WASHINGTON STATE PROGRAMS

REGULATORY REQUIREMENTS

APPENDIX

DOWNSTREAM PROVIDER

THIS WASHINGTON STATE PROGRAMS REGULATORY REQUIREMENTS APPENDIX

(this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between **UnitedHealthcare of Washington, Inc.** (referred to in this Appendix as "Carrier") or _____ (Subcontractor) and the party named in the Agreement ("Provider").

SECTION 1 APPLICABILITY

The requirements of this Appendix apply to "State Program" (as defined below) benefit plans sponsored, issued or administered by Carrier, including the State's Apple Health and related programs, and Washington Benefit Plans for the Uninsured, as governed by the State's designated regulatory agencies. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Carrier is required to amend or supplement this Appendix as required or requested by the State to comply with federal or State regulatory requirements, Provider agrees that Carrier shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2 DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

2.1 Administrative Function(s): Any obligation of Carrier under a State Contract other than the direct provision of Covered Services to Covered Persons. Administrative Functions include, but are not limited to, utilization/medical management, claims processing, Covered Person grievances and appeals, and the provision of data or information necessary to fulfill any of Carrier's obligations under a State Contract.

2.2 Claim: A bill for services, a line item of service or all services for one Covered Person within a bill.

2.3 Clean Claim: A Claim that can be processed without obtaining additional information from the provider of the service or from a third party.

2.4 Covered Person: An individual who is currently enrolled with Carrier for the provision of services under a State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.5 Contracted Services: Covered Services that are to be provided under the terms of the State

Contract.

2.6 Covered Services: Health care services that HCA determines are covered for Covered Persons.

2.7 HCA: Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

2.8 Primary Care Provider or PCP: A participating provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42
C.F.R. § 438.2. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

2.9 Provider: Any individual or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services.

2.10 State: The State of Washington or its designated regulatory agencies.

2.11 State Contract: Carrier's contract with the HCA for the purpose of providing and paying for Covered Services to Covered Persons enrolled in one or more State Programs.

2.12 State Program(s): The State of Washington Apple Health, Apple Health for Kids, Integrated Managed Care or other similar program(s) where Carrier provides services to Washington residents through a contract with the State. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

SECTION 3 PROVIDER REQUIREMENTS

The State Programs, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Carrier and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ii) serious impairment to bodily functions; or iii) serious dysfunction of any bodily organ or part.

ii) Emergency Services: Inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an Emergency Medical Condition.

iii) Medically Necessary or Medical Necessity: Services that are "Medically Necessary" as defined in WAC 182-500-0070. In addition, Medically Necessary services shall include services related to a Covered Person's ability to achieve age-appropriate growth and development.

3.2 Medicaid Eligibility. Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Carrier's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Carrier must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Carrier will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state.

3.3 Primary Care Provider (PCP) Requirements. Providers who are PCPs shall comply with the PCP requirements of the State Contract, as set forth in the applicable provider manuals, protocols, policies and procedures that Carrier has provided or delivered to Provider.

3.4 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability and wait time standard requirements established under the State Contract, as further described in the applicable provider manual. Provider also agrees to report accurately the information required for the Carrier's provider directory and any changes thereto. Carrier shall regularly monitor Provider's compliance with timely access and wait time standards and Provider shall implement appropriate corrective action in the event Provider fails to comply with the appointment wait time requirements under the State Contract.

3.5 Hours of Operation. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

3.6 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall accept payment from Carrier as payment in full and shall not request payment from the HCA or any Covered Person for Covered Services provided pursuant to the Agreement and the State Contract. Provider shall hold the State, HCA and its employees, the U.S. Department of Health and Human Services (DHHS) and Covered Persons harmless in the event that Carrier cannot or will not pay for such Covered Services. In accordance with 42 CFR Section 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Carrier is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the HCA nor Covered Persons shall be in any manner liable for the debts and obligations of Carrier and under no circumstances shall Carrier, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Pursuant to Washington Administrative Code (WAC) 182-502-0160, if the medical assistance services are not Covered Services, prior to providing the services, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgment in writing prior to rendering the service and report to Carrier any instances where a Covered Person is charged for the types of services identified under WAC 182-502-0160. Carrier will determine whether a Covered Person was charged for Covered Services inappropriately and may recover such payment as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.7 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the HCA and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The HCA may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.8 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Carrier delegates credentialing to Provider, Carrier will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Carrier's and the State Contract's credentialing requirements.

