HAWAII MEDICAL SERVICE ASSOCIATION

MEDICAL GROUP AGREEMENT FOR
MEDICARE PLANS

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THIS AGREEMENT, effective as of «Effec_Date», (“Effective Date”) is by and between Hawaii Medical Service Association (“HMSA”), a Hawaii nonprofit mutual benefit society, and «Add_Nm_1» (“Provider”), (each a “Party” and, collectively, the “Parties”) and arises out of the following circumstances:

1. HMSA has Medicare Cost contract(s) with the federal Centers for Medicare & Medicaid Services (“CMS”), pursuant to which HMSA enrolls, and arranges health care services for, HMSA Medicare Cost Plan Members;

2. HMSA offers Medicare Supplement Plans whereby HMSA arranges health care services for HMSA Medicare Supplement Plan Members;

3. HMSA desires to contract with CMS to become a sponsor of a Medicare Advantage Plan and/or a Medicare Advantage Prescription Drug Plan, in which capacity HMSA would enroll, and arrange health care and prescription drug services for, HMSA MA Plan Members and HMSA MA-PD Plan Members;

4. HMSA desires to contract with Provider to provide or arrange for Covered Services, through Provider’s employee Participating Physicians and Participating Allied Health Providers, to HMSA Medicare Cost, HMSA Medicare Supplement, HMSA MA Plan and HMSA MA-PD Plan Members; and

5. Provider desires to contract with HMSA to provide or arrange for Covered Services through its employee Participating Physicians and Participating Allied Health Providers under HMSA Medicare Cost, HMSA Medicare Supplement, HMSA MA and HMSA MA-PD Plans.

ARTICLE I. DEFINITIONS

Terms used throughout this Agreement are defined as follows:

1.1 Claim. A complete billing, or an adjustment to such billing, for Covered Services submitted by Provider on the CMS 1500 form, any other form approved by HMSA, or by electronic transmission accepted by HMSA.

1.2 Copayment. An amount that the Member is required to pay for Covered Services as set forth in the Plan Document and in accord with Medicare related statutes, regulations and subregulatory guidance.

1.3 Covered Service. A medical service or supply that qualifies for payment under terms set forth by CMS and the applicable Plan Document and that meets the Payment Determination Criteria set forth in Section 4.2 of this Agreement or that is a preventive service that is specifically described as covered in the Plan Document.

1.4 Eligible Charge. For a medical service or supply that qualifies for payment under Title XVIII of the Social Security Act (“Title XVIII”) and the regulations and subregulatory guidance promulgated thereunder by CMS (the “Medicare Rules”), the Eligible Charge for a Covered Service is the lower of (a) the actual charge as shown on the Claim or (b) the amount that otherwise would have been paid directly to the Provider under Title XVIII and Medicare Rules for the service or supply (the “Medicare Payment Amount”).
Where a Medicare Payment Amount has not been established, the Eligible Charge shall be the lower of (a) the actual charge as shown on the Claim or (b) the charge listed in HMSA’s Schedule of Maximum Allowable Charges (the “Schedule”). HMSA reserves the right to adjust the charges listed in the Schedule upon sixty (60) days’ written notice to Provider. Factors considered by HMSA in making these adjustments may include, but are not limited to, changes in the Honolulu Consumer Price Indices (All Items and Medical Care); cost of providing medical care; relative complexity of the service; payments for the service under federal, state, and other private insurance programs; and the competitive environment. For a Covered Service that does not have a charge listed in the Schedule, HMSA will establish the Maximum Allowable Charge.

1.5 **HMSA Participating Provider.** A health care professional or facility that has entered into a contract with HMSA to provide health care services.

1.6 **Medicare Advantage Covered Services (or “MA Covered Services”).** Those Covered Services which qualify for payment under an HMSA MA Plan or an HMSA MA-PD Plan.

1.7 **Medicare Advantage (“MA”) Program.** The program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare + Choice Program established under Part C of Title XVIII, including any implementing regulations or subregulatory guidance, and as such sources may be amended over time.

1.8 **Member.** A person who meets applicable eligibility requirements and is enrolled in a Plan and on whose behalf of the applicable Plan premiums have been paid. A Member includes any of the following:

1.8.1 **HMSA Medicare Advantage Plan Member (or “HMSA MA Plan Member”).** A person who is eligible for Covered Services under Title XVIII and the Medicare Rules, who meets applicable eligibility requirements for and is enrolled in an HMSA Medicare Advantage Plan.

1.8.2 **HMSA Medicare Advantage Prescription Drug Plan Member (or “HMSA MA-PD Plan Member”).** A person who is eligible for Covered Services under Title XVIII and the Medicare Rules, who meets applicable eligibility requirements for and is enrolled in an HMSA Medicare Advantage Prescription Drug Plan.

1.8.3 **HMSA Medicare Cost Plan Member.** A person who is eligible for Covered Services under Title XVIII and the Medicare Rules, who meets applicable eligibility requirements for and is enrolled in an HMSA Medicare Cost Plan.

1.8.4 **HMSA Medicare Supplement Plan Member.** A person who is eligible for Covered Services under Title XVIII and the Medicare Rules, who meets applicable eligibility requirements for and is enrolled in an HMSA Medicare Supplement Plan.

1.8.5 **Other MA Plan or MA-PD Plan Member.** A person who is eligible for Covered Services under Title XVIII and the Medicare Rules, who meets applicable eligibility requirements for and is enrolled in an MA Plan or MA-PD Plan offered by a Blue Cross and/or Blue Shield plan for which HMSA has agreed to arrange for the provision of Covered Services.

1.9 **Participating Allied Health Provider.** A professional health care provider that is employed by or contracted with Provider and that is not a physician. Participating Allied Health Providers include all non-physician providers employed by or contracted with Provider, including but not limited to physician assistants, physical therapists, home health providers, laboratories, radiology facilities, hospice programs and ambulatory surgery centers.

1.10 **Participating Physician.** A physician who is employed by or contracted with Provider.

1.11 **Participating Provider.** A Participating Allied Health Provider or a Participating Physician.
1.12 **Plan.** Any of the following HMSA health plans that provide benefits for services performed by Provider as well as a Blue Cross and/or Blue Shield plan that offers an MA Plan or MA-PD Plan for which HMSA has agreed to arrange for the provision of Covered Services.

1.12.1 **HMSA Medicare Advantage Plan (or “HMSA MA Plan”).** A plan offered by HMSA pursuant to a Medicare Advantage contract with CMS. Provider acknowledges that HMSA may develop additional HMSA Medicare Advantage Plans, covering differing types of health benefits, and that varying federal regulations may govern the varying HMSA Medicare Advantage Plans.

1.12.2 **HMSA Medicare Advantage Prescription Drug Plan (or “HMSA MA-PD Plan”).** A plan offered by HMSA pursuant to a Medicare Advantage Prescription Drug contract with CMS. Provider acknowledges that HMSA may develop additional HMSA Medicare Advantage Prescription Drug Plans, covering differing types of health and prescription drug benefits, and that varying federal regulations may govern the varying HMSA Medicare Advantage Prescription Drug Plans.

1.12.3 **HMSA Medicare Cost Plan.** A plan, such as 65C Plus, offered by HMSA pursuant to a Medicare Cost contract with CMS. Provider acknowledges that HMSA may develop additional HMSA Medicare Cost Plans, covering different types of health benefits, and that varying federal regulations may govern the varying HMSA Medicare Cost Plans.

1.12.4 **HMSA Medicare Supplement Plan.** A plan, such as Senior Connection, offered by HMSA pursuant to Chapter 431, Article 10A, Part III of the Hawaii Insurance Code and implementing regulations. Provider acknowledges that HMSA may develop additional HMSA Medicare Supplement Plans covering different types of health benefits, and that varying state and federal regulations may govern the varying HMSA Medicare Supplement Plans.

