**MOLINA HEALTHCARE OF WASHINGTON, INC.**

**COMBINED PROVIDER SERVICES AGREEMENT**

**SIGNATURE PAGE**

In consideration of the promises, covenants, and warranties stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its party. The Authorized Representative further acknowledges he/she received and reviewed this Agreement in its entirety.

The parties hereby acknowledge that Health Plan’s Provider Manual was made available to Provider for review prior to Provider’s decision to enter into this Agreement. Health Plan’s Provider Manual is available at the Health Plan’s website.

The Authorized Representative for each party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

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| **Effective** **Date** **of** **Agreement** (“Effective Date”): |

**Provider** **Signature** **and** **Information:**

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| --- | --- |
| Provider’s Legal Name (“Provider”) – as listed on applicable tax form (i.e. W-9): | |
| Name – Printed: | Authorized Signature: |
| Title: | Signature Date: |
| Telephone Number: | Fax Number – Official Correspondence: |
| Mailing Address – Official Correspondence:  [Provider Contract Notification Contact Address]  [City], [State] [Zip code]  Telephone Provider Contract Notification Contact Phone] | Payment Address – If different than Mailing Address: |
| Email Address – Official Correspondence:  [Provider Contract Notification Contact Email Address] | Tax ID Number – As listed on corresponding tax form: |
| NPI – That corresponds to the above Tax ID Number: | Specialty: |

**Health** **Plan** **Signature** **and** **Information:**

|  |  |
| --- | --- |
| Molina Healthcare of Washington, Inc., a Washington Corporation (“Health Plan”) | |
| Name – Printed: | Authorized Signature: |
| Title: | Countersignature Date: |
| Mailing Address – Official Correspondence:  [Molina Healthcare of Washington, Inc.  Attention: [President]  21540 30th Dr SE Ste 400  Bothell, WA 98021] | Email Address – Official Correspondence:  [Email: Molina Contract Notification Contact Email Address] |

**COMBINED PROVIDER SERVICES AGREEMENT**

This Combined Provider Services Agreement (“Agreement”) is entered by and between Molina Healthcare of Washington, Inc., a Washington corporation (“Health Plan”), and [Provider/Facility Name] (“Provider”). The purpose of this Agreement is to make available Covered Services to Members according to the terms and conditions set forth below.

**RECITALS**

1. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.
2. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.
3. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan’s Members in connection with Health Plan’s contractual obligations to provide and/or arrange for Covered Services for Health Plan’s Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

**ARTICLE ONE - DEFINITIONS**

1. Capitalized words or phrases in this Agreement shall have the meaning set forth below:
2. **Advance Directive** is a Member’s written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
3. Affiliate means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.
4. **Agreement** means this Combined Provider Services Agreement, all Attachments, and incorporated documents or materials.
5. **Capitated Provider** is a Provider who receives a monthly premium from Health Plan for each Member assigned to Provider. Capitated Provider may be responsible for payment of some or all covered health services (professional, institutional, pharmacy) incurred by Member.
6. CMS is the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.
7. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.
8. **Clean Claim** means a Claim for Covered Services that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the Claim.
9. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan Product or a Health Plan affiliate’s Product which covers the Member.
10. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Medicare or Medicaid Products, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
11. **Emergency Services** are Covered Services necessary to evaluate or stabilize the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. For Health Plan’s Medicaid Members, Emergency Services also includes any services defined as emergency services under 42 C.F.R. §438.114. Health Plan reserves the right to investigate certain emergency care Claims to determine if a Claim meets the definition of Emergency Services. If Health Plan denies a Claim on the basis that a reasonably prudent layperson would not have believed that an emergency health condition existed, the Member may exercise the right of appeal under the Grievance Program.
12. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.
13. **Government Contracts** means the contract between Health Plan and a governmental agency for a Product.
14. **Government Program Requirements** mean the requirements of governmental agencies for a Product, which includes, but are not limited to, the requirements set forth in the Government Contract.
15. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
16. **HCA** means The Washington State Health Care Authority.
17. **Health Benefit Exchange** means the Washington health benefit exchange established in RCW 43.71.020, et seq., the Health Benefit Exchange Act.
18. **Health Plan** means Molina Healthcare of Washington, Inc.
19. **HEDIS Studies** means Healthcare Effectiveness Data and Information Set.
20. **Hospital Provider(s)** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Provider to provide Covered Services to Members.
21. **Law** means, without limitation, federal, state/commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.
22. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.
23. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (a) appropriate and necessary for the symptoms, diagnosis or treatment of the Member’s medical condition; (b) provided for the diagnosis and direct care and treatment of such condition; (c) not furnished primarily for the convenience of the Member, the Member’s family, the treating provider, or other provider; (d) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (e) consistent with Health Plan policy.
24. **Medicare Advantage (“MA”)** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as “Medicare”). Medicare Advantage also includes Medicare Advantage Special Needs Plans (“MA-SNP”).
25. **Member(s)** means a person(s) enrolled in one of Health Plan’s benefit Products or a Health Plan affiliate’s benefit Product and who is eligible to receive Covered Services.
26. **Molina Fee Schedule** means the Health Plan’s fee schedule, inclusive of all reimbursement rates Health Plan is required to reimburse Provider within this Agreement. The Molina Fee Schedule is available upon request.
27. **Molina Marketplace** means the health benefit program offered and sold by Health Plan to individuals or employers who obtain health coverage through the Washington Health Benefit Exchange.
28. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan’s designee.
29. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified in the compensation exhibit(s), and which will include any successors to such Products.
30. **Prior Authorization** means the requirement that a provider must request, on behalf of a Member and when required by rule or state and government billing instructions, the state or governments designee’s approval to provide a health care service before the Member receives the health care service, prescribed drug, device, or drug-related supply.
31. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Hospital. All of said persons are bound by the terms of this Agreement.
32. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.
33. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.
34. **Subcontract** means any separate agreement or contract between the Contractor and an individual or entity (“Subcontractor”) to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.
35. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement, including delegation activities. For the avoidance of doubt, a Subcontractor does not include individual providers
36. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

