

## LETTER OF AGREEMENT

This Letter of Agreement (Agreement) is entered into by and between Rocky Mountain Health Network, Inc. ("RMHN") and City of Billings ("Plan Sponsor") for the benefit of its employee benefit plans and employees and dependents, effective January 1, 2020. The terms of the Agreement apply exclusively to the Plan Sponsor's employee benefit plans for employees, retirees and their eligible dependents.

### **Recitals**

**WHEREAS**, Plan Sponsor offers and/or administers a health benefit Plan on behalf of eligible employees and their dependents;

**WHEREAS**, RMHN is a Physician Hospital Organization (PHO) comprised of various healthcare providers ("Providers") engaged in the provision of health care services in communities throughout Montana and, among other goals, is committed to organizing and coordinating a network of Providers to deliver a comprehensive scope of services;

**WHEREAS**, RMHN has experience and expertise in developing and managing agreements with employers, payers and others;

**WHEREAS**, Plan Sponsor contracts for claims administration and other administrative services under an administrative services only agreement with EBMS to provide services on behalf of eligible employees and their dependents through a contracted network of participating providers;

**WHEREAS**, the purpose of the Agreement is to provide Plan Sponsor with a comprehensive network of Providers;

**WHEREAS**, the Plan Sponsor desires to enter into this Agreement with RMHN to obtain access to the network of Providers;

**NOW, THEREFORE**, in consideration of the mutual covenants and conditions set forth in the Agreement, the parties agree as follows:

### **Definitions**

**Benefit Plan** means a program offered by or administered by Plan Sponsor for the payment of Covered Services provided to an eligible Participant.

**Clean Claim** means a claim for Covered Services that (a) is timely received by the Plan Sponsor and/or its TPA, as applicable; (b) (i) when submitted via paper has all the elements of the UB 04 or CMS 1500 (or successor standard) forms; or (ii) when submitted via an electronic transaction, uses only permitted transaction code sets (e.g. CPT4, ICD9, ICD10, HCPCS) and has all the elements of the standard electronic formats required by applicable Federal authority; (c) is a claim for which the Benefit Plan is the primary payor or the Benefit Plan's responsibility as a secondary payor has been established; and (d) contains no defect, error or other shortcoming resulting in the need for additional information to adjudicate the claim.

**Coinsurance** means a cost-sharing obligation that requires the Participants to pay a percentage of the cost of specified Covered Services.

**Copayment** means the amount that a Participant is responsible to pay under the Plan Sponsor's Benefit Plan at the time of service.

**Covered Services** means those specified Medically Necessary health care services for which a Participant is eligible to receive benefits under the Benefit Plan.

**Deductible** means the amount a Participant must pay for Covered Services each calendar or plan year before a Plan Sponsor commences payment as defined under the Benefit Plan.

**Medical Necessity or Medically Necessary** means a medical service or medical supply, which meets all of the following criteria:

1. It is required for the treatment or diagnosis of a covered medical condition;
2. It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the Participant's covered medical condition;
3. It is known to be effective in improving health outcomes for the Participant's covered medical condition in accordance with sufficient scientific evidence and professionally recognized standards;
4. It is not furnished primarily for the convenience of the Participant or Provider of services; and
5. If this definition of Medically Necessary is not consistent with the definition of Medically Necessary in the Benefit Plan, the definition in the Benefit Plan will control.

Medical necessity alone does not determine coverage.

**Participant** means any person who is eligible to receive Covered Services under the terms and conditions of Plan Sponsor's Benefit Plan.

**Participating Provider** means a RMHN Provider who has opted into the Agreement with the Plan Sponsor.

**Third Party Administrator (TPA)** means the organization that processes insurance claims on behalf of the Plan Sponsor.