3.9 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.10 Subcontracts. Provider shall perform those services and reports to be provided as set forth in the Agreement, and may subcontract services only if permitted by Carrier in writing. If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, applicable requirements of the State Contract and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Carrier, to meet any additional State Program requirements that may apply to the services.

3.11 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered pursuant to the State Contract. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical

management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records, including but not limited to grievance and appeal records and any other records related to data, information, and documentations for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposition of records must be requested and approved by Carrier if the Agreement is continuous.

3.12 Records Access. Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

3.13 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs. Moreover, Provider agrees to permit the State, including HCA, MFCD and state auditor, and federal agencies, including but not limited to: CMS, Government Accountability Office, Office of the Inspector General, Office of Management and Budget, the Office of the Inspector General, the Comptroller General, and their designees, to access, inspect and audit any records or documents of Provider, and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time. Provider 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, Provider shall make copies of records and shall deliver them to the requestor, within 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 Provision exists for 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.

3.14 Privacy; Confidentiality. Provider understands that the use and disclosure of information concerning Covered Persons is restricted to purposes directly connected with the administration of the State Program and shall maintain the confidentiality of Covered Person's information and records as required by the State Contract and in federal and State law including, but not limited to, all applicable privacy, security and Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Public Law 104-191, and associated implementing regulations, including but not limited to 45 CFR Parts 160, 162, 164, as applicable and as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including but not limited to 42 CFR §438.224, 42 CFR Part 2, and 42 CFR Part 431, Subpart F; 42 CFR Part 434 and 42 CFR 438.6 (if applicable), as may be amended from time to time.

Access to member identifying information shall be limited by Provider to persons or agencies that require the information in order to perform their duties in accordance with this Agreement, including the U.S. Department of Health and Human Services (HHS), the HCA and other individuals or entities as may be required. (See 42 CFR §431.300, et seq. and 45 CFR Parts 160 and 164.) Any other party shall be granted access to confidential information only after complying with the requirements of state and federal laws, including but not limited to HIPAA, and regulations pertaining to such access. Provider is responsible for knowing and understanding the confidentiality laws listed above as well as any other applicable laws. Nothing herein shall prohibit the disclosure of information in summary, statistical or other form that does not identify particular individuals, provided that de-identification of protected health information is performed in compliance with the HIPAA Privacy Rule.

Federal and State Medicaid regulations, and some other federal and State laws and regulations, including but not limited to those listed above, are often more stringent than the HIPAA regulations. Provider shall notify Carrier and the HCA of any breach of confidential information related to Covered Persons within the time period required by applicable federal and State laws and regulations following actual knowledge of a breach, including any use or disclosure of confidential information, any breach of unsecured PHI, and any Security Incident (as defined in HIPAA regulations) and provide Carrier and the HCA with an investigation report within the time period required by applicable federal and State laws and regulations following the discovery. Provider shall work with Carrier and the HCA to ensure that the breach has been mitigated and reporting requirements, if any, complied with.

3.15 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title XIX and Title XXI of the Social Security Act;
ii) Title VI of the Civil Rights Act of 1964;
iii) Title IX of the Education Amendments of 1972, regarding any education programs and activities;
iv) The Age Discrimination Act of 1975;
v) The Rehabilitation Act of 1973;
vi) The Budget Deficit Reduction Act of 2005;
vii) The False Claims Act;
viii) The Health Insurance Portability and Accountability Act (HIPAA);
ix) The American Recovery and Reinvestment Act (ARRA);
x) The Patient Protection and Affordable Care Act (PPACA or ACA);
xi) The Health Care and Education Reconciliation Act;
xii) Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews;
xiii) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services Provider performs pursuant to the Agreement, including but not limited to:

a) All applicable standards, orders or requirements issued under Section 306 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 CFR Part 15), which prohibit the use of facilities included on the EPA List of violating Facilities. Any violations must

be reported to the HCA, DHHS, and the EPA;

b) Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.
c) Those specified for laboratory services in the clinical Laboratory Improvement Amendments (CLIA);
d) Those specified in Title 18 RCW for professional licensing;
e) Industrial Insurance – Title 51 RCW;
f) Reporting of abuse as required by RCW 26.44.030;
g) Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2;
h) Equal Opportunity in Employment (EEO) provisions, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by
E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."
i) The Copeland Anti-Kickback Act;
j) The Davis-Bacon Act;
k) The Byrd anti-Lobbying Amendment;
l) All federal and State nondiscrimination laws and regulations;
m) The American with Disabilities Act (ADA). Provider shall make reasonable accommodation for Covered Persons with disabilities in accord with the ADA for all Covered Services and shall assure physical and communication barriers do not inhibit Covered Persons with disabilities from obtaining Covered Services;
n) Any other requirements associated with the receipt of federal funds.

xiv) Applicable State and federal rules and regulations as set forth in the State Contract, including, but not limited to, the applicable requirements of 42 U.S.C. § 1396a(a)(43), 42
U.S.C. § 1396d(r), and 42 C.F.R. § 438.3(l), CFR 438.6(i), and 438.230(c)(2).
xv) Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews.

