Meeting Date: August 9, 2021
Agenda Item No:

Kitsap County Board of Commissioners

Office/Department: Human Services
Staff Contact:
Stephanie Lewis, SBHASO Regional Administrator, 337-4422
Doug Washburn, Human Services Director, 337-4526

Agenda Item Title: Behavioral Health Revenue Contract KC-456-21 between Kitsap County and UnitedHealthcare of Washington (United), to provide behavioral health crisis services for United Medicaid members.

Recommended Action: Move that the Board execute Contract KC-456-21 between Kitsap County and UnitedHealthcare of Washington.

Summary:	This **(Medicaid funded)** revenue contract with UnitedHealthcare of Washington (United) is effective January 1, 2021 and provides funding for behavioral health crisis services for United Medicaid members. The contract term is January 1, 2021 – June 30, 2022 and the revenue funding is estimated at $876,000 The contract details the overall parameters for the provision of the Medicaid funded crisis behavioral health services, laying out the expectations and regulations surrounding the delegation of crisis behavioral health services. The Salish Behavioral Health Administrative Services Organization (SBH-ASO) is responsible for ensuring that crisis behavioral health services are available to the Medicaid population in our region. The revenue for this contract is paid to the SBH-ASO on a capitated basis, with the SBH-ASO receiving a Per Member Per Month (PMPM) payment for each United Medicaid member in our region. Kitsap County is the administrative entity for the Salish Behavioral Health Administrative Organization (SBH-ASO), which contracts with Managed Care Organizations (MCOs) for crisis behavioral health services provided to Medicaid members and with the Healthcare Authority for behavioral health services provided to non-Medicaid individuals in Kitsap, Jefferson, and Clallam Counties. This contract with UnitedHealthcare provides the revenue to pay for crisis behavioral health services for United Medicaid membership, and includes the program requirements that the SBH-ASO and its provider network work under. Under the terms of the contract, the SBH-ASO is responsible for providing crisis behavioral health services, which includes crisis hotline, mobile crisis outreach and crisis intervention services.
Attachments:	1. Contract Review Sheet 2. KC-456-21

Fiscal Impact for this Specific Action

Expenditure required for this specific action:	$876,000 estimated
Related Revenue for this specific action:	$876,000 estimated

Cost Savings for this specific action:	$ N/A
Net Fiscal Impact:	100% Grant funded
Source of Funds:	1961 Medicaid

Fiscal Impact for Total Project N/A		
Office/Departmental Review & Coordination		
Office/Department	**Elected Official/Department Director**	
Human Services	Doug Washburn	

Contract Information			
Contract Number	**Date Original Contract or Amendment Approved**	**Amount of Original Contract Amendment**	**Total Amount of Amended Contract**
KC-456-21	Pending	$876,000 estimated	

Kitsap County
CONTRACT REVIEW SHEET
(Chapter 3.56 KCC)

A. CONTRACT INFORMATION *(for Contract Signing Authority, see KCC 3.56.075)*

1. Contractor: UnitedHealthcare of Washington
2. Purpose: Revenue contract to provide behavioral health crisis services to United Medicaid Members
3. Contract Amount: $876,000 estimated — Disburse [ ] — Receive [x]
4. Contract Term: January 1, 2021 – June 30, 2022
5. Contract Administrator: Stephanie Lewis — Phone: 337-4422

Approved: Doug Washburn — **Date:** 06/30/2021
Department Director

B. AUDITOR – Accounting Information

1. Contract Control No.: KC-456-21
2. Fund Name: Medicaid
3. Payment from-Revenue to CC/Account No.: 1961.3380.6402

Reviewer: Dave Schureman — **Date 7/1/2021**
4. Comments:

C. AUDITOR – Grant Review
Signature only required if grant funded contract

1. [X] Approved [ ] Not Approved

Reviewer: Dave Schureman — **Date 7/1/2021**
2. Comments: State grant

D. ADMINISTRATIVE SERVICES DEPARTMENT – Risk Manager Review

1. [X] Approved [ ] Not Approved

Reviewer: Anastasia Johnson — **Date:** 7/8/2021
2. Comments:

E. ADMINISTRATIVE SERVICES DEPARTMENT – Budget Manager Review
Signature required if $50,000 or more OR if signed by Board of Commissioners (regardless of dollar amount)

1. [X] Approved [ ] Not Approved

Reviewer: Kristofer Carlson — **Date:** 07/02/2021
2. Comments:

F. HUMAN RESOURCES – Human Resources Director Review
Signature only required if union or employment contract

1. [ ] Approved [ ] Not Approved

Reviewer: — **Date:**
2. Comments:

G. INFORMATION SERVICES – Information Services Director Review
Signature only required if technology contract

1. [ ] Approved [ ] Not Approved

Reviewer: — **Date:**
2. Comments:

H. PROSECUTING ATTORNEY

1. [X] Approved as to Form* [ ] Not Approved as to Form

Reviewer: Alan L. Miles — **Date:** 2021-07-14
2. Comments: *Comments to be provided separately.

Date Approved by Authorized Contract Signer: **Date**

RETURN SIGNED ORIGINALS TO: Hannah Shockley @ MS-23 X3530

ADMINISTRATIVE SERVICES AGREEMENT FOR CRISIS SERVICES

This ADMINISTRATIVE SERVICES AGREEMENT FOR CRISIS SERVICES (the "Agreement"), is effective the 1st day of January, 2021, (the "Effective Date") by and between UnitedHealthcare of Washington, Inc. ("United"), referred to ask "MCO" in this Agreement and Salish Behavioral Health Administrative Services Organization ("Salish"), through Kitsap County, its administrative entity, and supersedes any and all prior agreements, including prior amendments and any incorporated exhibits. Hereafter, MCO and Salish may be referred to individually as a "party" and collectively as the "parties."

RECITALS

WHEREAS, the Washington State Health Care Authority ("HCA"), through its Apple Health Medicaid program ("Apple Health"), purchases crisis health care services for eligible Washington residents; and

WHEREAS, United Healthcare of Washington Inc. "("United") is a Managed Care Organization ("MCO") that is authorized to arrange for the provision of Crisis Behavioral Health Services to eligible individuals ("Members") in the State of Washington; and

WHEREAS, HCA and United have entered into an agreement for United to arrange for certain professional and ancillary health care services, including Crisis Behavioral Health Services, to be provided to persons enrolled in Apple Health; and

WHEREAS, Salish formerly was a Regional Support Network and currently is organized and operating as a Behavioral Health Organization; Salish has amended its Operating Agreement and modified its internal structure to be organized and act as a Behavioral Health Administrative Services Organization effective January 1, 2020 to engage in the business of arranging for crisis behavioral health services on behalf of Members effective January 1, 2020; and

WHEREAS, United wishes Salish to provide certain administrative services in connection with crisis behavioral health services for Members under the terms of this Agreement.

NOW THEREFORE, in consideration of the commitments set forth below, the parties agree as follows:

1. **DEFINITIONS**.

1.1 **United Policies.** "United Policies" means United-maintained policies and procedures, provided or made available in writing to Salish.

1.2 **CMS.** "CMS" means the Centers for Medicare and Medicaid Services, the federal agency within the United States Department of Health and Human Services that is responsible for the Medicare and Medicaid programs.

1.3 **Compliance Requirements**. "Compliance Requirements" means: (i) state and federal laws and regulations, applicable to United or to Salish; (ii) all HCA Contract requirements; (iii) applicable NCQA Standards; and (iv) the terms of this Agreement.

1.4 **Crisis Behavioral Health Services**. "Crisis Behavioral Health Services" means evaluation and treatment of behavioral health crisis to all Medicaid-enrolled individuals experiencing a crisis. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional. Crisis Behavioral Health Services payable under this Agreement are set forth in Exhibit B, Crisis Services Statement of Work.

1.5 **Delegated Function**. "Delegated Function" means a core business function that MCO is required to perform, which a subcontractor is authorized to perform on MCO's behalf pursuant to a written agreement and that requires robust ongoing oversight to ensure compliance with applicable Compliance Requirements.

1.6 **HCA Contracts**. "HCA Contracts" means United's contracts with the Washington State Health Care Authority for the Apple Health program, including the *Apple Health (Medicaid) managed care contract*, the *Apple Health – Fully Integrated Managed Care contract*, and the *Apple Health – Fully Integrated Managed Care – Crisis Behavioral Health Services wrap-around contract*.

1.7 **Project Data**. "Project Data" means: (i) all information processed or stored on computers or other electronic media by Salish on MCO's behalf; (ii) information that is provided by MCO or its affiliates to Salish to access, use, store, maintain, or transmit; and (iii) any information derived from such information. Project Data includes, without limitation: (i) information on paper or other non-electronic media provided to Salish for computer processing or storage, or information formerly on electronic media; (ii) information provided to Salish by MCO or information related to the Services performed under the Agreement that is provided to Salish by a third party; and (iii) any Patient Identifying Information, as that term is defined in 42 C.F.R. §2.11, or Protected Health Information, as that term is defined in 45 C.F.R. §160.103 ("PHI"), that Salish receives from or on behalf of MCO.

1.8 **Subdelegate**. "Subdelegate" means a subcontractor of Salish who MCO has approved in writing to perform all or part of a Delegated Function under this Agreement.

1.9 **Health Care Authority.** "Health Care Authority" or "HCA" shall mean the Washington State Health Care Authority, the single-state agency responsible for Washington State's Medicaid programs, referred to as "Apple Health".

1.10 **Member**. "Member" means an individual enrolled as a member of MCO who is eligible to receive Crisis Behavioral Health Services under the Apple Health Medicaid program from or through MCO.

2. SERVICES

2.1 As used herein, "Services" includes Salish's performance of all contracted services, including any Delegated Functions.

2.2 **Compliance**. Salish shall perform the Crisis Services in accordance with applicable Compliance Requirements. To the extent that a Compliance Requirement related to this Agreement is not directly applicable to Salish, Salish shall perform its obligations in a manner that enables MCO to comply with such Compliance Requirement.

2.2.1 The Services will be performed in a professional, competent, and timely manner by appropriately qualified personnel that have the requisite knowledge, training, ability, and licensure or credentials to perform the Services in accordance with applicable Compliance Requirements and industry standards.

2.2.2 Salish shall comply with the Program Integrity requirements contained in the HCA Contracts, including the requirement to immediately report to MCO any instance of actual or potential Fraud of which Salish becomes aware, and MCO's HCA-approved Program Integrity Policies.

2.2.3 The parties acknowledge that Compliance Requirements may be amended during the term of this Agreement. Each party shall modify its performance to ensure ongoing compliance with applicable Compliance Requirements, as amended.

3. SALISH OBLIGATIONS

3.1 Salish shall cooperate with and participate in MCO's monitoring and oversight activities, which shall be performed in accordance with applicable Compliance Requirements MCO Policies, and industry standards.

3.2 Upon MCO's request, Salish shall provide to MCO any information necessary for MCO to meet its obligations under the HCA Contracts.

3.3 **Required Disclosures**. In accordance with HCA and CMS requirements, Salish is required to make certain disclosures to MCO concerning Salish's ownership and control, information on persons convicted of crimes, and other sensitive matters. Salish shall comply with all disclosure requirements as set forth herein, or as required by applicable Compliance Requirements.

3.3.1 Salish shall complete MCO's "Ownership and Control Interest Disclosure Form" ("OCID Form") within thirty-five (35) days of execution of this Agreement, MCO's reasonable request, or after any change in the information provided by

Salish on the OCID Form. This Agreement shall terminate unless Salish executes and returns to MCO the initial completed OCID Form.

3.3.2 Additional Disclosure Requirements. Within 35 calendar days of MCO's reasonable request, Salish shall provide to MCO:

3.3.2.1 Full and complete business information concerning: (i) the ownership of any subcontractor with whom Salish has had more than $25,000.00 of business transactions within the 12-month period prior to the date of the request; and (ii) any significant business transactions between Salish and any wholly owned supplier, or between Salish and any of its subcontractors, during the 5-year period prior to the date of the request.

3.3.2.2 A description of any transactions between Salish and a "party in interest," as defined in Section 1318(b) of the Public Health Service Act, including: (i) the sale, lease or exchange of any property; (ii) the furnishing for consideration of goods, services (including management services), or facilities, but not including salaries paid to employees for services provided in the normal course of their employment; and (iii) the lending of money or other extension of credit.

3.3.3 Information on Persons Convicted of Crimes. Upon execution of this Agreement and upon MCO's request thereafter, Salish shall investigate and disclose to MCO the identity of any individual who has been convicted of a criminal offense related to that person's participation in a federally funded health care program, including Medicaid, Medicare, and the Children's Health Insurance Program, since the inception of those programs, and who is: (i) a person who has an ownership or control interest in Salish; (ii) an agent or person who has been delegated the authority to obligate or act on behalf of Salish; or (iii) an agent, managing employee, general manager, business manager, administrative, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, Salish's day-to-day operations.

3.4 **Public Records Act**. The Parties acknowledge that Salish is subject to the strict requirements of the Washington Public Records Act, Chapter 42.56 RCW ("PRA"). Compliance with the requirements of the PRA by Salish shall not be violative of this Agreement or subject to the equitable power of any court, except as provided in the PRA. MCO retains the right to review records prior to disclosure, to claim exemption, and to challenge any disclosure request in court; provided, however, that MCO shall indemnify, defend, and hold Salish harmless from any and all resulting claims, penalties, or costs, including attorneys' fees.

3.5 **Licenses and Registrations**. Salish has and will maintain the licenses, permits, registrations, certifications, and other governmental authorizations necessary to conduct its business or perform the Services. Salish shall notify MCO in the event of a change in status of any required license, permit, registration, certification, or other authorization necessary for Salish's performance under this Agreement.

3.6 **No Exclusion**. Salish represents and warrants that, to its actual knowledge, it and its employees, directors, officers, and agents are not now and never have been: (i) sanctioned under a federal or state program or law; (ii) listed in the current List of Excluded Individuals and Entities by the Office of the Inspector General for the U.S. Department of Health and Human Services; (iii) listed on the General Services Administration's List of Parties Excluded from Federal Programs; (iv) otherwise excluded from participation in any federally-funded health care program, including Medicare and Medicaid.; or (v) convicted of a serious crime directly related to healthcare. Salish shall immediately notify MCO of any threatened, proposed, or actual change in the foregoing representations.

3.7 **Subcontractors**. If Salish subcontracts any part of its performance hereunder, it must enter a written agreement with the subcontractor, which must require the subcontractor to comply with applicable Compliance Requirements and MCO Policies. Any such subcontract shall also require the subcontractor to perform in a manner that enables MCO to comply with such Compliance Requirements and MCO Policies, regardless of whether such requirements are directly applicable to Salish or subcontractor.

3.7.1 Salish shall screen all new and existing subcontractors against the lists of excluded individuals referenced in Section 3.6, as well as applicable state-maintained exclusion list(s). If a Salish subcontractor is determined to be debarred, suspended, or otherwise excluded from receiving a subcontract funded in whole or in part by federal or state dollars, including Medicaid funds, Salish will immediately terminate its relationship with such subcontractor.

3.7.2 Salish may not subcontract any part of its performance of a Delegated Function without the prior written approval of MCO, which approval shall not be unreasonably withheld or delayed. If MCO approves a Salish Subdelegate to perform all or part of a Delegated Function hereunder, Salish shall ensure compliance with Exhibit A for itself and its Subdelegate.

3.8 **Taxes**. Salish will pay any taxes on its income as well as any compensation, taxes, and insurance associated with its employees and subcontractors. Neither Salish nor its representatives, employees, agents, or subcontractors, shall have any claim against MCO for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind arising from Salish's performance under this Agreement.

3.9. **Insurance**. At its sole expense and through the term of this Agreement, BH-ASO shall maintain the following insurance and coverage amounts to cover its provision of Services hereunder: (i) One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate for professional liability; (ii) One Million Dollars ($1,000,000) per occurrence and Two Million Dollars ($2,000,000) annual aggregate for commercial general liability; (iii) applicable state statutory limits for workers' compensation; and (iv) any other usual and customary policies of insurance applicable to BH-ASO or the Services being performed.

3.9.1 By requiring insurance, MCO does not represent that such coverage or limits will be adequate to protect BH-ASO. Such coverage and limits shall not be deemed as a limitation on BH-ASO's liability under the indemnities granted herein.

3.9.2 BH-ASO will obtain all insurance coverage specified herein from insurers with a current A.M. Best financial rating of A-, Class VII or better. All policies shall be primary with respect to any insurance maintained by BH-ASO.

3.9.3 If BH-ASO procures a "claims-made" policy to meet the insurance requirements herein, BH-ASO shall purchase "tail" coverage that provides for an indefinite reporting period upon the termination of any such policy or upon termination of this Agreement.

3.9.4 BH-ASO will promptly notify MCO of any material change in the carrier or in the amount or scope of required coverage. BH-ASO shall provide a certificate of insurance coverage within ten (10) days of UHCs request. BH-ASO's failure to maintain required insurance constitutes a material breach of this Agreement.

4. UNITED OBLIGATIONS

4.1 **Taxes**. MCO will pay applicable federal, state, and local taxes including sales, use, service, or other such taxes associated with its receipt of the Services.

4.2 **MCO Premises**. If Salish provides Services on MCO premises, MCO will provide Salish the space, furniture, fixtures, equipment, and supplies that MCO, in its sole discretion, deems reasonably necessary for the provision of Services. Salish shall use any space, furniture, fixtures, equipment, or supplies provided by MCO only for the performance of the Services covered by this Agreement, and not for any other purpose, including Salish's own private use. If Salish provides Services on MCO premises, Salish's on-site personnel will be required to follow applicable MCO protocols and complete any required training for on-site personnel.

4.3 **Ultimate Legal Responsibility**. Nothing in this Agreement terminates or modifies MCO's legal responsibility to carry out its obligations under the HCA Contracts. MCO shall remain responsible for oversight of all functions and responsibilities subcontracted to Salish.