1.13 **Plan Document.** The document issued by HMSA or a Plan that describes the health care and/or prescription drug benefits available to Members enrolled in a particular Plan.

1.14 **Provider E-Library.** The HMSA policies and procedures governing Provider services contained in the electronic provider resource library available through the HMSA web site (www.hmsa.com/portal/provider). For purposes of this Agreement, the Provider E-Library shall consist of those policies and procedures governing physician services.

**ARTICLE II. OBLIGATIONS OF PROVIDER**

2.1 **Authority to Bind Participating Providers.** Provider represents and warrants that it is legally authorized to negotiate on behalf of and to bind Participating Providers to abide by the terms and conditions of this Agreement, as amended from time to time. Provider agrees that it is Provider’s responsibility to assure that the obligations of Participating Providers under this Agreement are fully satisfied, and Provider shall take all steps necessary to cause Participating Providers to comply with and perform the terms and conditions of this Agreement. In addition, Provider hereby agrees to be bound, and Participating Providers shall be bound, by all applicable terms and conditions of any and all agreements that HMSA has entered into with CMS, which HMSA shall communicate or make available to Provider. Provider agree, and shall require Participating Providers to agree, that in the event of any inconsistency between this Agreement and any contract entered into between Provider and Participating Provider(s), the terms of this Agreement shall control. Upon request by HMSA, Provider shall provide to HMSA copies of Provider’s contracts with Participating Providers.

2.2 **Provision of Covered Services.** Provider shall, through Participating Providers and within the scope of Provider’s and the Participating Providers’ practice and licensure, provide or arrange for the provision of Covered Services to Members in accordance with the applicable Plan Document, federal and state law, and the Medicare Rules, and in a manner consistent with the requirements of this Agreement, HMSA’s contractual obligations to CMS, and HMSA policies and procedures.
Provider shall comply and ensure that Participating Providers shall comply with HMSA policies and procedures to ensure that Covered Services are provided in a culturally competent manner to Members, including those with limited English proficiency or reading skills, diverse cultural or ethnic backgrounds, or physical or mental disabilities. Provider shall discuss and shall ensure that Participating Providers discuss all treatment options with Members, including the option of no treatment, and shall further discuss and ensure that Participating Providers discuss all risks, benefits and consequences of treatment and no treatment. Provider shall instruct and shall ensure that Participating Providers instruct Members regarding follow-up care, and shall train and shall ensure that Participating Providers train Members regarding self-care as necessary. Provider shall provide HMSA with a list of its Participating Providers, and shall update this list whenever Provider employs or contracts with a new Participating Provider or an existing Participating Provider is no longer employed by or under contract to Provider or no longer meets HMSA’s credentialing or recredentialing criteria.

2.3 Standard of Care. Provider shall provide and shall ensure that the Participating Providers provide Covered Services in accord with generally accepted medical practices and standards applicable to physicians practicing in the same field under similar circumstances at the time of treatment.

2.4 Referrals. Provider shall comply and shall ensure that Participating Providers comply with all referral and preauthorization procedures set forth in the Provider E-Library. In addition, subject to each Participating Provider’s professional judgment of the Member’s best clinical interest and, 42 U.S.C. §1395dd, Provider shall ensure that each Participating Provider shall refer Members for Covered Services to other providers in the following order:

(a) To other HMSA Participating Providers and providers contracting with HMSA to provide Covered Services under Plans; or

(b) To providers and physicians participating in the Medicare program generally.

HMSA shall furnish or make available to Provider a current provider directory for Plans.

2.5 Availability. Provider shall make necessary and appropriate arrangements to ensure that medically necessary Covered Services are readily available to Members twenty-four (24) hours a day, seven (7) days a week from Provider or other HMSA Participating Providers providing back-up coverage to Provider. Provider shall make appropriate and necessary arrangements to ensure that HMSA Participating Providers providing back-up coverage to Provider do so in accordance with the requirements of this Agreement applicable to Provider.

2.6 Non-Discrimination on the Basis of Health or Other Status. When providing or arranging for the provision of Covered Services to Members, Provider shall not (and Provider shall ensure that Participating Providers shall not) discriminate against any Member, or deny, limit, or condition coverage or the furnishing of health care services or benefits to any Member on the basis of race, ethnicity, color, religion, creed, gender, marital status, sexual preference, national origin, age, financial status, source(s) of payment or membership in HMSA or evidence of insurability (including conditions arising out of acts of domestic violence), health status, including, but not limited to, medical condition (including mental as well as physical illness), mental or physical disability, claims experience, receipt of health care, medical history, genetic information, or any other criteria prohibited by law. Provider shall provide and shall ensure that Participating Providers provide Covered Services to Members in the same manner, in accordance with the same professional standards, and within the same time availability, as for its, his or her other patients.

2.7 Physician-Patient Relationship. Provider shall ensure that Participating Physicians (a) maintain the physician-patient relationship with each Member to whom Participating Physicians provide Covered Services; and (b) have the sole responsibility for the medical care and treatment of such Members. Nothing contained in this Agreement is intended or shall be interpreted to interfere with the
physician-patient relationship, or to impose any type of prohibition, disincentive, penalty or other negative treatment upon Participating Physicians for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to non-Covered Services.

2.8 Advance Directives. Provider shall discuss and ensure that Participating Providers discuss living will and durable powers of attorney in relation to medical treatment with the Member and the Member’s immediate family members as required by Haw. Rev. Stat. §432E. In addition, Provider and each Participating Provider:

(a) Shall not condition the provision of Covered Services or otherwise discriminate against a Member on the basis of whether or not such Member has executed an advance directive;

(b) Shall document in a prominent part of each Member’s current medical record whether or not the Member has executed an advance directive;

(c) Shall comply with Hawaii law and the law of any other state(s) in which it provides services to Members (whether statutory or recognized by the courts of competent jurisdiction) on advance directives, including, but not limited to, Hawaii’s Uniform Health-Care Decisions Act, Haw. Rev. Stat. Chapter 327E; and

(d) Shall cooperate with HMSA’s educational efforts regarding advance directives.

2.9 Licensure. Provider warrants and represents that each Participating Provider is and will remain, throughout the term of this Agreement, the holder of a currently valid, unrestricted, and unconditioned (a) license or certificate to practice in the State of Hawaii; (b) Federal Drug Enforcement Administration (DEA) certificate or Controlled Dangerous Substances (CDS) certificate in the State of Hawaii or approval required by any other law or regulation for the provision of Covered Services hereunder. HMSA may waive the drug certification requirement if the Provider and Participating Provider present evidence acceptable to HMSA that the certification is not required for the Participating Provider to deliver appropriate medical care. HMSA may waive the drug certification requirement if the Provider presents evidence that the certification is not required to deliver appropriate medical care. Provider warrants and represents that each Participating Allied Health Provider is and will remain, throughout the term of this Agreement, the holder of a currently valid, unrestricted, and unconditioned license, permit or approval required by law or regulation for the provision of Covered Services hereunder.

2.10 Credentialing. Provider shall require its Participating Providers who provide Covered Services to Members to comply with any and all credentialing and recredentialing requirements, policies, procedures and programs, including site visits, as established by HMSA and amended from time to time. Such cooperation and compliance shall include, but not be limited to, providing to HMSA, and to CMS, if requested, such data as HMSA may deem necessary to implement such requirements, policies, procedures and programs. Compliance shall be determined by an HMSA credentialing committee composed of practicing physicians. Failure to meet credentialing or recredentialing requirements may result in termination in accord with Article VII of this Agreement. Provider’s right to appeal such a termination decision is set forth in Section 8.1(b) of this Agreement. Provider shall further attest to the accuracy and completeness of any information provided to HMSA for credentialing or recredentialing purposes.

