

## HOSPITAL PARTICIPATION AGREEMENT

This Hospital Participation Agreement (“**Agreement**”) is made and entered into by and between \_\_\_\_\_, an acute care hospital licensed under the laws of the State of Hawaii, and the Principals of such entity all as listed in Attachment “A”(collectively “**Hospital**”) and WellCare Health Insurance of Arizona, Inc. d/b/a ‘Ohana Health Plan and those Affiliates that underwrite or administer health plans and are identified in one or more of the program attachments appended hereto (severally and collectively, as the context may require, “**Health Plan**”).

### RECITALS

**WHEREAS**, Hospital is a licensed acute care hospital operating in accordance with state and federal laws, rules and regulations, and that wishes to provide medical and related health care services to Health Plan Members; AND

**WHEREAS**, Health Plan offers plans of health benefits coverage for individuals eligible for and enrolled in government sponsored health plans and desires to include Hospital in selected provider network(s) for the provision of medical and related health care service by Hospital to Members.

**NOW THEREFORE**, in consideration of their mutual promises and consideration herein, the sufficiencies of which are hereby acknowledged, the parties agree as follows:

#### **Article I** **Definitions**

As used in this Agreement, unless otherwise defined in a program attachment all capitalized terms shall have the following meanings:

1.1 “**Affiliate**” means an entity that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, Health Plan. An entity “controls” any entity in which it has the power to vote, directly or indirectly, 50% or more of the voting interests in such entity or, in the case of a partnership, if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

1.2 “**Benefit Contract(s)**” means those health insurance coverage contracts, policies or other coverage documents issued or administered by Health Plan. For purposes of this Agreement, Benefit Contract means only those coverage contracts for plans offered or administered by Health Plan and which plans are referenced in one of the program attachments hereto.

1.3 “**Claim**” means a claim that has no defect, impropriety, lack of substantiating documentation, including the information necessary to meet the requirements for encounter data, and using a completed UB-04 or CMS-1500 form or their respective successor forms or alternative electronic equivalents (which electronic equivalents must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions), for Covered Services received timely by Health Plan and which complies with standard CMS coding guidelines, and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely by Health Plan.

1.4 “**CLIA**” means the Clinical Laboratory Improvement Amendments of 1988, as may be amended.

1.5 “**Covered Services**” means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Member Benefit Contract.

1.6 “**Designated Provider**” means those Health Plan subcontracted arrangements, capitated or otherwise, whereby certain specialty service or ancillary vendors and/or providers have assumed financial risk for the provision of certain Designated Services rendered to Members.

1.7 “**Designated Services**” means that certain category or set of Covered Services within a certain medical specialty that are made available by a Designated Provider.

1.8 “**Encounter Data**” means information, data and/or reports about clinical encounters and Covered Services rendered to Members as supported with documentation in the Member medical records and in a format that comports with the HIPAA 837 requirements.

1.9 “**Health Care Provider(s)**” means those physicians, hospitals, health care facilities, health care professionals and/or other health care providers licensed and/or authorized under the laws of the state or states in which services are provided who are: (a) employed or owned by Hospital; (b) rendering services to Members under this Agreement and identified in Attachment “B”; and (c) will be submitting Claims to Health Plan under this Agreement.

1.10 “**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, including without limitation its privacy, security and administrative simplification provisions, and the rules and regulations promulgated thereunder, each as may be amended from time to time.

1.11 “**Medically Necessary**” means those Covered Services and/or supplies that are: (a) appropriate and consistent with the diagnosis and treatment of the Member’s medical condition; (b) required for the care and treatment of Member’s medical condition directly except when care is preventive in nature; (c) compatible with the standards of acceptable medical practice in the community; (d) provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and severity of symptoms; and (e) are not experimental nor provided solely for the convenience of the Member or the health care provider.

1.12 “**Member**” means an individual who is enrolled with Health Plan and eligible to receive Covered Services under a Benefit Contract.

1.13 “**Member Expenses**” means copayments, coinsurance, deductibles and/or other cost-share amounts due from the Member for Covered Services pursuant to their Benefit Contract.

1.14 “**Participating Provider**” means a designated physician, practitioner, ancillary provider, hospital, facility or other provider contracted with and credentialed by Health Plan, or Health Plan’s designee, for participation in certain Health Plan provider network(s). Listings of Participating Providers generally are available on Health Plan’s website.

1.15 “**Principal**” means any owner of Hospital and/or owners of a majority interest, officer, directors and key management of the Hospital (or Hospital’s professional association, partnership or corporation).

1.16 “**Proprietary Information**” means information related to Health Plan: (a) which derives economic value, actual or potential, from not being generally known to or readily ascertainable by other persons who can obtain economic value from its disclosure or use; and (b) which is the subject of efforts that are reasonable under the circumstances to maintain its secrecy or proprietary status, including all tangible reproductions or embodiments of such information. Proprietary Information includes, but is not limited to, technical and non-technical data related to the formulas, patterns, designs, compilations, programs, inventions, methods, techniques, drawings, processes, finances, actual or potential customers and suppliers, existing and future products, manuals, policies and procedures, software, information and operational systems of Health Plan, Health Plan’s affiliates, subsidiaries or Health Plan’s parent company. Proprietary Information also includes information that has been disclosed to Health Plan or Health Plan’s affiliates by a third party and which Health Plan or any Health Plan affiliate, subsidiary or Health Plan’s parent company is obligated to treat as confidential.

1.17 “**Provider Manual**” means the Health Plan’s operating policies, standards, and procedures for Participating Providers including, but not limited to, Health Plan’s requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, disease and case management, quality assurance/improvement, advance directives, Member rights, grievances and appeals.

## **Article II** **Relationship**

2.1 Relationship of the Parties. In the performance of their respective duties and obligations hereunder, the relationship between the parties and their respective employees and agents is that of independent parties contracting with each other solely for the purpose of carrying out the terms of this Agreement. Nothing in this Agreement or otherwise should be construed or is deemed to create any other relationship, including one of employment, agency or joint venture. Except as specifically provided for herein, the parties agree that neither Hospital nor Health Plan will be liable for the activities of the other nor their respective agents or employees, including without limitation, any liabilities, losses, damages, injunctions, lawsuits, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or government agency arising out of or related to this Agreement.

2.1.1 Hospital acknowledges that: (a) there is no guarantee: (i) Health Plan will participate in any given government payor sponsored health benefit program; (ii) any Health Plan contract with any given government payor will remain in effect; or (iii) Members will be referred to Hospital; and (b) this is not an exclusive arrangement.

2.1.2 Hospital acknowledges that Health Plan, through Health Plan's parent company, WellCare Health Plans, Inc. has a corporate ethics and compliance program ("**The Trust Program**"), as may be amended from time to time, which includes information regarding Health Plan's policies and procedures related to fraud, waste and abuse and which provides guidance and oversight as to the performance of work by Health Plan, Health Plan employees, contractors and business partners in an ethical and legal manner. Participating Providers and other contractors of Health Plan are encouraged to report compliance concerns and any suspected or actual misconduct. Details of The Trust Program may be found under 'Corporate Governance' at the 'Investor Relations' section of Health Plan's web site [www.wellcare.com](http://www.wellcare.com).