4.4 **Oversight and Ongoing Monitoring**. MCO will monitor Salish's performance hereunder on an ongoing basis and subject Salish to formal review, consistent with Compliance Requirements, MCO Policies, and industry standards. Formal review may be completed no more than once every three (3) years. Such review shall be based on the specific activities contracted hereunder and shall address compliance with applicable Compliance Requirements.

4.5 **MCO's Grievance and Appeals System**. MCO has provided Salish information regarding MCO's grievance system, including: (i) the toll-free numbers to file oral grievances and appeals; (ii) the availability of assistance in filing; (iii) a Member's right to request continuation of benefits during an appeal or hearing and, if MCO's action is upheld, the Member's responsibility to pay for the continued benefits; (iv) a Member's right to file grievances and appeals, the ability of their

provider to file a grievance or appeal on the Member's behalf, and the requirements and timeframes for filing; and (v) a Member's right to a hearing, how to obtain a hearing, and representation rules at a hearing. Information regarding MCO's grievance system is available online at [MCO URL].

4.6 **Functions Not Delegated in this Agreement.** *United retains all other Quality Improvement, Claims/Encounter, Utilization Management and Credentialing & Recredentialing functions not specified in this agreement as the delegate's responsibility.*

5. COMPENSATION AND PAYMENT

5.1 All fees, reimbursement, payment, and other compensation related to Salish's performance hereunder are set forth in Exhibit C

5.2 Salish shall accept as payment in full the compensation set forth in Exhibits C, and shall make no request for payment from HCA or any Member for services rendered under this Agreement; *provided*, that no payment shall be deemed "payment in full" unless and until it meets the compensation level(s) set forth in Exhibit C. Salish, for itself and its representatives, employees, agents, and subcontractors, shall hold HCA, HCA employees, and all Members, harmless in the event of non-payment by MCO under the Agreement.

5.3 **Overpayment or Underpayment**. Salish shall reimburse MCO for any overpayment made hereunder within thirty (30) days of either Salish's discovery or MCO's written notification of such overpayment. MCO shall remit to Salish any underpayment within thirty (30) days of receipt of Salish's invoice substantiating such underpayment. Upon reasonable notice of intent, each party has the right of offset as to any amounts owed to either party against any amount owed by the other party.

5.4 **Federal Funds**. Each party is subject to the laws applicable to individuals and entities receiving federal funds, and shall inform all related entities and subcontractors that payments they receive are, in whole or in part, from federal funds. This Agreement shall be interpreted and performed in a manner that results in compliance with such laws.

6. TERM and TERMINATION

6.1 **Term**. This Agreement shall remain in effect until June 30, 2022, or extended by the parties via written and signed amendment .

6.2 **Termination**. This Agreement may be terminated prior to the expiration of the Term as follows:

6.2.1 Termination For Cause. Either party may terminate this Agreement for cause upon ninety (90) days' prior written notice to the other party specifying the cause for termination. The alleged violating party shall have ninety (90) days to rectify the specified cause, and if the cause is not rectified within that ninety (90) day period, the terminating party may terminate this Agreement upon written notice to the other

party. "Cause" for termination includes a party's material breach of its obligations under this Agreement.

6.2.2 Exclusion. If either party is excluded from participation in Medicare or Medicaid or if for any reason a party's performance under this Agreement is deemed illegal or unethical by a recognized body in the insurance or healthcare industry, then this Agreement shall automatically terminate.

6.2.3 Termination of HCA Contract(s) or Service Area(s). In the event that one or more HCA Contracts expires or is terminated, or MCO is no longer contracted as a Medicaid Managed Care Organization in an applicable service area, MCO may terminate the Agreement upon written notice to Salish.

6.2.4 Termination of BH-ASO Contract. In the event that Salish's BH-ASO contract with HCA expires or is terminated prior to the end of the Term of this Agreement, this Agreement shall immediately terminate.

6.2.5 Bankruptcy. If an assignment of a party's business for the benefit of creditors is made, if a petition in bankruptcy is filed by or against a party, if a receiver or similar officer is appointed to take charge of all or part of a party's property, or if a party is adjudicated bankrupt, the other party may terminate this Agreement upon written notice to the other party.

6.2.6 Failure to Meet Pre-Conditions of Delegation. If Salish's performance under this Agreement contemplates performance of any part of a Delegated Function, and Salish fails to meet MCO's pre-delegation requirements, then the Parties agree that MCO may terminate this agreement provided, however, that any such determination is subject to dispute resolution, if timely invoked, before such termination shall become effective.

6.3 **Effect of Termination or Expiration**.

6.3.1 Termination or Suspension of Delegated Function. Termination or suspension of Salish's performance of a Delegated Function, in whole or in part, shall not terminate or suspend this Agreement.

6.3.2 Existing Obligations Not Released. Rights, liabilities, and other obligations of the parties arising or incurred prior to the date of termination or expiration of this Agreement are not terminated by the termination or expiration hereof.

6.3.3 Ongoing Cooperation. The parties shall cooperate to ensure an efficient transition of the Services. Salish shall provide to MCO all Program Data, and any other documentation or information necessary to transition the Services to MCO or its third-party designee. If requested by a party, Salish and MCO will develop a mutually agreed upon transition plan to ensure the orderly transition of the Services and each party's ongoing compliance with applicable Compliance Requirements.

6.3.4 Financial Reconciliation. The parties shall reconcile and true up their financial relationship upon termination or expiration of this Agreement.

6.3.5 Survival. All terms and conditions of this Agreement, which expressly or by their nature should survive termination or expiration hereof, shall survive termination of expiration of this Agreement.

7. CONFIDENTIALITY

7.1 This Agreement, including all exhibits, attachments and other addenda hereto, contains the Work Product and other confidential and/or proprietary information of the parties. Neither party will disclose any term or condition hereof to a third party, except: as expressly permitted herein; to ensure a Party's compliance with applicable Compliance Requirements; or with the express, written permission of the other party.

7.2 **Confidential Information**. Each party shall keep confidential the other party's proprietary or confidential information, including the terms and conditions of this Agreement, and all information related to finances, methods of operation and competition, pricing, operations, personnel, Members, patients, computer programs and files, business strategies including cost data, utilization review techniques, medical management, quality assurance protocols, patents, trade secrets, know-how and other proprietary processes, and information included in manuals or memoranda, as they may now exist or may be developed or amended, including all Project Data and any Work Product or other information that Salish generates in its performance hereunder (collectively, "Confidential Information").

7.3 **No Disclosure of Confidential Information**. Neither party shall disclose the other party's Confidential Information, in whole or in part, directly or indirectly, to any person, firm, association or other entity for any unauthorized purpose, nor shall a party use any Confidential Information for its own purposes or for the benefit of any other person, firm, or entity unless: (i) such information is or becomes generally available to the public other than as a result of an unauthorized disclosure by the disclosing party; (ii) such information is required to be disclosed by law or by a judicial, administrative, or regulatory authority; or (iii) as necessary to enforce its rights and perform its agreements and obligations hereunder. Neither party shall reverse engineer, disassemble, or decompile any prototypes, software or other tangible objects which embody the other party's Confidential Information. Neither party shall use the other's name, logo, trademark, or other identifying information or make any public communication or advertisement without the express written consent of the other party.

7.4 **Confidentiality limitation**. All provisions of this Article 7 are subject to the limitations set forth in section 3.4 hereof.

8. **DATA SHARING; DATA SECURITY.**

8.1 **Additional Definitions**.

8.1.1 Data Breach. "Data Breach" means unauthorized disclosure or exposure of Project Data.

8.1.2 HIPAA. "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996.

8.1.3 HIPAA Rules. "HIPAA Rules" shall mean the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule.

8.2 **Data Management**.

8.2.1 Salish shall not access, use, or disclose Project Data in any manner that would constitute a violation of state or federal law or regulation, or this Agreement.

8.2.2 Salish shall not outsource, share, or retransfer Project Data to any person or entity, except to employees, agents, or subcontractors of Salish who must access or use Project Data in the performance of Salish's duties under this Agreement.

8.2.3 Salish will not permit any third party to access Project Data unless such third party is subject to a written agreement with Salish that incorporates the Data Management and Data Security requirements of this Article 8 of the Agreement. Salish will ensure that each such third party complies with all of the terms of this Agreement related to Project Data.

8.2.4 Salish will not access, use, process, or disclose Project Data other than as necessary to perform its obligations under this Agreement. Notwithstanding the foregoing, Salish may disclose Project Data as required by law. In such cases, Salish shall provide MCO with prompt written notice of any such legal or governmental demand and shall cooperate with MCO in any effort to seek a protective order or otherwise contest such required disclosure.

8.2.5 MCO possesses and retains all rights, title, and interest in and to Project Data, and Salish's use and possession of Project Data is solely on MCO's behalf and for the benefit of MCO. MCO may access and copy any Project Data in Salish's or a third party's possession at any time, and Salish will reasonably facilitate such access and copying promptly after MCO's request.

8.2.6 In its handling of Project Data, Salish will comply with applicable Compliance Requirements and MCO Policies.

8.2.7 Unless prohibited by Article 10 or Salish's independent legal obligations, upon expiration or termination of this Agreement, Salish will return to MCO or destroy

all Project Data in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom. This provision shall apply to any Project Data that is in Salish's possession or the possession of any individual or entity that received Project Data from Salish.

8.2.7.1 Salish will identify, in the form and manner reasonably requested by MCO, any Project Data, including any Project Data that Salish has disclosed to third parties, that cannot feasibly be returned to MCO or destroyed, and explain why return or destruction is infeasible. Salish will limit its further use or disclosure of such Project Data to those purposes that make return or destruction infeasible. Salish will, by its written agreement with any third party, require such third party to limit its further use or disclosure of the Project Data that the third party cannot feasibly return or destroy to those purposes that make the return or destruction of such information infeasible. Salish will complete these obligations as promptly as possible, but not later than thirty (30) calendar days following the effective date of termination or expiration of this Agreement.

8.2.7.2 Salish shall require any such third party to certify to Salish that it has returned or destroyed all Project Data that could be returned or destroyed. Salish will require any such third party to complete these obligations as promptly as possible, but not later than thirty (30) calendar days following the effective date of termination or expiration of this Agreement.

8.2.7.3 Salish's obligations to protect the privacy and safeguard the security of Project Data as specified in this Agreement will be continuous and will survive the termination or conclusion of this Agreement.

8.3 **Data Security**. In addition to the requirements of this Article 8, Salish will, at all times, exercise reasonable efforts to prevent the unauthorized access, use, or disclosure of Project Data.

8.3.1 Salish will maintain, implement, and comply with a written data security program that requires commercially reasonable policies and procedures to ensure compliance with the Data Security requirements of this Agreement as well as applicable Compliance Requirements.

8.3.1.1 Salish's data security policies and procedures will contain administrative, technical, and physical safeguards, including without limitation:

8.3.1.1.1 Guidelines on the proper disposal of Project Data after it is no longer needed to carry out the purposes of the Agreement;

8.3.1.1.2 Access controls on electronic systems used to store, maintain, access, or transmit Project Data;

8.3.1.1.3 Access restrictions at physical locations containing Project Data;

8.3.1.1.4 Encryption of electronic Project Data;

8.3.1.1.5 Two-factor procedures;

8.3.1.1.6 Testing and monitoring of electronic systems; and

8.3.1.1.7 Procedures to detect actual and attempted attacks on or intrusions into the systems containing or accessing Project Data.

8.3.1.2 Salish will review its data security policies and procedures and all other Project Data security precautions regularly, but no less frequently than annually, and will update and maintain policies, procedures, and practices to comply with applicable Compliance Requirements, changes in technology, and commonly known industry best practices.

8.3.1.3 Salish's written data security program shall meet or exceed the requirements of the HIPAA Rules, as currently in effect or later amended.

8.3.2 Salish will implement and maintain a program for managing actual or suspected Data Breaches.

8.3.2.1 Salish will report to MCO's Compliance Officer any actual or potential Data Breach immediately and not more than seventy-two (72) hours after Salish discovers such actual or potential Data Breach. Salish's report will include at least the following, provided that the absence of any information will not be cause for Salish to delay the report, and additional information will be provided in a subsequent report as soon as reasonably possible:

8.3.2.1.1 Identify the nature of the Data Breach, including a brief description of what happened, the date of the Data Breach and the date of the discovery of the Data Breach, and the number of individuals whose information may have been the subject of the Data Breach;

8.3.2.1.2 Identify the types of information that were involved in the Data Breach, and to the extent the Data Breach involved PHI, identify the types of PHI;

8.3.2.1.3 Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

8.3.2.1.4 Identify what corrective or investigational action Salish took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects, and to protect against any further Data Breaches;

8.3.2.1.5 Identify what steps the individuals who were the subjects of or affected by the Data Breach should take to protect themselves; and

8.3.2.1.6 Provide such other information as MCO may reasonably request.

8.3.2.2 In the event of a Data Breach, Salish shall immediately take such actions as may be necessary to preserve forensic evidence and eliminate the cause of the Data Breach.

8.3.2.3 Salish shall cooperate with MCO and law enforcement agencies, where applicable, to investigate and resolve the Data Breach, including without limitation by providing reasonable assistance to MCO in notifying affected individuals and/or entities. Salish will give MCO prompt access to such records related to a Data Breach as MCO may reasonably request; *provided*, that such records will be Salish's Confidential Information and Salish will not be required to provide MCO with records belonging to its other customers. The provisions of this subsection do not limit MCO's other rights or remedies, if any, resulting from a Data Breach.

8.3.2.4 Salish shall, to the extent it has caused a Data Breach, defend, indemnify, and hold MCO harmless from and against any claims, actions, loss, liability, damage, costs, or expenses, including but not limited to reasonable attorneys' fees, arising from any or all Data Breaches. The indemnification provided hereunder includes the full costs of forensic analysis, system remediation to eliminate the cause of the Data Breach, and notice to affected individuals, including but not limited to the services of a third-party firm.

8.4 **Disaster Plan**. Salish will maintain a Disaster Recovery and Business Continuation Plan ("Disaster Plan") that sets forth a strategy to reasonably respond to an event that impacts Salish's ability to timely perform its obligations under this Agreement, including a system breakdown and natural or man-made disasters. The Disaster Plan will include application and system recovery and/or manual procedures as well as operating procedures to enable continued provision of Services within forty-eight (48) hours of a disaster or system failure.

8.4.1 Salish will maintain or contract for a computing environment which includes the required hardware, software, network, power, and other related equipment or supplies necessary to execute the Disaster Plan.

8.4.2 Salish will test its Disaster Plan in accordance with the requirements of the HIPAA Security Rule, and at least annually and in the event of a material change in the computing environment. Salish will provide MCO with the results of such tests.

8.4.3 MCO or its designee may audit Salish's Disaster Plan to monitor compliance with this Section 8.4.

8.5 **Business Associate Agreement**. Under this Agreement, Salish is a Business Associate, as that term is defined in 45 C.F.R. §160.103, of MCO. As such, the parties have entered a Business Associate Agreement, which is attached hereto and by this reference incorporated herein as Exhibit D. In the event of a conflict between the terms of the Business Associate Agreement and these Data Security requirements, the terms of the Business Associate Agreement shall prevail in all cases involving PHI. Notwithstanding the foregoing, Salish shall be obligated to comply with the Data Security requirements so long as such compliance does not violate the terms of the Business Associate Agreement.

8.6 **Alcohol and Substance Abuse Records.** Each party acknowledges and agrees that if it receives, stores, processes, has access to, maintains, or otherwise deals 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.

9. INDEMNIFICATION

9.1 **MCO Indemnity**. MCO, for itself, its legal representatives, and its lawful successors and assigns, shall indemnify, defend, and hold harmless BH-ASO, and its officers, employees, and agents, from any claim, liability, loss, demand, cost, and expense of any kind, including reasonable attorney's fees and any disbursements, or regulatory penalties (collectively, the "Loss") that the BH-ASO may hereafter incur, sustain, or be required to pay by reason of MHW's breach of the Agreement or from the reckless, negligent, or intentional acts or omissions of MCO or its officers, employees, subcontractors, or agents.

9.2 **BH-ASO Indemnity**. BH-ASO, for itself, its legal representatives, and its lawful successors and assigns, shall indemnify, defend, and hold harmless MCO, and its officers, employees, and agents, from any claim, liability, demand, cost and expense of any kind, including reasonable attorney's fees and disbursements, or regulatory penalties (collectively, the "Loss") that MCO may hereafter incur, sustain, or be required to pay by reason of BH-ASO's breach of the Agreement, or from the reckless, negligent, or intentional acts or omissions of BH-ASO or its officers, employees, subcontractors, or agents. BH-ASO shall further indemnify and hold harmless HCA and HCA 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 BH-ASO or its officers, employees, subcontractors, or agents.

9.3 **Notice and Process**. Once the party entitled to indemnification under this Article 9 receives notice of a Loss for which such party will seek indemnification from the other party, the indemnified party will promptly notify the other party in writing. Such notice will describe any matters related to or with respect to the Loss of which the indemnified party has knowledge. However, failure to notify the indemnifying party of such a Loss will not relieve the indemnifying party of its obligations under this Article 9, except to the extent that the indemnifying party is

prejudiced by such failure. The indemnified party will give the indemnifying party the opportunity to control the response to the Loss, and any defense thereof, including without limitation, any agreement related to the settlement thereof; provided, however, that the indemnified party may participate, at its own expense, in any defense and any settlement, directly or through counsel of its choice. As soon as reasonably practicable after receiving written notice of the Loss, the indemnifying party will notify the indemnified party in writing as to whether the indemnifying party elects to assume control of the response, or any defense or settlement related to such Loss. If the indemnifying party elects not to assume such control, the indemnified party will have the right to respond to, defend, or settle the Loss as it may deem appropriate, at the cost and expense of the indemnifying party, which will promptly reimburse the indemnified party for such costs, expenses, and settlement amounts.

