

AMENDMENT TO THE COMBINED PROVIDER SERVICES AGREEMENT

THIS AMENDMENT TO THE COMBINED PROVIDER SERVICES AGREEMENT
("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc. ("Health Plan") and Providence Health & Services, Washington ("Provider").

Whereas, Health Plan and Provider entered into a Combined Provider Services Agreement ("Agreement"), February 10, 2021, as amended.

Whereas, Health Plan and Provider hereby agree to amend the Agreement in accordance with the terms and conditions of this Amendment.

Now therefore, in consideration of the rights and obligations contained herein, the parties to this Amendment, intending to be legally bound, do hereby agree as follows:

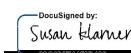
1. Article Five – General Provisions, 5.11 Attachments, of the Agreement is amended and attached hereto.
2. Exhibit 1s (Compensation Schedule) of the Agreement is amended and attached hereto.
3. Exhibit 2 (Concurrent Review and Denial Inpatient Services Pilot Program) of the Agreement is deleted in its entirety.
4. **Effective Date**. This Amendment shall become effective on January 1, 2022, and renew with and under the terms of the Agreement.
5. **Use of Defined Terms**. Terms utilized in this Amendment shall have the same meaning set forth in the definitions to the Agreement.
6. **Full Force and Effect**. Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect.

This Amendment is in addition to, and does not replace or supersede, the Agreement between Health Plan and Provider filed with Health Plan. All conditions and provisions of the Agreement, except as specifically modified herein, shall remain binding. If there is any ambiguity or inconsistency between the documents not specifically addressed in this Amendment, the original Agreement shall be operative and enforced.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

Providence Health & Services, Washington

By:


Susan Klammer

Its: SVP, Contracting

Date: 1/7/2022

Molina Healthcare of Washington, Inc.

By:


Andrew Nelson

Its: VP, Network Management

Date: 1/11/2022

Article Five – General Provisions

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-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 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 through December 31, 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 through December 31, 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

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.

EXHIBIT 1-E
Compensation Schedule - Integrated Managed Care

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, 2022, and remain in effect through December 31, 2022; thereafter the rates shall automatically renew for successive one (1) year terms, unless otherwise amended upon mutual agreement of the parties.

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:

	In Clinic - Per Hour	Out of Clinic - Per Hour
Outpatient - Individual:		
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