AMENDMENT TO MOLINA HEALTHCARE OF WASHINGTON, INC. (FORMERLY QUALMED WASHINGTON HEALTH PLAN, INC.)
HOSPITAL SERVICES AGREEMENT

THIS AMENDMENT TO THE HOSPITAL SERVICES AGREEMENT ("Amendment") is made and entered by and between Molina Healthcare of Washington, Inc. ("Health Plan") and University of Washington Medical Center ("Provider").

Whereas, Health Plan and Provider entered into a Hospital Services Agreement ("Agreement"), September 1, 1994 and

Whereas, Health Plan and Provider hereby agree to amend the Agreement in accordance with the terms and conditions of this Amendment.

Now therefore, in consideration of the rights and obligations contained herein, the parties to this Amendment, intending to be legally bound, do hereby agree as follows:

1. Attachment C-1 (Credentialing Delegation Services Addendum ("Addendum")) and Exhibit A (2017 Standardized Roster Data Points), attached hereto, is hereby added and incorporated into the Agreement.

2. Effective Date. This Amendment shall become effective on the date this Amendment is signed by Health Plan, and renew with and under the terms of the Agreement.

3. Use of Defined Terms. Terms utilized in this Amendment shall have the same meaning set forth in the definitions to the Agreement.

4. Full Force and Effect. Except as specifically amended by this Amendment, the Agreement shall continue in full force and effect.

This Amendment is in addition to, and does not replace or supersede, the Agreement between Health Plan and Provider filed, with Health Plan, except as otherwise provided in this Amendment. All conditions and provisions of the Agreement, except as specifically modified herein, shall remain binding. If there is any ambiguity or inconsistency between the documents not specifically addressed in this Amendment, the original Agreement shall be operative and enforced.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers thereunto duly authorized.

University of Washington Medical Center		**Molina Healthcare of Washington, Inc.**	
By:	Jacqueline Cabe	By:	Andrew Nelson
Its:	Chief Financial Officer, UW Medicine	Its:	VP, Network Management
Date:	1.24.18	Date:	1/25/18

ATTACHMENT C-1
CREDENTIALING DELEGATION SERVICES ADDENDUM

I. Delegation: This Addendum supersedes all previous Delegation Agreements, Attachments, Exhibits and/or Addendums. Provider shall begin performing the specific function delegated as of the date indicated by the Health Plan's committee in its notice to Provider of its approval of delegation (the "Start Date"). Provider is delegated for the credentialing activities described in Section II below. Delegation is contingent on Provider and its delegates in any tier meeting all applicable regulatory and accreditation requirements applicable to the lines of business contracted. These requirements include: National Committee for Quality Assurance (NCQA) Health Plan credentialing standards; Centers for Medicare and Medicaid Services (CMS) laws, regulations and CMS instructions; Washington State Health Care Authority (HCA) managed care laws, regulations, and contract requirements; Washington State Office of the Insurance Commissioner (OIC) laws and regulations; and Health Plan's requirements for credentialing delegation. Health Plan's requirements are stated in this attachment and in the most recent versions of Health Plan's delegation policies and procedures and annual program assessment documents, hereby incorporated by this reference.

II. Delegate Responsibilities for Credentialing Activities: The following credentialing activities are specifically delegated:

A. For Provider Physicians and other practitioners credentialed by Provider:

1. The mailing, receipt, and processing of applications for credentialing and recredentialing via the Washington Practitioner Application (WPA), or another application that addresses at least the following elements:
   a. Disclosure of current practice contact information, including but not limited to, primary mailing address, phone and fax numbers; and secondary mailing, phone and fax numbers if appropriate
   b. Disclosure of current State Licensure as applicable to which the practitioner is providing care to Health Plan members
   c. Disclosure of current Federal DEA registration(s), if applicable
   d. Disclosure of completed education and/or training in the appropriate specialty area(s)
   e. Disclosure of current or intended ABMS board certification(s), if applicable
   f. Disclosure of work history for the most recent five year period, or since granting of an initial license, whichever is less
   g. Disclosure of any current or past malpractice claims history, including but not limited to pending, dismissed, or closed cases
   h. Disclosure of current or past license sanction history
   i. Disclosure of current or past Medicare/Medicaid sanction history
   j. Disclosure of an inability to perform the essential functions of the position, with or without accommodation
   k. Disclosure of any present illegal drug use
   l. Disclosure of any history of loss of license
   m. Disclosure of any history of felony conviction(s)
   n. Disclosure of any loss or limitation of privileges or disciplinary action(s)
   o. Disclosure of professional liability malpractice insurance coverage currently in effect, dates of coverage, and amount of coverage
   p. Disclosure of primary admitting plan, or 24 hour coverage plan, if applicable