## **DUTIES OF RMHN**

### **Provide or Arrange for Covered Services**

RMHN agrees to arrange for the provision of Medically Necessary Covered Services on a timely basis, without regard to health status or medical condition, and in accordance with generally accepted medical practice guidelines and standards pursuant to the terms of this Agreement, and in accordance with applicable Plan Sponsor policies and procedures. Except in the case of emergency, RMHN Participating Providers agree to use reasonable commercial efforts to verify each Participant's eligibility prior to providing Covered Services. In the case of an emergency, Provider will notify Plan Sponsor and Plan Sponsor's TPA of the provision of Medically Necessary services to treat the emergency condition in accordance with Plan Sponsor's provision for notification.

RMHN Participating Providers agree to furnish Covered Services to Participant on the same basis as such services are made available to individuals who are not Participants, and without regard to the Participant's enrollment in a Benefit Plan. In providing services under the Agreement, RMHN Participating Providers shall exercise the degree of care, skill and knowledge expected of a prudent health care Provider and in a manner consistent with currently approved methods and practices in

Provider's medical specialty. Providers shall exercise professional medical judgment, free of any direction or control by Plan Sponsor, and shall remain solely responsible for the quality of services rendered.

### **Accessibility and Hours of Service**

Participating Provider shall arrange for the provision of Covered Services to Participants during normal business hours at the usual places of business of Provider. Provider shall ensure that Provider arranges for and maintains call schedules that provide appropriate call coverage to Participants in the event Participants are unable to contact their Participating Providers.

### **Licensing Requirements**

At all times during the term of this Agreement, RMHN and RMHN Participating Provider shall possess and maintain in good standing all necessary professional and facility licenses, certifications, registrations, permits and other approvals required by State and/or Federal law to provide or arrange for the provision of Covered Services to Participants.

### **Provider Network Notifications and Update**

RMHN will provide Plan Sponsor and Plan Sponsor's TPA with an initial roster of Participating Providers that includes information needed for claims processing. RMHN will provide ongoing updates to Plan Sponsor and Plan Sponsor's TPA.

### **Insurance**

RMHN and RMHN Participating Providers shall provide and maintain, at their sole cost and expense and for the duration of this Agreement, policies of general comprehensive liability and professional liability insurance, or self-insurance, in an amount acceptable to Plan Sponsor. Such policies shall insure against any claim or claims for damage arising by reason of personal injury or death occasioned directly or indirectly in connection with the acts or omissions of Provider, agents or employees pursuant to the terms of this Agreement. RMHN shall notify Plan Sponsor immediately but no more than two (2) business days from notification of any revocation, reduction in coverage, or termination of any such policy. Upon request, RMHN shall provide Plan Sponsor with evidence of compliance with this insurance requirement in the form of a certificate of insurance or evidence of self-insurance in an amount and form acceptable to Plan Sponsor.

### **Medical Management Programs**

RMHN agrees to comply with and participate in Plan Sponsor's and/or its TPA's medical management/utilization management programs and requirements, whichever is applicable, which may include but are not limited to, pre-authorization, notification, concurrent review, retrospective review, re-admission guidelines, case management, disease management programs, pharmacy and specialty pharmacy programs, referral management, quality assurance and improvement programs and medical necessity oversight.

RMHN further agrees to share Participant information as specifically related to these programs. RMHN Participating Providers are required to allow access to Participant records, provide for copying and release of records at Provider's expense, and to speak to the Plan Sponsor or its TPA or designee upon request, as allowed by law, in a timely manner to facilitate the Medical Management program. Non-compliance with the Medical Management program may result in non-payment.

### **Subcontract**

If RMHN subcontracts with any other provider to provide Covered Services to Participants hereunder, RMHN understands and agrees that the subcontract and the subcontracting provider must comply with all terms of this Agreement and applicable state law and regulation.