10. **MONITORING AND OVERSIGHT; RECORD RETENTION**

10.1 **Records**. Each party shall prepare, protect, and maintain appropriate records, including administrative, medical, and financial records, covering its performance under this Agreement, including the provision of Services, for at least ten (10) years from the later of (i) the date the Agreement terminates or expires, (ii) the date any inspection, audit, litigation or other action related to the records or their content concludes, or (iii) the date of final payment under the applicable HCA Contract(s). Financial records will follow generally accepted accounting principles. Upon reasonable notice, each party shall provide access to the other to inspect or audit its records related to this Agreement. In the event Salish dissolves for any reason within ten (10) years following termination of this Agreement, Salish shall arrange for retention of all books and records covering its performance under this Agreement at the Washington State Archives.

10.2 **Government Inspection and Auditing**. Each party shall permit, at any time, the State of Washington, including HCA, the Washington Medicaid Fraud Control Division ("MFCD"), and State Auditor's Office, the Secretary of the U.S. Department of Health and Human Services ("HHS"), the HHS Office of the Inspector General, CMS, the U.S. Government Accountability Office, the U.S. Office of Management and Budget, the Comptroller General, and their respective designees, to access, inspect and audit any records or documents of MCO, Salish or its subcontractors, and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted at any time.

10.2.1 Each party shall forthwith produce all documents, records and other data requested as part of such an inspection, audit, review, investigation or evaluation. If the requesting agency asks for copies of records, documents, or other data, each party shall make copies of such records at no charge to the requestor and shall deliver them to the requestor within 30 calendar days of the request, or any shorter time as authorized by law or court order.

11. **DISPUTE RESOLUTION**

Dispute Resolution. Each Party shall cooperate in good faith and deal fairly in its performance hereunder to accomplish the Parties' objectives and avoid disputes. The Parties will promptly meet and confer to resolve any problems that arise. If a dispute is not resolved, the Parties will

participate in and equally share the expense of a mediation conducted by a neutral third party professional prior to initiating litigation or arbitration. If the dispute is not resolved through mediation within thirty (30) days of the commencement of mediation and does not involve a claim for temporary or preliminary injunctive relief, the Parties shall arbitrate and not litigate their dispute. The arbitration shall be conducted in Seattle, Washington in accordance with the applicable American Arbitration Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration before a single arbitrator. The final decision of the arbitrator in such an instance shall be set forth in writing, signed by the arbitrator, and shall be binding on each Party. The Parties agree that the final award by the arbitrator may be entered as a judgment in any federal or state court with jurisdiction. Each party shall be responsible for its own fees and costs, including attorneys' fees related to the arbitration. Additionally each party agrees to pay fifty percent (50%) of the arbitration fees and administrative charges charged by the arbitrator. The Parties agree to litigate claims for temporary or preliminary injunctive relief in the Superior Court for Kitsap County, Washington.

12. **COMPLIANCE WITH LAWS**

12.1 **Compliance with Laws**. Each party will comply with applicable federal, state, and local laws and regulations, as amended, including but not limited to those specifically identified under the *Compliance with Applicable Law* Sections in the respective HCA Contracts, *Apple Health Subcontract Self-Assessment Checklist* as memorialized in the *Washington State Programs Regulatory Requirements Appendix* attached hereto.

12.2 **Non-Discrimination**. Neither party shall discriminate against any person because of race, color, national origin, ancestry, religion, gender, marital status, age, sexual orientation, gender identity (including gender presentation), health status, presence of a sensory, mental or physical disability, use of a service animal, or any other reason(s) prohibited by law. Neither party shall use any policy or procedure which has the effect of discriminating on the basis of any of the foregoing.

12.3 **Accommodations**. Salish shall make reasonable accommodations, as required by state and federal law, to ensure Members with disabilities are able to access and take full advantage of the Services on an equal basis with all other Members.

12.4 **Enrollee Rights**. Salish shall comply with any applicable federal and state laws that pertain to Member rights, and ensure that its staff and providers protect and promote those rights when furnishing Services to Members.

13. **GENERAL**

13.1 **Independent Contractor**. MCO and Salish are separate legal entities and independent contracting parties. Each party shall exercise ultimate control over its assets, operations, employees, and subcontractors, and retain ultimate authority and responsibility in exercising its powers, duties, and responsibilities, subject to the rights and responsibilities assumed under this Agreement.

13.2 **Work Product**. MCO shall retain full ownership and title to, and all other rights in, any data, materials, forms, equipment, and supplies obtained by Salish from or on behalf of MCO, including Project Data and all MCO Confidential Information. Works of authorship, reports, deliverables, and inventions that are designed, created, developed, or conceived in connection with the Services (collectively, the "Work Product") will be considered "works made for hire" as defined in the Copyright Act at 17 U.S.C. § 101. To the extent the Work Product is not "works made for hire," Salish hereby assigns all rights in the Work Product to MCO. Salish will execute any assignments and any other documents, and take any other action MCO reasonably requests, without payment of additional consideration, as may be necessary or advisable to convey full ownership of all intellectual property rights to the Work Product and to protect MCO's interest in the Work Product. This ownership provision does not apply to Salish's pre-existing intellectual property or to any invention or other creative works for which no MCO data, equipment, supplies, facility, or Confidential Information was used, which was developed entirely on Salish's own time, and which do not relate to MCO activities or the Services.

13.3 **Use of a Party's Marks.** Neither party shall use the other's name, logo, trademark, or other identifying information, or make any public communication or advertisement related to this Agreement or a party's performance hereunder, without the express written consent of the other party.

13.4 **Notice**. All notices or other communications required or permitted to be given hereunder shall be in writing and deemed to have been delivered to a party upon: (i) personal delivery to that party; (ii) if simultaneously mailed as provided herein, upon electronically confirmed delivery by facsimile to the telephone number provided by the party for such purposes; (iii) upon deposit for overnight delivery with a bonded courier holding itself out to the public as providing such services, with charges prepaid; or (iv) four (4) business days following deposit with the United States Postal Service, postage prepaid, and in any case addressed to the party as set forth below, or to another address that the party provides by notice to the other party:

If notice is to United, it shall be sent to:

UnitedHealthcare of Washington, Inc.
Attn: Director of Outpatient Behavioral Health Contracting – Western U.S.
Attn: Washington Behavioral Health Executive Director
1111 3rd Avenue, Suite 1100
Seattle, Washington 98101

If notice is to Salish, it shall be sent to:

Stephanie Lewis, Regional Administrator
Salish Behavioral Health Administrative Services Organization
614 Division Street
MS-23
Port Orchard, WA 98366

13.5 **Expenses**. Except as specifically provided herein, each party shall bear its own expenses related to its performance hereunder, including legal and accounting fees.

13.6 **Assignment**. Salish may not assign or transfer this Agreement without MCO's prior written consent. Any assignment without such consent shall be of no force and effect. MCO may not assign this Agreement without the prior written approval of the HCA. This Agreement shall be binding on the parties' successors and lawful assigns.

13.7 **HCA Required Subrogation**. In the event that any government entity undertakes a criminal, civil, or administrative action recovery against an entity that has directly or indirectly received funds under this Agreement, Salish agrees to subrogate to the State of Washington any claims arising under this Agreement that Salish has or may have against the entity from which recovery is sought.

13.8 **Choice of Law; Venue**. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington, without reference to conflict of laws principles, except to the extent pre-empted by federal law. All disputes arising from or relating to this Agreement will be within the exclusive jurisdiction of the state and/or federal courts located in Washington, and the parties hereby consent to such exclusive jurisdiction and waive any objections to venue.

13.9 **No Third Party Rights**. Nothing herein shall be construed or be deemed to create any rights or remedies in or for the benefit of any third party.

13.10 **Entire Agreement**. This Agreement, including all attachments, exhibits, and addenda hereto, constitutes the entire agreement between the parties with respect to its subject matter and supersedes all previous or contemporaneous agreements and understandings with respect to such subject matter.

13.11 **Construction**. This Agreement may be amended only by a writing signed by an authorized representative of each party. If a term or provision of this Agreement is held invalid or unenforceable, the invalid term or provision will be amended to achieve as nearly as possible the same economic and operational effect as the original, and all other terms and provisions of this Agreement will remain in full force. Waiver by either party of a breach of any provision herein by the other party will not operate or be construed as a waiver of any subsequent, similar, or other breach. The captions and headings appearing herein are for reference only and will not be considered in construing this Agreement. As used in this Agreement, "including" means "including without limitation." Ambiguities shall be reasonably construed in accordance with all relevant circumstances, and shall not be construed against either party, irrespective of which party is deemed to have authored the ambiguous provision. The rights of each party granted herein are cumulative and are in addition to any others that a party is entitled to by law. This Agreement may be executed in any number of counterparts, each of which will be an original and all of which together will constitute one and the same instrument.

14. **EXHIBITS INCLUDED IN AGREEMENT**

This Agreement contains the Exhibits identified below:

- Exhibit A-1 (Delegation Grid)
- Exhibit A-2 (Claims and Encounters Delegation Grid)
- Exhibit A-3 (Crisis Services – Additional Delegation Requirements Grid)
- Exhibit A-4 (Quality Improvement (QI) Delegation Grid)
- Exhibit A-5 (Utilization Management (UM) Crisis Services Delegation Grid)
- Exhibit A-6 (Business Requirements for sending 837-I & 837-P)
- Exhibit B (Crisis Services Statement of Work)
- Exhibit C (Compensation)
- Exhibit D (Business Associate Agreement)
- Exhibit E (Sample Provider Agreement)
- Exhibit F (Washington State Programs Regulatory Requirements Appendix)

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

UNITEDHEALTHCARE OF WASHINGTON, INC.

_____
Signature

_____
Name

_____
Title

_____
Date

SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZAITON, By KITSAP COUNTY BOARD OF COMMISSIONERS, Its Administrative Entity

KITSAP COUNTY BOARD OF COMMISSIONERS

Approved this ____ day of _____, 2019

_____
Signature

_____, Chair
Name

_____
Signature

_____, Commissioner
Name

_____
Signature

_____, Commissioner
Name

ATTEST:

_____
Signature

_____, Clerk of the Board
Name

UNITEDHEALTHCARE OF WASHINGTON, INC. ("United")
Delegation Grid
Exhibit A-1

The purpose of the following grid is to specify the responsibilities of Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, under the Agreement with respect to the specific activities that are delegated for Credentialing. The grid also describes the semi-annual reporting requirements. The specific scope of activities that relates to this delegation arrangement includes Behavioral Health Provider Credentialing. These activities may not be sub-delegated without notification to, and at prior approval by, United. (See section below on subdelegation.)

United does not formally delegate the responsibility for performing quality management and improvement activities on behalf of United. However, United does require Delegates to maintain a quality improvement and management program pertaining to delegated activities, and participate and cooperate in United quality improvement program, collect data for United quality improvement activities, and carry out corrective actions as required by United.

The delegation grid may be amended from time to time during the term of this Agreement by United to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

United will provide member experience and clinical performance data as requested by the Delegate and if it is relevant to the delegated responsibilities or activities. Member experience data may include but are not limited to: complaints, CAHPS 5.0H Survey results or other data collected on members' experience with the delegate's services. Clinical performance data may include: HEDIS measures, claims and other clinical data collected by the organization.

The process by which United evaluates Delegate performance and the remedies available to United if Delegate does not fulfill its' obligations are as follows.

Process of Evaluating Delegate's Performance

United will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. In addition, United will:

- Conduct an annual audit, to be performed offsite or onsite, to ensure compliance with all delegated activities,
- Provide written feedback on the results of the annual audit, and
- Implement corrective action plans if the delegate does not fully meet delegation requirements.

The consequences for failure to perform may include but are not limited to:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate

On-going performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. United reserves the right to conduct annual or ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulators

Corrective Action Plans

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification requirements, United will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, United reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement all together.

Subdelegation

It may be allowable for a Delegate to subdelegate specific activities that relate to Behavioral Health Crisis Services. Subdelegation will require approval by United evidenced by the signature at the end of this Delegation Grid and upon submission of a Delegation Chart (template to be provided by United). If the Delegate chooses to subdelegate any activities, the Delegate is giving the third-party authority to perform the delegated activities. As such, the Delegate is responsible for ongoing oversight of the subdelegate's performance and is required to report performance results to United.

United retains all other Credentialing & Recredentialing functions not specified in this agreement as the delegate's responsibility.

DELEGATION GRID				
Function	**Delegation Status**	**Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**United Activities**
CR 7: Assessment of Organizational Providers	☒ Delegated ☐ Not Delegated	ALL	N/A	N/A
Decision Making	☒ Delegated ☐ Not Delegated	Agency: Approved, Denied, Terminated, Pending. All verifications have 180 days freshness from date of decision.	At least monthly standard reporting in electronic format to designated MCO Staff/email	MCO retains the right to approve, suspend and terminate individual practitioners, providers and sites
Ongoing Monitoring	☒ Delegated	State Exclusion Website OIG	Completed by 15th of Month-Delegate is to	N/A

	☐ Not Delegated	SAM	maintain documentation	
Disclosure and/or Ownership Form	☒ Delegated ☐ Not Delegated	Collected at initial contracting and 36 months after or if any changes	N/A	If applicable to MCO

UNITEDHEALTHCARE OF WASHINGTON, INC. ("United")
Claims and Encounters Delegation Grid
Exhibit A-2

The purpose of the following grid is to specify the responsibilities of Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, under the Agreement with respect to the specific activities that are delegated regarding Claims and Encounter Data. The grid also describes the reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the delegation of Claims Processing and Payment and Encounter Data Submission by United to Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by United to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which United evaluates Delegate's performance and the remedies available to United if Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit A, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit A, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Delegate's Performance

United will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. In addition, United will:

- Conduct an annual audit to ensure all delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the delegate does not fully meet Compliance Requirements.

If United determines that Delegate has failed to adequately perform the delegated activities, United may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. United reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, United will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, United reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for Delegate to subdelegate specific activities that relate to Claims and Encounter Data. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of United. In addition to the requirements for subdelegation set forth in the Agreement, Delegate will submit to United a Delegation Chart (template to be provided by United). If a subdelegation is approved, the Delegate will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to United.

CLAIMS/ENCOUNTER BUSINESS REQUIREMENTS				
Function	**Delegation Status**	**Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**United Activities**
1. Encounter Data Definition of Encounter Data	☒ Delegated ☐ Not Delegated	Encounter Data means records of physical or behavioral health care services submitted as electronic data files created by the Delegate's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.	N/A	N/A
2. Encounter Data Dedicated Resource	☒ Delegated ☐ Not Delegated	Designate a person dedicated to work collaboratively with United on quality control and review of encounter data submitted to HCA.	N/A	United resource will partner with Delegate resource for quality control and review of encounter data.

3. Encounter Data Reporting requirements	☒ Delegated ☐ Not Delegated	Submit complete, accurate, and timely data for all services for which the Delegate's has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA.	Weekly	United will provide oversight of Delegate encounter data.
4. Encounter Data Expected turnaround time reporting encounter data	☒ Delegated ☐ Not Delegated	Encounter data must be submitted to United at a minimum weekly, and no later than thirty (30) calendar days from the end of the month in which the Delegate's paid the financial liability.	Weekly	United will monitor turnaround.
5. Encounter Data Submission and edits	☒ Delegated ☐ Not Delegated	Submitted encounters and encounter records must pass all system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Delegate	N/A	N/A
6. Encounter Data Duplicates	☒ Delegated ☐ Not Delegated	Submitted encounters or encounter records must not be a duplicate of a previously	N/A	N/A

		submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.		
7. Encounter Data RCW 42.56.270(11)	☒ Delegated ☐ Not Delegated	The Delegate must report the paid date, paid unit, and paid amount for each encounter. The "paid amount" data is considered the Delegate's proprietary information and is protected from public disclosure. "Paid amount" is defined as the amount paid for the service, or zero pay for cost based/invoice payments.	N/A	N/A
8. Encounter Data 42 C.F.R. § 438.606 Attestations	☒ Delegated ☐ Not Delegated	The Delegate shall send attestation to United to certify the accuracy and completeness of all encounter data with each file upload.	Monthly	United will receive monthly attestations from the Delegate. United will review and complete the monthly certification letter and send to the HCA.
9. Encounter Data 837 Requirements	☒ Delegated ☐ Not Delegated	The Delegate must be able to meet the requirements outlined in the attached requirements document.	N/A	N/A

10. Encounter Data Quality Assurance	☒ Delegated ☐ Not Delegated	The Delegate must validate the accuracy and completeness of all encounter data for behavioral health care services compared to the year-to-date general ledger of paid claims for the health care services.	Quarterly	United will oversee the quality assurance of the Delegate encounters.
11. Encounter Data Form D	☒ Delegated ☐ Not Delegated	Within sixty (60) calendar days of the end of each calendar quarter, the Delegate shall provide aggregate totals of all encounter data submitted and accepted during that quarter on the Apple Health - Integrated Managed Care Quarterly Encounter/General Ledger Reconciliation (Form D). Delegate shall reconcile the cumulative encounter data submitted and accepted for the quarter and contract year with the general ledger paid claims for the quarter. The Delegate shall provide justification for any discrepancies.	Quarterly	United will submit Form D to HCA.

		Delegate will complete Form D and send to United. HCA will approve or reject the discrepancy justifications and notify United of the decision 120 calendar days of the end of each calendar quarter.		
12. Claims Payment Standards Section 1902(a)(37) of the Social Security Act 42 C.F.R. § 447.46 WAC 284-170-431	☐ Delegated ☒ Not Delegated	The Delegate shall meet the timeliness of payment standards. These standards shall also be applicable to State-only and federal block grant fund payments. To be compliant with payment standards the Delegate 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 95 percent of clean claims within ninety (90) calendar days of receipt. The Delegate shall provide a monthly report to United of	N|A	N|A

		claims timeliness results. If standard is not met, provide root cause and corrective action until performance expectation is met.		