q. A statement attesting to the correctness and completeness of the application and all attachments

2. Verification from approved primary sources of all file elements as required by NCQA, CMS when applicable, and Health Plan as follows and within the identified timeframes:
   a. License(s) in States in which the practitioner is providing care to Health Plan members, within 180 calendar days of the current committee decision date.
   b. Current DEA Certificate registered to a practice location in each state in which the practitioner is providing care to Health Plan members, or DEA Coverage Plan when applicable, prior to committee decision date. Coverage Plans must be documented in each applicable file. When delegation includes CMS lines of business, verification of certificate or coverage plan must be within 180 calendar days of the current committee decision date.
      i. If a physician or other practitioner does not have a DEA certificate and is practicing in a specialty that would otherwise require a DEA certificate (i.e. Family Medicine, Rheumatology, Internal Medicine, etc.) a description of why there is no certificate and a DEA coverage plan must be documented in the file prior to the committee decision, within the timeframes identified directly above.
   c. Highest level of education and training, or board certification. Verification of completion of fellowship training via the educational institution does not meet the intent of this requirement.
      i. If a physician is practicing in a fellowship specialty, verification of completion of the fellowship program, or fellowship specialty board certified, must be completed.
      ii. If a physician has not yet completed fellowship training at the time of committee decision, the provider will not practice that fellowship specialty until completion is verified.
   d. Work history for the most recent 5 year period or since granting of initial licensure, whichever is less, disclosed in Month/Year format. Gaps of 6 months or more may be clarified verbally with the physician or other practitioner; gaps of 12 months or more must be clarified with the practitioner in writing. Verification must be documented on an application checklist or in a Memo to File that includes the date of verification and signature or initials of verifier. When delegation includes CMS lines of business, verification of work history must be within 180 calendar days of the committee decision date.
   e. Most recent 5 years of malpractice claims history, within 180 calendar days of the current committee decision date.
   f. History of license sanctions from the previous 5 years in all states in which the practitioner is/was licensed, within 180 calendar days of the current committee decision date.
   g. History of Medicare and Medicaid sanctions from the previous 5 years within 180 calendar days of the current committee decision date. When delegation includes CMS lines of business, verification of Medicare sanctions must come directly from the OIG and SAM webpage.
   h. Admitting privileges or coverage plan, when applicable. Primary Source Verification of this element is not required.
   i. Malpractice Insurance coverage within 180 calendar days of the current committee decision date. A practitioner attestation of coverage is not acceptable.

j. When delegation includes Medicare lines of business, review of the Medicare Opt-Out Affidavits List Report within 180 calendar days of the credentialing and recredentialing committee decision dates.
k. When delegation includes Medicare lines of business, review of Quality Information for all practitioners as a part of the recredentialing process within 180 calendar days of the recredentialing committee decision date.
l. Social Security Death Master File certified verification (initial and recredentialing)
m. Verification of provider's NPI (initial and recredentialing)
n. Verification of provider enrollment into ProviderOne

