group Practitioners will comply with FamilyCare's hearings process as set forth in its Policies and Procedures. FamilyCare may

suspend, restrict or terminate Group or a Group Practitioner's privileges to see Members in accordance with its Policies and Procedures. In the event that Group Practitioner's status is terminated in accordance with such Policies and Procedures, Group Practitioner's participation under this Agreement shall automatically terminate. If FamilyCare proposes to terminate Group Practitioner's participation under this Agreement, Group Practitioner may be entitled to a review or hearing as provided by FamilyCare's Policies and Procedures.

7. Addition of Plan or Amendment of Services and Compensation Attachment.

7.1 New Plan. FamilyCare may, in its sole discretion, notify Group from time to time of new Plans by sending Group a Services and Compensation Attachment covering each new Plan in which FamilyCare wishes Group and Group Practitioners to participate as provided in paragraph 11.1. If Group rejects the proposed Attachment within 30 days in accordance with paragraph 11.1, such Attachment shall not go into effect. If such Attachment becomes effective as provided in paragraph 11.1, Group shall notify its Group Practitioners about the new Plan and shall make any contract amendments required to make the terms and conditions of the new Attachment binding on its Group and Group Practitioners.

7.2 Amendment of Services and Compensation Attachment. FamilyCare may amend a Services and Compensation Attachment from time to time. Any such amendment shall be sent to Group as provided in paragraph 11.1. If Group rejects the amended Attachment within thirty (30) days in accordance with paragraph 11.1, then either party may terminate this Agreement in accordance with Section 6; until any such termination is effective, the Services and Compensation Attachment effective prior to termination shall continue in effect.

8. Relationship of the Parties. Nothing in this Agreement shall create any relationship between FamilyCare and Group or Group Practitioner other than that of independent entities contracting with each other solely for purposes of effectuating the provisions of this Agreement. Neither of the parties nor any of their respective employees or agents shall be deemed to be the employee or agent of the other. Except as specifically provided otherwise in this Agreement, FamilyCare shall have no authority to control or direct the time, place or manner in which Covered Services are provided by Group or Group Practitioner to Members.

9. Indemnification and Insurance.

9.1 Indemnification.

9.1.1 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 attorneys' 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 person or entity is a Participating Provider does not make such person an agent of FamilyCare. The principles of comparative fault shall govern the interpretation and enforcement of this indemnity provision.

9.1.2 FamilyCare shall not be liable to Members for any act of malpractice on the part of Group or Group Practitioners and Group and Group Practitioners shall indemnify, defend, and hold harmless FamilyCare from any such liability. The indemnity in the immediately

preceding sentence shall not apply to any alleged act of independent liability on the part of FamilyCare, or any of its respective employees or agents.

9.2 Liability Insurance. Group and Group Practitioners agree to ensure that it and all persons and entities performing services for Group or Group Practitioners 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 FamilyCare to insure Group and Group Practitioners, and its and their 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 Group or Group Practitioners, and activities performed by Group or Group Practitioners in connection with this Agreement. The amounts and extent of such insurance coverage shall be subject to the approval of FamilyCare, which approval shall not be unreasonably withheld. Certificates of Insurance for the above insurance policies shall be provided to FamilyCare upon request and shall provide that FamilyCare be given at least 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 FamilyCare as deemed necessary. FamilyCare recognizes that if Group is a public entity its liability may be limited by applicable law.

9.3 Tail Coverage. In the event that any policy required by this Section 9 is a “claims made” policy, a “tail” policy (extended reporting endorsement) shall be obtained by the insured party upon termination of such a policy as required to continuously maintain coverage under such policy throughout the term of this Agreement and for a period of not less than five years following the date of termination of the policy required by this paragraph. The “tail” policy shall have the same policy limits as the policy it extends.

9.4 Contracted Providers. If Group or Group Practitioners contract with health care professionals to provide services to Members, each contract between Group or Group Practitioners and such health care professionals shall require such health professionals to agree to and comply with all of the provisions of this Agreement, including this Section 9, as if such providers were a party to this Agreement. FamilyCare must authorize the use of a contractor to perform services covered under this Agreement prior to any such services being provided. FamilyCare has the sole discretion to deny authorization for contracting of health care services to be provided for Members. Group and Group Practitioners, and not FamilyCare, shall be responsible for any compensation or remuneration owed to such contractor.