### 2.2 Hospital Information.

2.2.1 Consistent with the provisions of Attachment "B", Hospital: (a) shall provide Health Plan with a complete list of all Hospital locations and the names and locations of all Health Care Providers; (b) represents and warrants that all Health Care Providers: (i) are appropriately licensed and/or certified under the laws of the State of Hawaii; and (ii) contract with managed care organizations and health insurance companies only through Hospital negotiated contracts; (c) agrees that it is Hospital's responsibility to assure the compliance of Health Care Providers with the terms and conditions of this Agreement; (d) that to the extent Hospital maintains written agreements with Health Care Providers, such agreements contain similar provisions to this Agreement; and (e) whenever in this Agreement the term "Hospital" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual Health Care Provider, as the context may require.

2.2.2 Hospital understands that: (a) Hospital and each Health Care Provider identified in Attachment "B" and/or who is added to the list in Attachment "B" subsequent to execution of this Agreement who is required to be credentialed and/or re-credentialed under Health Plan's policies must be individually credentialed by Health Plan, or Health Plan's designee, before providing Covered Services to Members as a Participating Provider and payment for any Health Plan authorized Covered Services rendered to Members shall be as a non-participating provider until successful completion of credentialing by Health Plan, or Health Plan's designee; (b) Health Plan reserves the right to suspend or terminate participation of Hospital or any Health Care Provider under this Agreement who does not meet or fails to meet or maintain Health Plan credentialing and/or re-credentialing standards; and (c) as part of the credentialing/re-credentialing process, Hospital hereby consents to and will cooperate with any requested on-site reviews.

2.2.3 In the event of any conflict between Hospital's agreements with Health Care Providers, if any, rendering services to Members under this Agreement and the terms of this Agreement, the parties agree that this Agreement shall control with respect to Covered Services rendered to Members. Upon reasonable request and where necessary to meet regulatory and/or government payor requirements and/or where necessary to confirm payment obligation, Hospital agrees to provide Health Plan, and/or an authorized government agency, with access to copies of Hospital's written agreements with Health Care Providers and to the extent not otherwise required by Health Plan for payment purposes and/or an authorized government agency, Hospital may redact fees paid by Hospital thereunder prior to giving access to such agreements.

2.2.4 Hospital agrees to accept and review applications from qualified physicians and other health care practitioners and providers for membership in Hospital's medical staff in accordance with Hospital medical staff privileging policies and procedures and bylaws.

2.2.5 Upon request, Hospital: (a) at no additional cost, agrees to provide Health Plan or Health Plan's authorized designee with the names and associated Hospital privilege status of physicians and other Participating Providers performing services at Hospital; and (b) agrees to assist Health Plan with setting up introductory meetings with hospital based providers (e.g., emergency room physicians, pathologists, radiologists, anesthesiologists, neonatologists, certified registered nurse anesthetists and intensivists) rendering services at Hospital.

2.2.6 Regardless of any provision to the contrary and with respect to participation under this Agreement and designation as a Participating Provider, Health Plan reserves the right to approve the participation under this Agreement of any new Health Care Provider who is required to be credentialed by Health Plan, or Health Plan's designee, or to terminate or suspend any Health Care Provider who is or will be providing services to Members under this Agreement and who does not meet or fails to maintain Health Plan credentialing and/or re-credentialing standards.

2.3 Member Communications. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between physicians and Members regarding a Member's medical condition or available treatment options. Hospital acknowledges and agrees that all patient care and related decisions are the responsibility of the treating physician and that, regardless of any coverage determination(s) made or to be made by Health Plan, Health Plan does not dictate or control clinical decisions with respect to the medical care or treatment of Members.

#### 2.4 Health Plan Information.

2.4.1 Hospital acknowledges and agrees that all rights and responsibilities arising in respect to individual Members shall be applicable only to Health Plan or Affiliate, as applicable, that issued the Benefit Contract covering the respective Member and may not be imposed or enforced upon any other Affiliate. The joinder of Health Plan entities under the designation "Health Plan" shall not be construed as imposing joint responsibility or cross guarantee between or among Health Plan entities.

2.4.2 Hospital agrees that all Proprietary Information and any other non-publicly available information given or transmitted by Health Plan are the confidential and proprietary information of Health Plan, and constitute Health Plan's trade secrets. Hospital agrees not to disclose any Proprietary Information to any person or entity without Health Plan's prior written consent, except as may be required by law or government agency.

(a) Hospital understands that Health Plan has developed, at a substantial investment, certain assets, including without limitation Health Plan membership, provider networks, contracts, manuals, advertising and marketing materials, and other beneficial property, are a part thereof. In recognition of this, Hospital agrees that during the term of this Agreement and for the one (1) year period following any expiration or termination of this Agreement, whether directly or indirectly, without the prior written consent of Health Plan, Hospital shall not: (i) disclose the names, addresses, or phone or identification numbers of any Member to any third party, except as required by process of law or regulation; or (ii) use any of Health Plan's materials, including, but not limited to, Member lists or other assets, directly or indirectly, to further the business purposes of Hospital or any Principal of Hospital. Regardless of any provision to the contrary, in the event of a violation or threatened violation of this section, Health Plan is entitled to seek all available remedies at law or equity including an injunction enjoining and restraining Hospital from violating this section. Hospital acknowledges that the provisions of this section are a separate and independent covenant and the enforcement of this section is not subject to any claims of defense, offset or breach of this Agreement by Health Plan.

2.5 Third Party Beneficiaries. Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of the Hospital and Health Plan. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party, including without limitation a Member.

2.6 Administrative Services. Health Plan, or Health Plan's designee, shall perform those administrative functions and/or activities as are necessary for the administration of Benefit Contracts, including without limitation provider network development, credentialing/re-credentialing, claims processing/adjudication, marketing, quality assurance/improvement, and utilization review/management. Any delegation of any one or more of such administrative functions or activities by Health Plan shall be: (a) consistent with Health Plan policies and procedures and pursuant to a written arrangement; and (b) in accordance with applicable state and/or federal laws, rules and regulations and government program requirements.

2.7 Software Use. Through use of or participation in certain processes or activities as a Health Plan contracted provider, Hospital may use certain software that is licensed to Health Plan and/or Health Plan's parent and/or affiliates. Use of such software is conditioned upon: (a) Hospital's strict compliance with any Health Plan information security guidelines; (b) compliance with HIPAA; (c) treatment of such software as Proprietary Information of Health Plan or Health Plan's licensor, as applicable; and (d) non-disclosure of such software to any third party without the prior written consent of Health Plan. Hospital shall return any copies of such software and purge all machine-readable mediate relating to such software upon request by Health Plan. These obligations of confidentiality, non-disclosure, and return of material survive any expiration or termination of this Agreement.

