AMENDMENT TO THE MEDICAL SERVICES AGREEMENT BETWEEN GROUP HEALTH COOPERATIVE AND KITTITAS COUNTY BOARD OF HEALTH

This Amendment dated February 4, 2010, is hereby incorporated into the Agreement between **Group Health Cooperative** (herein referred to as GHC) and **Kittitas County Board of Health** (herein referred to as Contractor) which became effective on December 1, 2009.

Notwithstanding the provisions of Section XIII.K of the Agreement, the parties agree that this Amendment shall be effective January 1, 2010. The parties further agree that this Amendment, signed by both parties, does not constitute a waiver of GHC's ability to amend the Agreement unilaterally pursuant to Section XIII.K.

I. The following existing language in Section II (Definitions) of the Agreement is modified as follows:

Medical Coverage Agreement	A contract, including an Evidence of Coverage, that describes a benefit program offered by a Health Carrier and specifies those health care services to be provided to individuals lawfully participating in that benefit program.

II. The following existing language in Section III (Services) of the Agreement is modified as follows:

B. GHC shall provide access to information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits as required by WAC 284-43-320(1) and as set forth in the Provider Manual. Additionally, GHC shall assure the provision of an Authorization Form defining services to be provided by Contractor when applicable. The Authorization Form shall specify coverage limitations, time limitations, and special circumstances such as coordination of benefits, Coinsurance, Copayment or Deductible requirements.

III. The following existing language in Section III (Services), Subsection C of the Agreement is modified as follows:

1. The prior authorization obligations contained in Section III.C. shall not apply in the event a Managed Care Member elects to obtain Covered Services under a point of service or preferred provider organization plan if offered by Health Carrier, except that prior authorization will be required for Managed Care Members under a GHO Medicare PPO Medical Coverage Agreement.. When prior authorization is required, the procedure described in C. above is applicable.

IV. The following existing lanuague in Section V (Licensure, Credentialing and Recredentailing) of the Agreement is modified as follows:

E. Should an individual health care practitioner be denied credentialing as provided under this section based upon quality of care findings, he/she may initiate a dispute resolution process as described in GHC policies and procedures which is separate from the contractor dispute resolution process provided in this Agreement. This does not apply if the health care practitioner fails to meet requirements established under A and B of this section. This process as defined in the Provider Manual will not preclude Contractor from pursuing judicial remedies in compliance with RCW 48.43.055 and WAC 284-43-322 regarding alternative dispute resolution provisions in provider contracts.

V. The following existing language in Section VII (Payment for Services), Subsection A (Primary Payment) is modified as follows:

2. Contractor shall be responsible for collecting from Managed Care Member any applicable Coinsurance, Copayments, and Deductibles unless otherwise stipulated by Health Carrier.

3 If authorization for Covered Services is required under the terms of the Managed Care Member's Medical Coverage Agreement but not obtained by Contractor, Contractor agrees not to bill Health Carrier or Managed Care Member for such services. In the event the Managed Care Member was not eligible for Covered Services on the date of service, Health Carrier, to the extent required by state law, shall be financially liable only for Covered Services that had prior authorization from the Health Carrier and were not provided or obtained through material misrepresentation.

VI. The following language is added to Section VII (Payment for Services), Subsection A (Primary Payment) of the Agreement:

4. GHC and Contractor mutually agree to comply with overpayment recovery standards as defined in RCW 48.43.600 and 48.43.605 and set forth in the Provider Manual.