### **Non-Covered Services/Exclusions**

Provider shall provide notice to Participant of their personal financial obligations for non-covered services, which includes services that are not Medically Necessary. Provider may bill a Participant for non-covered services if Provider has, prior to the provision of non-covered services, obtained a written acknowledgment and acceptance of financial responsibility from the Participant after full disclosure of (i) Provider's intent to bill Participant for non-covered services, and (ii) the non-liability of Plan Sponsor for such non-covered services.

### **Claims Payment**

Provider shall look only to Plan Sponsor for payment of claims. Provider may not collect or attempt to collect from Participant money owed to Provider by Plan Sponsor.

### **Acceptance of Payment**

Provider shall accept payment, as described in RMHN's confidential response to the City of Billings RFP Direct Contract request, as payment in full for Covered Services rendered, less Coinsurance, Copayments, Deductibles, and non-covered or ineligible charges as described in the Benefit Plan. Except for Co-payments, Provider agrees to refrain from billing Participant for any amounts due until such time that the claim is processed by Plan Sponsor or its TPA and any applicable Co-insurance and/or Deductible amounts have been properly identified on an EOB. Provider further agrees not to balance bill Participant for the difference between the amounts agreed to in the confidential RFP response and Provider's billed charges. In the event that a claim payment is under dispute or appeal, Provider shall refrain from seeking payment from the Participant until such dispute is resolved.

### **Records**

Providers shall establish and maintain medical, financial, and other records for Participants who receive Covered Services. Such records will be maintained in accordance with generally accepted medical, accounting, and bookkeeping practices, and will be preserved as may be necessary for compliance with applicable State and Federal laws, and accrediting bodies of the Provider. Provider shall make all records relating to this Agreement available to Plan Sponsor and/or its TPA, and governmental authorities having jurisdiction over this Agreement for inspection and copying at reasonable times upon receipt of at seven (7) days prior written notice. If Plan Sponsor requests the information pursuant to an inspection or an audit, then Plan Sponsor will protect the confidentiality of such records in accordance with applicable legal standards. Plan Sponsor will reimburse Provider for all reasonable copying costs incurred by Provider as a result of said record inspection or audit.

## **RESPONSIBILITIES OF PLAN SPONSOR**

### **Payment for Covered Services**

Plan Sponsor shall pay Providers for Covered Services rendered to Participants in accordance with the Benefit Plan and Claims Submission section of this agreement.

### **Directory and Promotion**

Plan Sponsor and/or TPA agree to include RMHN Participating Providers in appropriate directories or website listings.

**Eligibility**

Plan Sponsor shall require its TPA to confirm a Participant's eligibility for Covered Services upon request by Provider. Plan Sponsor shall assure reasonable access, through standard means of communication, including using electronic transaction as required by applicable law, for the confirmation that services are Covered Services and a Participant is eligible under the Benefit Plan.

**Provider's Right to Inform Patients**

Plan Sponsor shall not in any way preclude or discourage Provider's from informing Participants of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Participant's Benefit Plan, nor prohibit, discourage, or penalize Provider's otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this Agreement shall be construed to authorize Provider to bind Plan Sponsor or its TPA to pay for any services.

**ID Cards**

Plan Sponsor or its TPA shall provide each Participant with a membership identification card displaying any applicable network logos, the Participant's name and identifier, group name and/or number, telephone number to confirm eligibility and benefit verification, utilization management vendor name and telephone number to confirm necessary pre-authorization for services.

**Explanation of Benefits**

Plan Sponsor shall ensure that its TPA provides an Explanation of Benefits (EOB) during the claim adjudication process which, at a minimum, identifies: PAYOR, total billed charges, allowed amount in accordance with rate agreement, amount PAYOR responsible to pay, amount Participant responsible to pay, and non-covered codes or services.

**CLAIMS SUBMISSION AND PAYMENT****Claims Submission**

Provider shall use reasonable commercial efforts to submit a claim for services provided preferably within sixty (60) days but in no event later than one (1) year of the date services were incurred by the Participant, provided the Participant is identified as an eligible Participant under the Benefit Plan, and shall cooperate with Plan Sponsor or its TPA, as applicable, to provide additional information requested to process the claim as a Clean Claim.