**ARTICLE TWO - PROVIDER OBLIGATIONS**

1. **Serving as a Panel Provider.** Provider shall provide hospital inpatient and/or outpatient services to Members for the products specified in Exhibit 1 and its applicable sub-exhibits. Provider agrees that its facility information may be used in Health Plan’s provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this facility information.
2. **Standards for Provision of Care**
3. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider’s license, in accordance with this Agreement, Health Plan’s policies and procedures, the terms and conditions of the Health Plan Product which covers the Member, and the requirements of any applicable government sponsored program.
4. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.
5. **Facilities, Equipment, and Personnel.** Provider’s facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider’s duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.
6. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member, as an inpatient or outpatient, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan’s Provider Manual unless the situation is one involving the delivery of Emergency Services. Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care. For Emergeny Services that result in an admission, Provider shall notify Health Plan or its agent within 24 hours of stabilization and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan’s notification procedures described in the Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan of any admission within a maximum of 24 hours of admission. The approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization (WAC 182-500-0085).
7. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan (“participating providers”).
8. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by Health Plan’s drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider shall obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.
9. **Availability of Services.** Provider shall make Covered Services available 24 hours a day, 7 days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services Provider will make necessary and appropriate arrangements to ensure the availability of non-emergent Covered Services during Provider’s normal business hours, unless otherwise required by Laws or Government Program Requirements.
10. **Subcontract Arrangements.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing, consistent with the provision of 42 CFR 434.6, and shall bind Provider’s subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.
11. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations to Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.
12. **Standards for Hospital Providers**
13. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan’s Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.
14. **Contract with Hospital Providers.** Provider’s contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.
15. **Hospital Provider Information.** Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.
16. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(cs) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.
17. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan’s contracted providers, Health Plan’s medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider’s medical staff and the bylaws, rules and regulations of Provider.
18. **Notification.** Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider’s notification to Health Plan shall state Provider’s actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.
19. **Nondiscrimination.**
20. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.
21. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, national origin, ancestry, age, sex, height, weight, marital status, physical, sensory or mental disability unrelated to the individual’s ability to perform the duties of the particular job or position.
22. **Recordkeeping**
23. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member’s medical record upon the Member’s first encounter with Provider. The Member’s medical record shall contain all information required by Laws, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for at least ten (10) years.
24. **Confidentiality of Member Health Information.** Provider shall comply with all Laws, Health Plan’s policies and procedures, and government sponsored program requirements regarding privacy and confidentiality of Members’ health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider’s obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.
25. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.
26. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan, upon request and/or as may be required by Laws, Health Plan’s policies and procedures, applicable government sponsored health programs, Health Plan’s contracts with the government agencies, or third party payers, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS Studies, Health Plan’s Quality Improvement Program, Consumer Assessment of Health Plans (CAHPS), or Claims payment. Health Plan will not pay copying fees when records are requested for any of the above listed programs. Provider shall further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan.
27. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members’ health information including, but not limited to, medical records and billing records, in accordance with Laws, applicable government sponsored health programs, and Health Plan’s policies and procedures.
28. **National Provider Identifier (“NPI”).** In accordance with applicable statutes and regulations of HIPAA, Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI from the National Plan and Provider Enumeration System (“NPPES”) for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and encounters (both electronic and paper formats) submitted to Health Plan.
29. **Program Participation**
30. **Participation in Grievance Program.** Provider shall participate in Health Plan’s Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.
31. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan’s Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.
32. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan’s Utilization Review and Management Program or the utilization review and management program of Health Plan’s designee, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan or Health Plan’s designee in audits to identify, confirm, and/or assess utilization levels of Covered Services.
33. **Participation in Credentialing.** Provider shall participate in Health Plan’s credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider’s credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.
34. **Provider Manual.** Provider will follow the terms set forth in Health Plan’s Provider Manual, which may be amended from time to time at Health Plan’s sole discretion. Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan’s Provider Manual and any additional operating procedures and policies for Providers which are communicated to Provider in writing by Health Plan. Provider acknowledges it received Health Plan’s Provider Manual.
35. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs. Provider shall comply with any term or condition of those government sponsored program contracts that are applicable to the services to be performed under this Agreement.
36. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan’s Provider education and training efforts as well as Member education efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.
37. **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information (“Supplemental Materials”). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan’s interactive web-portal, with a physical copy available upon request. Supplemental Materials become binding upon Provider as of the Effective Date indicated on the Supplemental Materials or, if applicable, the Effective Date will be determined in accordance with this Agreement.
38. **Health Plan’s Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan’s electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange (“EDI”), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan’s interactive web-portal.
39. **Promotional and Marketing Activities.** At the request of Health Plan, Provider shall (1) display Health Plan promotional materials in its offices and facilities as practical, and (2) shall cooperate with and participate in all reasonable Health Plan’s marketing efforts. Provider shall not use Health Plan’s name in any advertising or promotional materials without the prior written permission of Health Plan.

As applicable, Provider shall not directly or indirectly conduct door-to-door telephonic, or other cold-call marketing of enrollment (42 CFR 438.104(b)(1)(v)).