2.11 Eligibility to Provide Covered Services. Provider warrants and represents that Provider and each Participating Provider, at the time of execution and throughout any term of this Agreement: (a) shall meet applicable HMSA credentialing or recredentialing requirements; (b) has not been suspended, debarred or excluded from participation in a federal health care program (as defined in 42 U.S.C. §1320a-7b(f)); (c) has not been sanctioned by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (the “OIG”); (d) has not been listed on the OIG’s web site List of
Excluded Individuals and Entities (the “LEIE”); (e) possesses state license(s) that have not been sanctioned or limited; (f) shall not at any time during the term of this Agreement arrange for the provision of Covered Services to Members through a person or entity that does not meet the foregoing criteria at the time services are rendered; (g) will immediately notify HMSA in writing if any state license that Provider or any Participating Provider possesses is sanctioned or limited; and (h) with respect to Participating Physicians, that no Participating Physician has opted out of Medicare at any point in the two (2) years prior to the effective date of this Agreement.

2.12 Required Disclosures. Provider shall notify HMSA immediately in writing of the occurrence of, and shall upon request provide HMSA with additional documentation or information regarding, any of the events indicated below:

(a) Provider becomes aware of an action to suspend, condition, revoke, terminate or subject to terms of probation or other restriction, any Participating Provider’s privileges at any medical facility or license, certification or accreditation relevant to the provision of Covered Services, including, but not limited to, a Participating Provider’s federal and/or state drug license or certificate; or

(b) A Participating Provider voluntarily surrenders or terminates any of that Participating Provider’s licenses, certifications, accreditations or privileges in anticipation of an action described in paragraph (a) above; or

(c) Provider or any Participating Provider is convicted of a fraud or felony or is suspended, debarred or excluded from participation in a federal health care program (as defined in 42 U.S.C. §1320a-7b(f)); or

(d) An act of nature or any event beyond Provider’s reasonable control occurs that substantially interrupts all or a portion of Provider’s business or practice, or that has a materially adverse effect on Provider’s ability to perform its or his or her obligations hereunder; or

(e) Provider fails to maintain the insurance coverage required under Article VI of this Agreement; or

(f) Any malpractice claim, judgment or settlement in which Provider or any Participating Provider is a named defendant; or

(g) There is a change in Provider’s business address, tax identification number, board certification or scope of practice; or

(h) Provider or any Participating Provider plans to terminate its, his or her practice, to close the practice to additional patients, or to discontinue the Provider’s participation in the Medicare Program; or

(i) Any Participating Provider becomes the subject of any disciplinary proceeding or action before the Hawaii Medical Board or the Board of Nursing or a similar agency in any state, or an agency of the federal government; or

(j) There is a change in the employment status, contractual status, or address of practice locations of any Participating Provider; or

(k) Any other situation arises that could reasonably be expected to affect Provider’s ability to carry out its or his or her obligations under this Agreement.

2.13 Access to Certain Benefits. Notwithstanding the provisions of Section 2.4 above, no referral shall be required for a Member to obtain a screening mammography or influenza vaccine from an HMSA Participating Provider, or to receive routine and preventive Covered Services from an HMSA
Participating Provider who is a women’s health specialist. In addition, no Copayment shall be required of a Member for a screening mammography or influenza vaccine.

2.14 Quality Improvement and Utilization Management. Provider shall cooperate and comply and shall ensure that Participating Providers cooperate and comply with HMSA’s medical policies and quality assurance, performance improvement and medical management programs. Such cooperation and compliance shall include, but not be limited to, providing to HMSA, and to CMS, if requested, such data as HMSA may deem necessary to implement HMSA’s quality improvement program and HMSA’s reporting requirements to CMS; participating in CMS and HHS quality improvement initiatives (including medical care evaluation studies, clinical practice guidelines, peer review, practice pattern analysis based on Claims data, audit of medical records, problem identification and resolution, and priority-setting); and, as requested by HMSA, consulting with HMSA regarding HMSA’s medical policy, quality improvement and medical management policies and the development of practice and utilization management guidelines.

Provider agrees and shall ensure that Participating Providers agree to work in good faith with HMSA to implement corrective actions recommended by an HMSA review committee composed of practicing physicians, and to permit such a committee to monitor and evaluate such corrective actions. Provider’s right to appeal a corrective action decision is set forth in Section 8.1(a) of this Agreement. Furthermore, with respect to the provision of Covered Services to HMSA Medicare Cost Plan Members, Provider shall comply with requirements for Quality Improvement Organization (“QIO”) review of such services as set forth in 42 C.F.R. 417.478(a), and shall furnish to the QIO requested on-site access to or copies of patient care records and other pertinent data, and permit the QIO or its subcontractor to examine Provider’s operations and records necessary for the QIO to carry out its functions. With respect to Provider’s participation in any HMSA MA-PD Plan, Provider shall cooperate, participate and support quality assurance, cost, utilization management and medication therapy management programs, and support e-prescribing in accordance with 42 C.F.R. Part 423, Subpart D.

Provider shall also participate in and comply with HMSA’s utilization management programs and requirements as described in the Provider E-Library and Plan Documents, and/or as required by regulatory and accrediting agencies, and shall ensure that Participating Providers so participate and comply. Payments may be reduced or denied if Provider or any Participating Provider fails to satisfy a utilization management requirement and an HMSA Medical Director or his or her designee determines that the service does not meet Payment Determination Criteria set forth in Section 4.2 of this Agreement. Provider shall not and shall ensure that Participating Providers shall not attempt to collect the reduced or denied payment from the Member.

HMSA’s utilization management programs may include, but are not limited to:

(a) Pre-certification for payment determination regarding whether a proposed service complies with the Payment Determination Criteria;

(b) Concurrent review to determine whether a continued inpatient hospital stay or other treatment protocols meet the Payment Determination Criteria;

(c) Retrospective review to evaluate appropriateness of care and care management and ensure that HMSA payments are consistent with Payment Determination Criteria;

(d) Focused review of specific procedures and/or specific providers;

(e) As applicable, concurrent review by case managers under applicable disease management programs, to determine whether the Member is receiving appropriate care and services for the Member’s condition;
Case management programs to identify less costly alternatives without compromising quality of care; and

Review of records in conjunction with credentialing.

2.15 Continuity of Care. Provider shall provide and shall ensure that Participating Providers provide appropriate medical information to other providers (a) when referring a Member to another provider, (b) at such Member’s request, or (c) at another provider’s request in order to ensure continuity of care and to avoid unnecessary duplication of services, unless such Member specifically objects.

2.16 Compliance. Provider shall comply and shall ensure that all Participating Providers comply with all state and federal statutory, regulatory and other requirements, subregulatory guidance (such as CMS manuals, training materials and guides), and Provider and HMSA contractual commitments related to the performance of Provider’s obligations under this Agreement and/or the delivery of the Medicare Part D benefit, including, but not limited to, Title XVIII of the Social Security Act, the Medicare Rules, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, requirements applicable to individuals and entities receiving federal funds, requirements designed to prevent or ameliorate fraud, waste and abuse, requirements governing participation in the Medicare Advantage Program, the Americans with Disabilities Act, applicable criminal statutes, the False Claims Act (31 U.S.C. §3729 et seq.) and State False Claims Acts, the Federal Health Care Program Anti-Kickback Act (42 U.S.C. §1320-7b(b)), the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the HIPAA Administrative Simplification rules at 45 C.F.R. Parts 160, 162 and 164, applicable provisions of the Food, Drug and Cosmetic Act, applicable civil monetary penalties and exclusions, the prohibition on inducements to beneficiaries (42 U.S.C. §1320a-7(a)(5)), and 42 C.F.R. §§400, 403, 411, 417, 422, 423, 1001 and 1003.