3.16 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Carrier nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care.

3.17 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee

of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of this Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.18 Conflict of Interest. Provider shall cooperate with Carrier's policies and procedures related to detecting and preventing conflicts of interest in accordance with federal laws for parties involved in public contracting.

3.19 Excluded Individuals and Entities. By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider is obligated to screen its employees and contractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded. Provider shall immediately report to Carrier any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The databases are called LEIE and EPLS and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Carrier will terminate the Agreement immediately and exclude from its network any provider who has been excluded from the Medicare, Medicaid or CHIP program in any state. Carrier may also terminate the Agreement if Provider or Provider's owners, agents, or managing employees are found to be excluded on a State or federal exclusion list.

3.20 **Disclosure.** Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable and submit disclosure to HCA on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider shall not give employees, volunteers, and/or subcontractor staff access to children and/or vulnerable adults until a criminal history background check is performed and a positive result is reported. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with HCA for submission of fingerprints upon a request from HCA or CMS in accordance with 42 CFR 455.434. If Provider fails to submit such information or fingerprints in a form and manner to be determined by HCA or CMS within thirty
(30) calendar days when requested by HCA or CMS, the Carrier must terminate or deny enrollment to Provider.

3.21 **Cultural Competency and Access.** Provider shall participate in Carrier's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical and mental disabilities, and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand. Provider shall provider physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities. United shall support and provide resources to Provider to comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to all Covered Persons.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

3.22 **Marketing.** Provider agrees to comply with the prohibition against direct and/or indirect door-to- door, telephonic, or other cold-call marketing of enrollment. As required under State or federal law and the State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be developed at the sixth grade reading level and submitted to Carrier to submit to the State Program for prior approval.

3.23 **Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with Carrier's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State contract and shall cooperate and assist the State Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs. Provider shall immediately refer credible allegations of fraud to HCA and the Medicaid Fraud Control Division (MFCD) as required in the State Contract.

In accordance with Carrier's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if such Provider receives annual payments under the

State Program of at least $5,000,000, Provider must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.24 Compliance with Medicaid Laws and Regulations. Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a Claim by Carrier or the HCA is conditioned upon the Claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each Claim the Provider submits to Carrier constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such Claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal health care programs. Provider's payment of a Claim may be temporarily suspended if Carrier provides notice that a credible allegation of fraud exists and there is a pending investigation. Carrier performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Carrier upon its request in order to determine appropriateness of coding. Claims payments may be temporarily suspended or adjusted if the Provider bills a claim with a code that does not match the service provided. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

3.25 Claims Information. Provider shall promptly submit to Carrier information needed to make payment. Provider must submit a Clean Claim no more than twelve (12) months after the calendar month in which the Covered Service is performed. Provider shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting Claims to Carrier.

3.26 Data; Reports. Provider shall cooperate with and release to Carrier any information necessary for Carrier to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Carrier. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Carrier and the State Contract. Data and reports must be provided within the timeframes specified and in a form that meets Carrier and State requirements. By submitting data to Carrier, Provider represents to Carrier that the data is accurate, and upon Carrier's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.27 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of

the Agreement insurance appropriate to the services to be performed under the Agreement. If Provider is a home health agency, Provider shall comply with the surety bond requirements in accordance with 42 CFR 441.16. Upon request, Provider shall make available to Carrier copies of its Certificate(s) of Insurance.

3.28 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the State Program and that it is eligible to participate in the State Program. Provider represents that it does not have a State Program provider agreement with HCA that is terminated, suspended, denied, or not renewed as a result of any action of the HCA, CMS, HHS, or the MFCD of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by Carrier under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.29 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Carrier's quality assessment, performance improvement and utilization review and management activities, which shall be tailored to the nature and type of services subcontracted. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Carrier or as required under the State Contract to ensure quality control for the health care provided, including but not limited to the accessibility of Medically Necessary health care, and Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Carrier or Provider. Provider shall adhere to the quality assurance and utilization review standards of the State Programs and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.30 Continuity of Care. Provider shall cooperate with Carrier to provide newly enrolled Covered Persons with continuity of treatment, including coordination of care to the extent required under law or required to ensure that ongoing care is not disrupted or interrupted. Provider shall also coordinate with Carrier to ensure continuity of treatment in the event Provider's participation with Carrier terminates during the course of a Covered Person's treatment by Provider.

