MOLINA HEALTHCARE OF WASHINGTON, INC.

COMBINED PROVIDER SERVICES AGREEMENT

This Combined Provider Services Agreement ("Agreement") is entered by and between Molina Healthcare of Washington, Inc., a Washington corporation ("Health Plan"), and Providence Health & Services, Washington ("Provider"). The purpose of this Agreement is to make available Covered Services to Members according to the terms and conditions set forth below.

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Covered Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE - DEFINITIONS

1.1 Capitalized words or phrases in this Agreement shall have the meaning set forth below:

a. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.

b. **Agreement** means this Combined Provider Services Agreement, all Attachments, and incorporated documents or materials.

c. **Capitated Provider** is a Provider who receives a monthly premium from Health Plan for each Member assigned to Provider. Capitated Provider may be responsible for payment of all covered health services (professional, institutional, pharmacy) incurred by Member.

d. **CMS** is the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.

e. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.

f. **Clean Claim** means a Claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.

g. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product which covers the Member.

h. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products, below the level of the arrangement between Health Plan (or applicant) and Provider. These written

arrangements continue down to the level of the ultimate provider for health and administrative services.

i. **Emergency Services** are Covered Services necessary to evaluate or stabilize 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 to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. For Health Plan's Medicaid Members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114. Health Plan reserves the right to investigate certain emergency care Claims to determine if a Claim meets the definition of Emergency Services. If Health Plan denies a Claim on the basis that a reasonably prudent layperson would not have believed that an emergency health condition existed, the Member may exercise the right of appeal under the Grievance Program.

j. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.

k. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

l. **HCA** means The Washington State Health Care Authority.

m. **Health Benefit Exchange** means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act.

n. **Health Plan** means Molina Healthcare of Washington, Inc.

o. **HEDIS Studies** means Healthcare Effectiveness Data and Information Set.

p. **Hospital Provider(s)** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Provider to provide Covered Services to Members.

q. **IPA** means Independent Practice Association.

r. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

s. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.

t. **Medicare** is the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

u. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products and who is eligible to receive Covered Services.

v. **Molina Health Benefit Exchange Product** means those health benefit programs offered and sold by Health Plan to individuals or employers who obtain health coverage through the Washington Health Benefit Exchange.

w. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified in the compensation exhibit(s), and which will include any successors to such Products.

x. **Prior Authorization** means the requirement that a provider must request, on behalf of a Member and when required by rule or state and government billing instructions, the state or governments designee's approval to provide a health care service before the Member receives the health care service, prescribed drug, device, or drug-related supply. The approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization (WAC 182-500-0085).

y. **Provider** means the person(s) and/or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services (42 CFR 438.2).. Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Hospital. All of said persons are bound by the terms of this Agreement.

z. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.

aa. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.

bb. **Subcontract** means any separate agreement or contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

cc. **Subcontractor** means any separate agreement or contract between Health Plan and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Health Plan is obligated to perform pursuant to Health Plan's contract with the State or CMS.

dd. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Serving as a Panel Provider.** Provider shall provide hospital inpatient and/or outpatient services to Members for the products specified in Exhibit 1. Provider agrees that its facility information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this facility information.

2.2 **Standards for Provision of Care**

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member or rendering services, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care. For services that result in an admission, Provider shall notify Health Plan or its agent within 24 hours of stabilization and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in the Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan of any admission within a maximum of 24 hours of admission or by the end of the next business day following.

   Provider may appeal a Clean Claim that was denied due solely to Provider's failure to obtain a prior authorization. A denial may be reversed on appeal if each of the following requirements are met: (i) Provider demonstrates the services provided by Provider were Medically Necessary based upon the information available to Provider at the time the services were provided; and (ii) Health Plan determines the services received by Member were benefits of the Member's Product. The Medical Necessity review may include, but is not limited to, a review of the length of stay and level of care provided such as observation or inpatient admission.

   Provider agrees to meet and discuss potential solutions to lower the rate of appeals should Health Plan determine appeals volume is higher than expected.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("participating providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Availability of Services**. Provider shall make Covered Services available 24 hours a day, 7 days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

h. **Subcontract Arrangements**. Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.

i. **Treatment Alternatives**. Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations to Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

2.3 **Standards for Hospital Providers**

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(cs) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's contracted providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification**. Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 **Nondiscrimination.**

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 **Recordkeeping**

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan's Quality Improvement Program, Consumer Assessment of Health Plans (CAHPS), or Claims payment. Health Plan will not pay copying fees when records are requested for any of the above listed programs. Provider shall further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan.

e. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

f. **National Provider Identifier ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and encounters (both electronic and paper formats) submitted to Health Plan.

2.6 **Program Participation**

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider will follow the terms set forth in Health Plan's Provider Manual, which may be amended from time to time at Health Plan's sole discretion. Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual and any additional operating procedures and policies for Providers which are communicated to Provider in writing by Health Plan. Provider acknowledges it received Health Plan's Provider Manual. In the event Provider Manual is in conflict with Agreement, Agreement will prevail.

f. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs. Provider shall comply with any term or condition of those government sponsored program contracts that are applicable to the services to be performed under this Agreement.

g. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

h. **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

i. **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal.

2.7 **Promotional Activities.** At the request of Health Plan, Provider shall (1) display Health Plan promotional materials in its offices and facilities as practical, and (2) shall cooperate with and participate in all reasonable Health Plan marketing efforts. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 **Licensure and Standing**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.**. Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state, commonwealth or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities ("LEIE" list), the System for Award Management ("SAM"), any other list maintained by a state, commonwealth, or federal government and every state, commonwealth, and the District of Columbia's Medicaid exclusion lists to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded, or could be suspended or excluded, from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan may collect the amount by: (i) offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider agrees it will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with laws and government program requirements. This section will survive any termination.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's financial soundness.

d. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan.

2.9 **Claims Payment**

a. **Submitting Claims.** Provider shall promptly submit to Health Plan Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include medical records required by Health Plan's policies and procedures. Claims must be submitted by Provider to Health Plan within three hundred sixty-five (365) days of providing the Covered Services that are the subject of the Claim. If Health Plan is not the primary payer under coordination of benefits, Provider must submit Claims to Health Plan within three hundred sixty-five (365) days from the primary payer's date of payment or date of contest, denial or notice. Except as otherwise provided by law or provided by government sponsored program requirements, any Claims

that are not submitted by Provider to Health Plan three hundred sixty-five (365) days from the date of providing the Covered Service or three hundred sixty-five (365) days from the primary payer's payment or date of contest, denial or notice shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Exhibit 1 and its applicable sub-exhibits. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments, Deductibles and Co-insurance.** Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member's Health Plan product.

d. **Member Hold Harmless.**

i. Provider hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan's insolvency, or breach of this contract will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or person acting on their behalf, other than Health Plan, for services provided pursuant to this Agreement. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for noncovered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's health plan.

ii. Provider agrees in the event of Health Plan's insolvency to continue to provide the services promised in this Agreement to Members of Health Plan for the duration of the period for which premiums on behalf of the Member were paid to Health Plan or until the Member's discharge from inpatient facilities, whichever time is greater.

iii. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's Health Plan.

iv. Provider may not bill the Member for Covered Services except for deductibles, copayments, or coinsurance where Health Plan denies payments because Provider has failed to comply with the terms of this Agreement.

v. Provider further agrees i) that the provisions of paragraphs i, ii, iii, iv of this section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Health Plan's Members; and ii) that this provision supersedes any oral or written contrary agreement not existing or hereafter entered into between Provider and Member or persons acting on their behalf.

vi. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of Health Plan with expectation of receiving payment directly or indirectly from Health Plan, such providers or facilities must agree to abide by paragraphs i, ii, iii, iv, v, of this section

e. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Exhibit 1 and its applicable sub-exhibits.

f. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan,

who receives a global capitation from Health Plan for both professional and facility services and is responsible for arranging for Covered Services through subcontractual arrangements ("Capitated Provider"), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan's agreements with such Capitated Providers. Capitated Provider will reimburse Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Exhibit 1 and its applicable sub-exhibits.