3. Ongoing monitoring of exclusions and sanctions as defined below:
   a. Maintain a tracking log for all ongoing monitoring sanction reports to include, at a minimum, month of report, release date of report, review date, documentation of findings/results or comments, initials of person who reviewed and report source;
   b. Review sanctions and limitations against licensure by state licensing agency within 30 calendar days of release from source;
   c. Review federal Medicare exclusion/sanction/termination lists not limited to OIG and SAM within 30 calendar days of release from the source and review state Medicaid exclusion/sanction/termination lists at initial credentialing and re-credentialing.
   d. Screening the LEIE and SAM lists monthly by the 15th of each month for all Contractor and subcontractor individuals and entities with an ownership or control interest, individuals defined as affiliates, as defined in the Federal Acquisition Regulation, of a person described in 42 C.F.R. § 1001.1001 (a)(1), and individuals that would benefit from funds received under this contract for newly added excluded individuals and entities 42 C.F.R. § 438.610(a), 42 C.F.R. § 438.610(b), SMD letter 2/20/98).
   e. And when delegation includes Medicare lines of business, monthly review of the Medicare Opt-Out Affidavits List Report within 30 calendar days of release from the source.
   f. Ongoing Monitoring Logs must be backed up with the documentation to show the list checked.

B. Credentialing committee review and decision-making to approve or deny Provider practitioners at both initial credentialing and recredentialing from a multi-disciplinary committee that includes representatives from appropriate specialty areas, including non-physician practitioners;
C. Ensuring that credentialing decision notifications are communicated to the provider in no more than 15 calendar days from the decision date;
D. Recredentialing of Physicians and other Practitioners at least once every 36 months in a manner similar to those described in Section II A above;
E. Handling credentialing/recredentialing decision appeals;
F. And oversight of any credentialing activities sub delegated to Credentials Verification Organizations (CVO) or other provider organizations. Provider agrees to not further sub delegate any Credentialing activities without written agreement from the Health Plan.

III. Policies and Procedures:

A. Provider's policies and procedures shall comply with all NCQA, CMS, state Medicaid requirements and Health Plan regulations as applicable, as well as any state regulations.

B. Provider shall make best efforts to notify Health Plan of any significant revisions to policies or procedures previously approved by Health Plan at least sixty (60) calendar days prior to implementation of the revision or amendment unless earlier implementation is required to effect compliance with any applicable statute or regulation or to protect the rights, health or safety of Health Plan Member. For examples of significant revisions to policies or procedures see section VI; Delegated Reporting Requirements.
C. Health Plan retains the right, at his sole discretion, to amend, add, change, or modify its delegation policies and procedures and any related documents upon reasonable notice to Provider.

IV. Excluded Healthcare Professional: Pursuant to section 1128 of the Social Security Act, Provider may not subcontract with an excluded healthcare professional/person. The Provider shall terminate subcontracts immediately when the Provider becomes aware of such excluded healthcare professional/person or when the Provider receives notice from Health Plan or HCA, whichever is earlier. Provider certifies that neither it nor its Provider contractor is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Provider is unable to certify to any of the statements in this certification, Provider shall attach a written explanation to this Agreement.

A. In the event an excluded individual is discovered during the Credentialing, Recredentialing, or Ongoing Monitoring process, Provider will:
   1. Report to Health Plan any excluded individual or entity within five (5) business days of discovery
   2. Report to Health Plan any actions taken by Provider to terminate the relationship with the excluded individual or entity
   3. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, within five (5) business days of discovery. If the individual owner is related to another owner, a managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or someone with controlling interest, report the individual only if they are a spouse, parent, child or sibling.
   4. Report for cause termination of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or someone with controlling interest, report the individual only if they are a spouse, parent, child or sibling within five (5) business days of discovery.

B. Provider shall maintain a list of any individual(s) with an ownership or controlling interest of 5% or more or who is a managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency, board of directors, agents with the authority to act on behalf of the provider, officers or directors of a provider entity that is organized as a corporation, or

someone with controlling interest related to another person with ownership or control interest as a spouse, parent , child, or sibling. List must be provided to Health Plan within five (5) business days of request.

V. Provider Obligations- Provider shall:

A. employ, subcontract or otherwise arrange for sufficient staff to provide each Delegated Function in a manner which does not impede Molina's administrative capacity to conduct its health care business;

B. provide verification of provider compliance with all Program Integrity requirements;

C. comply with policies and procedures that guide and require officers, employees, agents, and subcontractors to comply to Program Integrity requirements including but not limited to:
Section 1902(a)(68) of the Social Security Act;
42 C.F.R. § 438;
42 C.F.R. § 455;
42 C.F.R. § 1000 through 1008;
Chapter 182-502A WAC.