3.31 Informed Consent; Information for Covered Persons. To the extent applicable to Provider in performance of the Agreement, Provider shall obtain informed consent prior to treatment, or from persons authorized to consent on behalf of a Covered Person as described in RCW 7.70.065. Providers that are hospitals, nursing facilities, home health agencies, hospices, or organizations responsible for providing personal care, as well as PCPs that contract with any of the above entities, shall comply with federal and State law (WAC 182-501-0125 and 42 CFR 438.6(m)) and Carrier's policies regarding advance directives for adult Covered Persons. Provider shall also comply with the provisions of the Natural Death Act (RCW 70.122), and when appropriate, inform Covered Persons of their right to make anatomical gifts (RCW 68.50.540).

3.32 Special Health Care Needs. As applicable, Provider shall identify Covered Persons with special health care needs in the course of contact, or a Covered Person initiated health care visit, and report such identification to Carrier.

3.33 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to Carrier all information necessary for the reimbursement of any outstanding Medicaid claims.

3.34 **Health Information Systems.** Provider shall maintain a health information system that complies with the requirements of 42 CFR 438.242 and provides the information necessary to meet Provider's obligations under the Agreement and this Appendix.

3.35 **Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Carrier. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

3.36 **Encounter Data.** Provider agrees to cooperate with Carrier to comply with Carrier's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be accurate and include all services furnished to a Covered Person, including capitated provider's data and rendering provider information. Encounter data must be provided within the timeframes specified and in a form that meets Carrier and State requirements. By submitting encounter data to Carrier, Provider represents to Carrier that the data is accurate, and upon Carrier's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

3.37 **Health Records.** Provider agrees to cooperate with Carrier to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

3.38 **Non-Discrimination.** Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability.

3.39 **Advance Directives.** When applicable, Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 49, subpart I, 42 CFR § 417.436(d), 42 CFR § 422.128, and 42 CFR 438.3(i). In addition, as applicable, Provider must comply with Chapter 17.32 RCW (Mental Health Advance Directives).

3.40 **Termination.** In the event of termination of the Agreement, Provider shall promptly supply to Carrier all information necessary for the reimbursement of any outstanding Medicaid claims.

3.41 **Overpayment.** Provider shall to report to Carrier when it has received an overpayment and will return the overpayment to the Carrier within 60 calendar days after the date on which the

overpayment was identified. Provider will notify Carrier in writing of the reason for the overpayment.

3.42 **Electronic Visit Verification (EVV).** Provider shall cooperate with State requirements for electronic visit verification for personal care services and home health services, as applicable.

3.43 **Bi-Directional Behavioral and Physical Health Integration.** Outpatient behavioral health and primary care practices shall use reasonable efforts to complete the Washington Integrated Care Assessment (WA-ICA) as defined by the Clinical Integration Assessment Workgroup. Outpatient behavioral health and primary care practices shall use reasonable efforts to complete the WA-ICA in July of each year, consistent with the implementation schedule defined by the Clinical Integration Assessment Workgroup.

SECTION 4 ADDITIONAL REQUIREMENTS FOR DELEGATED ADMINISTRATIVE FUNCTIONS

4.1 This Section applies to those Providers to whom Carrier has delegated an Administrative Function. Provider shall perform those delegated Administrative Functions set forth in the Agreement through an exhibit or otherwise. Any changes or modifications to the Administrative Functions shall be agreed to in writing by the parties.

4.2 Prior to delegation, Carrier shall perform an evaluation of Provider's ability to successfully perform and meet the requirements of the State Contract for any delegated Administrative Function.

4.3 Provider agrees to cooperate with Carrier's requirements for delegation of Administrative Functions, including but not limited to ongoing monitoring and an annual evaluation for the purpose of determining Provider's compliance with requirements related to the delegated Administrative Functions. As a result of such monitoring activities, Carrier shall identify to Provider any deficiencies or areas for improvement mandated under the applicable State Contract and Provider shall take appropriate corrective action.