Provider agrees and shall ensure that Participating Providers agree to be bound by all federal laws and regulations pertaining to its, his or her responsibilities under this Agreement, whether or not specifically stated in this Agreement. Provider shall also comply and shall ensure that Participating Providers comply with all applicable policies, procedures, and requirements contained in the Provider E-Library or otherwise communicated by HMSA to Provider, including, but not limited to, HMSA’s compliance plan and such policies, procedures and/or initiatives combating fraud, waste and abuse.

2.17 Appeals and Grievances. Provider shall, and shall ensure that Participating Providers, cooperate and comply with, all HMSA Member appeals and grievances processes, as well as HMSA enrollment and disenrollment determinations, and shall provide medical records and other pertinent information to HMSA for such purpose within the time frame required by regulation or, if not so required, reasonably requested by HMSA or other authorized party. Such cooperation, processes and determinations shall be subject to all applicable federal statutes, regulations, and subregulatory guidance, including, without limitation, with respect to the administration and delivery of 65C Plus and Medicare Part C benefits, the requirements of 42 C.F.R. Part 422, Subpart M, and with respect to the administration and delivery of Medicare Part D benefits, the requirements of 42 C.F.R. Part 423, Subpart M. Provider acknowledges that such requirements and processes may differ by Plan, and that the requirements applicable to an HMSA MA-PD Plan shall be separate and distinct from the appeals and grievances requirements applicable to an HMSA MA Plan. Senior Connection Member appeals shall be subject to the processes set forth in the Provider E-Library.

2.18 Personal Care Physician (“PCP”) Responsibilities. Provider shall ensure that each Participating Physician who wishes to participate as a PCP shall complete the Physician Designation Form attached hereto as Exhibit A. For Members (other than Medicare Supplement Plan Members) who select a Participating Physician as their PCP, Provider agrees to and shall ensure that such Participating Physicians shall:
(a) Make every effort to coordinate and arrange for the provision of Covered Services to such Members; and

(b) Support programs to assure that such Members receive preventive services such as immunizations and other screening tests, and report the findings of such tests to such Members when appropriate;

(c) Identify and refer such Members to appropriate patient education and disease management programs sponsored by HMSA.

2.19 Specialist Responsibilities. If any Participating Physician is a specialist, Provider shall ensure that:
(a) such Participating Physician will complete and return the Physician Designation Form attached hereto as Exhibit A; and
(b) such Participating Physician shall provide appropriate and timely progress reports, including medical records, to a Member's PCP (as contemplated by Section 2.18), when in the Participating Physician's medical judgment, such reports are necessary to ensure proper coordination and enhance continuity of the patient's care.

2.20 Health Assessment. Provider shall cooperate with HMSA in the coordination of a health assessment of each new HMSA MA Plan Member or HMSA MA-PD Plan Member within ninety (90) days of the effective date of enrollment of each such person.

2.21 Continuation of Benefits. Provider shall continue to provide Covered Services to HMSA MA Plan Members and HMSA MA-PD Plan Members for the duration of the CMS-HMSA contract period through which CMS payments have been made, and shall ensure that the Participating Providers provide Covered Services. Such continuation of services shall be made in accordance with the terms and conditions of this Agreement as it may be amended and in effect at the time, including but not limited to the compensation rates and terms set forth therein. This continuation of benefits provision shall survive termination of this Agreement.

2.22 Submission of Administrative Data. Provider acknowledges that HMSA is required by CMS to maintain a health information system that collects, analyzes and integrates all data necessary to compile, evaluate and report certain statistical data related to costs, utilization and quality, and such other matters as CMS may require from time-to-time, including but not limited to clinical areas and effectiveness of care. Provider shall provide HMSA, or such other party designated by HMSA, in the form and within such time frames as may be prescribed by HMSA, such Claims data, medical records and other data as may be required by HMSA in order to fulfill HMSA's regulatory and contractual obligations to CMS. Such data shall conform to all relevant national standards and CMS requirements, and to the requirements for equivalent data for Medicare fee-for-service where appropriate. Provider acknowledges that such data will be used for purposes of obtaining federal reimbursement, and shall certify the accuracy, completeness and truthfulness of all data submitted to HMSA or CMS pursuant to this Article. Provider also shall submit a sample of medical records for validation of such data as required by CMS.

2.23 Exclusion of Certain Persons. Provider shall certify to HMSA that Provider shall review the LEIE and the General Service Administration’s (“GSA’s”) Lists of Parties Excluded from Federal Procurement and Non-Procurement Programs (collectively, the “OIG and GSA Lists”) upon initially hiring all employees and at least once a year thereafter to ensure that neither Provider, nor any Participating Provider, employee and/or manager responsible for administering or delivering Covered Services to HMSA MA Plan Members or HMSA MA-PD Plan Members pursuant to this Agreement is included on either the OIG or GSA Lists, and that Provider does not and shall not during the term of this Article employ or contract with any person, or with any entity that employs or contracts with any person, included on the OIG or GSA Lists for the administration or delivery of Covered Services or the performance of any of Provider’s other responsibilities pursuant to this Agreement. Provider shall further require all new and existing employees responsible for any aspect of the performance of Provider’s obligations under this Agreement to immediately disclose to Provider any debarment,
exclusion or other event that would make such employees ineligible to perform work related directly or indirectly to a federal health care program, including, but not limited to, a criminal conviction or civil judgment for fraudulent activity or a sanction under any federal program involving the provision of health care or prescription drug services. Provider shall further certify that in the event of such a disclosure, or if Provider or any Participating Provider, employee or manager appears on either of the OIG or GSA Lists, Provider shall: (i) immediately remove such person from any work related directly or indirectly to any federal health care program, including, but not limited to, the administration or delivery of any Medicare Part C or Part D benefits or the performance of any of Provider’s obligations pursuant to this Agreement; (ii) take appropriate corrective action; (iii) notify HMSA in writing of such removal and corrective action; and (iv) cooperate with any further corrective action requested or initiated by HMSA.

2.24 Claims for Payment. Provider shall submit all Claims for payment for Covered Services provided pursuant to this Agreement in accordance with the provisions of Article IV of this Agreement, and shall not request payment for Covered Services provided under this Article in any form from CMS or from any other agency of the United States or from any state for items and services furnished in accordance with this Article, except as may be approved by CMS.

2.25 Delegation of Duties. The Parties acknowledge that HMSA oversees and is accountable to CMS for any functions or responsibilities described in CMS’ Medicare Advantage and Medicare Part D regulations. Provider shall perform Provider’s obligations under this Agreement in a manner consistent with and in compliance with HMSA’s contractual obligations under HMSA’s Medicare Advantage and Medicare Advantage – Prescription Drug Program contract(s) with CMS. In the event that HMSA delegates to Provider any function or responsibility imposed pursuant to CMS’s contract(s) with CMS, such delegation shall be subject to the requirements set forth in 42 C.F.R. §§422.504(i)(4) and 423.505(i), as applicable and as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Agreement shall be subject to the prior written approval of HMSA and shall also be subject to the requirements set forth in 42 C.F.R. §§422.504(i)(4) and 423.505(i), as applicable and as they may be amended over time.

In addition, with respect to any responsibilities of HMSA pursuant to CMS’s contract(s) with CMS that HMSA delegates to Provider, Provider shall comply with all laws, rules, regulations and subregulatory guidance applicable to such responsibilities and shall allow HMSA to monitor Provider on an ongoing basis for such compliance.

Provider acknowledges and agrees that any delegation pursuant to this provision shall be subject to HMSA’s right to revoke the delegation or take other remedial action in the event that HMSA or CMS determines that Provider or its, his or her delegate has not performed satisfactorily.