VII. The following existing language in Section VII (Payment for Services), Subsection F (Claims Processing (for other than captiation payments)) of the Agreement is modified as follows:

1. Health Carrier shall pay claims in a timely manner not to exceed thirty (30) calendar days from the date of Health Carrier's receipt of a clean claim form or Health Carrier's determination it is the primary payer. For the purposes of this Section VII.F., a clean claim form shall be a CMS 1500 claim form, UB claim form, or HIPAA compliant electronic transaction which, in Health Carrier's opinion, has no defect, or impropriety, does not lack any required substantiating documentation, or does not have any particular circumstances requiring special treatment that prevents timely payment. Health Carrier shall pay or deny all claims within sixty (60) days of receipt or Health Carrier's determination it is the primary payer, except such time may be extended as agreed upon in writing by Health Carrier and Contractor on a claim-by-claim basis. Payment according to the terms of Section VII.F. shall not apply to claims about which there is substantial evidence of fraud or misrepresentations by Contractor, or for instances when Health Carrier has not been granted reasonable access to information under Contractor's control. The date of receipt of a claim is the date Health Carrier receives either written or electronic notice of claim. Health Carrier shall establish a reasonable method for confirming receipt of claims and to respond to Contractor inquiries about claims. Denial of claims must be communicated to Contractor and must include specific reasons for the denial. When claims are denied for reasons of medical necessity, Health Carrier must be prepared to disclose the supporting basis for the decision. Health Carrier assumes ultimate responsibility for assuring provisions of this section are in compliance should claims payment be delegated to a third party.

2. If Health Carrier fails to: 1) pay ninety-five percent (95%) of Contractor's total monthly volume of clean claims submitted under this Agreement within thirty (30) days of receipt or Health Carrier's determination it is the primary payer, and 2) pay or deny ninety-five percent (95%) of Contractor's total monthly volume of all claims within sixty (60) days of receipt or Health Carrier's determination it is the primary payer, Health Carrier shall pay interest to Contractor as calculated and set forth herein. Health Carrier shall pay Contractor simple interest at the rate of one percent (1%) per month on any clean claims not paid or denied within sixty (60) days of receipt from Contractor. Interest shall start accruing on the sixty-first (61) day after the receipt of a clean claim by Health Carrier and shall be prorated for any portion of

a month outstanding. Health Carrier shall add the interest payable to the amount of the unpaid claim.

VIII. The following paragraph is added to Section IX (Training, Education and Orientation):

GHC is required by law to provide certain training and education to entities with whom it contracts, regarding the fraud, waste and abuse compliance requirements of GHC and Contractor. Contractor shall require its employees and subcontractors to participate in such training as provided by GHC from time to time.

IX. The following language is added to Section XI (Medicaid and Medicare Contracting Requirements) of the Agreement:

H. GHC and Contractor agree that all activities performed under the Agreement will be clearly defined and include any associated reporting responsibilities as required under 42 CFR 422.504(i)(3)(ii) and 42 CFR 422.504(i)(4)(i).

I. Contractor acknowledges the obligation and authority of GHC and CMS to monitor the performance and revoke where necessary any applicable activities performed under the Agreement if the activities as defined in the Agreement are determined to be unsatisfactory as outlined in 42 CFR 422.50(i)(3)(ii) and 42 CFR 422.504(i)(4)(ii)-(iii).

X. The following existing language in Section XIII (General Provisions) of the Agreement is modified as follows:

A. Nondiscrimination: The parties agree not to discriminate against persons and to render services without regard to race, sex, marital status, religion, creed, national origin, color, age, health status physical or mental disability, Vietnam Era veteran or disabled veteran status or other groups protected by law. Additionally, the parties agree to develop and maintain policies and procedures that demonstrate they do not discriminate in the delivery of health care services.

G. Confidentiality: Except as authorized by both Contractor and GHC, as required by applicable laws and regulations, or as necessary to effectively carry out this Agreement, the terms of this Agreement shall not be divulged, in whole or part, by either party, its agents, employees, or subcontractors to any third party other than by GHC to a Health Carrier, a reinsurer, or a third-party consultant under contract with either GHC, a plan sponsor or a self-insured welfare benefit plan.

Except as specifically amended herein, and as necessary to incorporate the foregoing into the terms of the Agreement, the remaining terms and conditions of the Agreement shall remain in full force and effect.

Group Health Cooperative

Michele Anderson

By: _____
Michele L. Anderson

Title: Director, Provider Contracting

Date: February 4, 2010

Kittitas County Board of Health

By: _____
Kathy Bambrick

Title: Director

Date: _____