1. **Licensure and Standing**
2. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider’s licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.
3. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its owners, employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors (collectively, “Personnel”) have been excluded from participation in the Medicare Program, any state, commonwealth or the District of Columbia’s Medicaid Program, or any other federal health care program (collectively “Federal Health Care Program”). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities, the System for Award Management, any other list maintained by a state, commonwealth, or federal government and every state, commonwealth, and the District of Columbia’s Medicaid exclusion lists to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be checked for any new Personnel and thereafter not less than monthly. Provider will notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded, or could be suspended or excluded, from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider’s non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan may collect the amount by: (i) offsetting from amounts due to Provider; or (ii) issuing a recoupment letter to Provider. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.
4. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider’s financial soundness.
5. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider’s facility and the nature of Provider’s health care activities. If the coverage is claims made or reporting, Provider agrees to purchase similar “tail” coverage upon termination of the Provider’s present or subsequent policy. Provider shall deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan.
6. **Claims Payment**
7. **Submitting Claims.** Provider shall promptly submit to Health Plan Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the Claim if requested by Health Plan or otherwise required by Health Plan’s policies and procedures. Claims must be submitted by Provider to Health Plan within [one hundred eighty to three hundred sixty-five (180-365)] days of providing the Covered Services that are the subject of the Claim. If Health Plan is not the primary payer under coordination of benefits, Provider must submit Claims to Health Plan within [one hundred eighty to three hundred sixty-five (180-365)] days from the primary payer’s date of payment or date of contest, denial or notice. Except as otherwise provided by law or provided by government sponsored program requirements, any Claims that are not submitted by Provider to Health Plan within the timelines stated above shall not be eligible for payment, and Provider hereby waives any right to payment therefore.
8. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Exhibit 1 and its applicable sub-exhibits. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.
9. **Co-payments, Deductibles and Co-insurance.** Provider is responsible for collection of co-payments, deductibles and co-insurance, if any, provided for in the Member’s Health Plan Product.
10. **Member Hold Harmless.**
11. Provider hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan’s insolvency, or breach of this contract will Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or person acting on their behalf, other than Health Plan, for services provided pursuant to this Agreement. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for noncovered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member’s health plan.
12. Provider agrees in the event of Health Plan’s insolvency to continue to provide the services promised in this Agreement to Members of Health Plan for the duration of the period for which premiums on behalf of the Member were paid to Health Plan or until the Member’s discharge from inpatient facilities, whichever time is greater.
13. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member’s Health Plan.
14. Provider may not bill the Member for Covered Services except for deductibles, copayments, or coinsurance where Health Plan denies payments because Provider has failed to comply with the terms of this Agreement.
15. Provider further agrees i) that the provisions of paragraphs i, ii, iii, iv of this section shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Health Plan’s Members; and ii) that this provision supersedes any oral or written contrary agreement not existing or hereafter entered into between Provider and Member or persons acting on their behalf.
16. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of Health Plan with expectation of receiving payment directly or indirectly from Health Plan, such providers or facilities must agree to abide by paragraphs i, ii, iii, iv, v, of this section.
17. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Exhibit 1 and its applicable sub-exhibits.
18. **Payments which are the Responsibility of a Capitated Provider.** Provider agrees that if Provider is or becomes a party to a subcontract or other agreement with a provider contracted with Health Plan, who receives capitation from Health Plan and is responsible for paying for Covered Services through subcontractual arrangements (“Capitated Provider”), that Provider shall look solely to the Capitated Provider, and not Health Plan, for payment of Covered Services provided to Members that are covered by Health Plan’s agreements with such Capitated Providers.
19. **Claims Review**
20. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider’s intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider’s operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such Claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member’s emergency medical condition.
21. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless the medical information available to the Provider at the time the services were rendered do not support the specific services and/or level of care authorized by Health Plan or the prior authorization was based upon a material misrepresentation by the Provider. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.
22. **Reporting Requirements.** Provider’s failure to comply with Health Plan’s requirements regarding Provider’s identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.
23. **Offset.** In the event that Health Plan determines that a Claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Health Plan may make a written request for repayment: (1) within twenty-four (24) months after the date that the payment was made; (2) within thirty (30) months after the date that the payment was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the Claim; or (3) at any time if a third party is found responsible for satisfaction of the Claim as a consequence of liability imposed by law and Health Plan is unable to recover directly from the third party because the third party has either already paid or will pay Provider the health care services covered by the Claim. Provider may contest Health Plan’s request in writing by participating in the Claims dispute process as outlined in Section 2.10e. Overpayment and duplicate payment disputes must be submitted in writing within thirty (30) days of receipt of request. If it is decided that Health Plan will recover the contested payment, such refund may be recovered by way of offset or recoupment from current or future amounts due Provider after six (6) months have passed from the date Health Plan received Provider’s written notice contesting the repayment. In addition to any other contractual or legal remedy, if Provider fails to contest Health’s Plan’s request for a refund in writing within thirty (30) days of receipt of the request or if Provider contested the request and six (6) months has passed from the date Provider received Health Plan’s refund request, Health Plan may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. As a material condition to Health Plan’s obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider. Nothing in this section prohibits Provider from choosing at any time to refund to Health Plan any payment previously made by Health Plan to satisfy a Claim either by way of repayment by Provider or a request that Health Plan offset or recoup the money from current or future amounts due Provider.
24. **Claims Dispute Process.** In the event that Provider determines that a Claim has been improperly denied or underpaid, Provider may make a written request for payment: (1) within twenty-four (24) months after the date the Claim was denied or payment intended to satisfy the Claim was made or (2) within thirty (30) months after the date the Claim was denied or payment intended to satisfy the Claim was made if the request is related to coordination of benefits with another carrier or entity responsible for payment of the Claim. Provider may not request that payment be made any sooner than six (6) months after Health Plan’s receipt of the request. Any request for review of denied or underpaid Claims must be submitted to Health Plan in accordance with the requirements stated in this section and conform to the following instructions:
25. The request must specify why the Provider believes Health Plan owes the payment;
26. In the case of coordination of benefits, the request must include the name and mailing address of any entity that has disclaimed responsibility for payment;
27. The request must be addressed to the attention of Health Plan’s Provider Services Department;
28. The request must clearly indicate “Denied Claims Review Request” or “Adjustment Request”; and
29. The request must include all pertinent information, including, but not limited to, Claim number, Member identifier, denial letter, supporting medical records, and any new information pertinent to the request.
30. Health Plan will render a decision on all disputed Claims within sixty (60) days of receipt of the Claim.
31. Should Provider not be satisfied with Health Plan’s decision, Provider may proceed to the mediation steps outlined in the Provider Manual.
32. **Claims Review and Audit.** Provider acknowledges Health Plan’s right to review Provider’s Claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices. Provider acknowledges Health Plan’s right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan’s right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan’s right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Notwithstanding any other provision, Health Plan may perform retrospective utilization review of seven (7)-day readmissions for Members who are readmitted as an inpatient to the same hospital or a different hospital for the same condition within seven (7) calendar days. Provider shall cooperate with Health Plan’s audits of Claims and payments by providing access to requested Claims information, all supporting medical records, Provider’s charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan’s policies and data to determine the appropriateness of the billing, coding and payment.
33. **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.
34. **Compliance with Applicable Law.** Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, Title XIX and Title XXI of the SSA and Title 42 CFR, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; the Americans with Disabilities Act, and Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2, 42 U.S.C. § 1396a(a)(43), 1396d(r), and 42 CFR 438.6(i):
35. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment 1.
36. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid program are subject to the additional provisions set forth in Attachment 2, the effect of which provisions is limited solely to activities and Covered Services related to the state Medicaid program.
37. For Covered Services rendered to Members enrolled in a Molina Marketplace Product, Medicaid statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements of the Washington Health Benefit Exchange Act, including the 2012 regular session laws, chapter 87 Affordable Care Act Implementation and regulations adopted pursuant to RCW 43.71.
38. **Provider Non-solicitation Obligations.** Provider shall not unilaterally assign or transfer patients served under this Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider’s ability to fully inform Members of all available health care treatment options or modalities.
39. **Fraud and Abuse Reporting.** Provider shall report to Health Plan’s compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) business days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program or by state or federal agencies. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.
40. **Advance Directive.** Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.
41. **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services to Affiliate’s enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate’s enrollees.

