HAWAII MEDICAL SERVICE ASSOCIATION

PARTICIPATING PHYSICIAN AGREEMENT

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HAWAII MEDICAL SERVICE ASSOCIATION
PARTICIPATING PHYSICIAN AGREEMENT

THIS AGREEMENT, effective as of February 1, 2017, is by and between Hawaii Medical Service Association (“HMSA”), a Hawaii nonprofit mutual benefit society, and

«Contract_Holder_Name»

(“Participating Physician”), and arises out of the following circumstances:

1. HMSA operates and administers health plans for the benefit of its Members;
2. HMSA desires to contract with Participating Physician to provide or arrange Covered Services to Members of HMSA Plans;
3. Participating Physician desires to contract with HMSA to provide or arrange services as described in Paragraph 2 above; and
4. HMSA and Participating Physician wish to promote quality health care, Member satisfaction, Member’s choice of physician, and medical decision-making by Member in collaboration with his or her physician.

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 Participating Physician on the CMS 1500 form, another 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 Member’s Plan Document.
1.3 Covered Service. A medical service or supply that qualifies for payment under the terms of the Member’s Plan Document and meets payment determination requirements set forth in Section 4.2 of this Agreement, or a preventive service that is specifically described as covered in the Member’s Plan Document.
1.4 Deductible. The fixed dollar amount a Member must pay each calendar year before benefits subject to the annual deductible become available.
1.5 Eligible Charge. The Eligible Charge for a Covered Service is the lower of either the actual charge as shown on the claim or the charge listed for the service in HMSA’s Schedule of Maximum Allowable Charges (“Schedule”). For a Covered Service that does not have a charge listed in the Schedule, HMSA will in good faith establish the Maximum Allowable Charge. HMSA reserves the right to adjust the charges listed in the Schedule upon sixty (60) days’ written notice to Participating Physician. Factors considered by HMSA in establishing Maximum Allowable Charges or in making adjustments to the charges 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.

1.6 **Member.** A person who meets applicable eligibility requirements and is enrolled in a Plan and on whose behalf the applicable Plan premium has been paid.

1.7 **Participating Provider.** A physician or provider who has entered into a contract with HMSA to provide health care services to Members.

1.8 **Payor.** The party that is financially responsible for payment for Covered Services provided in accordance with this Agreement or an arrangement between HMSA and the applicable Plan. A Payor may be a self-funded employer, an insurance company, a health maintenance organization, a government program or other party which has engaged HMSA to administer the Plan. With respect to certain Plans, HMSA itself may be the Payor or an affiliate of HMSA may be the Payor.

1.9 **Plan Document.** The document issued by HMSA, an HMSA affiliate, or other Payor that describes Member Benefits.

1.10 **Plans.** HMSA health plans that provide benefits for services performed by Participating Physicians, including, but not limited to, Preferred Provider Plan, State Plan, Federal Plan, Health Maintenance Organization (HMO) Plans and Drug Riders. Also included are HMSA affiliate Plans, other Blue Cross and/or Blue Shield plans and the plans of their related companies, other health plans in which HMSA has an ownership interest, and plans HMSA has contracted with to provide services contemplated by this Agreement. A complete list of plans is furnished in the Provider E-Library.

1.11 **Provider E-Library.** The HMSA electronic resource library containing information regarding HMSA’s operating policies and procedures concerning providers that is available at http://hhin.hmsa.com. For purposes of this Agreement, the Provider E-Library shall consist of those materials indexed under “Medical.”

**II. OBLIGATIONS OF PARTICIPATING PHYSICIAN**

2.1 **Licensure.** Participating Physician warrants and represents that Participating Physician is and will remain, throughout the term of this Agreement, the holder of a currently valid, unrestricted, and unconditioned (a) license to practice medicine in the State of Hawaii, and (b) Drug Enforcement Agency Controlled Substances Registration Certificate and/or Certificate of Registration for Uniform Controlled Substances. HMSA may waive the drug certification requirement if the Participating Physician presents evidence acceptable to HMSA that the certification is not required to deliver appropriate medical care.