4.4 If Provider is at financial risk, Provider shall comply with, and maintain throughout the term of the Agreement, the solvency requirements established by Carrier from time to time. Carrier shall monitor Provider's compliance with such solvency requirements.

4.5 Provider shall maintain records necessary to adequately document the performance of delegated Administrative Functions and shall release to Carrier any data or information necessary for Carrier to perform its reporting obligations under the State Contract.

4.6 In addition to its termination rights under the Agreement, Carrier shall have the right to revoke any delegated Administrative Functions Carrier delegates to Provider under the Agreement or impose other sanctions consistent with the applicable State Contract if in Carrier's reasonable judgment Provider's performance of a delegated Administrative Function is inadequate.

SECTION 5 CARRIER REQUIREMENTS

5.1 **Prompt Payment.** Carrier shall pay provider pursuant to the State Contract, applicable State law and regulations, including the timeliness of payment standards specified for health carriers

in WAC 284-43-321 and the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as may be amended from time to time. To be compliant with both payment standards, Carrier shall pay or deny 95 percent of Clean Claims within thirty (30) calendar days of receipt, 95 percent of all Claims within sixty (60) calendar days of receipt and 99 percent of Clean Claims within ninety (90) calendar days of receipt; provided, however, that Carrier and Provider may agree to a different payment requirement in writing on an individual Claim. If a third party liability exists, payment of Claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Carrier otherwise requests assistance from Provider, Carrier will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Carrier shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. In accordance with 42 CFR 438.12 and 438.214(c), Carrier shall not discriminate with respect to the participation, reimbursement or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. Further, Carrier shall not discriminate with respect to the participation, reimbursement or indemnification of any provider who serves high-risk Covered Persons or specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Carrier from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Carrier that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Carrier shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment; or

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Carrier also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Grievance & Appeals. Carrier will supply Provider with information regarding Carrier's

grievance and appeals system, including: (a) the toll-free numbers to file oral grievances and appeals; (b) the availability of assistance in filing a grievance or appeal; (c) a Covered Person's rights to request continuation of benefits during an appeal or hearing and, if Carrier's action is upheld, the Covered Person's responsibility to pay for the cost of the benefits received for the first 60 calendar days after the appeal or hearing request was received; (d) a Covered Person's right to file grievances and appeals and the requirements and timeframes for filing, to include the availability of review by an IRO; and (e) a Covered Person's right to a hearing, how to obtain a hearing, and representation rules at a hearing.

5.6 **Termination, Revocation and Sanctions.** In addition to Carrier's termination rights under the Agreement, Carrier shall have the right to revoke any functions or activities Carrier delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in HCA's or Carrier's reasonable judgment Provider's performance under the Agreement is inadequate. Carrier shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation. The administrative guide located at www.uhcprovider.com describes applicable provider policies and procedures, including specific criteria for termination pursuant to this provision.

SECTION 6 OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Carrier has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Carrier of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract as it relates to the State Programs, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived. Carrier agrees to comply with the State Contract provisions relating to providing a reasonably accessible on-line location of policies and procedures. For this purpose, the administrative guide and other information is located at www.uhcprovider.com.

6.2 Monitoring. Carrier shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider at least every three (3) years and according to any other schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Carrier shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Carrier shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Carrier and/or required by the State Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Carrier and Provider practice and/or the performance standards established under the State Contract.

6.3 Delegation. The parties agree that, prior to execution of the Agreement, Carrier evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be reduced to writing and set forth in the Agreement or other written delegation agreement or addendum between the parties. In addition

to Carrier's termination rights under the Agreement, Carrier shall have the right to revoke any functions or activities Carrier delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Carrier's reasonable judgment Provider's performance under the Agreement is inadequate. Carrier shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

6.4 **Assignment.** No assignment of the Agreement shall take effect without the written agreement of the HCA.

6.5 **Termination Notice.** Notwithstanding the termination provisions set forth in the Agreement, Provider and Carrier shall provide at least ninety (90) days advance notice to the other party of intent to terminate the Agreement without cause. Such notice shall be in accordance with the terms of the Agreement.

6.6 **Health Care Acquired/Preventable Conditions.** Carrier and Provider acknowledge and agree that Carrier is prohibited from making payments to Provider for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by HCA. As a condition of payment, Provider shall identify and report to Carrier any provider preventable conditions in accordance with 42 CFR § 434.6(a)(12), 42 CFR §438, including but not limited to § 438.3, and § 447.26.