**ARTICLE THREE - HEALTH PLAN’S OBLIGATIONS**

1. **Compensation.** Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Exhibit 1 and its applicable sub-exhibits.
2. **Member Eligibility Determination.** Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.
3. **Prior Authorization Review.** Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.
4. **Medical Necessity Determination.** Health Plan’s determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member’s health program shall govern. The primary concern with respect to all medical determination shall be in the interest of the Member.
5. **Provider Directory.** Health Plan will provide Members with access to Health Plan’s Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.
6. **Provider Services.** Health Plan will maintain a Provider Manual describing Health Plan’s policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan’s policies and procedures.
7. **Medical Director.** Health Plan will employ a physician as medical director who shall be responsible for the management of the scientific, technical, and medical aspects of Health Plan.

**ARTICLE FOUR - TERM AND TERMINATION**

1. **Term.** This Agreement shall commence on the Effective Date indicated on page one of this Agreement and will continue in effect for one (1) year and will renew for successive one (1) year terms unless terminated by either Party in accordance with this Agreement or in accordance with applicable state licensing statutes and regulations set forth in Attachment 1 and Attachment 2.
2. **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred twenty (120) days written notice to the other party.
3. **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach will give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.
4. **Immediate Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:
5. Provider’s license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;
6. Provider fails to maintain insurance required by this Agreement;
7. Provider loses credentialed status;
8. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;
9. If Provider is capitated and Health Plan determines Provider to be financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;
10. Health Plan determines that Provider’s facility and/or equipment is insufficient to render Covered Services to Members;
11. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;
12. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider’s obligations under this Agreement;
13. Health Plan determines that health care services are not being properly provided, or arranged for, and that such failure poses a threat to Members’ health and safety.
14. **Termination Notification to Members.** Upon receipt of termination by either Health Plan or Provider, Health Plan will inform affected Members of such termination notice in accordance with the process set forth in the Provider Manual. Health Plan will make a good faith effort to ensure that such notice is provided at least thirty (30) days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty (30) days’ notice to all Members. Members may then be required to select another provider contracted with Health Plan prior to the effective date of termination of this Agreement.