2.26 Conflicts of Interest. Provider shall certify that Provider shall require Provider’s managers, officers and directors responsible for the administration or delivery of any HMSA MA-PD Plan benefits to sign a conflict of interest statement, attestation or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Medicare Part D benefits. Provider shall supply the form of such statement, attestation or certification to HMSA upon request.

2.27 Code of Conduct and Compliance Training. Provider shall adopt and follow a code of conduct particular to Provider that reflects a commitment to detecting, preventing and correcting fraud, waste and abuse in the administration or delivery of Medicare Advantage and Part D benefits. HMSA shall make HMSA’s own Code of Conduct available to Provider upon request. In addition, Provider shall conduct compliance training in accordance with Chapter 9 of the CMS Prescription Drug Manual and CMS subregulatory guidance concerning the Medicare Advantage Program, for all persons involved with Provider’s administration or delivery of Covered Services to HMSA MA Plan Members and HMSA MA-PD Plan Members, or shall make arrangements with HMSA for such persons to attend
such training as may be offered by HMSA. If Provider conducts such training, it will provide to HMSA upon request training logs and an attestation or certification as evidence of such training, on a form prescribed by HMSA.

2.28 Disclosure of Compliance Concerns. Provider shall report any compliance concerns or suspected or actual misconduct with respect to any HMSA MA Plan or HMSA MA-PD Plan or the performance of Provider’s obligations pursuant to this Agreement. HMSA shall provide easily accessible independent mechanisms to facilitate such reports.

2.29 Subcontractor Obligations. To the extent that Provider executes a contract with any other person or entity that in any way relates to Provider’s obligations under this Agreement, Provider shall require that such other person or entity assume the same obligations that Provider assumes under this Agreement, including as applicable, but not limited to, Sections 2.32 and 2.33, compliance with applicable laws, rules, regulations and subregulatory guidance; the certification of the accuracy, completeness and truthfulness of any data submitted to HMSA or CMS; and all other certifications herein required of Provider.

2.30 Notice of Termination to Members. In the event that Provider’s or any Participating Provider’s participation in any HMSA MA Plan or HMSA MA-PD Plan is terminated for any reason, Provider shall cooperate with HMSA and assist HMSA’s efforts to identify HMSA MA Plan Members or HMSA MA-PD Plan Members enrolled in such Plan(s) who are seen by Provider or such Participating Provider on a regular basis or, where the Participating Provider is a primary care physician, who are patients of such Participating Provider, and to notify such HMSA MA Plan Members or HMSA MA-PD Plan Members at least thirty (30) calendar days prior to the effective date of such termination.

2.31 Individual Providers Not Eligible to Provide Covered Services. Provider shall not provide Covered Services to Members through providers employed by or under contract to Provider who at the time services are provided: (a) are not Participating Providers; or (b) whose Hawaii license or certification to provide services contemplated by this Agreement is revoked, restricted, suspended, conditioned or expired.

2.32 Medical Records and Information. Provider shall (and shall ensure that each Participating Provider shall) (1) abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (2) ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas; (3) maintain the records and information in an accurate and timely manner; and (4) ensure timely access to Members of HMSA of the records and information that pertain to its Members.

2.33 Member Financial Responsibility. For all Members eligible for both Medicare and Medicaid, the Provider agrees and shall ensure that each Participating Provider agrees that it will not hold such Members liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Provider acknowledges and shall ensure that each Participating Provider acknowledges that HMSA will inform Provider of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid. Provider agrees and shall ensure that each Participating Provider agrees not to impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. For services furnished to such Members, Provider and Participating Provider will accept HMSA’s payment as payment in full or bill the appropriate State source.

ARTICLE III. OBLIGATIONS OF HMSA

3.1 Payment. HMSA shall pay Provider directly for Covered Services in accord with Article IV of this Agreement and with national timeliness standards as set forth in the Provider E-Library.
3.2 **Membership Cards.** HMSA shall issue membership cards to Members. Plan membership cards are for identification only. Possession of a Plan membership card is not a guarantee of eligibility.

3.3 **Eligibility Determination.** HMSA shall confirm Member eligibility to Provider electronically or telephonically.

3.4 **Provider E-Library.** HMSA shall make the Provider E-Library available to Provider through the HMSA website and shall provide a paper copy of the Provider E-Library to Provider upon request. Provider and Participating Providers shall comply with all policies, procedures and requirements contained in the Provider E-Library. Subject to Section 9.1 of this Agreement, HMSA reserves the right to amend any policy, procedure or requirement contained in the Provider E-Library upon ninety (90) calendar days’ written notice or on a timely basis as directed by the Medicare Program or CMS. For policies and procedures concerning medical issues, HMSA will consult with an HMSA advisory committee composed of practicing physicians.

3.5 **Provider Directory.** HMSA shall include Provider in an HMSA Provider Directory and make the directory available to HMSA Participating Providers and Members.

**ARTICLE IV. COMPENSATION**

4.1 **Payment.** HMSA shall pay Claims in accordance with the terms of the Provider E-Library. Except as otherwise provided in this Article IV, Provider shall accept the Eligible Charge as payment in full for Covered Services. Payment shall be conditioned on the eligibility of the Member and HMSA’s policies pertaining to the recognition of the service, whether billed alone or in combination with other services.

For Covered Services that qualify for payment under the Medicare Rules and the Medicare Cost Plan Document, MA Plan Document or MA-PD Plan Document, HMSA shall pay directly to Provider the Eligible Charge minus applicable Copayments and payments from third parties described in Section 4.4 of this Agreement.

For Covered Services that qualify for payment under the Medicare Rules and the Medicare Supplement Plan Document, HMSA shall pay directly to Provider the applicable Medicare deductible, coinsurance, Copayment, or other amount set forth in the Medicare Supplement Plan Document.

4.2 **Payment Determination Criteria.**

(a) A service or supply qualifies for payment under this Agreement if it qualifies for payment under the Member’s Plan Document (the “Payment Determination Criteria”).

(b) Payment determinations are based on policies adopted by HMSA Medical Directors in consultation with practicing physicians, as well as HMSA policies, peer reviewed literature and nationally recognized standards. Any determination that a service or supply does not meet payment determination requirements will be made by an HMSA Medical Director. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets payment determination requirements, even if it is specifically described in the Member’s Plan Document.

4.3 **Prohibition Against Member Billing and Collections.** Provider agrees that in no event, including but not limited to non-payment by HMSA, insolvency of HMSA or breach of this Agreement, shall Provider (or any Participating Provider) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or other persons (other than HMSA) acting on such Member’s behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting supplemental charges, deductibles or Copayments or Coinsurance, as specifically provided in the Plan Document, or fees.
for services or supplies that are not Covered Services delivered on a fee-for-service basis to Members, provided that Provider and the Participating Providers shall not bill or collect from a Member any charges for non-Covered Services or services that HMSA determines do not meet the Payment Determination Criteria unless a written Agreement of Financial Responsibility, (a) in the form available from the Provider E-Library, (b) specific to the service, and (c) signed by the Member or the Member’s legal representative, is obtained prior to the time services are rendered.

(a) Provider agrees and shall ensure that each Participating Provider agrees that these provisions shall survive the termination of this Agreement regardless of the reason for termination, including insolvency of HMSA, and shall be construed to be for the benefit of the Member.

(b) Provider agrees and shall ensure that each Participating Provider agrees that these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between the Provider (or the Participating Provider) and a Member, or persons acting on such Member’s behalf insofar as such contrary agreement relates to liability for payment for, or continuation of Covered Services provided under the terms and conditions of these clauses.

4.4 Coordination of Benefits and Third Party Collections. Provider shall cooperate with HMSA for the proper coordination of benefits and in the identification and collection of third party payments such as those from workers’ compensation, other health insurance, auto insurance, and other third party liability sources.