### **Article III** **Services**

3.1 Eligibility Verification. Hospital agrees to verify the eligibility of Members prior to rendering non-emergency services using processes made available by Health Plan to Participating Providers. In the event of emergency services, Hospital will verify Member eligibility as soon as reasonably practicable after rendering such services.

3.1.1 Health Plan, or Health Plan's designee, will provide Members with identification cards indicating enrollment with Health Plan. Members' Benefit Contracts will require them to present their identification cards when seeking Covered Services. Health Plan will provide access to Member eligibility information through electronic or other means.

3.2 Pre-Authorization. Hospital agrees to obtain pre-authorization for all non-emergency services in accordance with Health Plan's policies and procedures and as specified in the Provider Manual.

3.3 Provision of Services. Hospital shall provide those medical and related health care services available within the scope of Hospital's license or legal operating authority to Members: (a) on a twenty-four (24) hour a day, seven (7) day per week basis; (b) in accordance with the provisions of this Agreement; (c) on the same basis as those services rendered to other patients; (d) consistent with the prevailing practices and standards within the community; and (e) without discrimination on the basis of type of health benefit plan, source of payment, race, age, sex, national origin, religion, color, health status or handicap.

3.3.1 To the extent Hospital performs or has available laboratory procedures, tests and/or services: (a) all such laboratory equipment and supplies shall be maintained and all such laboratory procedures, tests and services shall be rendered in accordance with all applicable state and federal laws, rules and regulations, including without limitation CLIA; and (b) and such laboratory procedures, tests and/or services are not a Designated Service otherwise provided for in Section 3.3.3 below, Hospital shall provide Health Plan with a copy of Hospital's CLIA certificate(s) and/or changes thereto prior to execution of this Agreement and at any time thereafter before any available laboratory procedures, tests and/or services are rendered to Members.

3.3.2 Hospital shall and shall require Health Care Providers to obtain a National Provider Identification number (NPI) timely as required under §1173(b) of the Social Security Act, as enacted by §4707(a) of the Balanced Budget Act of 1997, and shall submit such NPI(s) to Health Plan prior to execution of this Agreement.

3.3.3 Hospital acknowledges that Health Plan may have certain subcontracted agreements with Designated Providers for Designated Services (e.g., mental and behavioral health services, outpatient laboratory services, non-medical vision or dental services). Health Plan will identify Designated Providers via the Provider Manual or otherwise. Unless Physician has obtained prior authorization from Health Plan, Hospital agrees to look solely to the appropriate Designated Provider for the provision of Designated Services to Members. In the event Hospital has a contract with a Designated Provider to provide Designated Services to Members, Hospital agrees to look to and bill only the Designated Provider for payment for the provision of Designated Services to Members.

3.4 Policies & Procedures. Hospital agrees to comply with: (a) all applicable government program requirements, policies, procedures and guidance applicable to those Health Plan products covered under this Agreement; and (b) Health Plan policies and procedures, including without limitation those addressing quality assurance/improvement, utilization management/review, fraud, waste and abuse, health plan accreditation, credentialing/re-credentialing, disease/case management, Member/provider grievances and appeals and such other administrative policies and procedures as are identified in the Provider Manual, as may be amended by Health Plan from time to time and which is incorporated herein by reference. Health Plan either will make copies of the Provider Manual and/or access to the electronic version of the Provider Manual available to Participating Providers, including without limitation Hospital, within the later of the ninety (90) day period following execution of this Agreement or approval of applicable state or federal agencies, where necessary. Hospital is responsible for disseminating the Provider Manual to Health Care Providers.

3.4.1 Health Plan will provide updates of material revisions or additions to the Provider Manual via posting to Health Plan's website or other means, which shall become binding upon Hospital thirty (30) days after such notice, or such lesser period of time as necessary for Health Plan to comply with any statutory, regulatory or accreditation requirements.

3.4.2 Hospital agrees to cooperate with Health Plan's quality improvement and utilization review/management activities as applicable to Hospital and/or Participating Providers, including without limitation: (a) prior authorization and verification of eligibility processes; (b) concurrent and retrospective reviews; and (c) implementation of corrective action and/or quality improvement plans initiated and/or required by Health Plan.

3.5 Grievances and Appeals Hospital agrees to cooperate and participate with Health Plan: (a) in Health Plan's grievance and appeals processes to resolve disputes that may arise between Health Plan and Members, including without limitation the timely provision of information and/or records and documents required by Health Plan; and (b) in provider appeals and dispute resolution processes developed and implemented by Health Plan.

#### **Article IV** **Claims/Encounter Data Submission & Payment**

4.1 Claim/Encounter Data Submission. During the term of this Agreement, Hospital shall prepare and submit electronically to Health Plan, or Health Plan's designee where applicable, Claims and Encounter Data for Covered Services rendered to Members along with all information necessary for Health Plan to process such claims and/or to verify Covered Services rendered to Members in accordance with published standards applicable to the health care industry and as designated by Health Plan, including without limitation use of certain electronic data interface companies or claims clearing houses used by Health Plan and in format(s) and with content otherwise required by a government sponsored health benefits program for which there is a program attachment to this Agreement within ninety (90) days' of the date of service or the date of discharge from an inpatient facility, as applicable. Health Plan, in Health Plan's sole discretion, may deny payment for any claims received following the above referenced time period(s). In the event payment is denied as described herein, any Member Expenses shall be adjusted accordingly.

4.1.1 When submitting Claims and/or Encounter Data to Health Plan, Hospital shall: (a) use the most current coding methodologies on all forms; (b) abide by all applicable coding rules and associated guidelines, including without limitation inclusive code sets; and (c) agree that regardless of any provision or term in this Agreement, in the event a code is formally retired or replaced, discontinue use of such code and begin use of the new or replacement code following the effective date published by the appropriate coding entity or government agency. Should Hospital

submit claims using retired or replaced codes, Hospital understands and agrees that Health Plan may deny such claims until appropriately coded and resubmitted.

4.1.2 Health Plan shall monitor Hospital's compliance with Health Plan's electronic Claims and/or Encounter Data submission, reporting, and/or other administrative requirements. Following the initial thirty (30) days after the Effective Date, in the event Health Plan determines that Hospital is not meeting such electronic submission requirements, Health Plan, in addition to any other provisions herein, will notify Hospital and within five (5) business days of receipt of such notice, Hospital shall identify for Health Plan and implement Hospital's actions for correction of such non-compliance.

#### 4.2 Payment.

4.2.1 Health Plan, or Health Plan's designee: (a) determines what services are Covered Services under the applicable Member Benefit Contract; and (b) will process and pay or deny Claims submitted by Hospital in accordance with the terms and conditions of this Agreement and applicable state and/or federal laws, rules and regulations regarding the timeliness of claims payments using Health Plan's routine claims and payment processing policies, procedures and guidelines, which may include claim and code audit and edit determinations and other claims logic implemented by Health Plan. Hospital agrees to accept as payment in full for Covered Services rendered to Members during the term of this Agreement the rates set out in the applicable program attachment(s) hereto. Unless otherwise provided for in a program attachment appended hereto, Hospital shall collect Member Expenses for Covered Services directly from Members, and shall not waive, discount or rebate any such Member Expenses.