2.2 **Required Disclosures.** Participating Physician shall notify HMSA in writing upon the occurrence of any of the events indicated below:

(a) Participating Physician’s license to practice in the State of Hawaii is suspended, conditioned, revoked, terminated, or subject to terms of probation or other restriction; or

(b) Participating Physician’s federal and/or state drug license is suspended, conditioned, revoked, or terminated; or
(c) Participating Physician becomes the subject of any disciplinary proceeding or action before the Hawaii Medical Board or a similar agency in any state, or an agency of the federal government; or

(d) Participating Physician is convicted of a fraud or felony or misdemeanor related to the Participating Physician’s professional practice or actions evidencing dishonesty, deceit, misrepresentation or other misconduct; or

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

(f) Participating Physician fails to maintain the insurance coverage required under Article VI of this Agreement; or

(g) Any malpractice claim in which the Participating Physician is a named defendant or any malpractice judgment or settlement; or

(h) There is a change in Participating Physician’s business address; or

(i) There is a change in Participating Physician’s federal tax identification number or National Provider Identifier (NPI); or

(j) Participating Physician plans to terminate his/her practice; or

(k) Participating Physician’s privileges at any medical facility or participation in any health plan or network is suspended, limited, revoked or terminated, subject to terms of probation or other restriction, if any such actions are taken due to the Participating Physician’s failure to meet credentialing, participation, or staff privilege requirements, or voluntarily surrendered in anticipation of any of the foregoing; or

(l) There is a change to Participating Physician’s board certification status; or

(m) Participating Physician appears on the U.S. Department of Health & Human Services Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) or the General Services Administration’s Excluded Parties List System (EPLS), or the Office of Personnel Management’s Sanction List; or

(n) Participating Physician has a financial interest in any entity which receives payment from HMSA for Covered Services rendered, ordered, or directed by Participating Physician; or

(o) Participating Physician participates in a concierge medicine program that requires a Member to pay for Covered Services; or

(p) Any other situation arises that could reasonably be expected to affect Participating Physician’s ability to carry out his/her obligations under this Agreement.

2.3 Credentialing. Participating Physician shall comply with any and all credentialing and recredentialing requirements and procedures as established by HMSA and amended from time to time. Compliance shall be determined by an HMSA credentialing committee. The members of the credentialing
committee will consist of an HMSA Medical Director and other members selected and appointed by
HMSA, a majority of whom will be practicing physicians. Failure to meet credentialing or
recredentialing requirements may result in termination in accord with Article VII of this Agreement.
Participating Physician’s right to appeal the termination decision is set forth in Section 8.1(b) of this
Agreement. Once credentialed, Participating Physician shall inform HMSA of any change to the
information provided on the Participating Physician’s most current HMSA credentialing application. In
the event that HMSA determines that a material misrepresentation or omission has been made with
regard to the most current credentialing application, HMSA shall have the right in its sole discretion to
draw the Participating Physician’s credentialed status, initiate a new credentialing review, and/or
terminate this Agreement by providing 60 calendar days’ notice as described in Article VII of this
Agreement.

2.4 Standard of Care. Participating Physician shall provide Covered Services in accord with generally
accepted medical practices and prevailing standards applicable to physicians practicing in the same field
under similar circumstances at the time of treatment.

2.5 Nondiscrimination. Participating Physician shall render services to Members in the same manner, in
accordance with the same standards, and within the same time availability, as for his/her other patients.
Participating Physician shall not refuse to render services to a Member based on the Member’s
disability, race, color, sex, sexual orientation, national or ethnic origin, age, gender identity or
expression, or religion.

2.6 Quality Improvement. As requested by HMSA, Participating Physician shall provide medical records
and other data for participation in ongoing HMSA quality improvement activities that may include
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.
Participating Physician agrees to work in good faith with HMSA to implement corrective actions
recommended in good faith by an HMSA review committee composed of practicing physicians, and to
permit this committee to monitor and evaluate such corrective actions. Participating Physician’s right to
appeal the corrective action decision is set forth in Section 8.1(a) of this Agreement.