4.5 Claims. Claims shall only be submitted under this Agreement for services and supplies rendered (a) personally by a Participating Provider or (b) by an employee of the Participating Provider incident to the Participating Provider's professional service, and under the Participating Provider's direct supervision. Services are “incident to” if furnished as an integral, although, incidental, part of the Participating Provider's personal professional services in the course of diagnosis or treatment. “Direct supervision” means that the Participating Provider must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing services. No payment shall be made on any Claims submitted more than one (1) year after the last day on which the services covered by the Claim were rendered, unless required by applicable coordination of benefits provisions. Provider shall not collect and shall ensure that no Participating Provider will collect payment from a Member for any Covered Services with respect to which the Claims submission period has expired.

Retrospective review of MA and MA-PD Plan claims for adjudication of payment is limited to eighteen (18) months from date of payment received by Provider with no limit for fraud or abuse (whether intentional or unintentional), third party liability, workers compensation, or when required by a self-insured plan.

4.6 Determination of Overpayments Using Sampling. If a review of voluminous Claims and records would be required to determine overpayments due to improper Claims billings by Provider, HMSA may determine overpayment amounts subject to refund under Section 4.7 of this Agreement based on Medicare-approved sampling guidelines. Any dispute regarding the calculation of the overpayment amount shall be resolved through the dispute resolution provision set forth in Article VIII of this Agreement.

4.7 Refund. Within thirty (30) calendar days of Provider’s becoming aware of an overpayment paid by HMSA, through receipt of notice from HMSA or otherwise, Provider shall refund to HMSA any overpayment paid by HMSA to Provider. HMSA shall have the right to offset the amount of any overpayment not refunded against any future payments due to Provider from HMSA under this Agreement or any other agreement with HMSA. HMSA shall have the right to offset future payments, regardless of whether the Provider has assigned the right to receive payments under this
Agreement or any other agreement with HMSA, or has otherwise directed HMSA to make payments under this Agreement or any other agreement to a third party.

4.8 Suspension of Payments. HMSA shall not make payments to Provider for Claims for services rendered by the Provider or any Participating Provider during any period:

(a) For which the Provider or the Participating Provider is suspended or excluded from participating in any federal health care program (as defined in 42 U.S.C. §1320a-7b(f));

(b) For which Provider or the Participating Provider has voluntarily excluded itself, himself or herself from rendering the services in an agreement or settlement with CMS or the federal government; or

(c) For which Provider or the Participating Provider does not meet HMSA’s criteria for participation as an HMSA Participating Provider.

Provider further agrees not to submit Claims to HMSA or bill Members under any such circumstances, and shall ensure that the Participating Providers shall not so submit Claims.

ARTICLE V. RECORDS

5.1 Record Retention. Provider shall (and shall ensure that each Participating Provider shall) prepare and maintain, and protect the confidentiality, security, accuracy and integrity of, all medical, health, enrollment and other records related to this Agreement or the provision of Covered Services to Members (including, but not limited to, medical, financial, accounting, administrative and billing records and other records contemplated by Section 5.2 of this Agreement) in an accurate and timely manner and in accordance with: (i) applicable state and federal laws and regulations including, but not limited to, applicable confidentiality requirements of HIPAA; and (ii) HMSA and Plan billing, reimbursement, and administrative requirements. Provider shall preserve all such records for the longer of (i) the period of time required by state and federal law or by any contract between HMSA and a government-sponsored program, including the periods required by Medicare programs; or (ii) ten (10) years from (a) the date of the last data entry, or (b) the date this Agreement ends, whichever is later. Provider shall (and shall ensure that each Participating Provider shall) release such information only in accordance with applicable law, HMSA policies and procedures and Section 5.2 of this Agreement. Provider will not process, transfer or handle HMSA MA Plan Members’ or HMSA MA-PD Plan Members’ protected health information, as defined in 45 C.F.R. §160.103, outside of the United States or one of the United States Territories, without the prior written approval of HMSA. Provider acknowledges that failure to prepare, maintain, protect, preserve or release records as required under this Section 5.1 shall constitute a material breach of this Agreement and may result in termination of this Agreement. This Section 5.1 shall survive termination of this Agreement.

5.2 Inspection and Access. Provider agrees and shall ensure that each Participating Provider agrees that HMSA, HHS, the Comptroller General or their designees, including, but not limited to, Medicare Drug Integrity Contractors (“MEDICs”), have the right to inspect, audit and evaluate quality, appropriateness and timeliness of provider services, as well as Provider’s and each Participating Provider’s facilities and any pertinent books, contracts, medical records, patient care documentation and other documents, papers and records of Provider or any Participating Provider relating to this Agreement or the provision of Covered Services hereunder, any aspect of services furnished to a Member during the term of this Agreement, and reconciliation of benefit liabilities and determination of amounts payable under this Agreement, or as the Secretary of HHS may deem necessary to enforce CMS’ contract with HMSA. Provider shall (and shall ensure that each Participating Provider shall) cooperate with and shall assist and provide such information and documentation to such entities as requested and in accordance with federal and state laws. Provider agrees and shall ensure that each Participating Provider agrees that the right to inspect, evaluate and audit any pertinent facility, information, books, contracts, records and other documents shall extend for a
period of ten (10) years following the termination date of the applicable contract between HMSA and CMS or until the date of completion of any audit, or until the expiration of any time frame that CMS may require via written notice provided to HMSA at least thirty (30) days before the normal disposition date, whichever is later, unless such time frame is extended for reasons specified by regulation (such as in the event of fraud).

With respect to Provider’s and Participating Providers’ provision of Covered Services to Medicare Cost Plan Members, Provider shall also establish and maintain procedures and controls so that no information contained in Provider’s records or records obtained from CMS or from others in carrying out the provisions of this Agreement shall be used or disclosed by Provider, any agent or employee of Provider, or any other provider except as provided in Section 1106 of the Social Security Act, or any successor provision, and regulations prescribed thereunder, as they may be amended from time to time.

Provider agrees that failure to promptly cooperate or provide information as required under this Section 5.2 shall constitute a material breach of this Agreement and may result in termination of this Agreement. Provider acknowledges that failure to cooperate with any entity listed above may result in a referral of HMSA and/or Provider to law enforcement or implementation of other corrective actions. In the event intermediate sanctioning in line with 42 C.F.R. Parts 422 Subpart O or 423 Subpart O is imposed on HMSA as a result of Provider’s failure to cooperate with any entity listed above, Provider agrees to indemnify and hold harmless HMSA from and against any and all losses incurred by HMSA to the extent arising out of or relating to Provider’s negligence or breach of its obligations.

This Section 5.2 shall survive termination of this Agreement.

ARTICLE VI. INSURANCE

6.1 Insurance Policies. Provider, at its sole cost and expense, shall either:

(a) Procure and maintain policies of general liability and professional insurance and other insurance necessary to insure Provider and its Participating Providers against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of this Agreement. Policies shall not be less than $1,000,000 per incident and $1,000,000 per policy with an excess liability of $3,000,000; or

(b) As approved by HMSA, procure and maintain a surety bond, proof of qualifications as a self insurer, or other securities affording financial responsibility substantially equivalent to that afforded under general liability and professional liability insurance policies in the amounts described in subsection (a) above.

6.2 Indemnification. Except as otherwise specifically provided elsewhere in this Agreement, each Party shall be solely responsible for its own negligence, acts or omissions.

ARTICLE VII. TERM AND TERMINATION

7.1 Term. The initial term of this Agreement shall be for one (1) year from the Effective Date unless earlier terminated in accordance with this Article VII. This Agreement shall renew automatically for additional and successive one (1) year terms, unless earlier terminated in accordance with this Article VII.