**ARTICLE FIVE -- GENERAL PROVISIONS**

1. **Indemnification.** Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys’ fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.
2. **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan’s Members. Nor shall any third party have any right to enforce the terms of this Agreement.
3. **Entire Agreement.** This Agreement, together with Attachments, Exhibits, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan, the contract between HCA and the Health Plan shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.
4. **Severability.** If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.
5. **Notice.**
6. **Delivery.** All notices required or permitted by this Agreement will be in writing and will be delivered: (i) in person; (ii) by U.S. Postal Service (“USPS”) registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by e-mail. Any notice sent with signature delivery confirmation or return receipt requested, is deemed given on the date of delivery. If no delivery date is shown, notice is deemed given two (2) business days after the postmark date. Notice delivered by USPS express mail, Federal Express, or by overnight courier that guarantees next day delivery is deemed given two (2) business days after delivery of the notice to USPS or the overnight courier. For delivery by facsimile transmission, the notice is deemed delivered upon confirmation of receipt of the transmission. For delivery by e-mail, the notice is deemed given on the date sent. All notices are deemed given if delivered as specified in this section.
7. **Names & Addresses.** The name, mailing address, e-mail address, and facsimile number set forth under the Signature Page will be the particular party’s information for delivery of notice. Each party may change its information through written notice in compliance with this section without amending this Agreement.
8. **Amendments.**
9. **Regulatory Amendments.** Health Plan may, without Provider’s consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement.
10. **Non-Regulatory Amendments.** Nothwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon sixty (60) days prior written notice to Provider. If Provider does not deliver to Health Plan a written notice of rejection of the amendment within that sixty (60) day period, the amendment shall be deemed accepted by and shall be binding upon Provider. In the event that the amendment is considered a “material amendment” as defined in RCW 48.39.005. Provider shall have the right to reject the amendment and such rejection will not affect the existing terms of the Agreement.
11. **Assignment.** Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.
12. **Dispute Resolution Process**
13. **Submission of Non-Claims Payment Related Disputes**
14. Provider shall submit any dispute (other than a dispute relating to Claims Payment, which are subject to Section 2.10(e)) to Health Plan in writing within sixty (60) days of when the issue arises.
15. Provider shall submit said disputes to the attention of Health Plan’s Provider Services Department.
16. **Health Plan Response to Non-Claims Payment Related Disputes**
17. Health Plan shall use best efforts to acknowledge by phone, e-mail or other writing, receipt of a dispute (other than a dispute relating to Claims, which are subject to Section 2.10(e)) within seven (7) business days.
18. Health Plan’s decision regarding disputes shall be communicated within sixty (60) days of Health Plan’s receipt of Provider’s written correspondence requesting review. If additional time is required Health Plan shall communicate this information to Provider within sixty (60) days.
19. Health Plan shall use its best efforts to investigate and resolve disputes within sixty (60) days of Health Plan’s receipt of Provider’s written correspondence.
20. **Nonbinding Mediation.** If Provider is dissatisfied with Health Plan’s final resolution of a dispute or if Health Plan fails to grant or reject Provider’s request for review of a dispute within thirty (30) days after it is received, Provider may submit the dispute to nonbinding mediation pursuant to chapter 7.07 RCW. Nonbinding mediation shall not be utilized to adjudicate matters that primarily involve review of Provider’s professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters.
21. **Corrective Action, Fair Hearing Plan, and Reporting to the State of Washington Medical Quality Assurance Commission and the NPDB.** Provider has a procedural right to appeal in the event that Health Plan’s peer review committee recommends filing a report to the Washington Medical Quality Assurance Commission and the NPDB. The appeal right, Fair Hearing process, and the requirement to report to the Washington Medical Quality Assurance Commission and NPDB are described in Health Plan’s Fair Hearing Plan.
22. **Arbitration.** Health Plan and Provider agree, as a condition precedent to the commencement of any civil action in any court of competent jurisdiction, to submit to arbitration all disputes arising from or related to this Agreement and the rendition of services to Members pursuant to this Agreement which are not otherwise resolved pursuant to the processes set forth at Sections 2.10(e) and 5.8; provided, however, that arbitration shall not be utilized to adjudicate matters that primarily involve review of Provider’s professional competence or professional conduct, and shall not be available as a mechanism for appeal of any determinations made as to such matters. Arbitration shall proceed according to the rules and regulations of JAMS Optional Arbitration Appeal Procedure, then in effect, and shall be conducted in King County, Washington. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law. Nor shall the arbitrator have the authority to award punitive damages. The parties recognize that the arbitrator’s decision is not binding and that either party may seek judicial remedies following the arbitration of a dispute. The panel of arbitrators shall be selected as follows: one arbitrator shall be designated by Health Plan; one arbitrator shall be designated by Provider; and the third arbitrator shall be selected by the arbitrators designated by Provider and Health Plan. Health Plan and Provider shall divide and share equally the cost of arbitration. Each party shall be responsible for its own attorneys’ fees.
23. **Attachments.** Each of the Attachments and Exhibits (as selected) and identified below is hereby made a part of this Agreement:

☐Attachment 1 - Required Provisions (Health Care Service Plans)

☐Attachment 2 - Required Provisions (Health Care Authority)

☐Attachment 3 - Medicare Program Requirements-Health Care Services

☐Attachment 3-A –Medicare Program Requirements-Coronavirus Disease Requirements

☐Attachment 4– Molina Marketplace - Laws and Government Program Requirements

☐Attachment 5 – Indian Health Care Providers Medicaid/CHIP Provisions

☐Exhibit 1-A - Compensation Schedule Medicaid (Version 1)

☐Exhibit 1-A - Compensation Schedule Medicaid (Version 2)

☐Exhibit 1-B - Compensation Schedule Medicare (Version 1)

☐Exhibit 1-B - Compensation Schedule Medicare (Version 2)

☐Exhibit 1-B - Compensation Schedule Medicare (Version 3)

☐Exhibit 1-C - Compensation Schedule Molina Marketplace (Version 1)

☐Exhibit 1-C - Compensation Schedule Molina Marketplace (Version 2)

☐Exhibit 1-C - Compensation Schedule Molina Marketplace (Version 3)

☐Exhibit 1-C-1 - Charge Description Master Limit Protection - Molina Marketplace (Version 3)

1. **Conflict with Health Plan Product.**  Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member’s Health Plan Product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan Product, the benefits, terms or conditions contained in the Member’s Health Plan Product shall govern.
2. **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.
3. **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party’s employees, or any other similar cause beyond the reasonable control of such Party if it is determined that such Party: (i) used the efforts a reasonable person would during a force majeure event to perform its duties under this Agreement; and (ii) the Party’s inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.
4. **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.
5. **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.
6. **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider’s non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.
7. **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties’ desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word “day” means calendar day unless otherwise specified; (ii) the term “business day” means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