2.7 Continuity of Care. Participating Physician shall provide appropriate medical information to other
providers (a) when referring a Member to another provider, (b) at the 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 the Member specifically objects.

2.8 Referral. Participating Physician shall use his/her professional judgment when referring Members to
other providers, and such referral decisions shall be based on the best interest of the Member.
Participating Physician is urged, however, to refer Members to other Participating Providers whenever
appropriate and practical for the financial protection of the Member. When referring Members to non-
Participating Providers, Participating Physician shall inform Members that the referral is to a non-
Participating Provider and that the Member may have increased out of pocket costs as a result. HMSA
shall provide notice in writing to Participating Physician if it becomes aware of a failure to so inform the
Member. Participating Physician’s subsequent failure to inform the Member after notice from HMSA
constitutes cause and may result in termination in accord with Article VII of this Agreement. HMSA
shall furnish Participating Physician with a current HMSA Participating Provider Directory or access to
such Directory.

2.9 Utilization Management. Participating Physician shall comply with HMSA’s utilization management
programs. Utilization management requirements are described in the Provider E-Library and Plan
Documents. Payments may be reduced or denied (including retroactively denied) if Participating
Physician fails to satisfy a utilization management requirement and an HMSA Medical Director or his or her designee determines in good faith that the service does not meet payment determination requirements set forth in Section 4.2 of this Agreement. Any recoupment efforts resulting from HMSA’s utilization management programs will be conducted in accord with HRS § 431:13-108, which may be amended from time to time. Participating Physician shall not attempt to collect the reduced or denied payment from the Member. Participating Physician’s right to appeal a utilization management program decision is set forth in Sections 8.1(a) and 8.2 of this Agreement.

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

(a) pre-certification for a payment determination regarding a proposed service;
(b) concurrent review to determine whether a continued inpatient hospital stay or other treatment protocols meet payment determination requirements set forth in Section 4.2 of this Agreement;
(c) retrospective review to evaluate appropriateness of care and care management; and
(d) focused review of specific procedures and/or specific providers.

2.10 Physician-Patient Relationship.

(a) Participating Physician shall maintain the physician-patient relationship with each Member to whom he or she provides medical care and treatment and be responsible for the medical care and treatment of such Members. Nothing contained in this Agreement is intended or shall be interpreted: (a) to interfere with the physician-patient relationship, (b) to discourage or prohibit a Participating Physician from discussing preventive, or treatment options, including medication, and without regard to what is covered under the Member’s Plan, or (c) to discourage or prohibit providing other medical advice or treatment deemed appropriate by the Participating Physician.

(b) Participating Physician shall not participate in a concierge medicine program that requires Members to pay for Covered Services. Such participation shall constitute cause as that term is used in Section 7.2 of this Agreement.

2.11 Health Information Technology. Participating Physician agrees that as Participating Physician implements, acquires, or upgrades health information technology systems, Participating Physician shall make reasonable efforts to utilize, where available, certified health information technology systems and products that meet interoperability standards recognized by the Secretary of Health and Human Services, as existing on the date of implementation, acquisition, or upgrade of health information technology systems. HMSA encourages Participating Physician to make efforts to demonstrate meaningful use of health information technology in accord with The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

2.12 Provider E-Library. Participating Physician shall comply with all policies, procedures, and requirements contained in the Provider E-Library as described more fully in Section 3.4 below.

III. OBLIGATIONS OF HMSA

3.1 Payment. HMSA shall pay Participating Physician directly for Covered Services in accord with Article IV of this Agreement and within the timeliness standards as set forth in the Provider E-Library.
3.2 **Membership Cards.** HMSA shall issue Plan 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 Participating Physician electronically or telephonically. Participating Physician understands and acknowledges that such verification is not a guarantee of payment.