7.2 Termination. Except as provided in Section 7.3 of this Agreement, HMSA may terminate this Agreement with or without cause by giving Provider at least sixty (60) calendar days’ written notice. Provider may terminate this Agreement, with or without cause, by giving HMSA at least sixty (60)
calendar days’ written notice. Notwithstanding the foregoing, in the event any contract between CMS and HMSA pursuant to which HMSA offers a Plan is terminated or nonrenewed, this Agreement shall terminate with respect to Provider’s provision of services to Members enrolled in that Plan, unless CMS and HMSA agree to the contrary. Such termination shall be accomplished by delivery of written notice to Provider of the date upon which termination will be effective.

7.3 Immediate Termination. HMSA shall have the right to terminate this Agreement immediately upon written notice to Provider due to the revocation, suspension, limitation, condition, or expiration of Provider’s or any Participating Physician’s license to practice medicine, or failure to meet any HMSA credentialing standard. Provider’s right to appeal the termination decision is set forth in Section 8.1(b).

7.4 Medicare Exclusion Termination. This Agreement shall automatically terminate if Provider or any Participating Provider is debarred or excluded from participating in the Medicare Program. The effective date of the termination shall be the same date as the effective date of the debarment or exclusion. Provider does not have a right to appeal the termination decision based on exclusion from the Medicare Program.

7.5 Effect of Termination. As of the date of any termination of this Agreement, this Agreement shall be considered of no further force or effect except that such termination shall not release Provider or HMSA from their respective obligations accruing prior to the date of termination, including, without limitation, the following:

(a) HMSA’s obligation to pay, in accordance with the terms of this Agreement, for Covered Services provided to Members prior to termination;
(b) Provider’s obligations as set forth in Article V of this Agreement;
(c) Provider’s agreement not to seek compensation from Members for Covered Services provided to Members prior to termination, as set forth in Section 4.3 above;
(d) Each Party’s responsibility for its own acts as set forth in Section 6.2 above;
(e) Provider’s obligations as set forth in Section 2.15 above;
(f) The Parties’ respective obligations under the dispute resolution provisions of Article VIII below; and
(g) The Parties’ obligations to maintain the confidentiality of proprietary information as set forth in Section 9.11 below.

7.6 Appeal of Termination. Provider’s right to appeal termination of this Agreement is set forth in Article VIII of this Agreement. Except for immediate termination under Section 7.3 of this Agreement, upon HMSA’s receipt of Provider’s request for appeal, any termination of this Agreement is suspended until the dispute is resolved. If an immediate termination is appealed, the termination remains in force until the dispute is resolved.

7.7 Participating Provider Immediate Disqualification. HMSA may disqualify any Participating Provider only upon written notice to Participating Provider and Provider due to the revocation, suspension, limitation, condition, or expiration of Participating Provider’s license to practice or certification to provide Covered Services contemplated by this Agreement. Provider’s right to appeal the disqualification decision is set forth in Article VIII.

7.8 Effect of Participating Provider Disqualification. As of the date of his or her disqualification, a Participating Provider may not render Covered Services to Members. Except for immediate disqualification, upon HMSA’s receipt of the Provider’s request for appeal, disqualification is
suspended until the dispute is resolved. If an immediate disqualification is appealed, the disqualification remains in force until the dispute is resolved.

ARTICLE VIII. CONTRACTUAL DISPUTE RESOLUTION

This Article VIII applies to all sections of this Agreement, notwithstanding reference in selected sections and survives the termination of this Agreement.

8.1 Internal Appeals.

(a) Disputes Other than Termination (Section 7.2) or Participating Provider Immediate Disqualification (Section 7.7). If Provider has any claim, dispute or cause of action arising out of this Agreement or its performance or breach, or in any way related to this Agreement, including but not limited to any or all claims, disputes or causes of action based upon contract, tort, statutory law or actions in equity, Provider shall submit a written request for review by HMSA within one year after such claim, dispute or cause of action accrues. HMSA shall issue a decision within sixty (60) calendar days of HMSA’s receipt of the request for review or, in the case of MA or MA-PD Plan claims, in accordance with time frames found in the Provider E-Library.

(b) Termination of This Agreement or Participating Provider Immediate Disqualification. Provider shall submit a written request for appeal within sixty (60) calendar days of receipt of a notice of termination from HMSA. This basis for the proposed termination shall be provided in the notice of termination or in a separate document provided in advance of the hearing before the review committee. An HMSA review committee composed of practicing physicians shall convene within thirty (30) calendar days of HMSA’s receipt of the request for appeal. The members of the HMSA review committee shall be selected and appointed by HMSA. Provider may appear to present evidence or testimony before the committee. Both Provider and HMSA may call and cross-examine witnesses who appear to present evidence and testimony before the review committee. Either Party may, at its option, be represented by counsel or another representative at the appeal. A record shall be made of the proceedings, and a copy provided to Provider upon request. Provider and HMSA may submit a written statement at the conclusion of the hearing. Provider will be notified of the review committee’s decision within five (5) working days following the hearing.

(c) Expedited Pre-Service Benefits Redetermination. Provider may request an expedited redetermination of any HMSA decision to deny payment for a service that has not yet been provided to a Member if a delay would: (a) seriously jeopardize the Member’s life or health; (b) seriously jeopardize the Member’s ability to gain maximum functioning; or (c) subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the redetermination request. Provider shall request an expedited redetermination and provide any additional information requested by HMSA. HMSA shall provide a decision in accord with national timeliness standards set forth in the Provider E-Library.

(d) Representation by an Attorney at an Internal Appeal. Neither HMSA nor Provider shall be represented by an attorney or other representative at the internal appeal pursuant to this Section 8.1, except as provided in Section 8.1(b) above. Both HMSA and Provider may be represented by counsel or another representative at arbitration in accord with Section 8.2(a) below. The procedures provided in this Section 8.1 are intended to provide a prompt and inexpensive means of dispute resolution, and are not intended to limit the scope of evidence or witnesses presented in any subsequent arbitration regarding the same claim, dispute, or cause of action.
8.2 **External Appeals.**

(a) **Arbitration Upon Exhaustion of Internal Appeal.** HMSA and Provider agree that any and all claims, disputes, or causes of action arising out of this Agreement or its performance, breach or termination or in any way related to this Agreement, including but not limited to any and all claims, disputes, or causes of action based upon contract, tort, statutory law, or actions in equity, shall be resolved by binding arbitration as set forth in this Agreement, except that, in lieu of arbitration, and only for disputes involving an MA or MA-PD Plan Member, Provider may elect review described in Section 8.2(b) below for certain billing disputes and review described in Section 8.2(c) below for certain medical necessity disputes.

If Provider disagrees with HMSA’s decision following exhaustion of internal appeals described in Section 8.1 above, Provider shall submit a written request for arbitration to HMSA’s Legal Services in Honolulu, Hawaii, within sixty (60) calendar days following the date of HMSA’s decision.