13. Claims processing Top Claims Denials Reporting	☐ Delegated ☒ Not Delegated	The Delegate shall produce and submit a quarterly claims denial analysis report. The first report each calendar year is due May 30th for services processed January – March. The report shall include the following data: Total number of approved claims for which there was at least one denied line. Completely denied claims. Total number of claims adjudicated in the reporting claim. Total number of behavioral health claims denied by claim line. Summary by reason and type of claims denied. The total number of denied claims divided by the total number of claims. For each of the five network billing providers with the highest number of total denied claims,	Quarterly	N|A

		the number of total denied claims expressed as a ratio to all claims adjudicated. Total number of Behavioral Health claims received, that were not approved upon initial submission. The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted. The top five reasons for behavioral health claims being rejected upon initial submission. The report shall include a narrative, including the action steps planned to address. The top five (5) reasons for denial, including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of denied claims and actions to address them.		

14. TPL Reporting	☐ Delegated ☒ Not Delegated	The Delegate shall submit a quarterly *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as claims that the Delegate denies due to TPL coverage. The report shall include recoveries or denied claim payments for any covered service. The Delegate shall calculate cost savings in categories. The Delegate shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data. The report is due by the sixtieth (60th) calendar day following the end of the quarter. The Delegate shall submit to United on the 15th of the month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care	N|A	N|A

		insurance coverage with any carrier, including the Delegate. The Delegate shall submit to United on the 20th of the following month a report (Subrogation Rights of Third-Party Liability (TPL) – Investigations) of any Enrollees who the Delegate newly becomes aware of a cause of action to recover health care costs for which the Delegate has paid under the Agreement.		
15. Participating and Non-Participating Reporting	☐ Delegated ☒ Not Delegated	The Delegate shall track and record all payments to Participating Providers and Non-Participating Providers in a manner that allows for reporting to United the number, amount, and percentage of claims paid to Participating Providers and Non-Participating Providers separately. The Delegate shall identify the type of providers and Subspecialty. The Delegate shall also	N/A	N|A

		track, document and report to the United any known attempt by Non-Participating Providers to balance bill Enrollees. The Delegate shall provide annual reports to United for the preceding state fiscal year (July 1 through June 30). The reports shall indicate the proportion of services provided by the Delegate's Participating Providers and Non-Participating Providers, by county, and including hospital-based physician services. Delegate shall submit the reports to United no later than August 15 of each year.		
16. Sub-delegation Agreements Delegate sub-delegation agreements with a vendor	☐ Delegated ☒ Not Delegated	Notify the United of sub-delegation vendor agreements the Delegate has; what duties do they perform, and how often.	N/A	N/A
17.Claims/Encounter Delegation Oversight Audit	☒ Delegated	United is required to perform an annual oversight delegation audit of	Annual	United will review the claims data set for the following:

Quality Assurance Audits	☐ Not Delegated	encounter data reporting/ claims processing. The objective of this audit is to assess the effectiveness of key internal controls by ensuring the accuracy, completeness, and timeliness of the encounter/claims processing functions. Delegate will provide Unitedclaims data set for specified time period.		• Review encounter/claims universe sample of all claims paid or denied for 1 year; • Verify the member was eligible for benefits on the dates of service; • Review encounter submission and reconciliation to ensure requirements are met; • Review claim payment calculations and verify that claims were paid accurately; • Verify claims were submitted by the provider within 365 days of dates of service; •Review responses to audit questionnaire to ensure compliance.

UNITEDHEALTHCARE OF WASHINGTON, INC. ("United")
Crisis Services – Additional Delegation Requirements Grid
Exhibit A-3

The purpose of this Crisis Services Delegation Grid is to specify the responsibilities of Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, under the Agreement with respect to the specific activities that are delegated for Crisis Services, including reporting requirements.

"Crisis Services," as defined by the HCA, means evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional.

The delegation grid may be amended from time to time during the term of this Agreement by United to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which United evaluates Delegate's performance and the remedies available to United if Delegate does not fulfill its obligations.

Process of Evaluating Delegate's Performance

United will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. Unless otherwise specified by United in writing, routine reports and documentation must be delivered to the designated United delegation oversight staff whose contact details will be provided on implementation of this agreement. In addition, United will:

- Conduct an annual audit to ensure all delegated activities comply with applicable delegation standards,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the delegate does not fully meet delegation requirements.

If United determines that Delegate has failed to adequately perform the delegated activities, United may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. United reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, United will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, United reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement all together.

Subdelegation

It may be allowable for Delegate to subdelegate specific activities that relate to Crisis Services (Other Reqs). As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of United. In addition to the requirements for subdelegation set forth in the Agreement, Delegate will submit to MCO a Delegation Chart (template to be provided by United). If a subdelegation is approved, the Delegate will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to United.

United retains all other functions not specified in this agreement, including those relating to Reporting Requirements, as the delegate's responsibility.

Function	Delegation Status	Delegate Activities	Reporting: Data, Frequency, & Submission	United Activities
HCA CONTARCT REQUIREMENTS				
24-7 Availability	☒ Delegated ☐ Not Delegated	Crisis Services shall be available 24-7-365, including regional crisis hotline that provides screening and referral services		
Immediate Access	☒ Delegated ☐ Not Delegated	Crisis Services shall be available to Members without the need for the member to complete an intake evaluation or other screening or assessment processes.		

Function	Delegation Status	Delegate Activities	Reporting: Data, Frequency, & Submission	United Activities
Encounter Data	☒ Delegated ☐ Not Delegated	Require submission of complete and accurate encounter data related to the provision of Crisis Services in HCA-prescribed formats	Weekly basis provide to United batches of such data	

Function	Delegation Status	Delegate Activities	Reporting: Data, Frequency, & Submission	United Activities
WASHINGTON ADMINISTRATIVE CODE REQUIREMENTS				
Crisis Services standards	☒ Delegated ☐ Not Delegated	Crisis services shall be performed in accordance with all state agency requirements, including Washington Department of Health and HCA regulatory requirements, applicable to Crisis Services and Crisis Services providers		
Daily Crisis Service Log	☒ Delegated ☐ Not Delegated	Daily Crisis Services will be kept on a standardized log, with data elements and formats that are mutually agreed upon, and submitted each business day to the MCO.	Daily (business day)	United will assist as needed to coordinate any services.

UNITEDHEALTHCARE OF WASHINGTON, INC. ("United")
Quality Improvement (QI) Delegation Grid
Exhibit A-4

The purpose of the following grid is to specify the responsibilities of Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, under the Agreement with respect to the specific activities that are delegated for Quality Improvement. The grid also describes at minimum semi-annual reporting requirements. The specific scope of activities that relates to this delegation arrangement includes Behavioral Health Telephone Access for Crisis Services at the discretion of the United. These activities may not be sub-delegated without notification to, and prior approval by, United. (See section below on subdelegation.)

United does not formally delegate the responsibility for performing quality management and improvement activities on behalf of United. However, United does require Delegates to maintain a quality improvement and management program pertaining to delegated activities, and participate and cooperate in United quality improvement program, collect data for United quality improvement activities, and carry out corrective actions as required by United.

The delegation grid may be amended from time to time during the term of this Agreement by United to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The process by which United evaluates Delegate performance and the remedies available to United if Delegate does not fulfill its' obligations are as follows.

Process of Evaluating Delegate's Performance

United will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. Unless otherwise specified by United in writing, routine reports and documentation must be delivered to the designated United delegation oversight staff whose contact details will be provided on implementation of this agreement.

In addition, United will:

- Conduct an annual audit, to be performed offsite or onsite, to ensure compliance with all delegated activities,
- Provide written feedback on the results of the annual audit, and
- Implement corrective action plans if the delegate does not fully meet delegation requirements.

The consequences for failure to perform may include but are not limited to:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate

On-going performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. United reserves the right to conduct annual or ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulators.

Corrective Action Plans

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification requirements, United will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, United reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement all together.

Subdelegation

It may be allowable for a Delegate to subdelegate specific activities that relate to Crisis Services telephone operations. Subdelegation will require approval by United evidenced by the signature at the end of this Delegation Grid and upon submission of a Delegation Chart (template to be provided by United). If the Delegate chooses to subdelegate any activities, the Delegate is giving the third- party authority to perform the delegated activities. As such, the Delegate is responsible for ongoing oversight of the subdelegate's performance and is required to report performance results to United.

United retains all other Quality Improvement functions not specified in this agreement as the delegate's responsibility.

DELEGATION GRID				
Function	**Delegation Status**	**Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**United Activities**
Behavioral Health Telephone Access *[QI 4.B.1 and QI 4.B.2*]	☒ Delegated ☐ Not Delegated	Telephones are answered by a live voice within 30 seconds with an abandonment rate within 5 percent.	Submission to United of a monthly summary report that includes total calls, call answer time and abandonment rate. Reports provided in electronic or hard copy.	United will receive and review monthly reports for performance review.

UNITEDHEALTHCARE OF WASHINGTON, INC. ("United")
Utilization Management (UM) Crisis Services Delegation Grid
Exhibit A-5

The purpose of the following grid is to specify the responsibilities of Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, under the Agreement with respect to the specific activities that are delegated for Utilization Management. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the delegation of Behavioral Health Utilization Management Crisis Services by United to Delegate.

The delegation grid may be amended from time to time during the term of this Agreement by United to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which United evaluates Delegate's performance and the remedies available to United if Delegate dos not fulfill its obligations.

Process of Evaluating Delegate's Performance

United will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Delegate performance on an ongoing basis. In addition, United will:

- Conduct an annual audit to ensure all delegated activities comply with applicable delegation standards,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the delegate does not fully meet delegation requirements.

If United determines that Delegate has failed to adequately perform the delegated activities, United may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. United reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, United will work with Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, United reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement all together.

Subdelegation

It may be allowable for Delegate to subdelegate specific activities that relate to Utilization Management Crisis Services. As provided for under the Agreement and as set forth herein, subdelegation requires the prior written approval of United. In addition to the requirements for subdelegation set forth in the Agreement, Delegate will submit to MCO a Delegation Chart (template to be provided by United). If a subdelegation is approved, the Delegate will be responsible for ongoing oversight of the subdelegate's performance and will be required to report performance results to United.

United retains all other Utilization Management functions not specified in this agreement as the delegate's responsibility.

DELEGATION GRID				
Function	**Delegation Status**	**Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**United Activities**
Members and practitioners can access staff to discuss UM issues *[UM 3]*	☒ Delegated ☐ Not Delegated	-Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. *[UM 3.A.1]* -Staff can receive inbound communication regarding UM issues after normal business hours. *[UM 3.A.2]* -Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. *[UM 3.A.3]* -TDD/TTY services for members who need them. *[UM 3.A.4]* - Language assistance for members to discuss UM issues. *[UM 3.A.5]*	At least semi-annual reporting on crisis line utilization delivered in electronic format to designated MCO staff/email.	United will receive and review semi-annual reports for performance review.

EXHIBIT A-6
Business Requirements for sending 837-I & 837-P

Encounter/File Format must be ANSI ASC X12N Version 5010 per State & Federal Guidelines.

Resources For Creating Files:

- 837 Healthcare Claim Professional and Institutional Guide (IG) version 5010. To purchase the IGs visit the http://www.wpc-edi.com/ (www.wpc-edi.com) or call (425) 562-2245.
- HIPAA 837I and 837P Implementation Guide @ www.wpc-edi.com/hipaa/HIPAA_40.asp
- 837 Encounter Data Companion Guide from State of Washington http://www.hca.wa.gov/
- Encounter Data Reporting Guide from State of Washington http://www.hca.wa.gov/
- Service Encounter Reporting Instructions (SERI) https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri
- Note: Follow SERI guidelines and MCO guidelines too when do not conflict with SERI guidelines.

High Level Requirements of the BH ASO:

1. Own the claim adjudication process for crisis claims. Crisis service codes shall include: H0030 and H2011.
2. Create and submit encounter data for all processed claims except completely denied claims.
3. The encounter data shall include the paid date and amount paid for each encounter header and line.
4. SFTP will need to be set up for transmitting encounter files.
5. Encounter data will be submitted weekly in accordance with the Encounter Data Reporting Guide and the IMC Service Encounter Reporting Instructions (SERI).
6. Separate file submissions will be created for IMC and BH-ASO. Every MCO has a unique Trading Partner ID (TPID) for each program. MCOs will coordinate with the BH-ASO to share TPID.
7. Encounter data to be submitted accurately and timely to send to the HCA within 30 days of claim payment.
8. Retrieve and track the file transmission responses sent. The MCOs will send the response files to monitor and resolve.
9. If files fail, correct the files and resubmit. Add an R to the file naming convention original file name portion of the first resubmission, R, R1, R2, etc. until file is accepted.
10. Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept as listed in the Encounter Data Reporting Guide.
11. Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

12. Review the response file and perform tracking to ensure each encounter sent receives a response file response of “accepted” or “rejected”.
13. If you are missing response file on any submitted encounters, allow 2 weeks (2 more response files) for slow returns from HCA. Encounters without a response file beyond two weeks need to be reported to MCO to investigate.
14. If encounters are rejected, you should correct the errors and resubmit them per EDRG guidelines.
15. Submit a weekly report to each MCO of Submitted, Accepted and Rejected encounters with claim counts, line counts and paid dollar amounts.
16. Provide weekly reports of quarterly data to ensure Rejected encounters are less than 1% of total encounters paid each quarter (does not apply for zero paid encounters).
17. Provide a designated team member from your encounter data team to work collaboratively with our encounter data team on control and review of encounter data submitted to each MCO. MCO will have a collaboration liaison.

EXHIBIT B
CRISIS SERVICES STATEMENT OF WORK

Salish Behavioral Health Administrative Services Organization ("Salish"), through Kitsap County, its administrative entity, shall provide to UnitedHealthcare of Washington, Inc. ("United") (also referred to as "MCO") the following services related to Salish's administration of Crisis Services on behalf of MCO:

1. General

1.1. During the term specified in the Agreement, Salish will provide the BH-ASO services necessary and sufficient for MCO to fulfill its obligations for "Crisis Service" provision as outlined in Section 9.15 of the AH-FIMC Contract. In the event that HCA revises the AH-FIMC Contract and changes the applicable section numbers, the obligations of Salish and MCO related to the fulfillment of "Crisis Service" remain intact and the section numbers referred to herein are assumed to change accordingly.)

1.2. In accordance with Section 9.15.3.1 of the AH-FIMC Contract, any sub-capitation arrangement between MCO and Salish for the services described in this Exhibit B must be reviewed and approved by HCA.

2. Covered Programs

2.1. Salish's services apply to MCO's Members in the Salish Regional Service Area enrolled in the benefit plans.

3. Covered Crisis Services

3.1. "Crisis Services" means evaluation and treatment of behavioral health crisis to all Medicaid-enrolled individuals experiencing a crisis. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional.

3.2. Salish shall arrange for the provision of Crisis Services under this Agreement in a manner that complies with applicable terms and conditions of the AH-FIMC Contract, including but not limited to the provisions of Section 9.15 of the AH-FIMC Contract.

3.3. Crisis Services shall be available twenty (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year. This shall include availability of a 24/7 regional crisis hotline that provides screening and referral to MCO's network of local providers, where applicable, and availability of a 24/7 mobile crisis outreach team.

3.3.1. Salish shall ensure that individuals are able to access Crisis Services without full completion of intake evaluations and/or other screening and assessment processes.

3.4. Salish shall collaborate with MCO to develop and implement strategies to coordinate care with community behavioral health providers for individuals with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that address the development and incorporation of wellness recovery action plans and mental health advance directives in treatment planning consistent with requirements in Section 14 of AH-FIMC Contract.

3.4.1. For MCO's Members calling for crisis services who already receive WISe or PACT services, Salish and/or its Subdelegate will attempt to coordinate with existing case management support.

3.5. Salish will evaluate and monitor the performance of the crisis system and develop corrective action where needed. Examples of how evaluation and monitoring may be carried out include, but are not limited to, the following:

3.5.1. Comparison of current and historical utilization.
3.5.2. Analysis of member and provider feedback.
3.5.3. Participation in region-level discussions led by the ACH.

3.6. Crisis service codes shall include:

3.6.1. H0030
3.6.2. H2011

4. IT Implementation

4.1. Per Section 9.15.6.3 of the AH-FIMC Contract, Salish shall establish information systems to support data exchange with MCO consistent with the requirements of the AH-FIMC Contract, including, but not limited to eligibility interfaces, exchange of claims and encounter data for Crisis Services provided or arranged by Salish pursuant to the Agreement, and sharing of care plans and mental health advance directives necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 CFR Part 2.

4.1.1. For each transaction type noted above, Salish will collaborate with MCO to develop and obtain approval of all business requirement documents, conduct necessary end-to-end testing and establish agreed upon service level agreements (SLAs); these of which will become an amendment to this Agreement.

4.1.2. Per Section 9.15.4 of the AH-FIMC Contract, and based upon the defined and agreed upon business requirements and completed acceptance testing performed by MCO, Salish will submit complete, accurate and timely encounter data related to the provision of Crisis Services to MCO in formats prescribed by HCA, and in accordance with deadlines that MCO must adhere to in order to avoid financial penalties imposed by

HCA. MCO will provide Salish with applicable file format and submission schedule information.

4.1.3. Salish will collaborate with MCO to develop business requirements, technical specifications, conduct end-end testing and obtain MCO's approval prior to moving any system changes into its production systems.

4.2. Per Section 9.15.6.4 of the AH-FIMC Contract, MCO shall make provisions for Salish to access a Member's individual service plan on a 24/7 basis for clients receiving BH services, where applicable.

5. Metrics and Monitoring

5.1. Salish will hold all of its subcontractors to the service level agreements and performance guarantees mandated by the HCA for handling of calls to the crisis line. Salish will provide MCO with the service level targets as well as monthly reports of service level performance. Salish will work with subcontractors to provide calls for audit upon MCO's request.