3.4 **Provider E-Library.** HMSA shall make the Provider E-Library available to Participating Physician through the HMSA web site and shall provide a paper copy of the Provider E-Library to Participating Physician upon request. Participating Physician 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 policies, procedures, and requirements in the E-Library and will provide at least sixty (60) calendar days’ written notice of material adverse changes.

3.5 **Participating Provider Directories and Websites.** HMSA shall list Participating Physician’s name and other information in an HMSA Participating Provider Directory and distribute the Directory or make it available to Participating Providers and Members. The same and/or other information may be published on the Blue Cross and Blue Shield Association’s website and/or HMSA’s website.

3.6 **Physician Advisory Committees.** HMSA shall establish and maintain physician advisory committees composed of Participating Physicians. These committees shall provide input to HMSA regarding various physician and clinical issues related to HMSA operations and programs. HMSA will consider recommendations for committee members from individual physicians and physician organizations in the community.

**IV. COMPENSATION**

4.1 **Payment.**

(a) Except as otherwise provided in this Article IV, Participating Physician shall accept the Eligible Charge as payment in full for Covered Services. HMSA shall pay directly to Participating Physician the Eligible Charge minus applicable Copayments, deductibles, and payments from third parties described in Section 4.6 of this Agreement provided that where HMSA is not the Payor, HMSA shall have no obligation to pay claims for which the Payor has not made sufficient funds available for such payment. Covered Services are medical services or supplies that qualify for payment under the terms of the Member’s Plan Document and meet payment determination requirements set forth in Section 4.2 of this Agreement or preventive services that are specifically described as covered in the Member’s Plan Document. Payment shall be based on the Member’s eligibility and HMSA’s policies pertaining to the recognition of the service, whether billed alone or in combination with other services. Participating Physician acknowledges and agrees that Participating Physician shall not seek payment from HMSA in the event of nonpayment by a non-HMSA Payor or in the event that a non-HMSA Payor fails to make sufficient funds available for payment regardless of the cause of such nonpayment or failure.

(b) **Pay-for-quality payment.** HMSA reserves the right to create one or more pay-for-quality programs. In that event, HMSA shall pay Participating Physician a pay-for-quality payment, provided that Participating Physician meets all eligibility, enrollment and award criteria of the program. The determination of whether a Participating Physician is eligible for pay-for-quality programs, amounts to be paid and frequency of payments shall be determined at HMSA’s sole
discretion. Notwithstanding anything in Section 9.1, HMSA reserves the right to adjust the pay-for-quality program upon at least sixty (60) days’ written notice to Participating Physician. The program descriptions, eligibility criteria, and scoring and payment methodologies for such pay-for-quality programs are set forth in the Provider E-Library.

4.2 Payment Determination Criteria.

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

(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 the Payment Determination Criteria in the Member’s Plan Documents will be made by an HMSA Medical Director.

(c) 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 the Payment Determination Criteria, even if it is specifically described in the Member’s Plan Document.

(d) The Participating Physician may contact HMSA for a payment determination regarding a procedure, service, or supply before rendering care.

(e) Participating Physician’s right to appeal the payment determination decision is set forth in Sections 8.1(a) and 8.2 of this Agreement.

4.3 Services and Supplies That Do Not Meet Payment Determination Criteria. If HMSA determines that any service or supply provided by Participating Physician does not meet HMSA’s Payment Determination Criteria in the Member’s Plan Document, then Participating Physician shall not bill or collect from a Member any charges for such service or supply, shall promptly refund the Member any Copayment that Participating Physician collected from the Member and shall hold the Member harmless from any charges related to the service or supply, unless a written acknowledgment of financial responsibility specific to the service or supply and signed by the Member or the Member’s legal representative is obtained prior to the time the service or supply is rendered.

Participating Physician’s right to appeal a decision pertaining to services that do not meet Payment Determination Criteria is set forth in Sections 8.1(a) and 8.2.

4.4 Services That Are Not Plan Benefits. Except as set forth in Section 4.3, this Agreement does not govern Participating Physician’s charges to a Member for services that are not Covered Services.