4.2.2 Regardless of any provision to the contrary, Hospital hereby authorizes Health Plan to deduct from amounts that may otherwise be due and payable to Hospital any such outstanding amounts that Hospital may, for any reason, owe Health Plan, including without limitation any adjustments to payments made to Hospital for errors and omissions relating to changes in enrollment, claims payment errors, data entry errors and/or incorrectly submitted claims.

4.2.3 The parties agree that nothing contained in this Agreement nor any payment made by Health Plan to Hospital is a financial incentive or inducement to reduce, limit or withhold Medically Necessary services to Members.

4.3 Coordination of Benefits/Recovery Rights. Payment for Covered Services provided to each Member are subject to reimbursement, subrogation and/or coordination with other benefits payable or paid to or on behalf of the Member, and to Health Plan's right of recovery in other third party liability situations. Health Plan will coordinate payment for Covered Services in accordance with the terms of Benefit Contracts and applicable state and federal laws, rules or regulations. If a Member has coverage from more than one payor or source, Health Plan will coordinate benefits with such other payor(s) in accordance with the provisions of Benefits Contracts. Hospital agrees to share information obtained or documentation required by Health Plan to facilitate Health Plan's coordination of such other benefits. If Hospital has knowledge of an alternative primary payor, Hospital shall bill such other payor(s) with the primary liability based on such information prior to submitting claims for the same services to Health Plan. To the extent permitted by law, if Health Plan is not Member's primary payor, payment for Covered Services from Health Plan shall be no more than the difference between the amount paid by the primary payor(s) and the applicable rate under this Agreement, less any applicable Member Expenses.

4.4 Member Hold Harmless. Hospital hereby agrees that in no event including, but not limited to, nonpayment by Health Plan, Health Plan's determination that services were not Medically Necessary, Health Plan's insolvency, or Health Plan's breach of this Agreement, shall Hospital bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. The parties agree that this provision: (a) shall be construed for the benefit of Members; (b) does not prohibit collection of Member Expenses for Covered Services from Members, unless otherwise provided for in a program attachment appended hereto; and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Hospital and Members or persons acting on their behalf.

4.5 Non-Covered Services. Health Plan will exclude from payment to Hospital the cost of any non-covered service. Hospital may charge and collect from Members for non-covered services if in each instance prior to their provision: (a) Member is advised in writing that the specific services are non-covered services; and (b) the Member affirmatively agrees in writing to assume financial responsibility for payment of such specific services after being so advised. If Hospital is uncertain whether a service is a Covered Service, Hospital agrees to obtain a coverage determination from Health Plan before advising the Member as to coverage and liability for payment and rendering services.

4.6 Claims/Payment Disputes. Should Hospital dispute payment or payments made by Health Plan under this Agreement, Hospital must notify Health Plan in writing of the dispute within ninety (90) days of the payment date or notice of denial or recoupment from Health Plan, or Health Plan's designee. Failure to submit such disputes within the above referenced time period constitutes a waiver of any such dispute and Health Plan's payment shall be considered final, with no further appeal provided.

## **Article V**

### **Records Access & Audits**

5.1 Maintenance. Hospital shall prepare, maintain and retain complete and accurate medical, fiscal and administrative records regarding Covered Services rendered to Members: (a) in accordance with generally accepted medical practice and Health Plan policies; (b) in a form required by applicable state and federal laws and regulations; and (c) for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of this Agreement occurs or from completion of any audit or investigation, whichever is greater, unless an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; or (ii) such greater period of time as provided for by law. Records that are under review or audit shall be retained until the completion of such review or audit should that date be later than the time frame(s) indicated above.

5.2 Access & Audit. Hospital agrees that Health Plan, or Health Plan's designee, shall have the right to audit and reasonable access and an opportunity to examine during normal business hours, on at least twenty-four (24) hours' advance notice, or such shorter period of time as maybe imposed on Health Plan by a federal or state regulatory agency or accreditation organization, the facilities, billing and financial books, records and operations of Hospital, any individual or entity performing services for or on behalf of Hospital or any related organization or entity, as they apply to the obligations of Hospital under this Agreement. The purpose of this requirement is to permit Health Plan to assure compliance by Hospital with all obligations, financial, operational, quality assurance, as well as other obligations of Hospital under this Agreement and Hospital's continuing ability to meet such obligations.

5.2.1 Hospital agrees to make copies of medical, administrative and/or financial records related to services rendered to Members available to Health Plan for inspection, review and/or audit upon request. Copies of such records shall be at no cost to Health Plan.

5.3 Transfer. Upon request from Health Plan, another treating provider or a Member, Hospital agrees to transfer a copy of the medical records and to provide relevant clinical information for Members referred and/or transferred to another provider or medical facility for any reason, including without limitation expiration or termination of this Agreement. The copy and transfer of medical records shall be at no cost to Health Plan or the Member.

5.4 Confidentiality. Hospital agrees to maintain the confidentiality of, use and/or disclosure any personally identifiable information, any protected health information and/or information contain in the medical records of Members in accordance and consistent with applicable state and federal laws, rules and/or regulations, including without limitation HIPAA.

**Article VI**  
**Laws, Regulatory Requirements, Licensure & Insurance**

6.1 Governing Law. This Agreement has been executed and delivered and shall be interpreted, construed and enforced in accordance with the laws of the State of Hawaii, without regard to its conflicts of laws provisions.

6.2 Compliance. The parties agree to comply with all applicable state and federal laws, rules, and/or regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any legal or administrative proceeding in matters in which such right is not recognized by such law, rule or regulation.

6.3 Excluded Individuals/Entities. Hospital and Health Plan respectively represent that neither is nor knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government sponsored health care program.

6.4 Reporting. Hospital agrees to provide Health Plan with timely access to records, reports, clinical information and/or Encounter Data in the format required by the Health Plan to allow Health Plan timely to meet obligations under contracts with any government agency sponsoring or overseeing Health Plan products covered under this Agreement.

6.5 Hospital Licensure/Certification. During the term of this Agreement, Hospital shall and shall require all employees, subcontractors, independent contractors and Health Care Providers of Hospital to procure and maintain in good standing: (a) such licensure, certification and/or registration as provided for in this Agreement and in accordance with applicable Hawaii and federal laws, rules and regulations; and (b) accreditation from a nationally recognized healthcare accreditation entity (e.g. The Joint Commission (JC)).

6.5.1 Hospital shall notify Health Plan immediately in writing upon the occurrence of any of the following as related to Hospital and/or Health Care Providers: (a) suspension, revocation, expiration or other restriction of licensure, certification and/or registration to practice or operate and/or accreditation; (b) the exclusion, suspension or bar from, or imposition of sanctions relating to any government payor program, or any settlement related thereto; (c) any disciplinary action initiated by any regulatory body; (d) any conviction of fraud or any felony; (e) settlement, whether voluntary or involuntary, related to any of the foregoing; and/or (f) any event that could reasonably be expected to impair the ability of Hospital and/or any Health Care Provider to meet Hospital's obligations under this Agreement.