6. Data and Reporting

6.1. Salish shall provide to MCO the following data related to Crisis Services on a monthly basis:

6.1.1. The number of MCO Members served by the crisis system.

6.1.2. The number and percentage of MCO Members referred for mobile outreach regardless of referral point (i.e., source of referral to the crisis line).

6.1.3. The estimated percentage of calls to the crisis hotline successfully diverted from Emergency Departments and/or ITA commitments.

6.1.4. Salish and MCO will collaborate to reach mutual agreement on the content and format of daily reporting, for the purpose of providing MCO timely information regarding Members in potential need of care management services. This may include reports of Members scheduled for release from jail, to allow MCO to connect Members with behavioral health services prior to release.

6.1.5. Salish will compile and report directly to DSHS Behavioral Health Non Encounter Transactional Data related to crisis and involuntary treatment services, conforming to the DSHS data dictionary specifications. This data will also be provided to MCO.

EXHIBIT C
COMPENSATION

JANUARY 1, 2021 – DECEMER 31, 2021

This Exhibit, along with the Administrative Services Agreement ("Agreement"), sets forth the terms and conditions which are applicable to the State Program Health Plan, as defined below.

ARTICLE 1
DEFINITIONS

The following terms shall have the meaning attributed below for purposes of the State Program Health Plan, as described in this Exhibit. Capitalized terms not otherwise defined herein shall have the meaning assigned to them in the Agreement.

1.1 Apple Health: The State's prepaid managed care health program for Medicaid-eligible persons.

1.2 Capitation Payments: Monthly payments made to Salish Behavioral Health Administrative Services Organization ("Salish"), through Kitsap County, its administrative entity, on a prepaid basis for Covered Behavioral Health Services provided or arranged by Salish under this Agreement.

1.3 State Program Member: An individual who is currently enrolled with MCO for the provision of services under a State Program, who resides in the service area covered by Salish.

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

1.5 State Contract(s): MCO's contracts, existing from time to time, with the State for the purpose of providing and paying for Covered Behavioral Health Services to State Program Members.

1.6 State Program(s): The State of Washington Medicaid and Apple Health programs. For purposes of this Exhibit, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

1.7 State Program Health Plan: The prepaid health plan operated by MCO pursuant to one or more State Contracts which provides Covered Behavioral Services to individuals eligible for the State Programs.

ARTICLE 2
COMPENSATION

2.1 Capitation Payments for Salish State Program Members. MCO shall make monthly Capitation Payments to Salish as payment for providing and arranging Covered Crisis Services to State Program members. Capitation Payments shall be paid as follows, subject to applicable adjustments set forth in the Agreement and this Exhibit:

2.1.1 Salish Capitation rate of $3.33 per member per month (pmpm), with thirteen percent (13%) for administration of the reconciled claims.

2.1.2 As specified in the Agreement, Salish and all Providers, and employees thereof, shall submit encounters (per MCO requirements) to MCO for Covered Crisis Services rendered to State Program Members. Said claim-based encounters shall be submitted electronically, either directly to MCO using HIPAA compliant formats or codes, or through a clearinghouse, as needed to convert non-compliant data formats and codes to HIPAA standard formats and codes.

2.1.3 Payment by MCO under this Exhibit represents the entire payment for the provision of Covered Crisis Services to State Program Members where such Covered Crisis Services are covered by Capitation Payments. No fee for service payment shall be made to Salish by MCO for providing Covered Crisis Services to State Program Members except for those Covered Crisis Services that are provided by Salish but not covered by Capitation Payments ("Non-Capitated Services").

2.1.4 In addition to Covered Crisis Services (including Crisis Line), the pmpm payment in this section includes Behavioral Health – Administrations Services Organization (BH-ASO) administration and Ombuds Services.

2.2 Capitation Payment Due Date. Each Capitation Payment shall be due and payable by the tenth (10th) day of the month for the current month's Capitated Covered Behavioral Health Services. In the event the tenth (10th) day of the month is not a business day, the Capitation Payment shall be due and payable on the next business day following the tenth (10th) day of the month.

2.3 Capitation Payment Documentation. MCO shall provide Salish with a capitation roster in support of each Capitation Payment.

2.4 Adjustments to Capitation Payments.

2.4.1 Retroactive adjustments due to enrollment changes or other changes affecting the number of capitated State Program Members may be made by MCO to the Capitation Payment following the process established by the State, or such other period of time as may be required by applicable law or the State. Such adjustments may include but not be limited to deductions from Capitation Payment for:

a) Any overpayments, until such time and to the extent the amounts owed to MCO are repaid.

b) Retroactive capitated State Program Member additions or deletions.

2.4.2 Capitation Payments shall be subject to retroactive adjustments either upward or downward due to retroactive changes in the number of State Program Members attributed to Salish during a contract period where Agreement is effective. MCO will use commercially reasonable efforts to make retroactive adjustments to

Capitation Payments within ninety (90) days after receiving notification of changes from the State. Adjustments may be made through offsets against future Capitation Payments or other payments under this Agreement.

2.5 Audit. MCO shall have the right to perform routine medical record chart audits at such time or times as MCO may reasonably elect to determine the completeness and accuracy of claims submissions. Salish acknowledges and agrees that failure to provide MCO with complete encounter submissions required by this Section in a timely and complete manner will constitute a material breach of the Agreement. In the event that claims submissions are found to be incomplete, MCO reserves the right upon sixty (60) days prior written notice to terminate this Exhibit or implement a fee-for-service payment methodology. In addition to MCO's other rights and remedies pursuant to this Agreement, MCO shall have the right to terminate this Exhibit and/or the Agreement.

2.6 Division of Financial Responsibilities. The parties acknowledge and agree to comply with their respective obligations specific to Covered Crisis Services attached as Exhibit B (CRISIS STATEMENT OF WORK).

2.7 Payments Following Termination of Agreement. Following termination of this Agreement, MCO shall make Capitation Payments to Salish as compensation for providing and arranging Covered Crisis Services to remaining Salish Members until such Members are reassigned.

2.8 Last Month's Capitation. In the event of termination of this Agreement, MCO may withhold from Salish's last month's Capitation Payment an amount reasonably estimated by MCO to equal the amount Salish owes to MCO pursuant to the terms of this Agreement and for which MCO does not have reserves or financial assurances.

2.9 Adequacy of Compensation. Salish agrees to accept payment as provided herein as payment in full for providing and arranging the Covered Behavioral Health Services required under this Agreement, whether that amount is paid in whole or in part by Member, MCO or any Subscriber, including other health care plans that pay before MCO as required by applicable state or federal coordination of benefits provisions. This Section does not prohibit Salish from collecting applicable Copayments, coinsurance, or deductibles consistent with the Managed Care Plans.

2.10 Character of Payments from MCO. Capitation Payments to Salish pursuant to this Agreement are for the primary purpose of compensating Salish for the value of Covered Crisis Services provided pursuant to this Agreement. Salish shall assure that claims and compensation for Covered Crisis Services provided or arranged pursuant to this Agreement are paid from the Capitation Payments from MCO and from other funds available to Salish as may be necessary for Salish to satisfy its financial obligations under this Agreement. Salish specifically agrees that MCO may exercise its recoupment rights as set forth above in the event Salish fails to comply with the foregoing.

2.11 Valuation of Covered Behavioral Health Services. Parties will work together in the establishment of a mutually agreed upon reporting methodology and format for the cost and utilization of services provided under this Agreement. The intent is for the methodology and format to minimize administrative burden for both parties.

EXHIBIT D
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is incorporated into and made part of the services agreements (collectively, the "Agreement") by and between Salish Behavioral Health Administrative Services Organization ("Delegate"), through Kitsap County, its administrative entity, on behalf of itself and its subsidiaries and affiliates ("Business Associate"), and United Healthcare of Washington, Inc. ("United") (also known as "Covered Entity" in this agreement), that involve the use or disclosure of PHI (as defined below). The parties agree as follows.

1. DEFINITIONS

1.1 All capitalized terms used in this BAA not otherwise defined herein have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended and supplemented (collectively, "HIPAA").

1.2 "Breach" means the acquisition, access, use or disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI, subject to the exclusions in 45 C.F.R. § 164.402.

1.3 "PHI" means Protected Health Information, as defined in 45 C.F.R. § 160.103, and is limited to the Protected Health Information received from, or received, created, maintained or transmitted on behalf of, Covered Entity.

1.4 "Privacy Rule" means the federal privacy regulations, and "Security Rule" means the federal security regulations, as amended, issued pursuant to HIPAA and codified at 45 C.F.R. Parts 160 and 164 (Subparts A, C & E).

1.5 "Services" means the services provided by Business Associate to Covered Entity to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI.

2. RESPONSIBILITIES OF BUSINESS ASSOCIATE. With regard to its use and/or disclosure of PHI, Business Associate agrees to:

2.1 not use and/or further disclose PHI except as necessary to provide the Services, as permitted or required by this BAA and in compliance with the applicable requirements of 45 C.F.R. § 164.504(e), or as Required by Law; provided that, to the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

2.2 implement and use appropriate administrative, physical and technical safeguards and comply with applicable Security Rule requirements with respect to ePHI, to prevent use or disclosure of PHI other than as provided for by this BAA.

2.3 without unreasonable delay, report to Covered Entity (i) any use or disclosure of PHI not provided for in this BAA and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. § 164.314(a)(2)(i)(C). For the purposes of reporting under this BAA, a reportable "Security Incident" shall not include unsuccessful or inconsequential incidents that do not represent a material threat to confidentiality, integrity or availability of PHI (such as scans, pings, or unsuccessful attempts to penetrate computer networks).

2.4 report to Covered Entity within ten business days: (i) any Breach of Unsecured PHI of which it becomes aware in accordance with 45 C.F.R. § 164.504(e)(2)(ii)(C). Business Associate shall provide to Covered Entity a description of the Breach and a list of Individuals affected (unless Covered Entity is a plan sponsor ineligible to receive PHI). Business Associate shall provide required notifications to Individuals and the Media and Secretary, where appropriate, in accordance with the Privacy Rule and with Covered Entity's approval of the notification text. Business Associate shall pay for the reasonable and actual costs associated with those notifications and with credit monitoring, if appropriate.

2.5 in accordance with 45 C.F.R. § 164.502(e)(1)(ii) and 45 C.F.R. § 164.308(b)(2), ensure that any subcontractors of Business Associate that create, receive, maintain or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions on the use and/or disclosure of PHI that apply to Business Associate with respect to that PHI, including complying with the applicable Security Rule requirements with respect to ePHI.

2.6 make available its internal practices, books and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule, in accordance with 45 C.F.R. § 164.504(e)(2)(ii)(I).

2.7 within ten business days after receiving a written request from Covered Entity or an Individual, make available to Covered Entity or an Individual information necessary for an accounting of disclosures of PHI about an Individual, in accordance with 45 C.F.R. § 164.528.

2.8 provide access to Covered Entity or an Individual, within ten business days after receiving a written request from Covered Entity or an Individual, to PHI in a Designated Record Set about an Individual, sufficient for compliance with 45 C.F.R. § 164.524.

2.9 to the extent that the PHI in Business Associate's possession constitutes a Designated Record Set, make available, within ten business days after a written request by Covered Entity or an Individual, PHI for amendment and incorporate any amendments to the PHI as requested in accordance with 45 C.F.R. § 164.526.

3. <u>RESPONSIBILITIES OF COVERED ENTITY.</u> Covered Entity:

3.1 shall identify the records it furnishes to Business Associate that it considers to be PHI for purposes of the Agreement, and provide to Business Associate only the minimum PHI necessary to accomplish the Services.

3.2 in the event that the Covered Entity honors a request to restrict the use or disclosure of PHI pursuant to 45 C.F.R. § 164.522(a) or makes revisions to its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520 that increase the limitations on uses or disclosures of PHI or agrees to a request by an Individual for confidential communications under 45 C.F.R. § 164.522(b), Covered Entity agrees not to provide Business Associate any PHI that is subject to any of those restrictions or limitations, unless Covered Entity notifies Business Associate of the restriction or limitation and Business Associate agrees in writing to honor the restriction or limitation.

3.3 shall be responsible for using administrative, physical and technical safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate pursuant to the Agreement, in accordance with the requirements of HIPAA.

3.4 shall obtain any consent or authorization that may be required by applicable federal or state laws

prior to furnishing Business Associate the PHI for use and disclosure in accordance with this BAA.

3.5 if Covered Entity is an employer sponsored health plan, Covered Entity represents that to the extent applicable, it has ensured and has received certification from the applicable Plan Sponsor that the Plan Sponsor has taken the appropriate steps in accordance with 45 C.F.R. § 164.504(f) and 45 C.F.R. § 164.314(b) to enable Business Associate on behalf of Covered Entity to disclose PHI to Plan Sponsor, including but not limited to amending its plan documents to incorporate the requirements set forth in 45 C.F.R. § 164.504(f)(2) and 45 C.F.R. § 164.314(b). Covered Entity shall ensure that only employees authorized under 45 C.F.R. § 164.504(f) shall have access to the PHI disclosed by Business Associate to Plan Sponsor.

4. PERMITTED USES AND DISCLOSURES OF PHI. Business Associate may:

4.1 use and disclose PHI as necessary to provide the Services to Covered Entity.

4.2 use and disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that any disclosures are Required by Law or any third party to which Business Associate discloses PHI provides written assurances that: (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law; and (ii) the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached, in accordance with 45 C.F.R. § 164.504(e)(4).

4.3 De-identify any PHI received or created by Business Associate under this BAA in accordance with the Privacy Rule.

4.4 provide Data Aggregation services relating to the Health Care Operations of the Covered Entity in accordance with the Privacy Rule.

4.5 use PHI for Research projects conducted by Business Associate, its Affiliates or third parties, in a manner permitted by the Privacy Rule, by obtaining documentation of individual authorizations, an Institutional Review Board, or a privacy board waiver that meets the requirements of 45 C.F.R. § 164.512(i)(1), and providing Covered Entity with copies of such authorizations or waivers upon request.

4.6 make PHI available for reviews preparatory to Research in accordance with the Privacy Rule at 45 C.F.R. § 164.512(i)(1)(ii).

4.7 use the PHI to create a Limited Data Set ("LDS") and use or disclose the LDS for the health care operations of the Covered Entity or for Research or Public Health purposes as provided in the Privacy Rule.

5. TERMINATION

5.1 Covered Entity may terminate this BAA and the Agreement if Business Associate materially breaches this BAA, Covered Entity provides written notice of the breach to Business Associate, and Business Associate fails to cure the breach within the reasonable time period set by Covered Entity.

5.2 Within thirty (30) days after the expiration or termination for any reason of the Agreement and/or this BAA, Business Associate shall return or destroy all PHI, if feasible to do so, including all PHI in

possession of Business Associate's subcontractors. In the event that return or destruction of the

5.3 PHI is not feasible, Business Associate may retain the PHI subject to this Section 5.2. Business Associate shall extend any and all protections, limitations and restrictions contained in this BAA to Business Associate's use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this BAA, and shall limit any further uses and/or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

6. MISCELLANEOUS The terms of this BAA shall be construed to allow Covered Entity and Business Associate to comply with HIPAA. Nothing in this Addendum shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever. Sections 4 and 5.2 shall survive the expiration or termination of this BAA for any reason.

7. PART 2 INFORMATION. The Parties have entered into one or more written or verbal arrangements (collectively, the "**Service Contract**") under which Contractor will provide certain services to Salish BHASO that may involve Contractor creating, receiving, maintaining, or transmitting PHI, as defined below, and Contractor may be considered a "Business Associate" of United under HIPAA and a "**Qualified Service Organization**" under the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at 42 CFR Part 2 ("**Part 2**"). To the extent that, in performing services for or on behalf of Salish BHASO under the Service Contract, Contractor uses, discloses, maintains, or transmits Part 2 Information, Contractor acknowledges and agrees that: (a) in creating, receiving, maintaining, transmitting, using, or disclosing Part 2 information, it is fully bound by Part 2; and (b) if necessary, it will resist in judicial proceedings any efforts to obtain access to Part 2 Information except as permitted by Part 2. Contractor acknowledges that any unauthorized disclosure of Part 2 Information may be a federal criminal offense.

UNITED HEALTHCARE OF WASHINGTON, INC. ("United")
Sample Provider Agreement
Exhibit E

Attached is a copy of the Salish Behavioral Health Administrative Services Organization Sample Provider Agreement Template.

SALISH BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES ORGANIZATION
(SBHASO)

CONTRACT
FOR PARTICIPATION IN THE
SBHASO NETWORK

WITH

[AGENCY NAME]

CONTRACT # [TBD]

[INSERT CONTRACT DATES]

EXHIBITS

Incorporation of Exhibits

The Provider shall provide services and comply with the requirements set forth in the following attached exhibits, which are incorporated herein by reference. To the extent that the terms and conditions of any Exhibit conflicts with the terms and conditions of this base contract, the terms of such Exhibit shall control.

Exhibit A – Schedule of Services

Exhibit B- Compensation Schedule

Exhibit C- Sub-Delegation Agreement

Exhibit D- Business Associate Agreement

CONTRACT FOR PARTICIPATION IN THE SBHASO NETWORK

THIS CONTRACT FOR THE PARTICIPATION IN THE SBHASO NETWORK (this "Contract"), pursuant to RCW Chapter 71.24 and all relevant and associated statutes, as amended, is made and entered into by and between the **Salish Behavioral Health Administrative Services Organization (SBHASO),** through Kitsap County, its administrative entity, and [INSERT PROVIDER NAME], (Provider), a Washington Behavioral Health Agency, [INSERT PROVIDER ADDRESS AND ZIP]. The effective date of this Contract is January 1, 2020 through December 31, 2020.