**ATTACHMENT 1**

**REQUIRED PROVISIONS**

**(HEALTH CARE SERVICE PLANS)**

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1. Provider hereby agrees that in no event, including, but not limited to nonpayment by Health Plan, Health Plan’s insolvency, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or person acting on their behalf, other than Health Plan, for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, co-payments, coinsurance, and/or noncovered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member’s health program.
2. Provider agrees, in the event of Health Plan’s insolvency, to continue to provide the services promised in this Agreement to Members of Health Plan for the duration of the period for which premiums on behalf of the Member were paid to Health Plan or until the Member's discharge from inpatient facilities, whichever time is greater.
3. Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in the Member's health program.
4. Provider may not bill the Member for Covered Services (except for deductibles, co-payments, or coinsurance) where Health Plan denies payments because Provider has failed to comply with the terms or conditions of this Agreement.
5. Provider further agrees (i) that the provisions of (1), (2), (3), and (4) of this Attachment shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.
6. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of Health Plan with the expectation of receiving payment directly or indirectly from Health Plan, such providers or facilities must agree to abide by the provisions of (1), (2), (3), (4), (5), (7), (11) and (12) of this Attachment.
7. Willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030 (5) & (6).
8. Health Plan will provide Provider not less than sixty (60) days’ notice of changes that affect Provider’s compensation and that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the contract, Provider may terminate the contract without penalty if the Provider does not agree with the changes. No change to this Agreement may be made retroactive without the express consent of Provider.
9. Health Plan does not preclude or discourage Provider from informing Members 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 patient's service agreement with Health Plan. Health Plan will not prohibit, discourage, or penalize Provider if otherwise practicing in compliance with the law from advocating on behalf of a Member with Health Plan. Members are free to contract at any time to obtain any health care services outside their Health Plan on any terms or conditions the Members choose. Nothing in this section shall be construed to authorize Provider to bind Health Plan to pay for any service.
10. Health Plan does not preclude or discourage Member or those paying for their coverage from discussing the comparative merits of different health carriers with Provider. This prohibition specifically includes prohibiting or limiting Providers participating in those discussions even if critical of a Health Plan.
11. Provider will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals or review of any adverse benefit determinations of Members subject to applicable state and federal laws related to the confidentiality of medical or health records. Provider is required to cooperate with audit reviews of encounter data in relation to the administration of Health Plan risk adjustment and reinsurance programs.
12. Provider shall furnish Covered Services to Members without regard to the Member's enrollment in Health Plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.
13. Provider may, in good faith, report to state or federal authorities any act or practice by Health Plan that jeopardizes Member health or welfare or that may violate state or federal law.
14. Terms and Conditions of Payment
15. For Covered Services provided to Members, Health Plan shall pay Provider, and Provider shall pay any of its subcontractors, as soon as practical but subject to the following minimum standards including any applicable federal regulations (i.e. 42 CFR 422.520(b)):
16. Ninety-five (95%) percent of the monthly volume of Clean Claims shall be paid within thirty (30) days of receipt by Health Plan or Health Plan’s agent;
17. Ninety-five percent (95%) of the monthly volume of all Claims shall be paid or denied within sixty (60) days of receipt by Health Plan or Health Plan’s agent;
18. Ninety-nine percent (99%) of the monthly volume of Clean Claims shall be paid within ninety (90) calendar days of receipt, except as agreed to in writing by the parties on a Claim-by-Claim basis.
19. A Claim is a bill for services, a line item of service or all services for one Member within a bill.
20. The date of receipt of a Claim is the date Health Plan or Health Plan’s agent receives either written or electronic notice of the Claim.
21. The date of payment is the date of the check or other form of payment.
22. Health Plan shall establish a reasonable method for confirming receipt of Claims and responding to Provider inquiries about Claims.
23. For those State products/programs covered by the Washington Administrative Code (WAC), failure of Health Plan to abide by the timely Claims payment standards delineated in WAC 284-170-431(2) shall result in a requirement to pay interest on undenied and unpaid Clean Claims more than sixty-one days old until Health Plan meets the standards under that subsection. Interest shall be assessed at the rate of one percent per month and shall be calculated monthly as simple interest prorated for any portion of a month. Health Plan shall add the interest payable to the amount of the unpaid claim without the necessity of Provider submitting an additional claim.
24. When Health Plan issues payment in Provider’s name and the Member’s name, Health Plan shall make Claim checks payable in the name of the Provider first and the Member second.
25. These standards do not apply to Claims about which there is substantial evidence of fraud or misrepresentation by Providers, facilities or Members, or instances where Health Plan has not been granted reasonable access to information under Provider’s control.
26. Health Plan and Provider are not required to comply with these terms and conditions of payment 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.
27. Notwithstanding any other provision of this Agreement, Provider is not required to grant Health Plan access to health information and other similar records unrelated to Members. This provision shall not limit Health Plan’s right to ask for and receive information relating to the ability of Provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.
28. Notwithstanding any other provision of this Agreement, any access Provider must grant Health Plan to medical records for audit purposes must be limited to only that necessary to perform the audit.
29. Provider maintains a reciprocal right to audit Health Plan’s denials of Provider’s Claims when Health Plan audits Provider’s Claims.
30. In the event Provider participates in Health Plan’s Medicare Programs, the following provisions shall apply:
31. Provider shall make all of its “Relevant Records” available for inspection, examination and copying by all federal and state agencies with regulatory authority over the subject matter of this Agreement. Provider shall permit such inspection at Provider’s place of business and at all reasonable times. “Relevant Records” shall mean all books and records of Provider related directly or indirectly to the goods and services furnished under the terms of this Agreement. Provider shall maintain such Relevant Records for the period of time required by applicable federal and state statutes, but in no event less than ten (10) years. This provision shall survive termination of the Agreement. (42 CFR 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).
32. Provider shall comply with the confidentiality and enrollee record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
33. Provider agrees that under no circumstance shall a subscriber or enrollee in Health Plan’s Medicare Programs be liable to the Provider for any sums owed by Health Plan to Provider. (42 CFR 422.504(g)(1)(i); and 42 CFR 422.504(i)(3)(i).).
34. If Provider is delegated any of the activities or functions of Health Plan as required in its contract with CMS, Provider agrees to comply with all applicable contractual provisions in the same manner as if Provider had executed such contract with CMS directly. The activities or functions delegated to Provider are set forth in the Agreement. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities shall be revoked upon not less than five (5) days prior written notice. The performance of such delegated activities shall be monitored by Health Plan on an ongoing basis, and Provider shall cooperate with all reasonable requests made by Health Plan in order to accomplish such monitoring. If Provider is delegated credentialing activities, Provider’s credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. (42 CFR 422.504(i)(3)(iii) and 422.504(i)(4)).
35. Provider agrees that any services it performs will be consistent with and comply with Health Plan’s contractual obligations with CMS. (42 CFR 422.504(i)(1) and 422.504(i)(3)(iii).
36. In the event of termination of this Agreement or Health Plan’s insolvency, Provider agrees to comply with the continuation of benefits provisions included in the Provider Manual. (42 CFR 422.504(g)(2).)
37. Upon termination of this Agreement without cause, Provider will continue to render Covered Services to Members until the earliest of the following: (1) the date Covered Services being rendered to Member by Provider are completed or medically appropriate provisions have been made by Health Plan for another provider to assume responsibility for providing such Covered Services; or (2) sixty (60) days following notice to the Member of Provider’s contract termination. The provision of such Covered Services and the reimbursement to Provider for such Covered Services shall be subject to all applicable terms of this Agreement on the same basis as Covered Services provided during the term of this Agreement
38. Provider will satisfy and be in compliance with all of the requirements in WAC 284-170-421(5).
39. Provider will ensure that all of its subcontractors will satisfy and be in compliance with all of the requirements in WAC 284-170-421(5).
40. Telemedicine Services.
41. Pursuant to RCW 48.43.735(8) and its implementing regulations, if Provider intends to bill a Member or Health Plan for an audio-only telemedicine service, Provider must obtain Member consent for the billing in advance of service being delivered.
42. Beginning January 1, 2023, Provider must have an established relationship with the Member to be eligible for reimbursement for audio-only telemedicine (RCW 48. 43.735).
43. Drug Utilization Review. Health Plan maintains documented drug utilization management criteria to align with RCW 48.43.420 and WAC 284-43-2020(2) and can be found on Health Plan’s website, https://www.molinamarketplace.com/marketplace/wa/en-us/Providers/Drug-List.