4.5 Prohibition Against Member Billings and Collections. In no event shall Participating Physician collect or attempt to collect from the Member any amount that HMSA or a Payor is obligated to pay Participating Physician under the Member’s Plan, whether HMSA’s nonpayment results from insolvency, HMSA’s breach of this Agreement, or any other cause.

4.6 Coordination of Benefits and Third Party Collections. Participating Physician 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.
4.7 **Claims.** Claims shall only be submitted under this Agreement for services and supplies rendered (a) personally by the Participating Physician, or (b) if the standard of care does not require that the service be provided by a physician, by the Participating Physician’s employee who meets all required licensure and certification requirements and is qualified to perform the service, incident to the Participating Physician’s professional service, and under the Participating Physician’s direct supervision. Services are “incident to” if furnished as an integral, although incidental, part of the Participating Physician’s personal professional services in the course of diagnosis or treatment. “Direct supervision” means that the Participating Physician 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 year after the last day on which the services covered by the Claim were rendered unless the delay was caused by coordination of benefits. Participating Physician shall not collect payment from Members for any Covered Services with respect to which the one-year claims submission period has expired. Participating Physician has the right to request a review by HMSA within one year of Participating Physician’s receipt of HMSA’s decision to deny or pay the claim.

Any recoupment efforts involving such Claims shall be conducted in accord with HRS § 431:13-108, as it may be amended from time to time.

4.8 **Refund.** Within sixty (60) calendar days (“Notice Period”) of Participating Physician’s receipt of notice from HMSA, Participating Physician shall refund to HMSA any overpayment made by HMSA to Participating Physician. HMSA shall have the right to offset the amount of any overpayment not refunded against any future payments due to Participating Physician from HMSA under this Agreement or any other agreement with HMSA. HMSA has the right of offset under this Section, regardless of whether the Participating Physician 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. HMSA also has the right to send the matter directly to a collection agency if after providing notice as described above: 1) Participating Physician terminates one or more agreements pursuant to which Participating Physician receives payment from HMSA, 2) if payments due from HMSA during the Notice Period multiplied by three (3) are insufficient to repay the overpayment, or 3) Participating Physician refuses in writing to repay the overpayment. If the matter is sent to a collection agency, Participating Physician shall owe HMSA all collection agency fees and costs related to the matter (which HMSA may recoup by offset) and Participating Physician’s right to arbitration pursuant to Section 8.2 of this Agreement will automatically be waived with respect to the refund at issue. Participating Physician shall refund directly to the Member any amounts in excess of Co-payments or Deductibles collected in connection with an overpayment subject to refund under this Agreement.

**V. RECORDS**

5.1 **Member’s Medical Record.** Participating Physician shall ensure that a medical record is established and maintained for each Member that fully documents, in a detailed and comprehensive manner, medical services rendered and billed. Participating Physician shall further ensure that such record is legible, signed and dated, in accord with generally accepted medical practices and all applicable federal and state statutory and regulatory requirements and permits effective professional medical review and medical audit processes and facilitates an adequate system for follow-up treatment. All amendments, modifications, updates or any other change made after the initial creation of the electronic medical
record shall be clearly identified as an amendment, modification, update or other change, and shall be dated and authenticated by the author.

5.2 Access to Records. “Records” are any and all Member records including, but not limited to, medical records, records relating to submission of claims to HMSA or other insurers, and billings by Participating Physician. Participating Physician shall allow HMSA Medical Directors or their designees access to records for the purposes of utilization management, quality assurance, credentialing, recredentialing, claims payment verification, fraud and abuse investigations, and government audits.

Subject to compliance with applicable federal and state laws, professional standards regarding the confidentiality of medical records, and Plan Documents, Participating Physician shall upon HMSA’s request:

(a) allow HMSA authorized personnel access to Records on Participating Physician’s premises in a reasonable manner and at a mutually agreeable time within five working days following notice from HMSA;

(b) transmit Records by telephone or other electronic means to HMSA within two weeks from the date of HMSA’s request; or

(c) provide copies of Records to HMSA within two weeks from the date of HMSA’s request.