I. RECITALS

WHEREAS, SBHASO is a Behavioral Health Administrative Services Organization formed in response to a request for a detailed plan and to contract with the State of Washington to operate as a regional support network until April 1, 2016 and as a behavioral health organization as of April 1, 2016, and as an administrative services organization as of January 1, 2020, as provided for in RCW 71.24.100; and

WHEREAS, effective January 1, 2020 SBHASO is contracted with the Washington State Health Care Authority to provide Behavioral Health Administrative Services, including the administration of Crisis Services, in the Salish Regional Service Area; and

WHEREAS, Provider is engaged in the provision of behavioral health services, including crisis intervention and/or stabilization services (Crisis Services) within Salish Regional Service Area; and

WHEREAS, SBHASO desires to have certain services performed by the Provider as described in Exhibit A, and further desires that Provider provide, market, distribute and otherwise do all things necessary to deliver such services in the Salish Regional Service Area; and

WHEREAS, Behavioral Health Providers contracted with SBHASO for participation in the SBHASO Network (Participating Providers) will deliver behavioral healthcare services to clients within the scope of their licensure or accreditation; and

WHEREAS, SBHASO will receive payment from MCOs and will facilitate payment to Provider for Crisis Services rendered to Members under the terms of this Contract; and

WHEREAS, the parties also wish to enter into a Business Associate Agreement to ensure compliance with the Privacy and Security Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy and Security Rules, 45 CFR Parts 160 and 164);

NOW THEREFORE, in consideration of payments, covenants, and agreements hereinafter mentioned, to be made and performed by the parties hereto, the parties mutually agree as follows:

II. CONTRACT

ARTICLE ONE – DEFINITIONS

For purposes of this Contract, the following terms shall have the meanings set forth below.

1.1 **Behavioral Health Administrative Service Organization (BH-ASO)**
An entity designated by the Health Care Authority (HCA) to administer behavioral health services and programs, including Crisis Services for residents in a defined Regional Service Area. The BH-ASO administers crisis services for all residents in its defined service area regardless of ability to pay, including Medicaid eligible clients. SBHASO has been designated to serve as the BH-ASO for the Salish Regional Service Area.

1.2 **Centers for Medicare and Medicaid Services (CMS)**
An administrative agency of the United States Government, responsible for administering the Medicaid program.

1.3 **Contract**
This Contract for Participation in the SBHASO Network, entered into between SBHASO and Provider, including all attachments and incorporated documents or materials.

1.4 **Crisis Services (Covered Services)**
Crisis intervention and/or stabilization services, within the normal scope of practice and licensure of Provider and are covered under contract Exhibit A and SBHASO Policies and Procedures between SBHASO and Participating Providers.

1.5 **Critical Incident**
A situation or occurrence that places a client at risk for potential harm or causes harm to a client. Examples include homicide (attempted or completed), suicide (attempted or completed), the unexpected death of a client, or the abuse, neglect, or exploitation of a client by an employee or volunteer.

1.6 **SBHASO Network**
Participating Provider network and SBHASO will operate a behavioral health crisis response network that will provide Crisis Services for the Salish Regional Service Area. SBHASO Network is a reference to the network of behavioral health crisis services providers contracted with the SBHASO, and neither this Contract nor any other understanding among participants is intended to create a separate legal entity.

1.7 **Healthcare Authority (HCA)**
The Washington State Health Care Authority.

1.8 **Health Plan**

A plan that undertakes to arrange for the provision of healthcare services to subscribers or enrollees, or to pay for or to reimburse for any part of the cost for those services, in return for a prepaid or periodic charge paid for by or on behalf subscribers or enrollees.

1.9 **MCO Policies and Procedures**

The MCO's compilation of operating policies, standards, and procedures for Participating Providers including, but not limited to, MCO's requirements for claims submission and payment, credentialing/re-credentialing, utilization review/management, case management, quality assurance/improvement, advance directives, Member rights, grievances and appeals.

1.10 **Managed Care Organization (MCO)**

An organization that combines the functions of health insurance, delivery of care, and administration. For the purposes of this Contract, MCO refers to those businesses identified by contract with the state as designated Medicaid Managed Care Organizations for Integrated Managed Care. As of the Effective Date of this Contract, the MCOs are Amerigroup, Coordinated Care, Molina and United Healthcare (Optum).

1.11 **Managed Care Organization (MCO) in Salish Regional Service Area**

An organization that combines the functions of health insurance, delivery of care, and administration. For the purposes of this Contract, MCO refers to those businesses identified by contract with the state as designated Medicaid Managed Care Organizations for Integrated Managed Care in the Salish Regional Service Area. As of the Effective Date of this Contract, the MCOs are Amerigroup, United Healthcare (Optum), Coordinated Care "Foster Care Program" and, Molina.

1.12 **Medically necessary service/medical necessity**

A requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this section, "course of treatment" may include no active intervention at all.

1.13 **Member**

An individual who receives Covered Services pursuant to this Contract, and who is assigned to an MCO.

1.14 **Provider**

The behavioral health care person(s) or agency contracting under this Contract, who meets all minimum criteria of MCO's credentialing plan, including all physicians, clinicians, allied health

professionals, and staff persons who provide health care services to clients by or through this Contract.

1.15 **Payor**

The entity (including company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of covered services rendered to clients.

ARTICLE TWO – NETWORK PROVIDER OBLIGATIONS

This Contract, SBHASO Policies and Procedures, Contract Exhibits, and their revisions each specify SBHASO's requirements for the array of services to be provided. Unless otherwise specified, these materials shall be regarded as the source documents for compliance with program requirements. In the event of any inconsistency between the requirements of such documents, the more stringent shall control.

2.1 **Network Participation**

Provider shall participate as part of the SBHASO Network and shall provide for the services specified in this Contract.

Provider agrees that its practice information may be used in MCO, SBHASO and HCA provider directories, promotional materials, advertising and other informational material made available to the public. Such practice information includes, but is not limited to, name, address, telephone number, hours of operation, type of services, and ability to accept new clients. Provider shall promptly notify SBHASO within thirty (30) days of any changes in this information.

2.2 **Standards for Provision of Care.**

2.2.1 **Provision of Covered Services**

Provider shall provide Covered Services to clients, within the scope of Provider's business and practice. Such services shall be provided in accordance with this Contract; SBHASO Policies and Procedures; MCO, SBHASO and HCA standards; MCO Policies and Procedures; the terms, conditions and eligibility outlined in Contract Exhibits; and the requirements of any applicable government sponsored program.

2.2.2 **Standard of Care**

Provider shall provide services to clients 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.

2.2.3 **Facilities, Equipment, and Personnel**

Provider's facilities, equipment, personnel and administrative services shall be maintained at a level and quality appropriate to perform Provider's duties and responsibilities under this Contract and to meet all applicable SBHASO legal and MCO contractual requirements, including the accessibility requirements of the Americans with Disabilities Act.

2.2.4 **Prior Authorization**

Where required or appropriate, the Provider shall work with SBHASO to obtain the prior MCO authorization in accordance with MCO's Policies and Procedures unless the situation is one involving the delivery of Emergency Services. Upon and following client assignment, the Provider shall coordinate the provision of such Covered Services to clients and ensure continuity of care in accordance with HCA, SBHASO and MCO requirements.

2.2.5 **Appointment Wait Times**

For MCO Members, Provider shall follow the more stringent of any applicable state or federal standards for appointment wait times, including those established by the HCA for Medicaid enrollees.

2.2.6 **Capacity**

Provider shall ensure availability of services for each of the service populations for which it is licensed and/or certified by Washington State Department of Health.

2.2.7 **Emergency Room Referral**

If Provider refers a client to an emergency room for Covered Services, Provider shall provide notification to SBHASO within twenty-four (24) hours of the referral.

2.2.8 **Prescriptions**

Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider shall abide by MCO'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 MCO if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of MCO contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

2.2.9 **Subcontract Arrangements**

Any subcontract arrangement entered into by Provider for the delivery of services to clients shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Contract including, but not limited to, terms relating to licensure, insurance, and billing of clients for services. SBHASO will provide ongoing monitoring and oversight to any and all subdelegation relationships.

2.2.10 **Availability of Services**

Provider shall make arrangements to assure the availability of services to clients on a twenty-four (24) hours a day, seven (7) days a week basis, including arrangement to assure coverage of client visits after hours when required by SBHASO Policies and Procedures. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

2.3 **Treatment Alternatives**

Providers shall in all instances obtain informed consent prior to treatment. Without regard to Medicaid Benefit Plan limitations or cost, the Provider shall communicate freely and openly with clients about their health status, and treatment alternatives (including medication treatment options); about their rights to participate in treatment decisions (including refusing treatment); and providing them with relevant information to assist them in making informed decisions about their health care.

2.4 **Promotional Activities**

At the request of SBHASO, Provider shall display MCO promotional materials in its offices and facilities as practical, in accordance with applicable law and cooperate with and participate in all reasonable MCO marketing efforts. Provider shall not use any SBHASO contracted MCO's name in any advertising or promotional materials without the prior written permission of SBHASO and applicable MCO.

2.5 **Marketing activities for Medicare/Medicaid Population**

Provider shall not undertake any marketing activities to the Medicare or Medicaid population, including but not limited to distribution of publications or promotional materials, without the prior written consent of SBHASO and applicable MCOs. The Provider shall not engage in direct or indirect door-to-door, telephonic, or other cold-call marketing of enrollment with clients or potential clients.

2.6 **Licensure, certification and other state and federal requirements**

Provider shall hold all necessary licenses, certifications, and permits required by law for the performance of services to be provided under this Contract. Provider shall maintain its licensure and applicable certifications in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Contract. Provider's loss or suspension of licensure or other applicable certifications, or its exclusion from any federally funded healthcare program, including Medicare and Medicaid, may constitute cause for immediate termination of this Contract. Provider warrants and represents that each employee and subcontractor, who is subject to professional licensing requirements, is duly licensed to provide Behavioral Health Services. Provider shall ensure that each employee and subcontractor have and maintains in good standing for the term of this Contract the licenses, permits, registrations, certifications, and any other governmental authorizations to provide such services.

2.7 **Independent medical/clinical judgement**

Provider shall exercise independent medical/clinical judgment and control over its professional services. Nothing herein shall give SBHASO, MCO, or HCA authority over Provider's medical judgment or direct the means by which they practice within the scope of their licensed, certified, and/or registered practice. Provider retains sole responsibility for its relationship with each client it treats, and for the quality of behavioral healthcare services provided to its clients. Provider is solely responsible to each of its client for care provided.

2.8 **Nondiscrimination.**

2.8.1 **Enrollment**. Provider shall not differentiate or discriminate in providing services to clients because of race, color, religion, national origin, ancestry, age, marital status, gender identity, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services, or any other basis prohibited by law. Provider shall render services to clients in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

2.8.2 **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, height, weight, marital status, gender identity, physical, sensory or mental disability, or any other basis prohibited by law unrelated to the person's ability to perform the duties of the particular job or position.

2.9 **Data Information System Requirements.**

2.9.1 **Provider shall:**

2.9.1.1 Have a health Information System (IS) that complies with the requirements of 42 CFR Part 438.242 and that can report complete and accurate data to SBHASO as specified in the SBHASO P&P;

2.9.1.2 Provider Claims Submission Requirements

2.9.1.2.1 For claims with no associated third-party liability, provider shall submit 90% of crisis claims within ten (10) business days from date of service, and 100% of crisis claims within thirty (30) calendar days.

2.9.1.2.2 For claims with an identified third-party liability, provider shall submit 90% of crisis claims within ten (10) business days from date of payment or receipt of explanation of benefits (denial), and 100% of crisis claims within thirty (30) calendar days from date of

payment or receipt of explanation of benefits (denial).

2.9.1.3 Remedy all data errors within thirty (30) days of receipt of an error report from the SBHASO IS;

2.9.1.4 Provide evidence to SBHASO, upon request, that error reports have been addressed;

2.9.1.5 Maintain up to date client contact information in the IS; and

2.9.1.6 Maintain a written business continuity and disaster recovery plan with an identified update process (at least annually) that insures timely restoration of the IS following total or substantial loss of system functionality. A copy of the plan submitted by the Provider through the credentialing process shall be made available upon request for review and audit by SBHASO, MCO, HCA, Department of Social Human Services (DSHS) or External Quality Review Organization.

2.10 **Care Coordination.**

2.10.1 Coordinate medical services. During the delivery of Crisis Services, the Provider shall coordinate all needed services for eligible clients, including but not limited to emergency medical services, behavioral health crisis services and services associated with the social determinants of health as needed.

2.10.2 Provision of data and information for purposes of care coordination. Provider shall cooperate with, participate in, and provide information and data in accordance to the Health Insurance Portability and Accountability Act (HIPAA), to support SBHASO's care coordination activities and to meet HCA care coordination obligations.

2.11 **Behavioral Health Screening and Assessment Requirements**

If Provider provides Behavioral Health services, Provider shall utilize the Global Appraisal of Individual Needs-Short Screener (GAIN-SS) and assessment process, including use of the quadrant placement. If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, Provider shall consider this information in the development of the client's treatment plan, including appropriate referrals. In addition, Provider shall implement, and maintain throughout the term of this Contract, the Integrated Co-Occurring Disorder Screening and Assessment process, including training for applicable staff. If Provider fails to implement or maintain this process, upon request of SBHASO, Provider shall provide a corrective action plan designed to ensure compliance with the requirements of this Section. Such plan shall allow for monitoring of compliance by SBHASO.

2.12 **Recordkeeping and Confidentiality**.

2.12.1 **Maintaining Client Medical Record**

Provider shall maintain a medical record for each client to whom Provider renders behavioral healthcare services. Provider shall establish each client's medical record upon the client's first encounter with Provider. The client's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all SBHASO P&Ps and MCO Policies and Procedures. Provider shall retain all such records for at least ten (10) years.

2.12.2 **Confidentiality of Client Health Information**

As of the date of this Contract, each party may be a Covered Entity under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), and must comply with the Administrative Simplification Provisions of HIPAA and with the applicable provisions of the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH Act"), including the Privacy Rule, Security Rule, Breach Notification Rule, and Enforcement Rule (the "HIPAA Rules"). The parties acknowledge that, in their performance under this Contract, each shall have access to and receive from the other party information protected under HIPAA and Chapter 70.02 RCW, the Washington State Health Care Information Access and Disclosure of 1991 ("Protected Health Information" or "PHI").

2.12.3 **Health Information System**

Provider shall implement a documented health information system and a privacy security program that includes administrative, technical and physical safe guards designed to prevent the accidental or unauthorized use or disclosure of client PHI and medical records. The information system and the privacy and security program shall, at a minimum, comply with applicable HIPAA regulations regarding the privacy and security of PHI, including but not limited to 42 CFR § 438.242; 45 CFR § 164.306(a); and 45 CFR § 162.200 as well as the HIPAA privacy provisions in Title 13 of the American Recovery and Reinvestment Act of 2009 ("ARRA").

2.12.4 **Delivery of Client Care Information and Client Access to Health Information**

Provider shall give SBHASO, MCO, HCA and/or clients access to client' health information including, but not limited to, medical records and billing records, for the purpose of inspection, evaluation, and audit, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and SBHASO policies and procedures.

2.12.5 **Federal Drug and Alcohol Confidentiality Laws**

Provider shall comply with 42 CFR Part 2, as applicable. If Provider is a "Part 2 program," as defined under 42 CFR §2.11, Provider shall obtain a signed written consent that complies with the requirements of 42 CFR Part 2 from each client,

prior to disclosing the client's Patient Identifying Information to MCO, SBHASO or HCA. For the purposes of this section, "Patient Identifying Information" shall have the same meaning as under 42 CFR §2.11. Such consent shall explicitly name MCO, SBHASO and/or HCA as an authorized recipient of the client's Patient Identifying Information. Provider shall maintain copies of each client's consent form in accordance with federal law. SBHASO reserves the right to audit Provider's records to ensure compliance with this Section.

2.13 **Client's copayments, coinsurance, and deductibles**.

2.13.1 **Third Party Payment**

The Provider shall have a written policy regarding third party payments that complies with provisions of SBHASO's contract with MCOs, as described in SBHASO policies and procedures.

2.13.2 **Medicaid enrollment**

The Provider shall aggressively work to convert non-Medicaid clients to Medicaid status, including helping families to access health insurance coverage for their children under the provisions of the Children's Health Insurance Program.

2.13.3 **Payment without delivery of services**

The Provider shall not bill, demand, collect or accept payment or deposit for missed, cancelled, or late appointments from any client receiving certification for medical assistance according to 42 CFR 435.914(a) and defined in WAC, including Title XIX and Medical Care Services.

2.13.4 **Cost-sharing**

The Provider will not require payment of any cost sharing amounts for Services covered by Medicare Parts A or B, when the client is enrolled in Medicare and Medicaid Programs (Dual Eligible Enrollees) if the applicable Medicaid Program is required to pay. In lieu of collecting cost sharing amounts under the Medicare Program, the Provider will bill Medicaid or forego collecting payments in full.

2.13.5 **Client financial obligation**

The Provider shall provide notice to clients of their personal financial obligations for non-covered services, and may bill clients for non-covered services only if the Provider has:

2.13.5.1 Provided the client with a full written disclosure of Provider's intent to directly bill the client for non-covered services (including a clear statement that client's assigned MCO is not financially obligated or otherwise liable to cover or provide any reimbursement, compensation, or other payment related to such non-covered services); and

2.13.5.2 Obtained a written acknowledgement and acceptance of financial responsibility from the client at the time of denial and prior to services being delivered.

2.13.6 **Client Hold Harmless**

2.13.6.1 Provider hereby agrees that in no event, including, but not limited to nonpayment by SBHASO, SBHASO 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 client or person acting on their behalf, other than SBHASO, for services provided pursuant to this Contract. 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 clients in accordance with the terms of the client's health plan.

2.13.6.2 If applicable, Provider agrees, in the event of SBHASO insolvency, to continue to provide the services promised in this Contract to clients of SBHASO for the duration of the period for which premiums on behalf of the clients were paid to SBHASO or until the client's discharge from inpatient facilities, whichever time is greater.

2.13.6.3 Notwithstanding any other provision of this Contract, nothing in this contract shall be construed to modify the rights and benefits contained in the client's health plan.