2.10 **Claims Review**

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such Claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless the medical information available to the Provider at the time the services were rendered do not support the specific services and/or level of care authorized by Health Plan or the prior authorization was based upon a material misrepresentation by the Provider. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** In the event that Health Plan determines that a Claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Health Plan may make a written request for repayment: (1) within twenty-four (24) months after the date that the payment was made; (2) within thirty (30) months after the date that the payment was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the Claim; or (3) at any time if a third party is found responsible for satisfaction of the Claim as a consequence of liability imposed by law and Health Plan is unable to recover directly from the third party because the third party has either already paid or will pay Provider the health care services covered by the Claim. Provider may contest Health Plan's request in writing by participating in the Claims dispute process as outlined in Section 2.10e. Overpayment and duplicate payment disputes must be submitted in writing within thirty (30) days of receipt of request. If it is decided that Health Plan will recover the contested payment, such refund may be recovered by way of offset or recoupment from current or future amounts due Provider after six (6) months have passed from the date Health Plan received Provider's written notice contesting the repayment. In addition to any other contractual or legal remedy, if Provider fails to contest Health's Plan's request for a refund in writing within thirty (30) days of receipt of the request or if Provider contested the request and six (6) months has passed from the date Provider received Health Plan's refund request, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. Nothing in this section prohibits Provider from choosing at any time to refund to Health Plan any payment previously made

by Health Plan to satisfy a Claim either by way of repayment by Provider or a request that Health Plan offset or recoup the money from current or future amounts due Provider.

e. **Claims Dispute Process**. In the event that Provider determines that a Claim has been improperly denied or underpaid, Provider may make a written request for payment: (1) within twenty-four (24) months after the date the Claim was denied or payment intended to satisfy the Claim was made or (2) within thirty (30) months after the date the Claim was denied or payment intended to satisfy the Claim was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the Claim. Provider may not request that payment be made any sooner than six (6) months after Health Plan's receipt of the request. Any request for review of denied or underpaid Claims must be submitted to Health Plan in accordance with the requirements stated in this section and conform to the following instructions:

i. The request must specify why the Provider believes Health Plan owes the payment;
ii. In the case of coordination of benefits, the request must include the name and mailing address of any entity that has disclaimed responsibility for payment;
iii. The request must be addressed to the attention of Health Plan's Provider Services Department;
iv. The request must clearly indicate "Denied Claims Review Request" or "Adjustment Request"; and
v. The request must include all pertinent information, including, but not limited to, Claim number, Member identifier, denial letter, supporting medical records, and any new information pertinent to the request.
vi. Health Plan will render a decision on all disputed Claims within sixty (60) days of receipt of the Claim.
vii. Should Provider not be satisfied with Health Plan's decision, Provider may proceed to the mediation steps outlined in Section 5.8.

f. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable leel. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits.. Provider shall cooperate with Health Plan's audits of Claims and payments by providing access to requested Claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

g. **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination**.**

2.11 **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, Title XIX and Title XXI of the SSA and Title 42 CFR, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; the Americans with Disabilities Act, and Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment 2.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment 3, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.

c. For Covered Services rendered to Members enrolled in a Molina Health Benefit Exchange Product, Medicaid statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements of the Washington Health Benefit Exchange Act, including the 2012 regular session laws, chapter 87 Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71.

2.12 **Provider Non-solicitation Obligations**. Provider shall not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 **Fraud and Abuse Reporting**. Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.

2.14 **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.15 **Confidentiality.** Each party agrees that the terms set forth in this Agreement are strictly confidential and neither party shall disclose such terms to any person or entity for purposes other than the administration of the Agreement without receiving prior written consent of the other party, except as required by law or government program.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Exhibit 1 and its applicable sub-exhibits.

3.2 **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.

3.5 **Provider Directory.** Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of the scientific, technical, and medical aspects of Health Plan.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term.** This Agreement shall commence on the date this Agreement is signed by Health Plan (Effective Date) and shall continue in effect for one (1) year; it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state licensing statutes and regulations set forth in Attachment 2 and Attachment 3.

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;

f. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

g. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members' health and safety.

4.5 **Termination Notification to Members.** Upon receipt of termination by either Health Plan or Provider, Health Plan will inform affected Members of such termination notice in accordance with the process set forth in the Provider Manual. Health Plan will make a good faith effort to ensure that such notice is provided at least thirty (30) days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty (30) days' notice to a provider or carrier to all

Members. Members may then be required to select another provider contracted with Health Plan prior to the effective date of termination of this Agreement.

ARTICLE FIVE - GENERAL PROVISIONS

5.1 **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 **Entire Agreement.** This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan, the contract between the Washington Department of Social and Health Services and the Health Plan shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 **Notice.** All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by US Postal Service registered, certified or Express mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, by electronic mail (e-mail) or other electronic means of delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Health Plan:

Molina Healthcare of Washington, Inc.
21540 30th Drive SE Suite #400
Bothell, WA 98021
Attention: President
Email: MHWProviderContracting@molinahealthcare.com

If to Provider:

Providence Health & Services
Attn: Payer Contracting – Contract Administration
4400 NE Halsey, Building 2, 3rd Floor
Portland, OR 97213
Fax: 971-712-2137
Email: Contract.Administration@providence.org

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.6 **Amendment.** Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Any other amendments to this Agreement shall require the written agreement of both parties.

5.7 **Assignment.** Neither Party may assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of the other Party. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of either party nor a change of its legal name shall be deemed an assignment.

5.8 **Dispute Resolution Process**

a. Submission of Non-Claims Payment Related Disputes

i. Provider shall submit any dispute (other than a dispute relating to Claims, which are subject to Section 2.10(e)) to Health Plan in writing within sixty (60) days of when the issue arises.

ii. Provider shall submit said disputes to the attention of Health Plan's Provider Services Department.

b. Health Plan Response to Non-Claims Related Disputes

i. Health Plan shall use best efforts to acknowledge by phone, e-mail or other writing, receipt of a dispute (other than a dispute relating to Claims, which are subject to section 2.10(e)) within seven (7) business days.

ii. Health Plan's decision regarding disputes shall be communicated within sixty (60) days of Health Plan's receipt of Provider's written correspondence requesting review. If additional time is required Health Plan shall communicate this information to Provider within sixty (60) days.

iii. Health Plan shall use its best efforts to investigate and resolve disputes within sixty (60) days of Health Plan's receipt of Provider's written correspondence.

c. Nonbinding Mediation. If Provider is dissatisfied with Health Plan's final resolution of a dispute or if Health Plan fails to grant or reject Provider's request for review of a dispute within thirty (30) days after it is received, Provider may submit the dispute to nonbinding mediation pursuant to chapter 7.07 RCW. Nonbinding mediation shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters.

5.9 **Corrective Action, Fair Hearing Plan, and Reporting to the State of Washington Medical Quality Assurance Commission and the NPDB.** Provider has a procedural right to appeal in the event that Health Plan's peer review committee recommends filing a report to the Washington Medical Quality Assurance Commission and the NPDB. The appeal right, Fair Hearing process, and the requirement to report to the Washington Medical Quality Assurance Commission and NPDB are described in Health Plan's Fair Hearing Plan.

5.10 **Arbitration**. Health Plan and Provider agree, as a condition precedent to the commencement of any civil action in any court of competent jurisdiction, to submit to arbitration all disputes arising from or related to

this Agreement and the rendition of services to Members pursuant to this Agreement which are not otherwise resolved pursuant to the processes set forth at Sections 2.10(e) and 5.8; provided, however, that arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider's professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. Arbitration shall proceed according to the rules and regulations of the American Arbitration Association, then in effect, and shall be conducted in King County, Washington. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law. Nor shall the arbitrator have the authority to award punitive damages. The parties recognize that the arbitrator's decision is not binding and that either party may seek judicial remedies following the arbitration of a dispute. The panel of arbitrators shall be selected as follows: one arbitrator shall be designated by Health Plan; one arbitrator shall be designated by Provider; and the third arbitrator shall be selected by the arbitrators designated by Provider and Health Plan. Health Plan and Provider shall divide and share equally the cost of arbitration. Each party shall be responsible for its own attorneys' fees.