**Payment of Claims**

Plan Sponsor shall pay Participating Provider for Covered Services provided to a Participant, subject to the following minimum standards:

- Plan Sponsor shall pay or cause its TPA to pay for Covered Services provided to Participants within thirty (30) business days of the date Plan Sponsor and/or its TPA receives a Clean Claim, unless Plan Sponsor and/or its TPA makes a reasonable request for additional information or documents in order to evaluate the claim during this time period. If Plan Sponsor and/or its TPA makes a request for additional information to evaluate the claim, Plan Sponsor and/or its TPA agree to provide an explanation of the necessary additional information in a format that meets the requirements of 29 CFR 2560.503-1 and Section 2719 of the Public Health Service Act and its implementing guidance and allow at least 45 days for the recipient to provide the information;
- Plan Sponsor and/or its TPA, as applicable, or Provider may request contractually supported corrective adjustments to a payment made to Provider hereunder during the twelve (12)

months following payment of the claim. Thereafter, the payment shall be deemed final and Plan Sponsor shall have no obligation to pay and Provider shall have no obligation to refund.

- Claims may be subject to standard claims editing software to detect bundling and unbundling, as well as incorrect billing. Upon request, Plan Sponsor shall provide Provider with an explanation of unbundling and incorrect billing edits.
- Plan Sponsor or its designated third party auditor (“Auditor”) may inspect claims data and billing records relating to the Covered Services provided to Plan Sponsor’s Participants at its expense. Audit materials or documentation provided by Provider will be confined to Plan Sponsor or Participant-specific information.

These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider or Participants.

### **Coordination of Benefits and Third Party Liability**

Provider agrees to cooperate with Plan Sponsor’s coordination of benefits (COB) and third party liability policies and programs.

## **MAINTENANCE OF RECORDS, INSPECTION AND AUDIT**

### **Maintenance of Records**

Provider shall maintain all appropriate medical, administrative and financial records for each Participant who receives services from Provider. Such records shall be maintained as is required by law and generally accepted medical practice and professional ethics.

Plan Sponsor shall have the right to request, inspect and audit any and all records of Provider related to a Participant as permitted by law, and as may be necessary for Plan Sponsor to perform its obligations under this Agreement. Where documents are requested by Plan sponsor for audit purposes, Plan Sponsor shall reimburse Provider for reasonable costs incurred in providing copies of requested documents, at the maximum amount allowed by Montana law, or if not specified by Montana law, a rate of \$.10 per page.

Provider shall have the right to request, inspect and audit any and all records of Plan Sponsor directly related to a Participant as permitted by law, and as may be necessary for Provider to perform its obligations under this Agreement. Where documents are requested, Provider shall reimburse Plan Sponsor for reasonable costs incurred in providing copies of requested documents, at the maximum amount allowed by Montana law, or if not specified by Montana law, a rate of \$.10 per page.

Neither party shall be reimbursed for copies of documents requested for purposes of payment of claims, resolution of quality of care or service concerns, complaints and/or grievances, or medical management review and coverage determinations.

### **Maintenance of Records**

Both parties shall retain all records relating to this Agreement for a minimum of seven (7) years.

### **External Audits**

Both parties agree to cooperate with any external audits mandated by state or federal law, and shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Participants, subject to applicable state and federal laws related to the confidentiality of medical record.

## **CONFIDENTIAL AND PROPRIETARY INFORMATION**

### **Information Relating to this Agreement**

Both parties agree that all information of this Agreement, as well as other information identified by either party, is confidential or proprietary, and shall not be disclosed without the prior written consent of the other party. Upon termination of this Agreement, any documents identified by either party as proprietary shall be returned to the respective party.