D. include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing process.

VI. Sub delegation: Health Plan retains the right to approve arrangements for any credentialing activities sub delegated by Provider or any of its delegates. Provider shall obtain Health Plan's approval prior to subdelegation in any tier of any credentialing activities initiated during the term of this Agreement, and shall report any change in approved subdelegation arrangements to Health Plan at least thirty (30) calendar days in advance of such change. Subdelegates shall be subject to all applicable federal and state regulations and requirements as stated in section I above.

A. Shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

1. Upon execution of contract with sub delegate collection of Ownership and or Controlling Interest Disclosure Form must be received 42 C.F.R. § 455.104(c)(1)(ii), upon request during the re-validation of enrollment process under 42 C.F.R. § 455.414 [42 C.F.R. § 455.104(c)(1)(iii)], and within thirty-five (35) business days

after any change in ownership of the subcontractor or provider 42 C.F.R. § 455.104(c)(1)(iv).

2. The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(1)(i).

3. If the subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and PO Box address. 42 C.F.R. § 455.104(b)(1)(i).

4. If the subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s). 42 C.F.R. § 455.104(b)(1)(iii).

5. If the subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. § 455.104(b)(1)(ii).

6. If the subcontractor or provider has a five percent (5%) ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s). 42 C.F.R. § 455.104(b)(1)(iii).

7. Whether any person with an ownership or control interest in the subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor/provider. 42 C.F.R. § 455.104(b)(2).

8. If the subcontractor or provider has a five percent (5%) ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(2).

9. Whether any person with an ownership or control interest in the subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider or in any managed care entity. 42 C.F.R. § 455.104(b)(4).

VII. Delegate Reporting Requirements: In addition to reporting requirements described in other sections of this Agreement, Provider shall provide Health Plan with the following information necessary for the oversight of delegated credentialing:

A. Immediate Notice: Within one business day of taking adverse action against a Provider Physician or other practitioner credentialed by Provider, including termination, suspension, or other disciplinary action, Provider shall provide written notice to Health Plan of such adverse action. Such notice shall include the specific reason(s) for the adverse action.

B. Provider shall use its best efforts to provide Health Plan with at least 90 calendar days prior written notice of new Provider Physicians or other practitioners joining Provider, and at least 120 calendar days prior written notice of Provider Physicians or other practitioners terminating participation with Provider. This requirement is in addition to Health Plan's monthly reporting requirements for credentialing delegates, which are summarized in C below.

C. Provider shall provide Health Plan monthly updates and quarterly full rosters using the

standardized roster template as required in the Health Plan policy, which is incorporated by reference, including, but not limited to:

1. Full provider roster on a quarterly basis; due to the Health Plan no later than the 15th of the month following the end of the quarter;
2. Monthly provider roster that includes at least all initial, recredentialed and terminated providers; due to the Health Plan no later than the 15th of each month;
3. Each of the above referenced rosters should be submitted to the Health Plan on the most recent version of the "Standardized Delegate Report Template". This template should not be altered from its original version and must include at a minimum the data points outlined in Exhibit A; attached.
4. And when applicable, a summary of any other activities carried out to improve performance.

D. Provider shall notify Health Plan of any significant changes to the Credentialing Program sixty (60) calendar days prior to change unless earlier implementation is required to effect compliance with any applicable statute or regulation or to protect the rights, health or safety of Health Plan Member. Significant changes include, but are not limited to, a change in provider types credentialed and/or not credentialed, a change in recredentialing cycle length, or a change in provider rights during the Credentialing or Recredentialing process.

E. Provider shall send all notices and reports for credentialing delegation to Health Plan's Delegation Team.

VIII. Health Plan Responsibilities:

A. Health Plan has delegated all credentialing and recredentialing responsibilities except facility credentialing and site visits based on a pre-delegation assessment of Provider's credentialing program, which found the credentialing program to be in substantial compliance with all application regulatory and accreditation requirements and required corrective action for all aspects that were not found to be fully compliant.