5.11 **Attachments.** Each of the Attachments and Exhibits (as selected) and identified below is hereby made a part of this Agreement:

☒Attachment 1 – Provider Identification Sheet
☒Attachment 2 – Required Provisions (Health Care Service Plans)
☒Attachment 3 – Required Provisions (Health Care Authority)
☒Attachment 4 – Medicare Program Requirements-Health Care Services
☐Attachment 5 – Indian Health Care Providers Medicaid/CHIP Provisions
☐Attachment 6 – Indian Health Care Providers–Qualified Health Plan
☒Exhibit 1-A - Compensation Schedule - Medicaid (Version 1)
☒Exhibit 1-A - Compensation Schedule - Medicaid (Version 2)
☒Exhibit 1-B - Compensation Schedule - Medicare (Version 1)
☒Exhibit 1-B - Compensation Schedule - Medicare (Version 2)
☒Exhibit 1-C - Compensation Schedule - Molina Marketplace (Version 1)
☒Exhibit 1-C - Compensation Schedule - Molina Marketplace (Version 2)
☒Exhibit 1-D - Compensation Schedule - Providence Health & Services - Oregon DBA Providence Medical Group - Clark County Service Locations
☒Exhibit 1-E - Compensation Schedule - Integrated Managed Care
☒Exhibit 1-F - Medicare Quality Bonus Program
☒Exhibit 2 - Concurrent Review and Denial Inpatient Services Pilot Program

5.12 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product shall govern.

5.13 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

5.14 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party if it is determined that such Party: (i) used the efforts a reasonable person would during a force majeure event to perform its duties under this Agreement; and (ii) the Party's inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.

5.15 **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

5.16 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.

5.17 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

5.18 **Business Continuity Plan**. Provider represents it currently maintains and will continue to maintain a plan to use during emergency events that adversely impact Provider's staffing and physical and technological infrastructure. For the purposes of this section, the plan will be referred to as the "Business Continuity Plan". The Business Continuity Plan will address, at a minimum: (i) processes and resources needed to ensure continuity and re-establishment of health care services; (ii) data backup and recovery procedures and fail-over procedures; (iii) how Provider will interact with its business continuity suppliers, if any; and (iv) alternate service/business locations. Within thirty (30) days following the Effective Date, Provider will attest it has a Business Continuity Plan containing the minimum elements outlined in (i) – (iv) herein. Thereafter, Provider will attest on an annual basis that that it maintains a Business Continuity Plan with the minimum required elements and that it has been tested.

5.19 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

5.20 **Ethical and Religious Directives.** Health Plan and Provider acknowledge that the Provider's policies and procedures in accordance with the Ethical and Religious Directives and the principles and beliefs of the Roman Catholic Church is a matter of conscience to Provider. Neither this Agreement nor any part hereof, except for the terms and conditions set forth in accordance with state and Federal law and government sponsored health program requirements, is intended to require Provider to violate said Ethical and Religious Directives in its operation. "Ethical and Religious Directives" means the Ethical and Religious Directives for Catholic Health Care Services dated June 2018, as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church, and as amended. The Ethical & Religious Directives are available at the following website: http://www.usccb.org/about/doctrine/ethical-and-religious-directives/. The applicable state and federal law and government sponsored health program requirements shall govern in the event of any conflict between; (a) the terms and conditions of this Agreement, and (b) Provider's "Ethical and Religious Directives" as set forth herein.

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

The parties hereby acknowledge that Health Plan's Provider Manual was made available to Provider for review prior to Provider's decision to enter into this Agreement. Health Plan's Provider Manual is available at the Health Plan's website.

Providence Health & Services, Washington

By: DocuSigned by: Susan Kramer 29C106E1459B430...

Its: SVP, Contracting

Date: 2/3/2021

Molina Healthcare of Washington, Inc.

By: DocuSigned by: Andrew Nelson 6F45AD3EE44148E...

Andrew Nelson

Its: VP, Network Management

Date: 2/10/2021

ATTACHMENT 1

Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

☒ Primary Care Physician:

☒ Specialist:

☒ Group/IPA (a list of constituent members with their License and DEA numbers is attached and incorporated herein)

☒ Hospital

☒ Ancillary Provider: Mental Health, Home Health & Hospice, PT/OT/ST, Skilled Nursing, Ambulatory Surgical Center

☐ Other:

Provider Name	Providence Health & Services, Washington		Billing Address	Multiple Locations – See Attached Roster
Telephone No.				
Facsimile No.				
Tax I.D. No.	200093280, 200670339, 300502262, 300502310, 300504080, 300635601, 320260353, 320261229, 320261234, 352345508, 352346161, 352369417, 364640211, 371573026, 611570502, 832802775, 910565557, 910567732, 910573108, 911491167, 911496520, 911512896, 911576519, 911644837, 911690631, 911692955, 911708341, 931265038		Physical Address	Multiple Locations – See Attached Roster
License No.				
NPI				
NPI Taxonomy Code				
DEA No.				

Please provide a roster of all locations and/or billing address from which the Provider(s) will submit bills to Health Plan. Use continuation page(s) if multiple providers under common ownership will submit bills under more than one TIN**.**

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

DocuSigned by:
Susan Klarner
28C10BE1458B430...

Provider Signature

Susan Klarner

Signatory Name (Printed)

SVP, Contracting

Signatory Title (Printed)

2/3/2021

Signature Date

ATTACHMENT 1
Provider Identification Sheet
Continuation Page

Use one or more continuation pages as necessary when multiple providers under common ownership (the Provider is signing on behalf of all of them) are expected to bill Health Plan under more than one TIN.

Provider Name			Billing Address	
Telephone No.				
Facsimile No.				
Tax I.D. No.			Physical Address	
License No.				
NPI				
NPI Taxonomy Code				
DEA No.				

Provider Name			Billing Address	
Telephone No.				
Facsimile No.				
Tax I.D. No.			Physical Address	
License No.				
NPI				
NPI Taxonomy Code				
DEA No.				

Provider Name			Billing Address	
Telephone No.				
Facsimile No.				
Tax I.D. No.			Physical Address	
License No.				
NPI				
NPI Taxonomy Code				
DEA No.				

Provider Name			Billing Address	
Telephone No.				
Facsimile No.				
Tax I.D. No.			Physical Address	
License No.				
NPI				
NPI Taxonomy Code				
DEA No.				

ATTACHMENT 2
REQUIRED PROVISIONS

(HEALTH CARE SERVICE PLANS)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health care service plans. These provisions shall be automatically modified to conform to subsequent amendments to such statutes, regulations, and agreements. Further, any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

1. Provider hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan's insolvency, 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 Member or person acting on their behalf, other than Health Plan, for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, co-payments, coinsurance, and/or noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's health program.

2. Provider agrees, in the event of Health Plan's insolvency, to continue to provide the services promised in this Agreement to Members of Health Plan for the duration of the period for which premiums on behalf of the Member were paid to Health Plan or until the Member's discharge from inpatient facilities, whichever time is greater.

3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's health program.

4. Provider may not bill the Member for Covered Services (except for deductibles, co-payments, or coinsurance) where Health Plan denies payments because Provider has failed to comply with the terms or conditions of this Agreement.

5. Provider further agrees (i) that the provisions of (1), (2), (3), and (4) of this Attachment 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, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

6. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of Health Plan with the expectation of receiving payment directly or indirectly from Health Plan, such providers or facilities must agree to abide by the provisions of (1), (2), (3), (4), (5), (7), (11) and (12) of this Attachment.

7. Willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5) & (6).

8. Health Plan will provide Provider not less than sixty (60) days' notice of changes that affect Provider's compensation and that affect health care service delivery 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 contract, Provider may terminate the contract without penalty if the Provider does not agree with the changes. No change to this Agreement may be made retroactive without the express consent of Provider.

9. Health Plan does not preclude or discourage Provider from informing Members 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 patient's service agreement with Health Plan. Health Plan will not prohibit, discourage, or penalize Provider if otherwise practicing in compliance with the law from advocating on behalf of a Member with Health Plan. Members are free to contract at any time to obtain any health care services outside their Health Plan on any terms or conditions the Members choose. Nothing in this section shall be construed to authorize Provider to bind Health Plan to pay for any service.

10. Health Plan does not preclude or discourage Member or those paying for their coverage from discussing the comparative merits of different health carriers with Provider. This prohibition specifically includes prohibiting or limiting Providers participating in those discussions even if critical of a Health Plan.

11. Provider will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals or review of any adverse benefit determinations of Members subject to applicable state and federal laws related to the confidentiality of medical or health records. Provider is required to cooperate with audit reviews of encounter data in relation to the administration of Health Plan risk adjustment and reinsurance programs.

12. Provider shall furnish Covered Services to Members without regard to the Member's enrollment in Health Plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

13. Provider may, in good faith, report to state or federal authorities any act or practice by Health Plan that jeopardizes Member health or welfare or that may violate state or federal law.

14. Terms and Conditions of Payment

    a. For Covered Services provided to Members, Health Plan shall pay Provider, and Provider shall pay any of its subcontractors, as soon as practical but subject to the following minimum standards including any applicable federal regulations (i.e. 42 CFR 422.520(b)):

        i. Ninety-five (95%) percent of the monthly volume of Clean Claims shall be paid within thirty (30) days of receipt by Health Plan or Health Plan's agent;

        ii. Ninety-five percent (95%) of the monthly volume of all Claims shall be paid or denied within sixty (60) days of receipt by Health Plan or Health Plan's agent;

        iii. Ninety-nine percent (99%) of the monthly volume of Clean Claims shall be paid within ninety (90) calendar days of receipt, except as agreed to in writing by the parties on a Claim-by-Claim basis.

    b. A Claim is a bill for services, a line item of service or all services for one Member within a bill.

    c. The date of receipt of a Claim is the date Health Plan or Health Plan's agent receives either written or electronic notice of the Claim.

    d. The date of payment is the date of the check or other form of payment.

    e. Health Plan shall establish a reasonable method for confirming receipt of Claims and responding to Provider inquiries about Claims.

    f. For those State products/programs covered by the Washington Administrative Code (WAC), failure of Health Plan to abide by the timely Claims payment standards delineated in 14.a above shall result in a requirement to pay interest on undenied and unpaid Clean Claims as described in WAC 284-170-431

    g. When Health Plan issues payment in Provider's name and the Member's name, Health Plan shall make Claim checks payable in the name of the Provider first and the Member second.

    h. These standards do not apply to Claims about which there is substantial evidence of fraud or misrepresentation by Providers, facilities or Members, or instances where Health Plan has not been granted reasonable access to information under Provider's control.

    i. Health Plan and Provider are not required to comply with these terms and conditions of payment 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.

15. Notwithstanding any other provision of this Agreement, Provider is not required to grant Health Plan access to health information and other similar records unrelated to Members. This provision shall not limit Health Plan's right to ask for and receive information relating to the ability of Provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

16. Notwithstanding any other provision of this Agreement, any access Provider must grant Health Plan to medical records for audit purposes must be limited to only that necessary to perform the audit.

17. Provider maintains a reciprocal right to audit Health Plan's denials of Provider's Claims when Health Plan audits Provider's Claims.

18. In the event Provider participates in Health Plan's Medicare Programs, the following provisions shall apply:

    a. Provider shall make all of its "Relevant Records" available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider's place of business and at all reasonable times. "Relevant Records" shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

    b. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).

    c. Provider agrees that under no circumstance shall a subscriber or enrollee in Health Plan's Medicare Programs be liable to the Provider for any sums owed by Health Plan to Provider. (42 CFR 422.504(g)(1)(i); and 42 CFR 422.504(i)(3)(i).).

    d. If Provider is delegated any of the activities or functions of Health Plan as required in its contract with CMS, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. The performance of such delegated activities shall be monitored by Health Plan on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).

    e. Provider agrees that any services it performs will be consistent with and comply with Health Plan's contractual obligations with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii).

    f. In the event of termination of this Agreement or Health Plan's insolvency, Provider agrees to comply with the continuation of benefits provisions included in the Provider Manual. (42 CFR 422.504(g)(2).)

19. Upon termination of this Agreement without cause, Provider will continue to render Covered Services to Members until the earliest of the following: (1) the date Covered Services being rendered to Member by Provider are completed or medically appropriate provisions have been made by Health Plan for another provider to assume responsibility for providing such Covered Services; or (2) sixty (60) days following notice to the Member of Provider's contract termination. The provision of such Covered Services and the reimbursement to Provider for such Covered Services shall be subject to all applicable terms of this Agreement on the same basis as Covered Services provided during the term of this Agreement

20. Provider will satisfy and be in compliance with all of the requirements in WAC 284-43-0120.

21. Provider will ensure that all of its subcontractors will satisfy and be in compliance with all of the requirements in WAC 284-43.

ATTACHMENT 3
REQUIRED PROVISIONS

(Health Care Authority)

The following provisions are required by (i) federal statutes and regulations applicable to medical assistance programs for the indigent, (ii) state statutes and regulations applicable to medical assistance programs for the indigent, or (iii) contracts and agreements between the Health Plan and the state agencies responsible for regulating risk-based medical assistance programs for the indigent. These provisions shall be automatically modified to conform to subsequent amendments to such statutes, regulations, and agreements. Further, any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

1. Provider shall provide reasonable access to facilities and financial and medical records for duly authorized representatives of the CMS, HCA, Department of Social & Health Services ("DSHS") or the Department of Health & Human Services ("DHHS") for audit purposes and immediate access for Medicaid fraud investigators.
2. Provider shall completely and accurately report encounter data to Health Plan. Provider shall have the capacity to submit all required data to enable Health Plan to meet the requirements in the Encounter Data Transaction Guide published by HCA.
3. Provider shall comply with Health Plan's fraud and abuse policies and procedures.
4. Provider shall not assign this Agreement without HCA's written agreement.
5. Provider shall comply with any term or condition of Health Plan's contracts with HCA that is applicable to the services to be performed by Provider.
6. Provider shall accept payment from the Health Plan as payment in full and shall not request payment from HCA or any enrollee for Covered Services performed under this Agreement.
7. Provider agrees to hold harmless HCA and its employees, CMS and its employees, and all enrollees served under the terms of this Agreement in the event of non-payment by Health Plan. Provider further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of Provider, its agents, officers, employees or contractors.
8. Provider agrees to comply with the HCA appointment wait time standards. Provider agrees to Health Plan's regular monitoring of timely access to Provider's services, and agrees to corrective action up to and including termination for cause in the event that Provider fails to comply with the appointment wait time standards.
9. Provider shall assure that all sterilizations and hysterectomies performed under this Agreement are in compliance with 42 CFR 441 Subpart F, and that the Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.
10. Provider shall make reasonable accommodation for Members with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit Members with disabilities from obtaining Covered Services.
11. Provider shall comply with all Program Integrity provisions as documented in Health Plan Provider Manual and as set forth by 42 CFR 438.608 and the Health Plan's contracts with HCA.
12. Provider shall comply with Patient Identifying Information from an alcohol or drug abuse "program", as defined in 42 C.F.R. §2.11, that is federally assisted in the manner described in 42 C.F.R. §2.12(b), then it is fully bound by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, with respect to such information and records, including but not limited to the duty to resist in judicial proceedings any efforts to obtain access to such information or records, other than as permitted by law.