6.6 Health Plan Licensure. Health Plan is and will remain properly licensed and/or accredited in accordance with the laws of the State of Hawaii.

6.7 Hospital Insurance. Hospital shall maintain and shall require Health Care Providers and their respective employees, subcontractors or independent contractors to maintain: (a) such policies of general and professional liability (malpractice) insurance as necessary to insure Hospital and Health Care Providers, respectively, against claims of personal injury or death alleged or caused by performance under this Agreement; (b) worker's compensation coverage in accordance with and to the extent required by the laws of the State of Hawaii; and (c) any stop-loss coverage as is or may be required by Health Plan and/or in accordance with applicable state and federal laws, rules and regulations. Such professional liability coverage for Hospital and each individual Health Care Provider participating under this Agreement shall be one million dollars (\$1,000,000) per occurrence/three million dollars (\$3,000,000) in the aggregate or such amounts as are required by state law, whichever is greater. Prior to execution of this Agreement as part of the credentialing process, and thereafter upon Health Plan request, Hospital shall: (a) provide evidence of such insurance coverage; and (b) provide Health Plan with ten (10) days advance notice of any material modification, cancellation or termination of such coverage.

6.8 Health Plan Insurance. Health Plan shall maintain such policies of general and professional liability insurance as necessary to insure Health Plan against claims regarding Health Plan operations and performance under this Agreement.

6.9 Member Actions. Hospital shall notify Health Plan immediately of any action concerning or brought by a Member against Hospital, Health Care Providers and/or Hospital's employees, subcontractors, or independent contractors.

## **Article VII**

### **Term and Termination**

7.1 Term. The term of this Agreement shall be for one (1) year commencing on the Effective Date. Thereafter, the Agreement shall automatically renew for periods of one (1) year unless either party provides written notice of non-renewal at least ninety (90) days prior to the end of the initial term or any renewal terms thereafter, or the Agreement terminated in accordance with Section 7.2 below.

7.1.1 Hospital acknowledges that, regardless of any provision to the contrary: (a) the Effective Date of this Agreement is dependent upon successful completion by Health Plan, or Health Plan's designee, of credentialing of Hospital and Health Care Providers listed in Attachment "B" who are required to be credentialed by Health Plan, or Health Plan's designee; and (b) after successful initial credentialing of Hospital and Health Care Providers identified in Attachment "B" on the date of execution, Health Plan will countersign this Agreement and complete the blank portions on the signature page indicating the Effective Date, and return a countersigned original to Hospital.

7.2 Termination. This Agreement may be terminated as follows:

7.2.1 Without Cause. Notwithstanding anything to the contrary herein, either party may terminate this Agreement at any time, without cause, upon ninety (90) days written notice to the other party.

7.2.2 With Cause. Either party may terminate this Agreement for material breach of any of the terms or provisions of this Agreement by providing the other party with at least ninety (90) days prior written notice specifying the nature of the alleged material breach. During the first sixty (60) days of the above referenced notice period, the breaching party may cure the breach to the reasonable satisfaction of the non-breaching party.

7.2.3 Immediate Termination. Health Plan, at Health Plan's sole election, may terminate this Agreement, and/or the participation of any Health Care Provider under this Agreement, immediately upon written notice to Hospital in the event of any of the following: (a) suspension, revocation, condition, expiration or other restriction of their respective licensure, certification and/or accreditation; (b) failure to meet or maintain credentialing/re-credentialing standards, as determined by Health Plan; (c) exclusion, suspension or bar of Hospital and/or any Health Care Provider from participation in any government health care program; (d) determination by a government agency or any judicial or administrative review body that Hospital and/or any Health Care Provider has engaged or is engaging in fraud; (e) failure by Hospital or any Health Care Provider to maintain the general and/or professional liability insurance coverage requirements of this Agreement; or (f) Health Plan's reasonable determination that Hospital or any Health Care Provider immediate termination is necessary for the health and safety of Member. Further, Health Plan may terminate this Agreement immediately upon written notice to Hospital in the event that: (i) there is a change in control in Hospital or any new owner or ownership is not acceptable to Health Plan; (ii) Hospital engages in or acquiesces to any act of bankruptcy, receivership or reorganization; or (iii) Health Plan permanently loses Health Plan's authority to do business in total or as to any segment of business, but then only as to that segment.

7.2.4 One Time Termination by Hospital. If, within the thirty (30) day period following the initial distribution or provision of electronic access to the Provider Manual as provided for in Section 3.4, Hospital should raise issues regarding or dispute a material part of the Provider Manual for which the parties are unable to come to a mutually agreeable resolution, Hospital may elect to terminate this Agreement upon sixty (60) days written notice to Health Plan. This provision does not apply to any updates or modifications to or subsequent editions of the Provider Manual made following initial publication or distribution.

7.3 Obligations Upon Termination. Upon termination of this Agreement under Sections 7.2.1 and 7.2.2, Hospital will continue to provide Covered Services to Members as indicated below and to cooperate with Health Plan to transition Members to other Participating Providers in a manner that ensures medically appropriate continuity of care. In accordance with the requirements of applicable government sponsored health benefits programs, Health Plan's accrediting bodies and applicable law and regulation, Hospital will continue to provide Covered Services to

Members after the termination of this Agreement, whether by virtue of insolvency or cessation of operations of Health Plan, or otherwise: (a) for those Members who are confined in an inpatient facility on the date of termination until discharge; (b) for all Members through the date of the applicable government sponsored health benefits program contract for which payments have been made by the applicable government agency; and (c) for those Members undergoing active treatment of chronic or acute medical conditions as of the date of expiration or termination through their current course of active treatment not to exceed ninety (90) days unless otherwise required by item (b) above. Unless otherwise provided for herein, the terms and conditions in this Agreement shall apply to such post-termination Covered Services.

7.4 Notice to Members. Regardless of any provision to the contrary, Hospital agrees: (a) that in the event of expiration or termination of this Agreement, Health Plan will communicate such expiration or termination of this Agreement to Members, as required and pursuant to applicable state and federal laws, rules and regulations and/or applicable government program requirements; and (b) to obtain the prior written consent of Health Plan for any Hospital communications designed for notice to Members and not other patients regarding the expiration or termination of this Agreement.

## **Article VIII Dispute Resolution**

8.1 Dispute Resolution. Health Plan and Hospital agree to attempt to resolve any disputes arising with respect to the performance or interpretation of this Agreement promptly by negotiation between the parties. Prior to submission of any unresolved disputes to binding arbitration pursuant to the provisions herein, Hospital agrees comply with Health Plan's administrative review and/or appeal procedures where applicable.

8.1.1 Other than disputes arising from or related to Section 2.4.2 and/or disputes alleging inappropriate or fraudulent billing practices for which the parties may pursue any available legal or equitable remedy including without limitation litigation, the exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions regarding application and/or interpretation of applicable state and/or federal laws, rules or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration.