### **Participant Health Information**

The parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, as amended (HITECH) all applicable requirements and obligations under HIPAA and HITECH governing any uses and disclosures of all Protected Health Information (PHI) or Electronic PHI (E-PHI) that may occur as a result of this Agreement as applicable to each party. Each party warrants it will maintain and protect the confidentiality of all PHI and E-PHI in accordance with its obligations under HIPAA, HITECH, and all applicable federal and state laws and regulations.

Upon termination of this Agreement, at the request of the party that owns PHI or E-PHI, the other party shall promptly return to the requesting party all such PHI or E-PHI which has been provided to it or dispose of such PHI or E-PHI in a mutually agreed upon manner.

### **Effect of Termination**

The parties understand that the requirements of this Section shall survive the termination of this Agreement.

## **INDEMNIFICATION**

Plan Sponsor and Provider shall indemnify and hold the other party harmless from loss, damage, or defense costs (including, but not limited to, reasonable attorney's fees) arising from actual or alleged negligent acts or omissions of the other party, its officers, employees, subcontractors, or other agents in performing services contemplated under the Agreement which are solely the responsibility of either Plan Sponsor or Provider. Neither party shall be liable for any liability of the other party, its agents, officers or employees, whether resulting from judgement, settlement, award fine or otherwise, which arises out of such other party's actions or omissions under the Agreement.

## **TERM & TERMINATION**

### **Term of Agreement**

This Agreement shall become effective January 1, 2020, and shall continue in effect for an initial five (5) year term (through December 31, 2024). At the end of this initial term, this Agreement can be renewed for an additional five (5) year term with mutual agreement of the parties.

### **Termination Without Cause**

Either party may terminate this Agreement without cause, upon one hundred eighty (180) days prior written notice to the other party.

### **Termination for Cause**

Either party may terminate this Agreement for cause by giving the other party thirty (30) days prior written notice. Such notice shall specify the reason(s) for termination and shall provide the other party thirty (30) days from the date of receipt of the notice of termination to correct the cause to the satisfaction of the complaining party. Should the cause not be cured within this thirty (30) day period, termination shall occur thirty (30) days from the end of that period.

#### Effect of Termination

This Agreement shall be of no further force or effect as of the effective date of termination except that:

- Plan Sponsor shall be responsible for payment of Covered Services provided by Provider to a Participant as of the effective date of termination.
- Provider shall not seek compensation from the Participant for any Covered Services provided under the terms of this Agreement prior to the termination date, except for any applicable Deductible, Copayment or Coinsurance amounts.
- Provider shall continue the treatment of Participants who were receiving care in an inpatient facility as of the effective date of termination, for a period which is the lesser of (i) the date the Participant is discharged from the facility, (ii) until Plan Sponsor arranges for the Participant to be transferred from the facility, or (iii) thirty (30) days after termination. The provisions of this Agreement, including negotiated reimbursement rates, will not apply after the Agreement termination date.

#### **DISPUTE RESOLUTION**

The parties will meet and confer in an attempt to resolve any dispute arising out of or relating to this Agreement. A dispute not resolved within thirty (30) days of this meeting will be submitted to mediation, which will be held in a mutually agreed upon location in Montana, in accordance with the American Arbitration Association (“AAA”) Rules of Procedure for Mediation. A single mediator, selected by AAA and having at least 10 years’ legal experience in ERISA and health care will mediate the dispute. If the dispute is not resolved through mediation, the parties will be free to pursue all legal and equitable remedies otherwise available, provided, however that any action taken or remedy sought must be initiated within one (1) year of the parties’ first meeting to resolve the dispute. In the event any party to this Agreement takes legal action to enforce its rights hereunder, including, but not limited to, the submission of an issue for mediation pursuant to this Section or a request for an injunction or other equitable relief through the courts, each party to such action shall bear their own costs and expenses related to such action, and one-half (1/2) of any common costs and expenses of mediation.

The provisions of this Section shall not affect either party’s right to terminate this Agreement as provided for under the Term and Termination Section of this Agreement.