B. Health Plan's oversight responsibilities are described in sections V-VI and XIII of this attachment. In addition, Health Plan will:

1. review monthly any other required reports as described in section VI on an ongoing basis;
2. monitor federal and state exclusions, sanctions and license limitations for the entire Health Plan network, including practitioners for whom credentialing is delegated;
3. conduct required site visits and medical record keeping practice review according to Health Plan policy.

C. Health Plan will provide Provider with monthly reports of applicable member complaints received on Health Plan's Member Services toll-free line and applicable adverse event information for Provider members.

D. Review of applicable Member Complaints and Adverse Events, and implementing appropriate interventions, when applicable.

E. Review monthly report information and follow-up with Provider as necessary.

F. Requiring a corrective action plan (CAP) for any compliance issues identified and tracking it to completion.

IX. Right to Approve and Terminate: Health Plan retains the right to review and approve, deny, suspend or terminate practitioners for participation under the terms of this Agreement if Health Plan credentialing requirements are not met. Health Plan agrees to notify Provider in writing within one business day of taking an adverse action against any Provider physician or other practitioner and to evaluate its decision promptly if new information is provided by Provider.

X. Pre Delegation Assessment:

A. Prior to delegating functions to Provider, Health Plan shall conduct a comprehensive pre-delegation assessment of Provider's ability and administrative capabilities to perform each delegated function, including a review of Provider's policies and procedures, committee minutes, and files as applicable. Upon mutual agreement of date and time, Provider shall provide Health Plan representatives with access to any office or location where each such function will be performed, to personnel directly responsible for performing such function, and to all other relevant and necessary information pertaining to Provider's ability and capacity to perform such function. Except as provided in paragraph (C) below, performance by Provider of any delegated function shall commence only upon completion, to Health Plan's sole satisfaction, of the pre-delegation assessment for that function.

B. The appropriate Health Plan quality committee shall, in its discretion, issue a decision whether or not to accept the proposed delegation agreement. The decision will be based off of the results of the pre-delegation assessment. Health Plan will provide a written report to Provider of all pre-delegation assessment results, with a request for follow-up if appropriate, and the status of the decision to delegate each function.

C. In circumstances where a previous contract exists between Health Plan and Provider that included delegation of specific function(s), the pre-delegation requirements of Section IX (Pre-Delegation Assessment) of this Addendum shall be waived with respect to only that particular function(s). Such waiver shall not affect the application of such function to all other terms and conditions of this Addendum.

D. In the event Provider has NCQA accreditation/certification at the time of delegation, on-site review and assessment requirements may be modified. However, current policies and procedures and an NCQA accreditation/certification letter must be forwarded to Health Plan, along with other requested pre-delegation materials. Documentation of NCQA accreditation/certification does not preclude the standard submission of reports and activities as required by this Addendum.

XI. Annual Program Assessment: Subsequent to pre delegation assessment, and following reasonable advance notice, Health Plan shall conduct annual assessments of Provider's credentialing program. Health Plan shall base such assessment on NCQA, CMS, HCA, and OIC standards for credentialing and will include review of credentialing and recredentialing files. Provider shall provide access to all records necessary to assess Provider's credentialing program. CMS requirements for Medicare will only be reviewed for Providers with agreements that include Medicare lines of business. Provider will be placed on a CAP for any missing policy or documentation requirement or any file element that scores less than ninety percent (96%). Annual assessments/audits will be in person and onsite. For onsite reviews and assessments, Provider shall provide Health Plan representatives with reasonable access to; (1) any office or location where such function is performed, (2) personnel directly responsible for performing such function, and (3) all other relevant and necessary information pertaining to the Provider's performance under this addendum. In the event that the Provider has or earns NCQA accreditation/certification during the tenure of delegation, on-site review and assessment requirements may be modified. However, current policies and procedures and an NCQA accreditation/certification letter must be forwarded to Health Plan on an annual basis and as otherwise requested. Documentation of NCQA accreditation does not preclude the standard submission of reports and activities as required by this addendum. If providers NCQA accreditation status changes, provider will provide timely notification to Molina.