8.1.2 The party initiating binding arbitration shall provide prior written notice to the other party identifying the nature of the dispute, the resolution sought, the amount, if any, involved in the dispute, and the names and background of at least two (2) potential arbitrators. The submission of any dispute to arbitration shall not adversely affect any party's right to seek available preliminary injunctive relief.

8.1.3 Any arbitration proceedings shall be held in a mutually agreed upon location in Hawaii in accordance with and subject to the Arbitration Rules, Procedures and Protocols of Dispute Prevention and Resolution, Inc. ("DPR") then in effect, or under such other mutually agreed upon guidelines and before a single arbitrator selected by the parties. Discovery shall be permitted in the same manner, types and times periods provided for by the Federal Rules of Civil Procedure. To the extent the parties are unable to agree upon an arbitrator, the parties agree to use an arbitrator selected by the DPR from a list of arbitrators chosen by the parties as individuals with knowledge and expertise in the area or issue in dispute.

8.1.4 The arbitrator: (a) may construe or interpret but shall not vary or ignore the terms of this Agreement; (b) shall be bound by applicable state and/or federal controlling laws, rules and/or regulations; and (c) shall not be empowered to certify any class or conduct any class based arbitration. The decision of the arbitrator shall be final, conclusive and binding. Judgment upon the award rendered in any such arbitration may be entered in any court of competent jurisdiction, or application may be made to such court for judicial application and enforcement of the award, as applicable law may require or allow.

8.1.5 Each party shall assume its own costs (including without limitation its own attorneys' fees and such other costs and expenses incurred related to the proceedings), but the compensation and expenses of the arbitrator

and any administrative fees or costs of any arbitration proceeding(s) hereunder shall be borne equally by Health Plan and Hospital.

## **Article IX Miscellaneous**

9.1 Notices. Any notice required or permitted to be given under this Agreement, except notices of Provider Manual updates pursuant to Section 3.3.1, shall be in writing and shall be delivered (a) in person; (b) by certified mail, postage pre-paid, return receipt requested; (c) by facsimile; or (d) by commercial courier that guarantees delivery and provides a receipt. Any notice shall be effective only upon delivery, which for any notice given by facsimile, shall mean notice that has been received by the party to whom it is sent as evidenced by confirmation of transmission by the sender. Such notices shall be sent to the locations identified below the parties' respective signature to this Agreement. Either party may from time to time specify in writing to the other party a change in address for purposes of notice hereunder. Unless a notice specifically limits its scope, notice to any one party included in the term "Hospital" or "Health Plan" shall constitute notice to all parties included in the respective terms.

9.2 Amendment. Any amendment to this Agreement must be made in writing and executed by both parties. Notwithstanding the above: (a) this Agreement shall be automatically amended to comply with applicable state and/or federal laws, rules or regulations and/or accreditation requirements to which Health Plan is or may be subject and/or applicable government sponsored health benefits program requirements for which there is a program attachment included in this Agreement.; and/or (b) Health Plan may amend this Agreement upon thirty (30) days written notice to Hospital, unless Hospital objects in writing to such amendment during the thirty (30) day notice period, Hospital shall be deemed to have accepted the amendment.

9.3 Assignment. This Agreement is intended to secure the provision of services by Hospital, as such Hospital may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of or successor to the assets or operations of Health Plan or to any affiliate of Health Plan, provided that the assignee agrees to assume those Health Plan obligations hereunder so assigned. As used in this Section 9.3, the term "assign" or "assignment" shall also include a change of control of a party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such party.

9.4 Severability. If any part of this Agreement should be determined invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

9.5 Waiver. Waiver of any breach of any provision of this Agreement or of any of the remedies available to either party in the event of a default or breach of this Agreement shall not be deemed a waiver of any other provision or a waiver of any subsequent or continuing breach of the same provision or a party's right to elect a remedy at any subsequent time if a condition of default or breach continues or recurs.

9.6 Force Majeure. Neither party shall be deemed to be in default for a delay or failure to perform an act under this Agreement resulting from civil or military authority, acts of public enemy, war, fires, earthquake, flood or other natural disaster.

9.6.1 Regardless of any provision to the contrary: (a) In the event of a natural disaster, system failure and/or other event that may adversely impact and/or results and/or may result in Hospital's temporary inability to meet any one or more of Hospital's obligations under this Agreement (including without limitation the obligation to provide Covered Services to Members), Hospital represents that Hospital has in place a recovery plan inclusive of a mechanism for notice to contracted entities (including without limitation Health Plan) and the timing of assumption of obligations; and (b) Should Hospital be unable to meet Hospital's obligations under this Agreement due to such an unanticipated event beyond Hospital's control for a period of more than forty-eight (48) hours, Health Plan, in Health Plan's discretion, immediately may terminate this Agreement and/or revoke any one or all administrative activities or functions delegated by Health Plan to Hospital hereunder, if any, upon written notice to Hospital. In such event, payments attributable to such delegated administrative activities or functions, if any, shall be adjusted accordingly.

9.7 Use of Name. Neither party will advertise or utilize any marketing materials, logos, trade names, service marks, or other materials created or owned by the other without their prior written consent. Neither party shall acquire any right or title in or to the marketing materials, logos, trade names, service marks or other materials of the other. Notwithstanding the above, the parties: (a) Hospital may include the name of Health Plan in listings of health plans in which Hospital participates; and (b) Health Plan may use certain demographic and descriptive information regarding Hospital information and/or publications identifying Participating Providers, and as may be required under any government payor sponsored health benefits program contract.

9.8 Confidentiality. The parties agree to treat as confidential and not to disclose the terms of this Agreement and/or information regarding any dispute arising out of this Agreement to any third party without the express written consent of the other party, except pursuant to a valid court order or when disclosure is required by a government agency. Notwithstanding any provision to the contrary, the parties agree that each may discuss the payment methodology contained herein with Members requesting such information, and further that Health Plan may disclose the payment rates and terms to: (a) capitated and/or risk-bearing Participating Providers; (b) designated Health Plan vendors performing services for Members and whose compensation from Health Plan is in whole or in part related to amounts paid to Participating Providers; and/or (c) current and/or prospective plan or program clients of Health Plan.

9.9 Duplicate Originals & Captions. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which constitute one and the same Agreement. The captions in this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.

9.10 Incorporation of Attachments, Exhibits and Addenda. Attachments "A", "B", "C" and their associated exhibits are incorporated herein by reference and made a part of this Agreement.

9.11 Entire Agreement. This Agreement, inclusive of all attachments, exhibits, amendments, addenda and documents incorporated herein, is the entire agreement between the parties with regard to the subject matter hereof. Unless otherwise provided for in the Agreement, there are no other agreements or understandings, either oral or written, between the parties affecting this Agreement and this Agreement supersedes all prior or contemporaneous agreements, negotiations and understandings between the parties with regard to the subject matter hereof.