ATTACHMENT 4
MEDICARE PROGRAM REQUIREMENTS--HEALTH CARE SERVICES

This attachment sets forth applicable laws and government program requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to laws or government program requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Advantage Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a law or government program requirement will not be effective and will be interpreted in a manner that is consistent with the applicable law and government program requirement. This attachment only applies to the Medicare Advantage Product.

1.1 **Definitions.**

a. **Completion of Audit** means a completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.

b. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage Organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

c. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.

d. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

e. **Medicare Advantage Organization** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

f. **Related Entity** means any entity that is related to the Medicare Advantage Organization by common ownership or control and; (i) performs some of the Medicare Advantage Organization's management functions under contract or delegation; (ii) furnishes services to Medicare enrollees under an oral or written agreement; or (iii) leases real property or sells materials to the Medicare Advantage Organization at a cost of more than $2,500 during a contract period.

1.2 **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and Related Entity, through ten (10) years from the final date of the Final Contract Period of the contract entered into between CMS and the Medicare Advantage Organization or from the date of completion of any audit, whichever is later.

1.3 **Right to Audit Directly from FDR.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under section 1.2, of this attachment, directly from any First Tier Entity, Downstream Entity, and Related Entity. For records subject to review under section 1.2, except in exceptional circumstances, CMS will provide notification to the Medicare Advantage Organization that a direct request for information has been initiated.

1.4 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements, including: (i) abiding by all laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) ensuring that medical information is released only in accordance with applicable law, or pursuant to court orders or subpoenas; (iii) maintaining the records and information in an

accurate and timely manner; and (iv) ensuring timely access by Members to the records and information that pertain to them.

1.5 **Hold Harmless.** Members will not be held liable for payment of any fees that are the legal obligation of the Medicare Advantage Organization.

1.6 **Cost Sharing.** For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (i) accept the Health Plan payment as payment in full; or (ii) bill the appropriate State source.

1.7 **Delegation.** Any services or other activity performed in accordance with a contract or written agreement by Provider or a Downstream Entity of Provider are consistent and comply with the Medicare Advantage Organization's contractual obligations.

1.8 **Prompt Payment.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with laws, government program requirements, and this Agreement. Health Plan will make such payment within sixty (60) days.

1.9 **Compliance with Medicare Laws.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.

1.10 **Benefit Continuation.** Provider agrees to provide for continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge

1.11 **Accountability.** Health Plan may only delegate activities or functions to a First Tier Entity or Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan's contractual obligations.

1.12 **Reporting**. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.

EXHIBIT 1-A
Compensation Schedule - Medicaid (Version 1)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Hospital Services:

Inpatient Services

Covered Services shall be paid at one hundred three percent (103%) of the Provider's State of Washington Medicaid Fee-For-Service Program Inpatient payment rates in place at the time of delivery of services as known by Health Plan. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services

Covered Services shall be paid at one hundred three percent (103%) of the Provider's State of Washington Medicaid Fee-For-Service Program Outpatient payment rate in place at the time of delivery of services. This Outpatient payment rate shall be applied for all Outpatient Services, except for those which are reimbursed according to specific State of Washington Medicaid Fee-For-Service Program fee schedules as they exist at the time services are rendered.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Primary Care Services

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred percent (100%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Specialty Care Services

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred seven percent (107%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

III. Mental Health Services:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred seven percent (107%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

IV. Home Health and Hospice:

Medical Equipment and Supplies**:**
Covered Services shall be paid at one hundred five percent (105%) of the Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

Revenue Codes:
Covered Services shall be paid at one hundred five percent (105%) of the Spokane County Medicaid Fee-For-Service Program, for Spokane County, fee schedule in place at the time services are rendered.

Private Duty Nursing:
Covered Services shall be paid at one hundred five percent (105%) of Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

All Other Services:
Covered Services shall be paid at one hundred five percent (105%) of Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

V. Physical Therapy, Occupational Therapy, and Speech Language Pathology:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred five percent (105%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

VI. Skilled Nursing Facility and Ambulatory Surgery Center:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred five percent (105%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

VII. Other Payments: None

EXHIBIT 1-A
Compensation Schedule - Medicaid (Version 2)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services

Covered Services shall be paid at one hundred three percent (103%) of the Provider's State of Washington Medicaid Fee-For-Service Program Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

Outpatient Services

Covered Services shall be paid at one hundred three percent (103%) of the Provider's State of Washington Medicaid Fee-For-Service Program Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Washington Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not exceed one hundred percent (100%) of the Medicare Fee-For-Service Program allowable payment rate, as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Primary Care Services

Covered Services shall be paid at an amount equivalent to one hundred (100%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicaid Fee-For-Service Program allowable payment rates.

Specialty Care Services

Covered Services shall be paid at an amount equivalent to one hundred seven (107%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicaid Fee-For-Service Program allowable payment rates.

Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Washington Medicaid Fee-For-Service Program fee schedule as of the date(s) of service, shall not exceed one hundred percent (100%) of the Medicare Fee-For-Service Program allowable payment rate, as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

III. Mental Health Services:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred seven percent (107%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

IV. Home Health and Hospice:

Medical Equipment and Supplies:

Covered Services shall be paid at one hundred five percent (105%) of the Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

Revenue Codes:

Covered Services shall be paid at one hundred five percent (105%) of the Spokane County Medicaid Fee-For-Service Program, for Spokane County, fee schedule in place at the time services are rendered.

Private Duty Nursing:

Covered Services shall be paid at one hundred five percent (105%) of Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

All Other Services:

Covered Services shall be paid at one hundred five percent (105%) of Spokane County Medicaid Fee-For-Service Program fee schedule in place at the time services are rendered.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

V. Physical Therapy, Occupational Therapy, and Speech Language Pathology:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred five percent (105%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

VI. Skilled Nursing Facility and Ambulatory Surgery Center:

For Covered Services billed under one of Provider's tax identification numbers, reimbursement shall be at one hundred five percent (105%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Notwithstanding the above, in no event will payment for any Covered Service exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

VII. Other Payments: None

EXHIBIT 1-B
Compensation Schedule – Medicare (Version 1)

Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided in accordance with the Medicare Advantage Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of: (i) Provider's billed charges; or (ii) at an amount equivalent to one hundred eight percent (108%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for place of service or geography), as of the Date of Service. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-B
Compensation Schedule - Medicare (Version 2)

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eight percent (108%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eight percent (108%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at percent (50%) of billed charges.

II. Professional Services:

Covered Services shall be paid at an amount equivalent to one hundred eight percent (108%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at percent (50%) of billed charges.

Updates to Reimbursement:

Provider shall notify Health Plan of any updates to their Medicare reimbursement rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 1)
Effective through December 31, 2020

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Hospital Services:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-two and five tenths percent (162.5%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-two and five tenths percent (162.5%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Covered Services shall be paid at one hundred sixty-two and five tenths percent (162.5%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at one hundred sixty-nine percent (169%) of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 2)
Effective through December 31, 2020

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-two and five tenths percent (162.5%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-two and five tenths percent (162.5%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-two and five tenths percent (162.5%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

Updates to Reimbursement:

Provider shall notify Health Plan of any updates to their Medicare reimbursement rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 1)
Effective January 1, 2021 through December 31, 2021

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Hospital Services:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-seven and four tenths percent (167.4%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-seven and four tenths percent (167.4%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Covered Services shall be paid at one hundred sixty-seven and four tenths percent (167.4%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at one hundred sixty-nine percent (169%) of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 2)
Effective January 1, 2021 through December 31, 2021

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-seven and four tenths percent (167.4%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-seven and four tenths percent (167.4%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Covered Services shall be paid at an amount equivalent to one hundred sixty-seven and four tenths percent (167.4%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

Updates to Reimbursement:

Provider shall notify Health Plan of any updates to their Medicare reimbursement rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 1)
Effective January 1, 2022 through December 31, 2022

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Hospital Services:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred seventy-three (173%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred seventy-three percent (173%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Covered Services shall be paid at one hundred seventy-three percent (173%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at one hundred sixty-nine percent (169%) of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 2)
Effective January 1, 2022 through December 31, 2022

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred seventy-three percent (173%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred seventy-three percent (173%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Covered Services shall be paid at an amount equivalent to one hundred seventy-three percent (173%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

Updates to Reimbursement:

Provider shall notify Health Plan of any updates to their Medicare reimbursement rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 1)
Effective January 1, 2023

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Hospital Services:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eighty (180%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Inpatient rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eighty percent (180%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program allowable Outpatient payment rates, as of the date of service. Rates shall be updated and made retroactively effective to the 1st of the month in which Health Plan learns of Provider's revised rate be that through its own research or notification from Provider or State.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Hospital & Clinic Based:

Covered Services shall be paid at one hundred eighty percent (180%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at one hundred sixty-nine percent (169%) of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-C
Compensation Schedule - Molina Marketplace (Version 2)
Effective January 1, 2023

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Critical Access Hospital:

Inpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eighty percent (180%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) inpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

Outpatient Services:

Covered Services shall be paid at an amount equivalent to one hundred eighty percent (180%) of the Provider's CMS (Centers for Medicare & Medicaid Services) Final Critical Access Hospital (CAH) outpatient payment rates in place at the time of delivery of services as known by Health Plan.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

Organ Acquisition Cost (OAC):

Any claim submitted by a Certified Transplant Center (CTC) which contains Organ Acquisition Costs must be accompanied by form CMS-2552-10, Worksheet D4, Parts I-IV: V Computation of Organ Acquisition Costs and Charges for Hospitals Which Are Certified Transplant Centers ("Cost Report"). Organ Acquisition Costs shall be paid at the full amount detailed on the Cost Report.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

II. Professional Services:

Covered Services shall be paid at an amount equivalent to one hundred eighty percent (180%) of the payment Provider would otherwise have been entitled to had the Covered Services been billed directly under the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

If there is no payment rate in the Medicare payment program as of the date of service, payment shall be at one hundred sixty-nine percent (169%) of the prevailing Medicaid Fee-For-Service Program fee schedule in effect on the date of service

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

Updates to Reimbursement:

Provider shall notify Health Plan of any updates to their Medicare reimbursement rates by CMS. Rate letter(s) shall be provided to Health Plan within 30 days of receipt by Provider.

EXHIBIT 1-D
Compensation Schedule
Providence Health & Services - Oregon DBA Providence Medical Group
Clark County Service Locations
Effective through December 31, 2020

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs as specified in Attachment C, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

Medicaid Programs:

Apple Health Family (AHF), Apple Health with Premium (AHPREM), FIMC (Fully Integrated Managed Care) Apple Health (FIMC-AH), and FIMC with Premium (FIMC-PREM):

Antepartum Care and Maternity Services

118% of the current Washington Medicaid Fee Schedule for CPT codes 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, and 59622. Also includes the high-risk condition codes 99211-99215, and the labor management codes 99221-99223 and 99356-99357, when billed with the appropriate WA Medicaid modifiers with a high-risk diagnosis.

Adult Office Visit Health Care Services

(Members 21 years of age and older)
118% of the current Washington Medicaid Fee Schedule for CPT codes 99201-99205 and 99211-99215.

Children's Office Visit Health Care Services

(Members who are 20 years and younger)
109% of the current Washington Medicaid Fee Schedule for CPT Codes 99201-99215, 99381-99385, 99391-99395, and 99460-99463.

Physical, Speech and Occupational Therapy

105% of the current Washington Medicaid Fee Schedule when provided by a licensed physical, speech or occupational therapist.

Radiology Services

114% of the current Washington Medicaid Fee Schedule for CPT Codes 70000-77260 and 78000-79999.

Anesthesia

109% of the current Washington Medicaid Fee Schedule.

All Other Professional Services

118% of the current Washington Medicaid Fee Schedule.

DME Reimbursement Rate

100% of the current Washington Medicaid Fee Schedule based on DME type. DME & Supply codes that have no Medicaid pricing will be paid at 90% of the current Medicare Fee Schedule.

Injectable Reimbursement Rates

90% of the current Medicaid Fee Schedule. Injectable codes that have no Medicaid pricing will be paid at 90% of the current Clinical Injection Fee Schedule for Medicare.

Pathology and Lab CPT and Associated HCPCS Codes

100% of the current Medicaid Fee Schedule. Lab & Pathology codes that have no Medicaid pricing will be paid at 90% of the current Medicare Clinical Lab Fee Schedule.

Procedure Codes without Associated Medicaid Fee Schedule

90% of the current Medicare Fee Schedule. The fee schedule is based upon the CMS Non-Facility Relative Value Scale of RBRVS and will be geographic adjusted.

Procedure Codes without associated Medicaid or Medicare Allowable Fee Schedule

60% of Practitioners Usual Customary Billed Charges.

Apple Health Blind and Disabled (AHBD), Apple Health Adult (AHA), FIMC Blind and Disabled Apple Health (FIMC-BD), and FIMC Apple Health Adult (FIMC-AHA):

Antepartum Care and Maternity Services

105% of the current Washington Medicaid Fee Schedule for CPT codes 59400, 59409, 59410, 59412, 59414, 59425, 59426, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, and 59622. Also includes the high-risk condition codes 99211-99215, and the labor management codes 99221-99223 and 99356-99357, when billed with the appropriate WA Medicaid modifiers with a high-risk diagnosis.

Adult Office Visit Health Care Services

(Members 21 years of age and older)
105% of the current Washington Medicaid Fee Schedule for CPT codes 99201-99205 and 99211-99215.

Children's Office Visit Health Care Services

(Members who are 20 years and younger)
105% of the current Washington Medicaid Fee Schedule for CPT Codes 99201-99215, 99381-99385, 99391-99395, and 99460-99463.

Physical, Speech and Occupational Therapy

105% of the current Washington Medicaid Fee Schedule. When provided by a licensed physical, speech or occupational therapist.

Radiology Services

105% of the current Washington Medicaid Fee Schedule for CPT Codes 70000-77260 and 78000-79999.

Anesthesia

105% of the current Washington Medicaid Fee Schedule.

All Other Professional Services

105% of the current Washington Medicaid Fee Schedule.

DME Reimbursement Rate

100% of the current Washington Medicaid Fee Schedule based on DME type. DME & Supply codes that have no Medicaid pricing will be paid at 90% of the current Medicare Fee Schedule.

Injectable Reimbursement Rates:

90% of the current Medicaid Fee Schedule. Injectable codes that have no Medicaid pricing will be paid at 90% of the current Clinical Injection Fee Schedule for Medicare.

Pathology and Lab CPT and Associated HCPCS Codes

100% of the current Medicaid Fee Schedule. Lab & Pathology codes that have no Medicaid pricing will be paid at 90% of the current Medicare Clinical Lab Fee Schedule.

Procedure Codes without Associated Medicaid Fee Schedule:

90% of the current Medicare Fee Schedule. The fee schedule is based upon the CMS Non-Facility Relative Value Scale of RBRVS and will be geographic adjusted.

Procedure Codes without associated Medicaid or Medicare Allowable Fee Schedule:

60% of Practitioners Usual Customary Billed Charges.

Medicare Programs:

Covered Services shall be paid at one hundred and eight percent (108%) of the Medicare Fee-For-Service Program allowable payment rates, as of the date of service.

Molina Health Benefit Exchange Product:

Covered Services shall be paid at one hundred sixty-two and five tenths percent (162.5%) of the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate in the prevailing local and geographically adjusted Medicare Fee-For-Service Program fee schedule in effect on the date of service, payment shall be at one hundred sixty-nine percent (169%) of the Medicaid Fee-For-Service Program fee schedule in effect on the date of service.