The Parties agree that failure to promptly 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 and/or refund to HMSA of payments made for any claim(s) for which records are not provided. Such payments shall be “overpayments” as that term is used in Section 4.8 above.

5.3 Confidentiality. HMSA and Participating Physician agree to keep confidential and to take the usual precautions to prevent the unauthorized disclosure of any and all medical records and information required to be prepared or maintained by Participating Physician or HMSA under this Agreement. All protected health information (“PHI”) used or disclosed by any party under this Agreement is subject to various state and federal statutory privacy standards and laws, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH”), and regulations adopted thereunder by the Department of Health and Human Services (45 C.F.R. Parts 142, 160, 162 and, 164). The Parties shall treat all PHI at all times in accordance with HIPAA standards. This provision shall survive the termination of the Agreement.

VI. INSURANCE

Participating Physician, at his or her sole cost and expense, shall secure and maintain from an insurance company or indemnity trust (each of which must be acceptable to HMSA), professional and general liability insurance to insure Participating Physician and his/her shareholders, officers, employees, and agents. General liability shall be an amount adequate for the risk insured against. Professional liability insurance shall have limits of not less than one million dollars ($1,000,000.00) per occurrence, and not less than one million dollars ($1,000,000.00) in the aggregate annually. Participating Physician shall provide certificates of coverage as requested by HMSA, and shall obligate the carrier of each such insurance policy to give HMSA written notice by certified mail at least thirty (30) days prior to cancellation or other termination of such policy.
VII. TERM AND TERMINATION

7.1 Term. When executed by both parties, this Agreement shall become effective as of the date noted on page 1 of this Agreement and shall continue in effect through January 31, 2020, unless sooner terminated by either party upon written notice in accord with this Article VII.

7.2 Termination. Except as set forth in Section 7.3, HMSA may only terminate this Agreement with cause by giving the Participating Physician at least sixty (60) calendar days’ written notice. Participating Physician may only terminate this Agreement, with or without cause, by giving HMSA at least sixty (60) calendar days’ written notice.

7.3 Immediate Termination. HMSA shall have the right to terminate this Agreement immediately only upon written notice to Participating Physician due to 1) revocation, suspension, limitation, condition, or expiration of Participating Physician’s license to practice medicine, or 2) if Participating Physician appears on the U.S. Department of Health & Human Services Office of Inspector General’s List of Excluded Individuals/Entities (LEIE) or the General Services Administration’s Excluded Parties List System (EPLS). Participating Physician’s right to appeal the termination decision is set forth in Section 8.1(b).

7.4 Effect of Termination. As of the date of termination, this Agreement shall be considered of no further force or effect except that such termination shall not release Participating Physician 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 accord with the terms of this Agreement, for Covered Services provided to Members prior to termination;

(b) Participating Physician’s obligation to retain and to provide HMSA access to Records as set forth in Article V of this Agreement;

(c) Participating Physician’s agreement not to seek compensation from Members for Covered Services provided while this Agreement is in force except for applicable Copayments and deductibles; and

(d) Participating Physician’s and HMSA’s obligation to resolve disputes pursuant to Article VIII of this Agreement.

7.5 Appeal of Termination. Participating Physician’s right to appeal termination of the Agreement is set forth in Article VIII of this Agreement. Except for immediate termination, upon HMSA’s receipt of Participating Physician’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.

VIII. 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 Immediate Termination (Section 7.3) of this Agreement. If Participating Physician 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 and all claims, disputes or causes of action based upon contract, tort, statutory law, or actions in equity, Participating Physician must submit a written request for review by HMSA within one year after the event giving rise to such claim, dispute or cause of action. HMSA shall issue a decision within sixty (60) calendar days of HMSA’s receipt of the request for review or within thirty (30) calendar days if the request is for non-urgent pre-service benefits redetermination. 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.