**ATTACHMENT 2**

**REQUIRED PROVISIONS**

**(Health Care Authority)**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicaid Products. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicaid Products. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid Products.

1. Provider shall provide reasonable access to facilities and financial and medical records, computers or other electronic systems where Medicaid-related activities or work is conducted at any time, for duly authorized representatives of the CMS, HCA, Department of Social & Health Services (“DSHS”) or the Department of Health & Human Services (“DHHS”) for audit purposes and immediate access for Medicaid fraud investigators. The Provider must comply with behavioral health supplemental data reporting requirements, including the requirements outlined in SERI and the Behavioral Health Data Guide (BHDG). The BHDG describes the content of the supplemental data for each transaction, requirements for frequency of reporting, required data fields, valid values for data fields, and timeliness reporting guidelines.
2. Provider shall completely and accurately report encounter data to Health Plan. Provider shall have the capacity to submit all required data to enable Health Plan to meet the requirements in the Encounter Data Transaction Guide published by HCA.
3. Provider shall comply with Health Plan’s fraud and abuse policies and procedures.
4. As applicable, Provider shall adhere to the WISe (Wraparound with Intensive Services) Manual and participate in all WISe-related quality activities.
5. Provider shall not assign this Agreement without HCA’s written agreement.
6. Provider shall comply with any term or condition of Health Plan’s contracts with HCA that is applicable to the services to be performed by Provider.
7. Provider shall accept payment from the Health Plan as payment in full and shall not request payment from HCA or any enrollee for Covered Services performed under this Agreement.
8. Provider agrees to hold harmless HCA and its employees, CMS and its employees, and all enrollees served under the terms of this Agreement in the event of non-payment by Health Plan. Provider further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of Provider, its agents, officers, employees or contractors.
9. Provider agrees to comply with the HCA appointment wait time standards. Provider agrees to Health Plan’s regular monitoring of timely access to Provider’s services, and agrees to corrective action up to and including termination for cause in the event that Provider fails to comply with the appointment wait time standards.
10. Provider shall assure that all sterilizations and hysterectomies performed under this Agreement are in compliance with 42 CFR 441 Subpart F, and that the Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.
11. Provider shall make reasonable accommodation for Members with disabilities, in accord with the Americans with Disabilities Act, for all Covered Services and shall assure physical and communication barriers shall not inhibit Members with disabilities from obtaining Covered Services.
12. Provider shall comply with all Program Integrity provisions, including, but not limited to the Washington Medicaid Contract and the following regulations: Sections 1902(a)(68) and 1128J(d) of the Social Security Act, 42 C.F.R. § 438.608 , 42 C.F.R. § 455, 42 C.F.R. § 1000 through 1008, and Chapter 182-502A WAC, and Chapters 74.09 and 74.66 RCW and as documented in Health Plan Provider Manual and as set forth by 42 CFR 438.608 and the Health Plan’s contracts with HCA.
13. Provider shall comply with Patient Identifying Information from an alcohol or drug abuse “program”, as defined in 42 C.F.R. §2.11, that is federally assisted in the manner described in 42 C.F.R. §2.12(b), then it is fully bound by the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, with respect to such information and records, including but not limited to the duty to resist in judicial proceedings any efforts to obtain access to such information or records, other than as permitted by law.
14. Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.
15. Behavioral Health Services. If Provider provides behavioral health services, Provider must:
16. Hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Agreement.
17. Notify the Health Plan in the event of a change in status of any required license or certification.
18. Use the Global Appraisal of Individual Needs-Short Screener (“GAIN-SS”) and assessment process that includes use of the quadrant placement.
19. Failure to implement and maintain the Integrated Co-Occurring Disorder Screening and Assessment process shall result in corrective action.
20. If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate referrals.
21. As applicable, Provider shall ensure that all written information provided to Members or potential Members is: accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth (6) grade reading level, provided in a font size no smaller than 12 point, and fulfills other requirements of the Contract as may be applicable to the materials. Molina must have the written approval of HCA prior to use, as required by the Washington Medicaid Contract (42 CFR 438.10(d)(6)).
22. As applicable, for Members who have primary health insurance, benefits available under the Washington Medicaid Contract shall be secondary to any other medical coverage, in accordance with applicable state and federal law. Provider shall not refuse or reduce services provided under the Washington Medicaid Contract solely due to the existence of similar benefits provided under any other health care contracts. Provider shall pay preventive pediatric care, and services covered under EPSDT, including Applied Behavior Analysis treatment services and medically intensive children’s program services, and then seek reimbursement from third parties (42 CFR 433.139(b)(3), 42 USC 1396(a)(25), RCW 41.05A.005).
23. As applicable, Provider shall not directly or indirectly conduct door-to-door telephonic, or other cold-call marketing of enrollment (42 CFR 438.104(b)(1)(v)).
24. Health Plan shall provide to Provider required information on the grievance and appeal system (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)). This information shall include the toll-free numbers to file oral Grievances and Appeals, the availability of assistance in filing a Grievance or Appeal, including informing the Enrollee about Ombuds services and how to access these services, the Member’s right to request continuation of Medicaid benefits during an appeal or hearing and, if the Health Plan’s Adverse Benefit Determination is upheld, that the Member may be responsible to pay for the cost of the benefits received for the first sixty (60) calendar days after the appeal or hearing request was received, the Member’s right to file Grievances and Appeals and their requirements and timeframes for filing, the Member’s right to a hearing, how to obtain a hearing, and representation rules at a hearing, the Provider may file a Grievance or request an adjudicative proceeding on behalf of an Member.
25. Provider shall have and maintain insurance appropriate to the services to be performed and shall make copies of Provider’s Certificates of Insurance available to Health Plan if requested.
26. If Provider is at financial risk, as defined in the Washington Medicaid Contract, Health Plan will establish, enforce and monitor solvency requirements, and Provider shall comply with such requirements.
27. As applicable, Members have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington. The services to which Members may self-refer are: 1 - family planning services and supplies, and sexually transmitted disease screening and treatment services provided at participating or non-participating providers, including but not limited to family planning agencies, such as Planned Parenthood, 2 – immunizations, sexually-transmitted disease screening and follow up, HIV screening, tuberculosis screening and follow up, and family planning services through and if provided by a local health department, 3 – immunizations, sexually transmitted disease screening, family planning and behavioral health services through and if provided by a school-based health center, 4 - all services received by American Indian or Alaska Native Members at an IHCP, and 5 – crisis response services, including crisis intervention, crisis respite, investigation and detention services; and evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.
28. Provider shall disclose the following to Health Plan upon contract execution, upon request during the re-validation of enrollment process, and within thirty-five (35) business days after any change in ownership of Provider: the name and address of any person (individual or corporation) with an ownership or control interest in Provider; if Provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address; if Provider has corporate ownership, the tax identification number of the corporate owner(s); if Provider is an individual, date of birth and Social Security Number; if Provider has a 5 percent ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s); whether any person with an ownership or control interest in 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 Provider; if Provider has a 5 percent 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 Provider; and whether any person with an ownership or control interest in Provider also has an ownership or control interest in any Managed Care entity.
29. As applicable, Provider shall ensure interpreter services are provided free of charge for Enrollees and Potential Enrollees with a primary language other than English or those who are Deaf, DeafBlind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract (42 C.F.R. 438.10(d)(4)). Interpreter services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and Health Plan, or Provider, or any of its providers, including but not limited to customer service, all interactions with any provider for any covered service, Emergency Services and all steps necessary to file Grievances and Appeals including requests for Independent Review of Health Plan decisions.
30. This Agreement does not terminate Health Plan’s legal responsibility to HCA for any work performed under the Washington Medicaid Contract nor for oversight of any functions and/or responsibilities Health Plan delegates to Provider.
31. The Health Plan and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation If the requesting agency asks for copies of records, documents, or other data, the Health Plan and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).
32. As applicable, Health Plan and its subcontractors are required to comply with chapter 71.32 RCW (Mental Health Advance Directives).
33. Provider shall agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, Medical Equipment, or other health care related products or services.
34. Provider agrees to Release to Health Plan any information that is necessary for Health Plan to perform any of its obligations under the HCA Contract.
35. As applicable, Health Plan may not prohibit a Provider acting within their lawful scope of practice from advising or advocating on behalf of a Member who is their patient for any information the Member needs to decide among all relevant treatment options.
36. Provider shall investigate and disclose to Health Plan at contract execution or renewal, and upon request by Health Plan, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is a person who has an ownership or control interest in Provider, an agent or person who has been delegated the authority to obligate or act on behalf of Provider, or an agent, 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 Provider pursuant to 42 C.F.R. § 455.106(a) and § 455.101.
37. If Provider is also a home health agency, Provider shall be in compliance with the surety bond requirements of Section 4708(d) of the Balanced Budget Act of 1997 and 42 C.F.R. § 441.16.