If there is no payment rate achieved in the above methodologies, reimbursement shall be paid at fifty percent (50%) of billed charges.

EXHIBIT 1-E
Compensation Schedule - Integrated Managed Care
Effective through December 31, 2021

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with Health Plan's programs participation, on a fee-for-services basis, at the lesser of; (i) Provider's allowable charge description master rate, or (ii) the amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

This attachment applies to Members enrolled in Integrated Managed Care Apple Health, IMC Apple Health Adult, IMC Apple Health Blind and Disabled, IMC Apple Health with Premium (collectively referred to as "IMC"), and Behavioral Health Services Only ("BHSO"):

Reimbursement for services based on State of Washington Medicaid Fee-For-Service rates must be billed according to Health Care Authority billing guidelines. Reimbursement not based on State of Washington Medicaid Fee-For-Service rates must be billed according to the Health Care Authority (HCA) Integrated Managed Care Service Encounter Reporting Instructions ("SERI").

Provider agrees to follow Health Plan's IMC Companion Guide, which is intended to supplement the use of SERI. Health Plan may unilaterally change or modify the IMC Companion Guide from time to time, as updates are made to SERI or Health Plan policies and procedures.

Upon request, Provider shall submit annual independently audited financial statements to Health Plan based upon Provider's prior fiscal year-end financial statements.

Notwithstanding any other term of the Agreement, Health Plan may unilaterally adjust (i.e. increase or decrease) the reimbursement amounts or revise the source of funding if actuarial data, Health Plan's behavioral health premium or General Fund – State ("GFS") funding changes.

Services reimbursed with GFS dollars are subject to the availability of GFS funds and are subject to GFS prioritization as specified by HCA.

The rates below pertaining to **services rendered in the Thurston-Mason Region (Thurston and Mason Counties)** will become effective on January 1, 2020, and remain in effect through December 31, 2021.

1. **Fee-For-Service Programs**
   Covered Services not specified elsewhere, shall be paid at the Fee-for-Service rates below. Services reimbursed at a Per Hour rate are prorated by minute when provided by persons with the specified credentials.

   Behavioral Health Fee-For-Service:

Outpatient - Individual:	In Clinic - Per Hour	Out of Clinic - Per Hour
Psychiatrists/MDs (MD/DO)……	$485.10	$485.10
Nurse Practitioner/Physician Asst (NP/PA)……	$306.60	$306.60
Registered Nurse/LPN (RN)……	$193.20	$247.80
PhD and Masters-Level Providers (MA/MSW)……	$148.05	$192.15
Bachelors, AA Level Clinician (BA/AA)……	$117.60	$153.30
Peer Counselor (Para)……	$93.45	$119.70
Outpatient - Group:		
Psychiatrists/MDs (MD/DO)……	$121.28	$121.28
Nurse Practitioner/Physician Asst (NP/PA)……	$76.65	$76.65
Registered Nurse/LPN (RN)……	$48.30	$61.95
PhD and Masters-Level Providers (MA/MSW)……	$37.01	$48.04

Bachelors, AA Level Clinician (BA/AA)…….	$29.40	$38.33
Peer Counselor (Para)……..	$23.36	$29.93

Health Plan shall make payment to Provider for all Covered Services not included in the Service Types above at one hundred percent (100%) of the State of Washington Medicaid Fee-For-Service Program fee schedule in effect on the date of service (submitted in units as directed in the fee schedule).

2. Community Care Center

Community Care Center services will be reimbursed on a Fee-For-Services basis applying reimbursement rates listed in section I above.

3. Proportionate Share Reimbursement Programs

3.1 Definitions:

3.1.1 *Budget Amount:* The annual budget amount for the contracted Program. Separate budget amounts may be called out based on the funding source (eg. Medicaid vs. Non-Medicaid).

3.1.2 *ESSB Monthly Allocation Reimbursement:* Health Plan payments for ESSB Enhancement funding shall be Health Plan's Proportionate Share of the Budget Amount.

3.1.3 *Clean Invoice*: The term used to describe an invoice that is free of errors and incorrect information (i.e. ineligible Members), contain all data elements required by Health Plan for payment.

3.1.4 *Non–Medicaid* (funds): The term used to describe GFS funds.

3.1.5 *Program*- The term used to describe treatment service categories, modalities, and levels of care encompassed in each Budget Amount.

3.1.6 *Proportionate Share:* Health Plan's proportionate share of the Budget Amount is assessed monthly and based on one of the following methodologies:

A. *Market Share:* The Health Plan's proportionate share for this budget shall be based on Health Plan's percentage of IMC and BHSO members in the specified Region (e.g. if Health Plan's membership is 50% of the total Medicaid membership in the region, Health Plan is responsible for 50% of that month's Budget Amount). Proportionate share will be assessed on a monthly basis. Health Plan will utilize membership data that has up to a two-month lag from the current month of service.

3.2 Health Plan shall make payment to Provider for the below Proportionate Share Programs.

Program	**Medicaid ESSB 6032 Budget**		**Reimbursement Methodology**	**Proportionate Share Methodology**
	Annual	**Monthly**		
Mental Health Enhancement Funding (ESSB 6032)	$8,800.00	$733.33	ESSB Monthly Allocation	Market Share

EXHIBIT 1-F
Medicare Quality Bonus Program

I. Medicare Quality Program Definitions

A. **Quality Program** means a program where Provider has agreed to share with Health Plan accountability for improving quality outcomes for Quality Program Assigned Members in exchange for a Quality Performance Bonus.

B. **Quality Program Assigned Members** ("Assigned Members") means members assigned to Provider for the Quality Program that are in the Medicare Product "Molina Medicare Options Plus."

C. **Quality Performance Bonus** means an incentive payment to reward Provider for meeting certain quality measure benchmarks.

D. **Quality Incentive Measures (QIMs)** means quality measures and targets for which Provider is eligible to earn the Quality Performance Bonus. The QIMs are identified in Section III, Quality Incentive Measures, and Data Collection.

E. **Missing Services** means the Covered Services that Assigned Members have yet to receive to satisfy a Quality Incentive Measure.

F. **Supplemental Data Feed** means an automated data feed that includes data elements that might not otherwise be collected on claims or encounters but that are necessary to prove compliance with HEDIS® measure technical specifications (i.e. historical data). The Supplemental Data Feed is formatted to allow Health Plan to load the data to its HEDIS® accredited/certified database to satisfy the National Committee for Quality Assurance (NCQA) HEDIS® administrative specifications for data collection. Health Plan will review the format requirements for the Supplemental Data Feed with provider annually to account for any changes in contracted measures, NCQA technical specifications, and/or data collection requirements.

G. **Contract Period** means a twelve (12) month period. The two Contract Periods for the Medicare Quality Bonus Program are as follows:
   1. Contract Period 1: January 1, 2019 - December 31, 2019
   2. Contract Period 2: January 1, 2020 – December 31, 2020

II. Termination and Eligibility

A. **Termination.** Either party shall have the right to terminate this Quality Program in the event of a material breach of the Medicare Quality Bonus Program Agreement by either party. Termination shall be effective within thirty (30) days after the party claiming the breach provides the other party written notice specifying the material default, and the other party fails to cure such default within such thirty (30) day notice period.

B. **Eligibility**. To remain eligible for any payment under the Program, Provider must: (i) have an active agreement; and (ii) be a participating provider with Molina at the time payment under the Program is issued to qualifying providers. The parties recognize that payments may be subject to adjustments due to retroactive changes in Assigned Members' enrollment with Molina. Such adjustment will be, as applicable, added to or deducted from payments due under the Program.

III. Quality Incentive Measures and Data Collection

A. **Quality Incentive Measures (QIMs).** QIMs and targets for the Contract Period are displayed in Table 1 below. The QIMs apply to all Quality Program Assigned Members in aggregate. Health Plan may update the QIMs and targets to reflect any changes to the Medicare STAR Ratings measures. Health Plan will inform Provider of any updates via amendment to this Exhibit.