XII. Corrective Action: Health Plan shall request corrective action for any deficiencies identified through, but not limited to pre-assessments, annual assessment activities, report monitoring activities, member or participating Provider complaint monitoring activities and/or through regulatory oversight by federal or state authorities listed in section I and VI above. Provider shall respond in writing within thirty (30) calendar days of receipt of a request for a corrective action from Health Plan, and shall complete corrective action in a manner and timeframe acceptable to Health Plan. Health Plan and Provider agree to allow reasonable time periods to cure deficiencies. Should CMS, HCA, OIC, or Health Plan, determine that Provider is not performing satisfactorily after having been given a reasonable timeframe to cure deficiencies, Health Plan will rescind credentialing delegation upon thirty (30) calendar days advance written notice to Provider. Health Plan agrees not to rescind credentialing delegation without having first requested corrective action from Provider unless ordered to do so by CMS, HCA, or OIC.

XIII. Federal and State Reviewers: Upon request and with reasonable advance notice, Provider shall provide access to credentialing files and records for duly authorized representatives of the federal and state government.

XIV. NCQA Reviewers: Provider agrees to provide access to credentialing files and records for NCQA reviewers as necessary to facilitate Health Plan's NCQA accreditation process. Health Plan agrees to provide Provider with notice of a file request within one business day of receiving the request from NCQA. Provider will send all requested files to the Health Plan within one business day of request. Non-compliance with submitting files requested for Health Plan audits may result in immediate termination of applicable delegated function(s).

XV. Delegation Termination: In the event this Agreement or credentialing delegation ends, Provider and Health Plan will develop a mutually agreeable transfer of Provider's credentialing file information necessary for Health Plan to adopt Provider's credentialing cycle.

XVI. Confidentiality: Provider and Health Plan shall only use member and practitioner information shared under this Agreement for credentialing and credentialing delegation oversight purposes. Provider and Health Plan agree to hold all provider and member information shared under the terms of this Agreement confidential, except as required by law. Protected health information (PHI) shall mean information defined as such in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This also includes any sensitive provider information, such as social security number, date of birth or Tax ID.

A. Provider may use and disclose PHI as follows:
   1. To the member (or member's representative) who is the subject of the PHI;
   2. To carry out treatment, payment and healthcare operations necessary to fulfill Provider's obligations under this Agreement;
   3. Pursuant to and in compliance with a valid written authorization;
   4. To regulatory agencies, public health agencies, law enforcement, and judicial and administrative hearing officials, or as otherwise required by law.

B. Safeguards to prohibit the inappropriate use or disclosure of protected health information and sensitive information are described as follows.
   1. Provider shall not request, use or release more than the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure.
   2. Provider shall establish safeguards to prevent unauthorized use or disclosure of PHI and sensitive information.
   3. Provider shall immediately report to Health Plan any unauthorized uses or disclosures

of which it becomes aware, and shall take all reasonable steps to mitigate any harmful effects of such breach.

4. Provider shall ensure that all of its subcontractors and agents are bound by the same restrictions and obligations contained herein whenever PHI is made accessible to such subcontractors or agents.

C. Provider stipulates that:

1. Any subdelegates have safeguards to protect information from inappropriate use or disclosure;
2. Provider and any subdelegates will provide members with access to their protected health information as required by law;
3. Provider will inform Health Plan in writing if any inappropriate uses or disclosures of information occur;
4. Provider will continue to protect information shared under the terms of this Agreement after delegation ends as required by law.

XVII. Protection from Discovery: Assessment documents, corrective action, reports, and correspondence pertaining to credentialing delegation are protected from discovery under RCW 43.70.510 as part of Health Plan's confidential quality improvement program.