9.5 Survival. This Section 9 shall survive termination of this Agreement.

10. Access and Maintenance of Records and Information.

10.1 Access. This Agreement and all records which are directly pertinent to this Agreement necessary to verify the nature and extent of costs of services provided by Group or Group Practitioners, or relating to medical or behavioral health services, price, performance, compliance, quality of services and timeliness of services, will be made available to FamilyCare, the State of Oregon, the Oregon Health Authority, AMH, the U.S. Department of Health and

Human Services, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, and all of their duly authorized representatives as may be necessary for compliance by FamilyCare with all applicable federal and state laws and regulations. Such representatives shall have access to documents, papers, and records of Group and Group Practitioners, which are pertinent to the Plan for the purpose of making examination, excerpts and transcripts. Group and Group Practitioners shall, upon 30 days' notice, provide a suitable work area and copying capabilities or make such copies as requested to facilitate such a review upon reasonable written notice to Group or Group Practitioners. Such rights to inspect and copy records and information shall continue for 10 years following the date of termination of this Agreement or completion of any audit commenced prior to termination, whichever is later. Group and Group Practitioners shall include a provision requiring any contractor of Group or Group Practitioners providing services under this Agreement to comply with this paragraph, and shall require all organizations related to Group and Group Practitioners to comply with this paragraph.

10.2 Medical Records (Maintenance and Access). Medical and treatment records of Members shall be maintained and preserved by Group and Group Practitioners for a time period of no less than 10 years in accordance with general standards applicable to such records. Subject to confidentiality laws, and upon receipt of three business days' prior written notice from FamilyCare, Group and Group Practitioners shall permit FamilyCare, FamilyCare's designated representatives, or applicable state and federal regulatory agencies to inspect such records, and shall provide copies of such records to FamilyCare upon request. If an audit, litigation, or other action involving the records is started before the end of the 10-year period, the records must be retained until all issues arising out of the action are resolved or until the end of the 10-year period, whichever is later. Group and Group Practitioners shall also cooperate with FamilyCare, AMH, the Oregon Department of Justice Medicaid Fraud Unit, and the Centers for Medicare and Medicaid Services, or other authorized state or federal reviewers, for purposes of audits, inspection and examination of Member medical and treatment records. Medical and treatment records documentation must be sufficiently complete and accurate to permit evaluation and confirmation that coordinated care services were authorized and provided, Referrals were made, and outcomes of coordinated care and Referrals were sufficient to meet professional standards applicable to the health care professional and must meet the requirements under FamilyCare's Policies and Procedures.

10.3 Financial Records (Maintenance and Access). Group and Group Practitioners agree to cooperate with FamilyCare so that FamilyCare may meet any state or federal access requirements imposed on FamilyCare and arising out of this Agreement. Group and Group Practitioners shall maintain financial records, including the amounts of any payments received from FamilyCare, Members or from others on behalf of Members, for at least ten years after final payment is made under this Agreement. If an audit, litigation, or other action involving the records is started before the end of the ten-year period, the records must be retained until all issues arising out of the action are resolved or until the end of the ten-year period, whichever is later. All such records shall be maintained pursuant to generally accepted accounting standards and in accordance with applicable state and federal law and all regulations issued pursuant thereto. Group and Group Practitioners shall provide access to such records to FamilyCare, FamilyCare's designated representatives, and state and federal regulatory agencies, as may be required.

10.4 Confidentiality and Proprietary Information. The parties agree to maintain the confidentiality of this Agreement and all documents, terms, and conditions relating to reimbursement rates and methods and other proprietary information of the other party. Upon request, the parties agree to return all copies of documents containing the other party's proprietary information upon termination of this Agreement and to otherwise keep such proprietary information confidential.

10.5 Review Charges. Medical and treatment records or financial records requested by FamilyCare for claims payment, concurrent and/or retrospective review or for audit under the Quality Improvement and Utilization Management Programs shall be provided to FamilyCare by Group or Group Practitioners. Neither FamilyCare nor Member will be charged a fee for the cost associated with providing copies of such records or documents.

10.6 Access to Medical Records Upon Termination. Group and Group Practitioners shall provide FamilyCare and Members with reasonable access to medical and treatment records of Members maintained by Group or Group Practitioner for a period of ten years after the termination of this Agreement, and at any time thereafter that such access is required in connection with a Member's medical or behavioral health care. FamilyCare will be entitled to obtain copies of Member's medical and treatment records if it either makes arrangements to have such copies prepared on Group or Group Practitioner's premises (in which case, Group or Group Practitioner will be entitled to reimbursement for the reasonable costs incurred in collecting the records and supervising the copying process), or agrees to reimburse Group or Group Practitioner for the reasonable cost of preparing such copies. The provisions of this paragraph will not operate to waive or limit any restriction on release or disclosure of patient records established in any other provision of this Agreement or as otherwise required by law. The provisions of this paragraph will not operate to waive or limit any right of access to medical and treatment records that Members have under any provision of state or federal law.