#### **GENERAL PROVISIONS**

##### **Independent Contractors**

Each party to this Agreement shall be acting as an independent contractor. None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement.

**Amendment**

This Agreement may be amended from time to time by either party only by providing the other party sixty (60) days advance written notice of the amendment, and only upon the mutual written consent of the parties.

**Severability/Conformity with Law**

In the event any provision of this Agreement is rendered invalid or unenforceable by any State or Federal regulation, or declared null and void by any court of competent jurisdiction, the remaining provisions of this Agreement shall remain in full force and effect to the fullest extent possible consistent with the intent and purpose of this Agreement, unless the severance of any such provision substantially impairs the benefits of the remaining provisions of this Agreement. This Agreement shall be interpreted, and if necessary, amended, to conform to applicable federal and state law in effect on or after the Agreement's effective date.

**Entire Agreement**

This Agreement, its Attachments, and any documents incorporated herein by reference, constitute the entire Agreement between the parties. No implied covenants shall be read into this Agreement. This Agreement supersedes all prior agreements between the parties.

**Waiver of Breach**

Neither the failure nor delay on the part of either party to exercise any right under this Agreement shall serve as a waiver of that right. If either party should waive a breach of any provision of this Agreement, it shall not be deemed or construed as a waiver of any other breach of the same or different provision.

**Applicable Law**

This Agreement shall be governed by and construed in accordance with the laws of the State of Montana and applicable Federal laws and regulations.

**Medical Care**

It is hereby understood that Provider is solely responsible for all decisions and liability regarding their medical care and treatment of Participants. It is also agreed that the traditional relationship between Provider and patient shall in no way be affected by or interfered with by any of the terms of this Agreement. Provider understands that any determinations made by Plan Sponsor or its TPA and any determinations made in connection with utilization review are solely for purposes of determining whether services are Covered Services under the terms of a Benefit Plan and the extent to which payments may be made thereunder. Accordingly, such determinations shall in no way affect the responsibility of Provider to provide appropriate services to Participants.

**Assignment**

Neither party shall assign this agreement without the express written consent of the other.

**Notices**

Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and may be sent electronically or by U.S. mail, First Class, postage prepaid, to RMHN or Plan Sponsor at their respective addresses set forth on the signature page of this Agreement, except for notice given under Confidential and Proprietary Information Section, which shall be sent by Certified Mail, return receipt requested. Notice shall be deemed given when received or three (3) business days after notice is deposited in the mail as set forth above, whichever is earlier.

**Force Majeure**

Neither party shall be required to comply with the provisions of this Agreement if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

IN WITNESS WHEREOF, the parties have executed this Agreement through a duly authorized representative as of the dates noted below:

<b>For RMHN:</b> By: <u>Carol A. B</u> Printed Name: <u>CAROL A. BEAM</u> Title: <u>CEO</u> Date: <u>11-12-2019</u>  Address: Rocky Mountain Health Network, Inc. 2475 Village Lane, Suite 302 Billings, MT 59102	<b>For Plan Sponsor:</b> By: _____ Printed Name: _____ Title: _____ Date: _____  Address: City of Billings Human Resources Department 210 N 27 <sup>th</sup> Street Billings, MT 59101
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## **SCHEDULE SUMMARY**

In accordance with Exhibit 3A of the RFP issued by the City of Billings for Direct Contracting Services effective January 1, 2020, RMHN has agreed to not request or share any proprietary or confidential financial information, fee schedules or reimbursement rates with anyone other than the Plan Sponsor's consultant and the Plan Sponsor's TPA. All the information contained in the following Schedules is deemed proprietary:

SCHEDULE A – NETWORK

SCHEDULE B – OCCUPATIONAL HEALTH SERVICES

SCHEDULE C – EMPLOYEE ASSISTANCE PROGRAM (EAP)

SCHEDULE D - WELLNESS