(b) Termination of This Agreement. Participating Physician may appeal HMSA’s decision to terminate this Agreement. In order to appeal HMSA’s termination of this Agreement, Participating Physician must submit a written request for appeal within sixty (60) calendar days of receipt of a notice of termination from HMSA. The 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. If the termination is pursuant to a recommendation by HMSA’s Credentialing Committee, the appeal must conform to HMSA’s policies and procedures related to credentialing in addition to this section 8.1(b). 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. Participating Physician may appear to present evidence or testimony before the committee. Both Participating Physician 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 shall be provided to Participating Physician upon request. Participating Physician and HMSA may submit a written statement at the conclusion of the hearing. Participating Physician will be notified of the review committee’s decision within five working days following the hearing.

(c) Expedited Pre-Service Benefits Redetermination. Participating Physician 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 Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the redetermination request. For an appeal under this Section 8.1(c), Participating Physician shall request an expedited redetermination and provide any additional information requested by HMSA.

8.2 External Appeals.

Arbitration Upon Exhaustion of Internal Appeal. HMSA and Participating Physician 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 unless arbitration is waived pursuant to Section 4.8 of this Agreement.

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

Arbitration of disputes between HMSA and Participating Physician shall be conducted by an independent arbitration service mutually selected by HMSA and Participating Physician. Arbitration shall be conducted in Honolulu, Hawaii, except that if the physician’s office is on a Neighbor Island, the physician may participate in the arbitration by telephone. If HMSA and Participating Physician are unable to agree upon an arbitration service within thirty (30) calendar days of HMSA’s receipt of Participating Physician’s request for arbitration, Dispute Prevention and Resolution, Inc. (“DPR”), or, if DPR is not available, another arbitration service selected by HMSA, will conduct the arbitration. If the two parties (HMSA and Participating Physician) 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 Hawaii Uniform Arbitration Act, HRS Chapter 658A, and the arbitration service’s arbitration rules (or such other arbitration rules as the parties may mutually agree); to the extent not inconsistent with the arbitration provisions in this Agreement. The arbitrator may hear and determine motions for summary disposition pursuant to HRS 658A-15(b). The arbitrator shall also hear and determine any challenges to the arbitration agreement and any disputes regarding whether a controversy is subject to an agreement to arbitrate. In order to make the arbitration hearing fair, expeditious and cost-effective, discovery by both parties shall be limited to requests for production of documents material to the claims or defenses in the arbitration. Limited depositions for use as evidence at the arbitration hearing may occur as authorized by HRS §658A-17(b). Each party (HMSA and Participating Physician) will pay its own attorney and witness fees, provided that the arbitrator shall award attorney fees and costs in an amount authorized by law 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 Participating Physician practicing as an individual in a group of less than six Participating Physicians. 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 Participating Physician 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 Hawaii Uniform Arbitration Act. There shall be no consolidation of parties in the arbitration proceeding. The arbitrator may award any remedy that can be granted by a court in like circumstances, provided that no award of punitive damages or exemplary damages shall be made. The parties shall take appropriate precautions to protect the confidentiality of any personal health information related to the arbitration proceeding.

8.3 Limitations on Appeals. Participating Physician 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 Participating Physician seek review of the same denied service, the
Member’s review shall go forward and the Participating Physician’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.

8.4 Review of HMSA’s Schedule of Maximum Allowable Charges. Participating Physician may submit a written request for a review of a specific Eligible Charge by HMSA staff. If the Participating Physician disagrees with the staff’s review decision, Participating Physician must submit within sixty (60) calendar days of Participating Physician’s receipt of the HMSA staff review decision a written request for review by the HMSA fee review committee. The HMSA fee review committee shall be composed of practicing physicians selected and appointed by HMSA and may submit recommendations for consideration by HMSA. The determination of charges in HMSA’s Schedule of Maximum Allowable Charges shall be at HMSA’s sole discretion.

IX. MISCELLANEOUS PROVISIONS

9.1 Amendments. Except as set forth in this Agreement, this Agreement may be amended only by mutual agreement of the parties except that HMSA may amend this Agreement as necessary to comply with federal or state law. HMSA may revise the Provider E-Library to make routine changes. Routine changes are defined as any changes other than changes that are both: (1) substantive and (2) inconsistent with the terms of this Agreement. HMSA shall provide at least sixty (60) days’ prior written notice of any revisions to the Provider E-Library that are not routine changes, as defined herein.