2.13.6.4 Provider may not bill the client for covered services (except for deductibles, copayments, or coinsurance) where SBHASO denies payments because the Provider has failed to comply with the terms or conditions of this Contract.

2.13.6.5 Provider further agrees (i) that the provisions of this subsection 2.13.6 shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of SBHASO clients, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and clients or persons acting on their behalf.

2.13.6.6 If Provider contracts with other providers or facilities who agree to provide covered services to clients of SBHASO with the expectation of receiving payment directly or indirectly from SBHASO, such providers or facilities must agree to abide by the provisions of this subsection 2.13.6.

2.13.6.6 Willfully collecting or attempting to collect an amount from a client knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

2.13.7 **Payment in Full**

Provider shall hold HCA and its employees, and all clients, including Members, harmless in the event of non-payment by SBHASO. Provider shall not request payment from HCA, or any enrollee for services provided pursuant to this Contract. Additionally, Provider shall at all times comply with WAC 182-502-160.

2.13.8 **HCA Hold Harmless**

Each party shall indemnify and hold HCA harmless against all injuries, deaths, losses damages, claims, suits, liabilities, judgments, costs and expenses which may accrue against HCA or its employees through the intentional misconduct, negligence, or omission of Provider, or its agents, officers, employees or subcontractors.

2.14 **Program Participation**.

2.14.1 **Participation in Grievance Program**

Provider shall implement a Grievance Program that complies with WAC 246-341 or its successors and shall participate in MCO's Grievance Program and cooperate with MCOs in identifying, processing, and promptly resolving all client complaints, grievances, or inquiries.

2.14.2 **Participation in Quality Improvement Program**

2.14.2.1 Provider shall develop and implement a quality management plan in accordance with requirements outlined in SBHASO policies and procedures or the Provider's accrediting entity.

2.14.2.2 Provider shall cooperate and participate in the SBHASO quality assessment and performance improvement activities and performance improvement projects identified by SBHASO, MCO and/or HCA.

2.14.2.3 The Provider shall review the components of the quality management plan at least annually such review will include submitting a report to SBHASO on any quality assurance activity or changes to the quality management plan.

2.14.3 **Participation in Utilization Review and Management Program**

Provider shall participate in and comply with the SBHASO and MCO's Utilization Review and Management Program, including all policies and procedures regarding

prior authorizations, and shall cooperate with MCO, and/or HCA in audits to identify, confirm, and/or assess utilization levels of services.

2.15 **Notices**.

2.15.1 **Critical Incident Reporting**

Provider shall send immediate notification to SBHASO and, when indicated, to the applicable MCO of any Critical Incident involving a client. Notification shall be made during the business day on which Provider becomes aware of the Critical Incident. If Provider becomes aware of a Critical Incident involving a client after business hours, Provider shall provide notice to SBHASO and, when indicated, to the applicable MCO as soon as possible the next business day. Provider shall provide to SBHASO and, when indicated, to the applicable MCO all available information related to a Critical Incident at the time of notification, including: a description of the event, including the date and time of the incident, the incident location, incident type, information about the individuals involved in the incident and the nature of their involvement; the client's or other involved individuals' service history with Provider; steps taken by Provider to minimize potential or actual harm; and any legally required notification made by Provider. Upon MCO's request, and as additional information becomes available, Provider shall update the information provided regarding the Critical Incident and, if requested by MCO, shall prepare a written report regarding the Critical Incident, including any actions taken in response to the incident, the purpose for which such actions were taken, any implications to Provider's delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents. Reporting shall comport with SBHASO policies an procedures.

2.15.2 **Notice of sites/services change**

Provider shall, prior to making a public announcement of any site or service changes, notify SBHASO in writing and receive approval at least:

2.15.2.1 One hundred twenty (120) days prior to closing a Provider site, or opening any additional site(s) providing services under this Contract.

2.15.2.2 Thirty (30) days prior to any Provider change that would significantly affect the delivery of or payment for services provided, including changes in tax identification numbers, billing addresses or practice locations.

2.15.2.3 If Provider discontinues services or closes a site in less than thirty (30) days, Provider shall notify SBHASO as soon as possible and prior to making a public announcement.

2.15.2.4 Provider shall notify SBHASO of any other changes in capacity that result in the Provider being unable to meet any requirements of this Contract. Events that affect capacity include but are not limited to: a decrease in the number, frequency, or type of a required service to be

provided; employee strike or other stoppage related to union activities; or any changes that result in Provider being unable to provide timely, medically necessary services.

2.15.2.5 If any of the above events occurs, Provider shall submit a plan to SBHASO and, if requested, shall meet with SBHASO to review the plan at least Thirty (30) business days prior to the event. The plan should include the following:

2.15.2.5.1 Notification of service/site change;

2.15.2.5.2 Client notification and communication plan;

2.15.2.5.3 Plan for provision of uninterrupted services by client; and

2.15.2.5.4 Any information that will be released to the media.

2.15.3 **Termination of Services**

Provider shall provide SBHASO at least one hundred twenty (120) calendar days written notice before Provider, any clinic, or subcontractor ceases to provide services to clients.

2.15.4 **Reporting Fraud**

Provider shall comply with RCW 48.135 concerning Insurance Fraud Reporting and shall notify SBHASO and the applicable MCO's Compliance Department of all incidents or occasions of suspected fraud, waste or abuse involving Services provided to a client. Provider shall report a suspected incident of fraud, waste or abuse, including a credible allegation of fraud, within five (5) business days of the date Provider first becomes aware of, or is on notice of, such activity. The obligation to report suspected fraud, waste or abuse shall apply if the suspected conduct was perpetrated by Provider, Provider's employee, agent, or subcontractor, or client. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against suspected fraud, waste or abuse. Upon request by SBHASO, MCO or HCA, Provider shall confer with the appropriate State agency prior to or during any investigation into suspected Fraud, waste or abuse. For purposes of this section, the terms fraud and abuse shall have the same meaning as provided for in 42 CFR §455.2.

2.16 **Participation in Credentialing**

Provider shall participate in SBHASO's credentialing and re-credentialing process as outlined in SBHASO policies and procedures, that shall satisfy, throughout the term of this Contract, all credentialing and re-credentialing criteria established by MCOs. Provider shall immediately notify SBHASO 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 SBHASO, SBHASO may, at its discretion, terminate this Contract and/or reassign clients to another provider.

2.17 **Provider Training and Education**

Upon the request of SBHASO, the Provider shall participate in Training when required by the HCA, MCO, and/or SBHASO and as described in Exhibit D – Business Associate Agreement, Program Integrity Addendum.

2.17.1 **Exception to required training**

Requests to allow an exception to participation in a required training must be in writing and include a plan for how the required information will be provided to targeted Provider staff;

2.17.2 **Safety and violence-prevention training**

Provider shall ensure that all community behavioral health employees who work directly with clients are provided with at least annual training on safety and violence-prevention topics described in RCW 49.19.030;

2.17.3 **Cultural humility training**

Provider shall ensure that all community behavioral health employees who work for Providers are provided with at least annual training on cultural humility; and

2.17.4 **Health Education/Training**

Provider shall ensure that all community behavioral health employees who work directly with clients receive Health Education/Training as requested by SBHASO.

2.17.5 **Provider Non-Solicitation**

Provider shall not solicit or encourage clients to select any particular 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 clients of all available health care treatment options or modalities

ARTICLE THREE – SBHASO OBLIGATIONS

3.1 **Administrative Support**

SBHASO shall provide the administrative support to the SBHASO Network and will collaborate with Providers in:

3.1.1 Establishing and maintaining a multispecialty provider network that is geographically distributed through the service area and that promotes client choice and access to Participating Providers;

3.1.2 Developing and implementing Participating Provider practice protocols and supports;

3.1.3 Creating alliances with other medical practices/groups and providers to help assure the delivery of whole-person and integrated care, where applicable;

3.1.4 Participating in performance measurement, including the reporting of state defined performance measures (e.g., HEDIS measures and HCA identified behavioral health measures); and

3.1.5 Providing support and training on proper coding of services and data transmissions related to encounters.

3.2 **Collection of service encounters**

For services provided to Members, SBHASO shall collect service encounters from the Participating Providers and submit them to the appropriate MCO.

3.3 **Payment**

SBHASO shall pay Provider for services provided according to the SBHASO established rate schedule, detailed in Exhibit A, Exhibit B, SBHASO policies and procedures

3.3.1 SBHASO shall provide reasonable notice of not less than 60 days of changes that affect Provider's compensation or the delivery of health care services.

3.4 **Submission of Claims**

If Provider submits claims for Services rendered under this Contract, the following requirements shall apply:

3.4.1 **Clean Claims Standards**

Except as agreed to by the parties on a claim-by-claim basis, SBHASO shall pay or deny not less than (i) ninety-five percent (95%) of Clean Claims received from Provider within thirty (30) days of receipt; (ii) ninety-five percent (95%) of all claims received from Provider within sixty (60) days of receipt; and (iii) ninety-nine percent (99%) of all Clean Claims received from Provider within ninety (90) days of receipt.

3.4.2 **Clean Claim – Definition**

For purposes of this Section 3.4, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this Section 3.4.

3.4.3 **Failure to Comply**

If SBHASO fails to meet its obligations in this paragraph, SBHASO shall pay Provider interest at the rate of one percent (1%) per month on all unpaid Clean Claims that have not been denied and which have aged sixty-one (61) or more days, until such time as SBHASO is again in compliance with the requirements of this Section.

3.5 **Coordination**

SBHASO shall be responsible for coordinating with Participating Providers to meet the obligations identified in this Contract.

3.6 **Patient Care**

SBHASO shall comply with WAC 284-170-421 which states:

3.6.1 No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients 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 the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service.

No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier.

ARTICLE FOUR - TERM AND TERMINATION

4.1 **Term**

This Contract is effective on January 1, 2020, and will remain in effect for an initial term of one year ("Initial Term"), unless this Contract is sooner terminated as provided in this Contract or either Party gives the other Party written notice of non-renewal of this Contract not less than one hundred eighty (180) days prior to the end of the then-current term.

4.2 **Termination without Cause**

This Contract may be terminated without cause by either party upon providing at least sixty (60) days written notice to the other party.

4.3 **Termination with Cause**

Either party may terminate this Contract by providing the other party with a minimum of ten (10) business days prior written notice in the event the other party commits a material breach of any provision of this Contract. Said notice must specify the nature of said material breach. The breaching party shall have seven (7) business days from the date of the breaching party's receipt of the foregoing notice to cure said material breach. In the event the breaching party fails to cure the material breach within said seven (7) business day period, this Contract shall automatically terminate upon expiration of the ten (10) business days' notice period.

4.4 **Immediate Termination**

Unless expressly prohibited by applicable regulatory requirements, SBHASO may immediately suspend or terminate the participation of a Provider in any or all products or services by giving written notice thereof to Provider when SBHASO determines that (i) based upon available information, the continued participation of the Provider appears to constitute an immediate threat or risk to the health, safety or welfare of client(s), or (ii) Provider's fraud, malfeasance or non-compliance with any regulatory requirements is reasonably suspected. During such suspension, the Provider shall, as directed by SBHASO, discontinue the provision of all or a particular contracted Service to client(s). During the term of any suspension, Provider shall notify client(s) that their status as a Provider has been suspended. Such suspension will continue until the Provider's participation is reinstated or terminated.

4.5 **Termination Due to Change in Funding**

In the event funding from MCO, SBHASO, State, Federal, or other sources is withdrawn, reduced, or limited in any way after the effective date of this Contract and prior to its normal completion, either party may terminate this Contract subject to re-negotiations with a minimum ninety (90) day written notification.

4.5.1 **TERMINATION PROCEDURE**

The following provisions shall survive and be binding on the parties in the event this Contract is terminated:

4.5.1.1 Provider and any applicable subcontractors shall cease to perform any services required by this Contract as of the effective date of termination and shall comply with all reasonable instructions contained in the notice of termination which are related to the transfer of individuals, distribution of property and termination of services. Each party shall be responsible only for its performance in accordance with the terms of this Contract rendered prior to the effective date of termination. Provider and any applicable subcontractors shall assist in the orderly transfer/transition of the individuals served under this Contract. Provider and any applicable subcontractors shall promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

4.5.1.2 Provider and any applicable subcontractors shall immediately deliver to SBHASO or its successor, all MCO/HCA and SBHASO assets (property) in Provider and any applicable subcontractor's possession and any property produced under this Contract. Provider and any applicable subcontractors grant SBHASO/MCO/HCA the right to enter upon Provider and any applicable subcontractor's premises for the sole purpose of recovering any SBHASO/MCO/HCA property that Provider and any applicable subcontractors fails to return within 10 business days of termination of this Contract. Upon failure to return SBHASO/MCO/HCA property within ten (10) business days of the termination of this Contract, Provider and any applicable subcontractors shall be charged with all reasonable costs of

recovery, including transportation and attorney's fees. Provider and any applicable subcontractors shall protect and preserve any property of SBHASO/MCO/HCA that is in the possession of Provider and any applicable subcontractors pending return to SBHASO/MCO/HCA.

4.5.1.3 SBHASO shall be liable for and shall pay for only those services authorized and provided through the date of termination. SBHASO may pay an amount agreed to by the parties for partially completed work and services, if work products are useful to or usable by SBHASO.

4.5.1.4 If SBHASO terminates this Contract for default, SBHASO may withhold a sum from the final payment to Provider that SBHASO determines is necessary to protect SBHASO against loss or additional liability occasioned by the alleged default. SBHASO shall be entitled to all remedies available at law, in equity, or under this Contract. If it is later determined Provider was not in default, or if Provider terminated this Contract for default, Provider shall be entitled to all remedies available by law, in equity, or under this Contract.

4.6 **Termination Notification to Clients**

SBHASO will inform affected clients of any termination pursuant to this Contract in accordance with the process set forth in the applicable MCO Policies and Procedures. Clients may be required to select another provider contracted with SBHASO prior to the effective date of termination of this Contract.

ARTICLE FIVE - FINANCIAL TERMS AND CONDITIONS

5.1 GENERAL FISCAL ASSURANCES

Provider shall comply with all applicable laws and standards, including Generally Accepted Accounting Principles and maintain, at a minimum, a financial management system that is a viable, single, integrated system with sufficient sophistication and capability to effectively and efficiently process, track and manage all fiscal matters and transactions. The parties' respective fiscal obligations and rights set forth in this section shall continue after termination of this Contract until such time as the financial matters between the parties resulting from this Contract are completed.

5.2 **FINANCIAL ACCOUNTING REQUIREMENTS**

Provider shall:

5.2.1 The Provider shall establish and maintain a system of accounting and internal controls which complies with generally accepted accounting principles promulgated

by the Financial Accounting Standards Board (FASB), the Governmental Accounting Standards Board (GASB), or both as is applicable to the Provider's form of incorporation.

5.2.2 Ensure all SBHASO funds, including interest earned, provided pursuant to this Contract, are used to support the public behavioral health system within the Service Area;

5.2.3 Ensure under no circumstances are individuals charged for any Covered Services, including those out-of-network services purchased on their behalf;

5.2.4 Produce annual, audited financial statements upon completion and make such reports available to SBHASO upon request.

5.2.4.1 **FINANCIAL REPORTING**
Provider shall provide the following reports to SBHASO:

5.2.4.1.1 The SBHASO shall reimburse the Provider for satisfactory completion of the services and requirements specified in this Contract and its attached exhibit(s).

5.2.4.1.2 The Provider shall submit an invoice and all accompanying reports as specified in the attached exhibit(s), including its final invoice and all outstanding reports. The SBHASO shall initiate authorization for payment to the Provider not more than thirty (30) days after a complete and accurate invoice is received.

5.2.4.1.1 The Provider shall submit its final invoice and all outstanding reports as specified in this contract and its attached exhibit(s). If the Provider's final invoice and reports are not submitted as specified in this contract and its attached exhibit(s), the SBHASO will be relieved of all liability for payment to the Provider of the amounts set forth in said invoice or any subsequent invoice.

5.2.4.2 **LIABILITY FOR PAYMENT AND THE PURSUIT OF THIRD-PARTY REVENUE**
Provider shall be responsible for developing financial processes that enable them to reasonably ensure all third-party resources available to enrollees are identified and pursued in accordance with the reasonable collection practices, which Provider applies to all other payers for services covered under this Contract. Ensure a process is in place to demonstrate

all third-party resources are identified and pursued in accordance with Medicaid being the payer of last resort.

Provider shall maintain necessary records to document all third-party resources and report to SBHASO on a biennial basis or upon the request of SBHASO the amount of such third-party resources collected for all service recipients during the quarter by source of payment.

ARTICLE SIX -OVERSIGHT AND REMEDIES

6.1 OVERSIGHT AUTHORITY

SBHASO, HCA, DSHS, Office of the State Auditor, the Department of Health and Human Services (DHHS), CMS, the Comptroller General, or any of their duly-authorized representatives have the authority to conduct announced and unannounced: a) surveys, b) audits, c) reviews of compliance with licensing and certification requirements and compliance with this Contract, d) audits regarding the quality, appropriateness and timeliness of behavioral health services of Provider and subcontractors and e) audits and inspections of financial records of Provider and subcontractors.

Provider shall notify SBHASO when an entity other than SBHASO performs any audit described above related to any activity contained in this Contract.

In addition, SBHASO/MCO will conduct reviews in accordance with its oversight of resource, utilization and quality management, as well as, ensure Provider has the clinical, administrative and fiscal structures to enable them to perform in accordance with the terms of the contract. Such reviews may include, but are not limited to: encounter data validation, utilization reviews, clinical record reviews, program integrity, administrative structures reviews, fiscal management and contract compliance. Reviews may include desk reviews, requiring Provider to submit requested information. SBHASO will also review any activities delegated under this contract to Provider.

6.2 REMEDIAL ACTION

SBHASO may require Provider to plan and execute corrective action. Corrective Action Plan (CAP) developed by Provider must be submitted for approval to SBHASO within thirty (30) calendar days of notification. CAP must be provided in a format acceptable to SBHASO. SBHASO may extend or reduce the time allowed for corrective action depending upon the nature of the situation as determined by SBHASO.