10.7 Survival of Provisions. This Section 10 will survive the termination of this Agreement.

11. Miscellaneous.

11.1 Amendment. This Agreement may be amended, and an Attachment to this Agreement may be amended or added, at any time upon the written agreement of the parties. FamilyCare may amend this Agreement, or amend or add an Attachment to this Agreement, by notifying Group in writing of the proposed amendment or addition. If no written objection to such amendment or addition is received by FamilyCare within 30 days of the date of the notice, such amendment or addition shall become effective without any further action required of FamilyCare or Group and Group Practitioners. If Group or Group Practitioner objects to such amendment or addition within the 30-day period, such amendment or addition will not go into effect. If state or federal law, government agency regulations or accrediting agency requirements change and affect any provisions of this Agreement or an Attachment to this Agreement, then this Agreement or the applicable Attachment will be amended to conform with such changes effective on notice to Group or Group Practitioners of the required amendments. FamilyCare will give Group and Group Practitioners written notice of such required changes.

11.2 Dispute Resolution and 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 in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. 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 mediation or arbitration equally, including filing, administration, and mediator's or arbitrator's fees, but to be responsible each for its own attorneys' fees and other costs incurred. 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, each party shall be responsible for its own attorneys' fees and costs, except as provided by paragraph 5.5.

11.3 Assignment. This Agreement shall be binding upon, and shall inure to the benefit of, the parties to it, and their respective heirs, legal representatives, successors and assigns. Group or Group Practitioner may not assign its rights, duties or obligations under this Agreement without the prior written consent of FamilyCare. Any merger, consolidation, share exchange or transaction involving a change in the ownership of more than 50 percent of any class of shares, membership units, partnership units or other such interests of Group shall constitute an assignment for purposes of this paragraph 11.3. FamilyCare may assign this Agreement to a successor by affiliation, merger, acquisition or transfer of assets or otherwise without consent of Group.

11.4 No Third Party Beneficiary. Except as expressly provided in paragraph 5.3 or a Services and Compensation Attachment, nothing in this Agreement, express or implied, shall be construed to confer upon any person, firm or corporation other than the parties hereto and their respective successors or assigns, any remedy or claim under or by reason of this Agreement or any term, covenant or condition hereof, as third party beneficiaries or otherwise, and all of the terms, covenants and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns as provided herein.

11.5 Notice. All notices required by this Agreement shall be in writing addressed to the party to whom the notice is directed at the address of that party set forth below the signatures on this Agreement and shall be deemed to have been given for all purposes upon receipt when personally delivered; one day after being sent, when sent by recognized overnight courier service; two days after deposit in United States mail, postage prepaid, regular or certified mail; or on the date transmitted electronically to the email address of the other party or by facsimile. Any party may designate a different address or a different person for all future notices by notice given in accordance with this paragraph.

11.6 Entire Agreement. This Agreement is the entire agreement of the parties. There are no promises, terms, conditions, or obligations other than those contained in this Agreement. This Agreement shall supersede all prior communications, representations, and agreements, oral or written, of the parties.

11.7 Interpretation. The paragraph headings are for the convenience of the reader only and are not intended to act as a limitation on the scope or meaning of the paragraphs themselves. Both parties have had the opportunity to review and negotiate this Agreement and consult with

such attorneys and advisors as they deemed appropriate prior to execution of this Agreement. This Agreement shall not be construed against the drafting party.

11.8 Severability. The invalidity of any term or provision of this Agreement shall not affect the validity of any other provision.

11.9 Waiver. Waiver by any party of strict performance of any provision of this Agreement shall not be a waiver of or prejudice any party's right to require strict performance of the same provision in the future or of any other provision.

11.10 Governing Law. This Agreement shall be interpreted and enforced according to the laws of the State of Oregon.

11.11 Counterparts. This Agreement may be executed in multiple counterparts, each of which together shall constitute one agreement, even though all parties do not sign the same counterpart.

11.12 Required Medicaid Contract Language. The contract provisions set forth in the attached Oregon Health Plan – Specific Provisions in Attachment B are specifically incorporated into this Agreement by this reference. In the event there is a conflict between the language in this Agreement and the provisions in such Attachment B, then the Oregon Health Plan – Specific Provisions in Attachment B shall control.

11.13 Attachments. All Attachments referred to in this Agreement are incorporated by reference.

The parties, by signature of their authorized representatives on the signature page of this Agreement, agree to be bound by the terms and conditions of this Agreement.



**FAMILYCARE, INC.
MEDICAID GROUP PROVIDER AGREEMENT
SIGNATURE PAGE**

This Agreement (“Agreement”) is made and entered into by the Parties named below, as evidenced by their signatures below:

FAMILYCARE, INC.:

By: _____
[signature]

Name/Title: _____

Dated: _____

Address: 825 NE Multnomah, Suite 1400
Portland, OR 97232

**CLACKAMAS COUNTY
Acting by and through its Health, Housing and Human Services Department,
Health Centers Division:**

By: _____
[signature]

Name/Title: _____

Dated: _____

Address: _____

Tax Identification Number: _____

EFFECTIVE DATE: _____