**ATTACHMENT 3**

**MEDICARE PROGRAM REQUIREMENTS--HEALTH CARE SERVICES**

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Medicare Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicare Product.

1. **Definitions.**
2. **Completion of Audit** means a completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Organization, Medicare Organization contractor or Related Entity.
3. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare benefit, below the level of the arrangement between a Medicare Organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider for health and administrative services.
4. **Final Contract Period** means the final term of the contract between CMS and the Medicare Organization.
5. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with a Medicare e Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare program.
6. **Medicare Organization** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare contract requirements.
7. **Related Entity** means any entity that is related to the Medicare Organization by common ownership or control and; (i) performs some of the Medicare Organization's management functions under contract or delegation; (ii) furnishes services to Medicare enrollees under an oral or written agreement; or (iii) leases real property or sells materials to the Medicare Organization at a cost of more than $2,500 during a contract period.
8. **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and Related Entity, through ten (10) years from the final date of the Final Contract Period of the contract entered into between CMS and the Medicare Organization or from the date of completion of any audit, whichever is later.
9. **Right to Audit Directly from FDR.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under section 1.2, of this attachment, directly from any First Tier Entity, Downstream Entity, and Related Entity. For records subject to review under section 1.2, except in exceptional circumstances, CMS will provide notification to the Medicare Organization that a direct request for information has been initiated.
10. **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements, including: (i) abiding by all laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) ensuring that medical information is released only in accordance with applicable law, or pursuant to court orders or subpoenas; (iii) maintaining the records and information in an accurate and timely manner; and (iv) ensuring timely access by Members to the records and information that pertain to them.
11. **Hold Harmless.** Members will not be held liable for payment of any fees that are the legal obligation of the Medicare Organization.
12. **Cost Sharing.** For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (i) accept the Health Plan payment as payment in full; or (ii) bill the appropriate State source.
13. **Delegation.** Any services or other activity performed in accordance with a contract or written agreement by Provider or a Downstream Entity of Provider are consistent and comply with the Medicare Organization's contractual obligations.
14. **Prompt Payment.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days.
15. **Compliance with Medicare Laws.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.
16. **Benefit Continuation.** Provider agrees to provide for continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan’s contract with CMS terminates, or, in the event of insolvency, through discharge
17. **Accountability.** Health Plan may only delegate activities or functions to a First Tier Entity or Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan’s contractual obligations.
18. **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310.