B. **Data collection for QIMs.** Both Parties acknowledge and agree that:

1. Health Plan will use the prevailing Medicare Part C & D Star Ratings Technical Notes and will provide necessary information to Provider related to QIM technical specifications and associated codes and guidelines.
2. Health Plan will use claims (and/or encounters) to identify Assigned Members eligible for Missing Services.
3. Provider must submit to Health Plan claims (and/or encounters) with valid billing codes and/or Supplemental Data Feeds if applicable.
4. Health Plan will determine the Quality Performance Bonus using (1) claims (and/or encounters) with valid billing codes submitted during the Contract Period and up to 90 days after the Contract Period, and (2) Supplemental Data Feeds (if applicable) submitted during the Contract Period and up to 90 days after the Contract Period.
5. Health Plan will not review medical charts to determine if the QIM Missing Service was rendered. Health Plan will not accept supplemental data in a non-standard format.

Table 1: Quality Incentive Measures

Quality Incentive Measures*	Target 1 (4-Star)	Target 2 (5-Star)
Breast Cancer Screening	78%	83%
Care for Older Adults - Functional Status Assessment	80%	90%
Care for Older Adults - Medication Review	85%	93%
Care for Older Adults - Pain Assessment	90%	97%
Colorectal Cancer Screening	78%	85%
Comprehensive Diabetes Care - Eye Exam	76%	84%
Comprehensive Diabetes Care - HbA1c Control (<9)	80%	91%
Comprehensive Diabetes Care - Monitoring for Nephropathy	98%	100%
Disease Modifying Anti - Rheumatic Drug Therapy for Rheumatoid Arthritis	83%	90%
Medication Reconciliation Post-Discharge - Total	66%	80%
Osteoporosis Management in Women Who Had a Fracture	71%	96%
Statin Therapy for Patients with Cardiovascular Disease	85%	91%
Plan all Cause Readmissions	8%	5%
Medication Adherence for Diabetes Meds	86%	91%
Medication Adherence Hypertension (RAS antagonists)	88%	92%
Medication Adherence for Cholesterol (Statins)	83%	87%
Statin Use in Persons with Diabetes (SUPD)	83%	91%

*Note: Quality Incentive Measures are defined in the Medicare Part C and D Star Ratings Technical Notes and developed and/or endorsed by the National Committee for Quality Assurance (NCQA) and/or Pharmacy Quality Alliance (PQA).

IV. Quality Performance Bonus Reconciliation Process

A. Provider is eligible to receive the Quality Performance Bonus for achieving either Target 1 or Target 2 for eligible Assigned Members.
B. Attainment of QIM Target 1 is worth fifty cents per member per month ($0.50 PMPM) for Assigned Members that are eligible for that QIM. Attainment of QIM Target 2 is worth one dollar per member per month ($1.00 PMPM) for Assigned Members that are eligible for that QIM. If Provider achieves Target 2, Provider will be paid only the Target 2 bonus (not Target 1 Bonus and Target 2 bonus).

V. Health Plan Reporting Obligations and Settlement Timing

A. Health Plan will make reasonable efforts to supply Provider with a list of eligible Assigned Members and Missing Services list each month.

B. Settlement Timing

   a. Health Plan will make reasonable efforts to submit a "Final Quality Program Bonus Report" within seven (7) months after the Contract Period.

   b. Within thirty (30) days receipt of the Final Quality Program Bonus Report", Provider shall review the analysis and determine if they agree or disagree with the report ("Review Period"). If Provider disagrees with the report within the Review Period, Health Plan and Provider will promptly meet and make a good faith attempt to resolve the matter. If Health Plan and Provider are unable to resolve the disagreement through the good faith meeting, Provider may submit the dispute to nonbinding mediation in accordance with the Combined Provider Services Agreement, as applicable. If no response is received by Health Plan within thirty (30) days of receipt, or if the dispute is not timely submitted for nonbinding mediation, it shall be determined that the Contract Period Final Shared Savings Calculation Report is accepted by Provider. Within thirty (30) days after the expiration of the Review Period, Health Plan shall remit payment of the applicable Quality Performance Bonus to Provider.

VI. Compliance with Applicable Laws

A. **Compliance with Laws.** The parties will comply with all laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

B. **Legislation Regulating Provider Risk.** Health Plan and Provider acknowledge that future laws, regulations or policies may require changes to the terms and conditions set forth in this Amendment. If changes to such laws, regulations or policies occur, then both parties hereby agree to negotiate in good faith to amend this Attachment to conform with any such changes. Each party shall make best efforts to minimize any (i) impact to the intent of the terms and conditions of the terms and conditions set forth in this Amendment, and/or (ii) harm to each other. Health Plan represents that as of the effective date of this Amendment, it is not aware of any laws, administrative rulings or other position statements from applicable regulatory agencies that would subject provider to insurance obligations for the activities undertaken by Provider pursuant to this Agreement.

EXHIBIT 2
Concurrent Review and Denial Inpatient Services Pilot Program

Term: Program will become effective within sixty (60) of the effective date of the entire Agreement. Either party may term this pilot program with sixty (60) days written notice.

HOSPITAL REMOVAL OF DENIALS - INPATIENT CLAIMS WITH NO PRIOR AUTHORIZATION:
Molina Healthcare and Providence Health & Services have agreed to the following pilot program. Molina will continue to expect its contracted primary care providers and specialists to obtain prior authorization for elective services. This protects the hospital from providing care that is not medically necessary per Milliman Clinical Group (MCG) criteria. However, if an inpatient claim is presented where prior authorization was not obtained, Molina will pay the claim and review as needed for medical necessity. Post service reviews for medical necessity will utilize Milliman Clinical Group (MCG) criteria. If a service delivered is not addressed in Milliman Clinical Group (MCG), other criteria will be applied including but not limited to: Molina Medical Coverage Guidelines, Hayes Ratings and consultation with outside experts. Medical Necessity denials will be accompanied by a determination letter with includes the specific criteria used as well as the determination. Payments rendered for services retrospectively determined to not meet medical necessity will require repayment to Molina per the terms of contract. This pilot program excludes Medicare Advantage Special Needs Plan and Medicare Advantage plan as described in Attachment C of this agreement.

Prior Authorization is also utilized to help ensure claims will not be denied for reasons other than non-medically necessary services. The hospital is protected from incurring the costs for these types of denied services when the authorization is obtained prior to the delivery of services. For example, Pre-existing conditions apply to the Basic Health membership and could come into play if the prior authorization process is bypassed. Other scenarios could be denial for "not a covered benefit," or "member not eligible at the time of services". In these situations, the claim would be appropriately denied and a review for medical necessity would not change the outcome. If these types of non-covered services are provided by the hospital any amounts paid in claims would be recovered from the hospital upon retrospective review.

Pilot Program: Admission Management.

Admission Category	Current Requirement	Pilot Requirement
Elective Admissions - members under age 3	Prior Authorization for services. Notification via census**. Review only after prior authorized days have been used.	Prior Authorization for services. Notification via census. Review only after 7 days.
Elective Admissions - members age 3+	Prior Authorization for services. Notification via census. Review only after prior authorized days have been used.	Prior Authorization for services. Notification via census. Review only after 7 days.
Urgent/Emergent Admissions - members under age 3	Notification via census. Review required within 72 hours of notification. Additional reviews as needed.	No Change - Notification via census. Review required within 72 hours of notification. Additional reviews as needed.
Urgent/Emergent Admissions - members age 3+	Notification via census. Review required within 72 hours of notification. Additional reviews as needed.	Notification via census. Review only after 7 days.
*Notification and Concurrent review requirements for all services not specifically mentioned above, including all current requirements for neonates, hemophilia and transplant services, remain unchanged. Discharge planning is available through Molina's utilization management staff on request for all admissions ** Census notification is industry standard		