Exhibit A

2017 Standardized Roster Data Points

Column	Column Header	Required	Comments
A	Delegate Comments	Y	
B	Delegated Credentialing Date Original	Y	
C	Last Delegated Cred Committee Date	Y	
D	Next Delegated Credentialing Date	O	
E	Delegated Provider Term Date	Y	
F	Delegated Provider Term Reason	Y	
G	Provider Designation	Y	
H	Name Last	Y	
I	Name First	Y	
J	Name Middle	Y	
K	Provider Title	Y	
L	Provider Gender	Y	
M	Provider DOB	Y	
N	Provider Ethnicity	Y	
O	Provider Individual NPI	O	
P	Provider Medicare Number	Y	
Q	Provider Languages (non-English)	N	
R	Primary Specialty/Expertise	O	
S	Primary Specialty Taxonomy	Y	
T	Primary Specialty Board Status	Y	
U	Primary Specialty Board Name	Y	
V	Primary Specialty Board Issue Date	Y	
W	Primary Specialty Board Expiration Date	Y	
X	Secondary Specialty/Expertise	Y	
Y	Secondary Specialty Taxonomy	O	
Z	Secondary Specialty Board Status	Y	
AA	Secondary Specialty Board Name	Y	
AB	Secondary Specialty Board Issue Date	Y	
AC	Secondary Specialty Board Expiration Date	Y	
AD	Supervising Physician (if applicable)	Y	
AE	Supervising Physician Specialty (if applicable)	O	
AF	Supervising Physician Specialty	Y	
AG	Medical School Program Degree	O	
AH	License Number	O	
AI	License State	N	
AJ	License Issue Date	N	
AK	License Expiration Date	N	
AL	DEA Number	N	
AM	DEA State	N	
AN	DEA Expiration Date	N	
AO	Primary Practitioner Service Location	N	
AP	Group Name-Location of Service	N	
AQ	Group TIN	N	
AR	Address/Service Location Group NPI	N	
AS	Address/Service Location Line 1(No PO Box)	N	
AT	Address/Service Location Line 2	Y	
AU	Address/Service Location City	Y	

AV	Address/Service Location State	Y	
AW	Address/Service Location Zip Code	Y	
AX	Address/Service Location Phone	Y	
AY	Address/Service Location Fax	Y	
AZ	Address/Service Location Email	Y	
BA	Address/Service Location Effective Date	Y	
BB	Address Service Location Provider Type at Location (PCP, SPC, Dual, ANC)	Y	
BC	Address/Service Location List in Directory (Y/N)	Y	
BD	Address/Service Location Patient Panel (Y/N) (if applicable)	Y	
BE	Accepting New Patients	Y	
BF	Address/Service Location Patient Panel	Y	
BG	Address/Service Location Panel Status	Y	
BH	Address/Service Location Age Restrictions (None, 18 & Younger, 19 & Older)	Y	
BI	Address/Service Location Gender Restrictions (None, Female, Male)	Y	
BJ	Address/Service Location Advertise for Women's Health (Y/N)	N	
BK	Address/Service Location Delivers Babies? (Y/N)	Y	
BL	Address/Service Location Wheelchair/Handicap Accessible	Y	
BM	Address/Service Location General Hours	Y	
BN	Address/Service Location Spoken by Office Staff (non-English) (if applicable)	Y	
BO	Interpretation Services Available (Y/N)	Y	
BP	Telemedicine Services Available (Y/N)	Y	
BQ	Telemedicine Services Described	Y	
BR	Billing/Remit Address Group Name as listed on W9	Y	
BS	Billing/Remit Address DBA Name as listed on W9	Y	
BT	Billing/Remit Address Tax ID	N	
BU	Billing/Remit Address NPI	Y	
BV	Billing/Remit Address Line 1	Y	
BW	Billing/Remit Address Line 2	Y	
BX	Billing/Remit Address City	Y	
BY	Billing/Remit Address State	Y	
BZ	Billing/Remit Address Zip Code	Y	
CA	Billing/Remit Address Phone	Y	
CB	Billing/Remit Address Fax	Y	
CC	Billing/Remit Address Email	Y	
CD	Certified Substance Abuse Medication Prescriber	O	
CE	Specify whether they are solely a hospital based provider	Y	
CF	Medicaid ID/Provider One ID Number	Y	
CG	Hospital Affiliation Name (if applicable)	Y	
CH	Hospital/Status Category (if applicable)	Y	
CI	Website Address	Y	
CJ	Cultural Competency	Y	

KEY: Y= Yes Required for Molina Healthcare
N= No Not Required for Molina Healthcare
O= Optional to provide