Arbitration of disputes between HMSA and Provider shall be conducted by an independent arbitration service mutually selected by HMSA and Provider. Arbitration shall be conducted in Honolulu, Hawaii, except that if Medical Group’s office is on a Neighbor Island, Medical Group may participate in the arbitration by telephone. If HMSA and Provider are unable to agree upon an arbitration service within thirty (30) calendar days of HMSA’s receipt of Provider’s request for arbitration, Dispute Prevention and Resolution, Inc. (“DPR”) will conduct the arbitration. If the two Parties (HMSA and Provider) are unable to agree upon an arbitrator within thirty (30) calendar days following the submission of the claim to the arbitration service, then the two Parties shall select an arbitrator in accordance with the arbitration service’s arbitrator selection procedures. The arbitration will be conducted pursuant to the Federal Arbitration Act, 9 U.S.C. §1 et seq., and the arbitration service’s arbitration rules applicable to the Federal Arbitration Act, or pursuant to such other arbitration rules as the Parties may mutually agree. The arbitrator may hear and determine motions for summary judgment under the same standards applicable under Rule 56 of the Federal Rules of Civil Procedure. Each Party (HMSA and Provider) will pay its own attorney and witness fees, provided that the arbitrator may award attorney fees and costs to a prevailing party related to any claim or contention of a nonprevailing party, that the arbitrator determines was frivolous or wholly without merit. Fees and costs of the arbitrator and the arbitration service may be awarded by the arbitrator as the arbitrator determines is appropriate except that HMSA shall pay the filing and arbitrator’s fees if the prevailing party in the arbitration is a Provider practicing as an individual in a group of less than six Providers. If no award is made, fees and costs of the arbitrator and the arbitration service shall be shared equally by both parties. The decision of the arbitrator shall be final and binding on HMSA and the Provider and judgment shall be entered thereon upon timely motion by either Party in a court of competent jurisdiction. No other action may be brought in any court in connection with this decision, except as provided under the Federal Arbitration Act. There shall be no consolidation of parties in the arbitration proceeding. The Parties shall take appropriate precautions to protect the confidentiality of any personal health information related to the arbitration proceeding.

(b) **Disputes Related to Billing for MA and MA-PD Plan Members Only.** After exhaustion of internal appeal remedies described in Section 8.1(a) above and in lieu of arbitration, Provider may submit a request for external review of HMSA’s application of its coding and payment rules and methodologies for fee for service claims of a patient-specific factual situation. Requests must be submitted not later than ninety (90) days after exhaustion of the internal appeal outlined in Section 8.1(a) above. Decisions of the external review panel are final and binding on HMSA and the Provider. No other action may be brought in any court or as an arbitration in connection with this decision. This provision will remain in effect until April 22,
2011. For more information about the review process and its requirements, including details about how to submit a request for review, please see the Provider E-Library.

(c) Disputes Related to Medical Necessity Determinations for MA and MA-PD Plan Members Only. After exhaustion of internal appeal remedies described in Section 8.1(a) above and in lieu of arbitration, Provider may submit a request for external review of HMSA’s adverse determination relating to medical necessity. Review shall be available through an independent review organization (IRO) identified by HMSA. Request for such review must be received by HMSA within sixty (60) days from the date of the internal appeal denial. Decisions of the external reviewer are final and binding on HMSA and the Provider. No other action may be brought in any court or as an arbitration in connection with this decision. This provision will remain in effect until April 22, 2011. For more information about the review process and its requirements, including details about how to submit a request for review, please see the Provider E-Library.

8.3 Limitations on Appeals. Provider may not initiate internal appeal or external appeal of a denied service if:

(a) The Member or his or her authorized representative is currently seeking or has sought review related to the same denied service. In the event both the Member or his or her authorized representative and the Provider seek review of the same denied service, the Member’s review shall go forward and the Provider’s request for review will be dismissed.

(b) As to external review only, the Member is covered under a self-insured plan and the Plan sponsor has not agreed by contract to participate in HMSA’s external review programs; or

(c) The Member or his or her authorized representative files or has filed suit for the denial of health care services or supplies regarding an adverse determination as to the denied service.

ARTICLE IX. MISCELLANEOUS PROVISIONS

9.1 Amendments. This Agreement may only be amended by mutual, written agreement of the Parties, except that, as directed by CMS, HMSA may amend this Agreement by providing written notice to Provider in a manner consistent with Title XVIII, Medicare Rules, or directives of CMS or the federal government.

9.2 Assignment. Neither HMSA nor Provider shall assign or transfer rights, duties, or obligations under this Agreement without the prior written consent of the other Party.

9.3 Captions. The captions contained herein are for reference purposes only and shall not affect the meaning of this Agreement.

9.4 Cooperation of Parties. Provider and HMSA agree to meet and confer in good faith on common problems including, but not limited to, those pertaining to Member complaints, customer service, utilization of services, credentialing, authorization, Claims and reporting procedures, and information and forms provided to Provider for use with Members. A request to meet and confer under this provision shall not relieve either Party of their obligations under this Agreement.

9.5 Entire Agreement. This Agreement, together with Plan Documents and the Provider E-Library as amended from time to time, contains the entire agreement between the Parties and supersedes all prior agreements and negotiations, either oral or in writing, with respect to the subject matter hereof.

9.6 Governing Law. This Agreement shall be construed and enforced in accord with the laws of the State of Hawaii.
9.7 **Members’ Appeal Rights.** Appeal rights of Members, as defined by the Medicare Program, shall be outlined in such Members’ Plan Documents.

9.8 **Notices.** Any notice required to be given pursuant to the amendment or termination of this Agreement shall be in writing and shall be sent, postage prepaid, by certified mail, return receipt requested, to HMSA or to Provider at the address below. The notice shall be effective on the date of delivery.

If to HMSA:
Provider Services
Attention: **PDCA – ROOM 509**
Hawaii Medical Service Association
P. O. Box 860
Honolulu, HI 96808-0860

If to Provider:
[Mailing address as reported by Provider to HMSA.]

9.9 **Partial Invalidity.** If, for any reason, any provision of this Agreement is held invalid, the remaining provisions shall remain in full force and effect.

9.10 **Relationship of Parties.** In the performance of the work, duties, and obligations assumed under this Agreement, it is mutually understood and agreed that each Party and its agents, employees, or representatives are at all times acting and performing as independent contractors and that neither Party shall consider itself or act as the agent, employee, or representative of the other.

Provider expressly acknowledges that this Agreement constitutes a contract between Provider and HMSA, that HMSA is an independent plan operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the “Association”), permitting HMSA to use the Blue Cross and Blue Shield Service Mark in the State of Hawaii, and that HMSA is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than HMSA and that no person, entity, or organization other than HMSA shall be held accountable or liable to Provider for any of HMSA’s obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMSA other than those obligations created under other provisions of this Agreement.

9.11 **Confidentiality of Proprietary Information.** The Parties acknowledge that each may disclose confidential and proprietary information to the other in the course of this Agreement. All information jointly developed by the Parties pursuant to this Agreement or disclosed by one Party to the other in the course of performance of this Agreement, which is not otherwise publicly available, shall be deemed confidential and shall not be disclosed by the receiving Party to any third party without the prior written consent of the other Party.

9.12 **Use of Name.** Provider acknowledges that HMSA has a proprietary interest in its legal and business names. Provider shall not use HMSA’s name without HMSA’s prior written consent.

9.13 **Waiver.** The waiver by either Party of any breach of any provision of this Agreement, of any warranty, or of any representation set forth herein shall not constitute a continuing waiver of any subsequent breach of either the same or any other provision, warranty, or representation of this Agreement.
IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date(s) written below.

Hawaii Medical Service Association «Add_Nm_1»

By: ____________________________  By: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Paul Schnur
Title: Vice President  Its: ____________________________
Provider Contracting

Date of Signature ____________________________  Date of Signature ____________________________

By: ____________________________
(Signature)

(Print name)

Title: ____________________________

Date of Signature ____________________________

THIS CONTRACT IS NOT EFFECTIVE UNTIL SIGNED BY HMSA.
PERSONAL CARE PHYSICIAN DESIGNATION FORM

Members will be asked to select a Personal Care Physician (PCP) to provide or arrange for their health care services.

Please indicate your participation in HMSA’s Plan(s) as a PCP or Specialist and return this form to HMSA.

Check one only:

[ ] I agree to participate in HMSA’s Plan(s) as a Personal Care Physician (PCP).
[ ] I agree to participate in HMSA’s Plan(s) as a Specialist.

__________________________________  ____________________________
«Add_Nm_1»  Date of Signature

«Root_Number»