9.12 Survival. The following provisions survive the expiration or termination of this Agreement regardless of cause: Sections 2.1, 2.2.4, 2.4, 2.4.1, 2.4.2, 2.7, 3.1, 3.2, 3.3, 3.3.2, 3.4, 7.3, 7.4, 9.1, 9.7 and 9.8, Articles IV, V, VI and VIII, and Attachment "C" and all of its subparts.

9.13 Document Construction. The parties have participated jointly in the negotiation and drafting of this Agreement. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by the parties and no presumption or burden of proof shall arise favoring or disfavoring any party by virtue of the authorship of any provision(s) of this Agreement.

*<Signatures Follow>*



**Attachment A**  
**Ownership Disclosure**

Name of Legal Entity: \_\_\_\_\_  
*(Should Match Entity Identified as "Hospital" in the opening paragraph on Page 1)*

- \_\_\_\_\_ Corporation
- \_\_\_\_\_ Partnership
- \_\_\_\_\_ Limited Liability Company

List the names, addresses and percentage of ownership of all officers, directors, Principals and key management of Hospital:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

\*Hospital has a continuing obligation to notify the Health Plan of any changes to the information listed above and of any change of ownership of Hospital.

**--TO BE COMPLETED BY HOSPITAL PRIOR TO EXECUTION OF THIS AGREEMENT--**

**Attachment B**  
**Hospital Location(s) & List of Health Care Providers**

(1) Prior to execution of the Agreement and at any time thereafter during the term of the Agreement, Hospital agrees to provide Health Plan with demographic information for Hospital and for each of the Hospital locations and the Health Care Providers seeking participation under this Agreement, including:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license number(s)
- Medicare/Medicaid ID number(s)
- Federal tax ID number(s)
- NPI number(s)
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Identification for each Health Care Provider listed that is a multi-provider practice, and whether the individual licensed health care practitioners or providers are employed or owned by or contracted with such multi-provider practice using the designation “(E)” or “(C)” respectively
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contract person

(2) All information identified above should be provided for each Hospital location and/or Health Care Provider; attach the information or submit separate written document or electronic data containing said information, indicating if a specific piece of information regarding Hospital and/or Health Care Provider is otherwise provided in credentialing applications submitted to Health Plan.

(3) Hospital agrees, on behalf of Hospital and Health Care Providers, that Health Plan may use such demographic and descriptive information relating to Physician and Health Care Providers in Participating Provider information distributed by Health Plan or Health Plan designee.

(4) Hospital shall provide Health Plan with no less than sixty (60) days’ prior written notice of any change: (i) in tax identification/NPI/government program identification number or numbers of Hospital and/or any Health Care Provider; (ii) closing of a location; and/or (iii) any Health Care Provider contract termination or cessation of association with Hospital.

**I: General Provisions.** In addition to the terms and conditions of the Agreement, the following definitions and provisions apply only as to Covered Services rendered to Members covered under those Hawaii State Government Agency sponsored health benefit plans identified below that are offered and/or administered by Health Plan and identified below, and shall control in the event of any conflict between the provisions of the Agreement and this Attachment “C”.

- **Hawaii Medicaid Plans offered and/or administered by Health Plan**

Health Plan will provide advance written notice of additions or deletions to plans listed above, which written notice shall serve to modify this Attachment “C” of the Agreement without need for signature of Hospital, regardless of any provisions to the contrary. Hospital understands and agrees that Health Plan, in Health Plan’s sole discretion, may elect to develop and/or implement Hawaii State Government Agency sponsored health benefit plans with limited or alternative provider networks in which Hospital does not participate.

**A. Definitions.** For purposes of this Attachment “C” and its associated exhibits, the following additional terms shall have the meaning set out below:

(1) **“Advanced Directive”** means a written instruction, such as a living will or durable power of attorney for healthcare, recognized under Hawaii law relating to the provision of healthcare when the individual is incapacitated.

(2) **“Clean Claim”** means a Claim that can be processed without obtaining additional information from the provider of service or such provider’s designated representative. It includes a claim with errors originating in the DHS claims systems. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

(3) **“CMS”** means the Centers for Medicare and Medicaid Services.

(4) **“Copayment”** means a specific dollar amount or percentage of the charge identified which is paid by a Medicaid Member at the time of service to Health Plan for Covered Services provided to the Medicaid Member.

(5) **“Covered Services”** means those Medically Necessary medical, related health care and other services and benefits more fully described in the Provider Manual and to which the Medicaid Member is entitled under Hawaii’s QExA Program.

(6) **“Cultural Competency”** means a set of interpersonal skilled that allow individuals to increase their understanding, appreciation, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better culturally diverse Medicaid Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

(7) **“DHS”** means the Hawaii Department of Human Services.

(8) **“Emergency Medical Condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

(9) “**Emergency Services**” means any inpatient and outpatient Covered Services that are furnished by a provider that is qualified to furnish services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(10) “**Encounter Data**” means information, data and/or reports about clinical encounters and Covered Services rendered to Medicaid Members as supported with documentation in the Medicaid Member medical record and/or records documenting the Covered Services and in a format that comports with the HIPAA 837 requirements and any additional DHS, Hawaii QExA Program and/or Medicaid Contract requirements.

(11) “**EPSDT**” or “Early and Periodic Screening, Diagnosis and Treatment” means a Title XIX mandated program that covers screening and diagnostic services to determine physical and mental conditions in Medicaid Members less than twenty-one (21) years of age, and healthcare treatment and other measures to correct or ameliorate any conditions identified during the screening process.

(12) “**Incentive Arrangement**” means any payment mechanism under which a provider may receive additional funds from Health Plan for meeting targets specified in the Agreement.

(13) “**Medicaid Member(s)**” means those individuals determined eligible by the DHS to receive medical services under traditional Medicaid under Title XIX of the Social Security Act and the DHS rules and regulations and enrolled in a Medicaid Plan offered and/or administered by Health Plan and who is designated by Health Plan.

(14) “**Medicaid Plan**” means one or more Medicaid/QExA plans in the Medicaid Program offered or administered by Health Plan. For purposes of this Agreement, ‘Medicaid Plan’ means those identified in this Section I above and in Health Plan’s Medicaid Contract.

(15) “**Medicaid Program**” means the Hawaii Medicaid managed care program run and administered by the DHS, or DHS’ successor.

(16) “**Medicaid Contract**” means Health Plan’s contract(s) with the DHS, to arrange for the provision of health care services to certain persons enrolled in a Medicaid Plan and eligible for Medicaid under Title XIX of the Social Security Act.

(17) “**Medical Necessity**” is defined in Hawaii Revised Statutes (HRS) 432E-1.4 or those Health Interventions that Health Plan is required to cover within the specified categories that meet the criteria identified below, whichever is the least restrictive:

- (a) The Health Intervention must be used for a Medical Condition;
- (b) There is Sufficient Evidence to draw conclusions about the Health Intervention’s effects on Health Outcomes;
- (c) The Sufficient Evidence demonstrates that the Intervention can be expected to produce the intended effects on Health Outcomes;
- (d) The Health Intervention’s beneficial effects on Health Outcomes outweigh its expected harmful effects; and
- (e) The Health Intervention is the most Cost-Effective method available to address the Medical Condition.