9.2 Assignment. Neither HMSA nor Participating Physician shall assign or transfer rights, duties, or obligations under this Agreement without the prior written consent of the other party. Changes of ownership or changes in majority control of a Participating Physician’s practice, and assignments of this Agreement by operation of law, are assignments of this Agreement for the purposes of this Section 9.2.

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. Participating Physician 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 Participating Physician 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. One or more attachment(s) or exhibit(s) may be attached to this Agreement, setting forth additional provisions included in this Agreement. By executing this Agreement, the parties acknowledge that these attachments or exhibits are expressly incorporated into this Agreement and are binding on the parties. In the event of any inconsistent or contrary language between an attachment or exhibit and any other part of this Agreement, the attachments or exhibits will control, to the extent applicable. Each attachment(s) or exhibit(s) shall be effective until the effective date of termination of this Agreement unless such
attachment(s) or exhibit(s) expires by its terms or is separately terminated by either Party pursuant to the terms of such attachment(s) or exhibit(s).

9.6 **Governing Law.** This Agreement shall be construed and enforced in accord with the laws of the State of Hawaii.

9.7 **Legal Compliance.** HMSA and Participating Physician shall comply with all state and federal laws and regulations in performance of this Agreement and obtain approval of all duly constituted government authorities, including the procurement of all licenses and permits required to provide services hereunder.

9.8 **Members’ Appeal Rights.** Members’ appeal rights are outlined in their Plan Documents.

9.9 **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 Participating Physician at the address below. The notice shall be effective on the date of delivery.

If to HMSA:

Hawaii Medical Service Association  
Attention: **PDA (7-PDA)**  
P. O. Box 860  
Honolulu, HI 96808-0860

If to Participating Physician:

Mailing address as reported by Participating Physician to HMSA.

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

9.11 **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.

Participating Physician expressly acknowledges that this Agreement constitutes a contract between Participating Physician 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 Marks in the State of Hawaii, and that HMSA is not contracting as the agent of the Association. Participating Physician further acknowledges and agrees that he/she 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 Participating Physician for any of HMSA’s obligations to Participating Physician 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.

9.12 **Responsibility for Acts.** Each party is responsible for its own actions. This Section 9.12 shall survive termination of this Agreement.
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.

9.14 **Execution.** This Agreement may be executed by HMSA and Participating Physician in counterparts, all of which taken together will be deemed one and the same instrument. Facsimile and photocopy signatures shall have the same binding effect as manual, original signatures.
IN WITNESS WHEREOF, the undersigned have executed this Agreement as of the date(s) written below.

«Contract_Holder_Name»

By: ________________________________                                    ______________________________
(Physician Signature)                                                                  Date of Signature

(Print Name if Signature is from an Authorized Physician Representative)

Hawaii Medical Service Association

By: ________________________________                                    ______________________________
Paul Schnur, Chief Contract Negotiator                                                  Date of Signature

By: ________________________________                                    ______________________________
(Executive Signature)                                                                  Date of Signature

(Executive Print Name)                                                                  (Executive Title)

Optional Selection of Term

The HMSA Participating Physician Agreement as presented provides for a term through January 31, 2020. If you would like to extend the term of this agreement for two additional years, please read the statement below and sign your name accordingly.

I request that my HMSA Participating Physician Agreement be amended as follows:

7.1   Term. When executed by both parties, this Agreement shall become effective as of the date noted on page 1 of this Agreement and shall continue in effect through January 31, 2022, unless sooner terminated by either party upon written notice in accord with this Article VII.

PHYSICIAN SIGNATURE (required): __________________________________________

DATE SIGNED (required): __________________________________________

DATE RECEIVED BY HMSA: __________________________________________

THIS CONTRACT IS NOT EFFECTIVE UNTIL SIGNED BY HMSA.