For purposes of this definition, the following terms are defined as:

(i) “**Medical Condition**” means a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

(ii) “**Health Outcomes**” means outcomes of Medical Conditions that directly affect the length or quality of a person’s life.

(iii) “**Sufficient Evidence**” means evidence considered to be sufficient to draw conclusion, if it is peer-reviewed, is well-controlled, directly or indirectly relates to the Intervention to Health Outcomes, and is reproducible both within and outside of research settings.

(iv) “Health Intervention” means an activity undertaken for the primary purpose of preventing, improving or stabilizing a Medical Condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family, or practitioner, are not considered Health Interventions.

(v) “Cost-Effective” means there is no other available Health Intervention that offers a clinically appropriate benefit at a lower cost.

(18) “**Post-Stabilization Services**” means Covered Services related to an Emergency Medical Condition that are provided after a Medicaid Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Medicaid Member’s condition.

(19) “**QExA**” or “**QUEST Expanded Access**” means the capitated managed care program that provides all acute and long term care services to individuals eligible as aged, blind or disabled (ABD) under the Medicaid Program.

(20) “**Urgent Care**” means the diagnosis and treatment of Medical Conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within twenty-four (24) hours.

**II: Additional Medicaid Program Obligations and Requirements.** In addition to the other provisions set forth in the Agreement, the following additional provisions are provider obligations and/or provider contract requirements under Health Plan’s Medicaid Contract and Hawaii laws, rules and/or regulations.

**A. Relationship**

(1) Health Plan does not:

(a) Prohibit providers from (i) discussing the health status, medical care and treatment or non-treatment options with Medicaid Members that may or may not reflect the Health Plan’s position or may or may not be Covered Services, (ii) acting within the lawful scope of their respective medical practices, (iii) advising or advocating on behalf of a Medicaid Member for treatment or non-treatment options, (including any alternative treatments that might be self-administered), or (iv) providing information the Medicaid Member needs in order to decide among all relevant options; (v) discussing the risks, benefits and consequences of treatment or non-treatment; (vi) advocating on behalf of a Medicaid Member in a grievance system, utilization management process or individual authorization process to obtain coverage for Medically Necessary Covered Services; or (vii) discussing the Medicaid Member’s right to participate in decisions regarding the Medicaid Member’s healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions; nor

(b) Discriminate with respect to participation, reimbursement, or indemnification of providers acting within the scope of their respective professional license or certification, solely on the basis of such license or certification nor does Health Plan discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments; and

(c) Regardless of anything to the contrary above, Hospital agrees that: (i) Health Plan is not required to provide, reimburse for, or provide coverage for counseling or referral services for specific services if Health Plan objects to the service on moral or religious grounds; and (ii) that this Paragraph II(A)(1) is not and shall not be construed as an “any willing provider” contract obligation and does not prohibit measures used by Health Plan to limit participation to meet the needs of its Medicaid Members and/or to maintain quality and cost controls.

(2) As indicated in Section 2.1.2 of the Agreement, Health Plan has a compliance program entitled “The Trust Program”. Acknowledging that Hospital is a business partner (as that term is used in Health Plan’s compliance program, The Trust Program) of Health Plan, Hospital agrees to comply with the standards of The Trust Program as they apply to Hospital and services rendered by Hospital to Medicaid Members and Health Plan policies and procedures applicable to Participating Providers and the provisions of the Provider Manual regarding fraud, waste and abuse programs and activities.

**B. Services**

(1) During the term of the Agreement, up to and including the last day the Agreement is in effect, and during any continuation of care period following expiration or termination of this Agreement identified herein, Hospital agrees to: (a) accept Medicaid Members for treatment unless Hospital applies for and receives from Health Plan a waiver for this requirement; and (b) provide Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and the Medicaid Contract and shall not refuse to provide Medically Necessary or preventive Covered Services to Medicaid Members.

(2) Hospital shall:

(a) maintain hours of operation no less than the hours of operation offered to other patients, and provides timely access to physician appointments to comply with the availability schedule: Emergency Services – immediately (24 hours a day/7 days a week) and without prior authorization, Urgent Care & pediatric sick visits – within twenty-four (24) hours, Primary Care adult sick care – within seventy-two (72) hours, Routine Primary Care visits for adult & children – within twenty-one (21) days, and specialists or non-emergency hospital stays – within four (4) weeks;

(b) comply with the Health Plan's Cultural Competency plan as made available to Participating Providers by Health Plan and/or as set out in the Provider Manual and under which Hospital shall render services to Medicaid Members of all cultures, races, ethnic backgrounds and religions in a manner that recognizes, values, affirms and respects the worth of Medicaid Members and protects and preserves their dignity;

(c) not make referrals for designated health services to healthcare entities with which Hospital or a member of Hospital's family has a direct or indirect (regardless of how many levels removed from a direct interest) ownership or investment interest in the form of equity, debt, compensation management, or other means (including without limitation an option or non-vested interest) in any such entity;

(d) comply with corrective action plans initiated and/or required by Health Plan; and

(e) enroll and complete appropriate forms for the VFC program, if Hospital provides vaccines to children.

**C. Claims/Encounter Data Submission & Payment**

(1) Regardless of any provision to the contrary, Hospital:

(a) Subject to the terms and conditions of the Medicaid Contract and the Medicaid Member's Benefit Contract, shall look solely to Health Plan for payment of Covered Services rendered to newborns of Medicaid Members until such newborn is enrolled in a different QExA health plan or in a QUEST health plan or other health plan;

(b) Acknowledges and agrees and shall require Health Care Providers to agree: (i) that Medicaid Member Expenses are included in the payment from Health Plan; and (ii) not to seek payment from or to collect Medicaid Member Expenses from Members;

(c) Will refund any payment or amounts received from Health Plan that exceed the Medicaid Member Expenses for the prior coverage period;

(d) Acknowledges and agrees to bill or assess charges for services to Medicaid Members as provided for in the Agreement and the Provider Manual, and consistent with the Medicaid Contract;

(e) Agrees to submit annual cost reports to the Med-QUEST Division (MQD) of DHS;

(f) Agrees to certify that information included in Claims and/or Encounter Data submitted by Hospital for Covered Services rendered to Medicaid Members under this Agreement is accurate, complete and truthful to the best of Hospital's knowledge, belief and information available at the time;

(g) Agrees to submit Encounter Data to Health Plan, or Health Plan's designee, on a monthly basis as provided for in the Medicaid Contract and that except to the extent specifically required by applicable state or federal law or regulation, submission of Encounter Data to Health Plan as provided for under the Agreement does not require consent from the Member; and

(h) Agrees that neither the DHS nor any Medicaid Member will be held liable for: (a) the Health Plan's failure or refusal to pay valid Clean Claims submitted by Hospital to Health Plan; (b) services provided to a Medicaid Member for which DHS does not pay Health Plan under the Medicaid Contract; and/or (c) services provided to a Medicaid Member for which the Health Plan or DHS does not pay the individual or the healthcare