6.2.1 CAP must include:

6.2.1.1 A brief description of the findings; and

6.2.1.2 Specific actions to be taken, a timetable, a description of the monitoring to be performed, the steps taken and responsible individuals that will reflect the resolution of the situation.

6.2.2 CAP may:
Require modification of any policies or procedures by Provider relating to the fulfillment of its obligations pursuant to this Contract.

6.2.3 CAP is subject to approval by SBHASO, which may:

6.2.3.1 Accept the plan as submitted;

6.2.3.2 Accept the plan with specified modifications;

6.2.3.3 Request a modified plan; or

6.2.3.4 Reject the plan.

6.2.4 Provider agrees that SBHASO may initiate remedial action as outlined below if SBHASO determines any of the following situations exist or if corrective actions have not been completed within the timetable acceptable to SBHASO:

6.2.4.1 If a problem exists that poses a threat to the health or safety of any person or poses a threat of property damage/an incident has occurred that resulted in injury or death to any person/resulted in damage to property.

6.2.4.2 Provider has failed to perform any of the behavioral health services required in this Contract, which includes the failure to maintain the required capacity as specified by SBHASO to ensure enrolled individuals receive medically necessary services, including delegated functions; except, that no remedial action pursuant to subsection (e) hereof shall be taken if such failure to maintain required capacity is due to any interruption in, or depletion of the available amount of money to Provider as described in Exhibit B of this contract for purposes of performing services under this contract; however, in such an instance, SBHASO may terminate all or part of this contract on as little as thirty (30) days written notice.

6.2.4.3 Provider has failed to develop, produce and/or deliver to SBHASO any of the statements, reports, data, data corrections, accountings, claims and/or documentation described herein, in compliance with all the provisions of this Contract.

6.2.4.4 Provider has failed to perform any administrative function required under this Contract, including delegated functions. For the purposes of this section, "administrative function" is defined as any obligation other than the actual provision of behavioral health services.

6.2.4.5 Provider has failed to implement corrective action required by the state and within SBHASO prescribed timeframes.

6.2.5 SBHASO may impose any of the following remedial actions in response to findings of situations as outlined above.

6.2.5.1 Withhold two (2%) percent of the next monthly payment and each monthly payment thereafter until the corrective action has achieved resolution. SBHASO, at its sole discretion, may return a portion or all of any payments withheld once satisfactory resolution has been achieved.

6.2.5.2 Compound withholdings identified above by an additional one-half of one percent (1/2 of 1%) for each successive month during which the remedial situation has not been resolved.

6.2.5.3 Revoke delegation of any function delegated under this contract.

6.2.5.4 Deny any incentive payment to which Provider might otherwise have been entitled under this Contract or any other arrangement by which SBHASO provides incentives.

6.2.5.5 Termination for Default, as outlined in this Contract.

6.3 **NOTICE**

6.3.1. Any notices required in accordance with any of the provisions herein shall be delivered personally to or sent by USPS registered or certified mail to:

SBHASO to: **Administrator**
SBHASO, Kitsap County Department of Human Services
614 Division St, MS-23
Port Orchard, WA 98366-4676

Contractor to: [**Contact]**
[Provider Agency]
[Address]
[City, State ZIP]

6.3.2. The Contractor shall maintain electronic mail access and contact during the regular business hours associated with the performance of contractual obligations under the Agreement.

ARTICLE SEVEN -GENERAL TERMS AND CONDITIONS FOR CONTRACTOR

7.1 **ASSIGNMENT**

Except as otherwise provided within this Contract, this Contract may not be assigned, delegated, or transferred by Provider without the express written consent of SBHASO and any attempt to transfer or assign this Contract without such consent shall be void. The terms "assigned", "delegated", or "transferred" shall include change of business structure to a limited liability company of any Provider Member or Affiliate Agency.

7.2 **AUTHORITY**

Concurrent with the execution of this Contract, Provider shall furnish, upon request, SBHASO with a copy of the explicit written authorization of its governing body to enter into this Contract and accept the financial risk and responsibility to carry out all terms of this Contract including the ability to pay for all expenses incurred during the contract period.

7.3 **COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS AND OPERATIONAL POLICIES**

The parties shall comply with all relevant state or federal law, policy, directive, or government sponsored program requirements relating to the subject matter of this Contract. The provisions of this Contract shall be construed in a manner that reflects consistency and compliance with such laws, policies and directives. Without limiting the generality of the foregoing, the parties shall specifically comply with the following:

7.3.1 Title XIX and Title XXI of the SSA and Title 42 CFR;
7.3.2 All applicable Office of the Insurance Commissioner (OIC) statutes and regulations;
7.3.3 Americans with Disabilities Act of 1990;
7.3.4 All local, State and Federal professional and facility licensing and certification requirements/standards that apply to services performed under the terms of this Contract;
7.3.5 All applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 US 1857(h)), Section 508 of the Clean Water Act (33 US 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 shall be reported to HCA/DSHS, DHHS and the EPA.

7.3.6 Any applicable mandatory standards and policies relating to energy efficiency, which are contained in the State Energy Conservation Plan, issued in compliance with the federal Energy Policy and Conservation Act;

7.3.7 Those specified in RCW Title 18 for professional licensing;
7.3.8 Reporting of abuse as required by RCW 26.44.030;
7.3.9 Industrial insurance coverage as required by RCW Title 51;
7.3.10 RCW 38.52, 70.02, 71.05, 71.24 and 71.34;
7.3.11 WAC 182-538 and 246-341;
7.3.12 Provider must ensure it does not: a) operate any physician incentive plan as described in 42 CFR §422.208; and b) does not Contract with any subcontractor operating such a plan.
7.3.13 State of Washington Medicaid State Plan and 1915(b) Medicaid Behavioral Health Waiver or their successors, which documents are incorporated by reference;
7.3.14 HCA/MCO Quality Strategy;
7.3.15 State of Washington behavioral health system mission statement, value statement and guiding principles for the system;
7.3.16 State Medicaid Manual (SMM), OMB Circulars, BARS Manual and BARS Supplemental Behavioral Health Instructions;
7.3.17 Any applicable federal and state laws that pertain to Medicaid enrollee or individual's rights. Provider shall ensure its staff takes those rights into account when furnishing services to individuals.
7.3.19 42 USC 1320a-7 and 1320a-7b (Section 1128 and 1128(b) of the SSA), which prohibits making payments directly or indirectly to physicians or other providers as an inducement to reduce or limit behavioral health services provided to individuals;Any policies and procedures developed by DSHS/Health Care Authority which governs the spend-down of individual's assets;
7.3.20 Provider and any subcontractors must comply with 42-USC 1396u-2 and must not knowingly have a director, officer, partner, or person with a beneficial ownership of more than five (5%) of Provider, BHA or subcontractor's equity, or an employee, Provider, or consultant who is significant or material to the provision of services

under this Contract, who has been, or is affiliated with someone who has been, debarred, suspended, or otherwise excluded by any federal agency.

7.3.21 Federal and State non-discrimination laws and regulations;

7.3.22 HIPAA (45 CFR parts 160-164);

7.3.23 Confidentiality of Substance Use Disorder 42 CFR Part 2;

7.3.24 HCA-CIS Data Dictionary and its successors;

7.3.25 Federal funds must not be used for any lobbying activities.

7.4 If Provider is in violation of a federal law or regulation and Federal Financial Participation is recouped from SBHASO, Provider shall reimburse the federal amount to SBHASO within twenty (20) days of such recoupment.

7.5 Upon notification from HCA/MCO, SBHASO shall notify Provider in writing of changes/modifications in CMS policies and/or HCA contract requirements.

7.6 **COMPLIANCE WITH SBHASO OPERATIONAL POLICIES**

Provider shall comply with all SBHASO operational policies that pertain to the delivery of services under this Contract that are in effect when the Contract is signed or come into effect during the term of the Contract. SBHASO shall notify Provider of any proposed change in federal or state requirements affecting this Contract immediately upon SBHASO receiving knowledge of such change.

7.7 **CONFIDENTIALITY OF PERSONAL INFORMATION**

Provider shall protect all Personal Information, records and data from unauthorized disclosure in accordance with 42 CFR §431.300 through §431.307, RCWs 70.02, 71.05, 71.34 and for individuals receiving SUD services, in accordance with 42 CFR Part 2 and WAC 246-341. Provider shall have a process in place to ensure all components of its provider network and system understand and comply with confidentiality requirements for publicly funded behavioral health services. Pursuant to 42 CFR §431.301 and §431.302, personal information concerning applicants and recipients may be disclosed for purposes directly connected with the administration of this Contract and the State Medicaid Plan. Provider shall read and comply with all HIPAA policies.

7.8 **CONTRACT PERFORMANCE/ENFORCEMENT**

SBHASO shall be vested with the rights of a third-party beneficiary, including the "cut through" right to enforce performance should Provider be unwilling or unable to enforce action on the part of its subcontractor(s). In the event Provider dissolves or otherwise discontinues operations, SBHASO may, at its sole option, assume the right to enforce the terms and conditions of this Contract directly with subcontractors; provided SBHASO keeps Provider reasonably informed concerning such enforcement. Provider shall include this clause in its contracts with its subcontractors. In the event of the dissolution of Provider, SBHASO's rights in indemnification shall survive.

7.9 **COOPERATION**

The parties to this Contract shall cooperate in good faith to effectuate the terms and conditions of this Contract.

7.10 **DEBARMENT CERTIFICATION**

Provider, by signature to this Contract, certifies Provider and any Owners are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency from participating in transactions (Debarred) and is not listed in the Excluded Parties List System in the System for Award Management (SAM) website, as outlined in SBHASO policies and procedures. Provider shall immediately notify SBHASO if, during the term of this Contract, Provider becomes debarred.

7.11 **EXCLUDED PARTIES**

Provider is prohibited from paying with funds received under this Contract for goods and services furnished, ordered, or prescribed by excluded individuals and entities SSA section 1903(i)(2) of the Act; 42 CFR 455.104, 455.106 and 1001.1901(b)).

7.11.1 Provider shall monitor for excluded individuals and entities by:

7.11.1.1 Screening Provider and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract.

7.11.1.2 Screening monthly newly added Provider and subcontractor's employees and individuals and entities with an ownership or control interest for excluded individuals and entities that would benefit directly or indirectly from funds received under this Contract.

7.11.1.3 Screening monthly Provider and subcontractor's employees and individuals and entities with an ownership or control interest that would benefit from funds received under this Contract for newly added excluded individuals and entities.

7.11.2 Report to SBHASO:

7.11.2.1 Any excluded individuals and entities discovered in the screening within 10 business days;

7.11.2.2 Any payments made by Provider that directly or indirectly benefit excluded individuals and entities and the recovery of such payments;

7.11.2.3 Any actions taken by Provider to terminate relationships with Provider and subcontractor's employees and individuals with an ownership or control interest discovered in the screening;

7.11.2.4 Any Provider and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in SSA section 1128 with 10 business days of Provider becoming aware of the conviction;

7.11.2.5 Any subcontractor terminated for cause within 10 business days of the effective date of termination to include full details of the reason for termination;

7.11.2.6 Any Provider and subcontractor's individuals and entities with an ownership or control interest.

7.11.3 Provider must provide a list with details of ownership and control no later than 30 days from the date of ratification and shall keep the list up-to-date thereafter.

7.11.4 Provider will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. Provider will immediately recover any payments for goods and services that benefit excluded individuals and entities it discovers.

7.11.5 Provider will immediately terminate any employment, contractual and control relationships with an excluded individual and entity it discovers.

7.11.6 Civil monetary penalties may be imposed against Provider if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees (SSA section 1128A(a)(6) and 42 CFR 1003.102(a)(2)).

7.11.7 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of five percent (5%) or more, or are a managing employee (i.e., a general manager, business manager, administrator, or director) who exercises operational or managerial control or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 CFR 455.104(a) and 1001.1001(a)(1)).

7.11.8 In addition, if SBHASO/MCO/HCA notifies Provider that an individual or entity is excluded from participation by HCA, Provider shall terminate all beneficial, employment, contractual and control relationships with the excluded individual or entity immediately.

7.11.8.1 The list of excluded individuals will be found at: http://exclusions.oig.hhs.gov/.

7.11.8.2 SSA section 1128 will be found at: http://www.ssa.gov/OP_Home/ssact/title11/1128.htm.

7.12 **DECLARATION THAT INDIVIDUALS UNDER THE MEDICAID AND OTHER BEHAVIORAL HEALTH PROGRAMS ARE NOT THIRD-PARTY BENEFICIARIES UNDER THIS CONTRACT**

Although SBHASO, Provider and subcontractors mutually recognize that services under this Contract may be provided by Provider and subcontractors to individuals under the Medicaid program, RCW 71.05 and 71.34 and the Community Behavioral Health Services Act, RCW 71.24, it is not the intention of either SBHASO or Provider that such individuals, or any other persons, occupy the position of intended third-party beneficiaries of the obligations assumed by either party to this Contract. Such third parties shall have no right to enforce this Contract.

7.13 **EXECUTION, AMENDMENT AND WAIVER**

This Contract shall be binding on all parties only upon signature by authorized representatives of each party. This Contract or any provision may be amended during the contract period, if circumstances warrant, by a written amendment executed by all parties. Only SBHASO or designee has authority to waive any provision of this Contract on behalf of SBHASO.

7.14 **HEADINGS AND CAPTIONS**

The headings and captions used in this Contract are for reference and convenience only and in no way define, limit, or decide the scope or intent of any provisions or sections of this Contract.

7.15 **INDEMNIFICATION**

To the fullest extent permitted by law, Contractor shall indemnify, defend and hold harmless the SBHASO, Kitsap County, Jefferson County and Clallam County, and the elected and appointed officials, officers, employees and agents of each of them, from and against all claims resulting from or arising out of the performance of this contract, whether such claims arise from the acts, errors or omissions of Provider, its subcontractors, third parties, the SBHASO, Kitsap County, Jefferson County or Clallam County, or anyone directly or indirectly employed by any of them or anyone for whose acts, errors or omissions any of them may be liable. "Claim" means any loss, claim, suit, action, liability, damage or expense of any kind or nature whatsoever, including but not limited to attorneys' fees and costs, attributable to personal or bodily injury, sickness, disease or death, or to injury to or destruction of property, including the loss of use resulting therefrom. Provider's duty to indemnify, defend and hold harmless includes but is not limited to claims by Provider's or any subcontractor's officers, employees or agents. Provider's duty, however, does not extend to claims arising from the sole negligence or willful misconduct of the SBHASO, Kitsap County, Jefferson County or Clallam County, or the elected and appointed officials, officers, employees and agents of any of them. For the purposes of this indemnification provision, Provider expressly waives its immunity under Title 51 of the Revised Code of Washington and acknowledges that this waiver was mutually negotiated by the parties. This provision shall survive the expiration or termination of this contract.

7.16 **INDEPENDENT CONTRACTOR FOR SBHASO**

The parties intend that an independent contractor relationship be created by this contract. Provider acknowledges that Provider, its employees, or subcontractors are not officers,

employees, or agents of SBHASO. Provider shall not hold Provider, Provider's employees and subcontractors out as, nor claim status as, officers, employees, or agents of SBHASO. Provider shall not claim for Provider, Provider's employees, or subcontractors any rights, privileges, or benefits which would accrue to an employee of SBHASO. Provider shall indemnify and hold SBHASO harmless from all obligations to pay or withhold Federal or State taxes or contributions on behalf of Provider, Provider's employees and subcontractors unless specified in this Contract.

7.17 **INSURANCE**

For the duration of the contract and until all work specified in the contract is completed, Contractor shall maintain in effect all insurance as required herein. Work under this contract shall not commence until evidence of all required insurance and bonding is provided to the SBHASO. Evidence of such insurance shall consist of a completed copy of the Certificate of Insurance, signed by the insurance agent for the Contractor and returned to:

Administrator, SBHASO
Kitsap County Department of Human Services
614 Division Street, MS-23
Port Orchard, WA 98366.

7.17.1 The Contractor's insurer shall have a minimum A.M. Best's Rating of A-VII.

7.17.2 Coverage shall include the following terms and conditions:

7.17.2.1 The policy shall be endorsed and certificate shall reflect that the SBH-ASO and Clallam, Jefferson and Kitsap Counties are named as an additional insureds on the Contractor's General Liability Policy with respect to the activities under this Contract

7.17.2.2 The policy shall provide and the certificate shall reflect that the insurance afforded applies separately to each insured against which a claim is made or a suit is brought except with respect to the limits of the Contractor's liability.

7.17.2.3 The policy shall be endorsed and the certificate shall reflect that the insurance afforded therein shall be primary insurance and any insurance or self-insurance carried by Kitsap County on behalf of the SBH-ASO shall be excess and not contributory insurance to that provided by the Contractor.

7.17.2.4 If for any reason, any material change occurs in the coverage during the course of this contract, such changes shall not become effective until forty-five (45) days after Kitsap County Risk Management Division has received written notice of changes.

7.17.2.5 SBH-ASO and Clallam, Jefferson and Kitsap Counties have no obligation to report occurrences unless a claim is filed with the SBH-ASO; and SBH-ASO or Clallam, Jefferson or Kitsap Counties have no obligation to pay premiums.

7.17.3 The Contractor shall insure that every officer, director, or employee who is authorized to act on behalf of the Contractor for the purpose of receiving or depositing funds into program accounts or issuing financial documents, checks or other instruments of payment for program costs shall be bonded to provide protection against loss.
7.17.3.1 Fidelity bonding secured pursuant to this contract must have coverage of $100,000 or the highest planned advance or reimbursement for the program year, whichever is greater.
7.17.3.2 If requested, the Contractor will provide a copy of the bonding instrument or a certification of the same from the bond issuing agency.

7.17.4 Workers' Compensation and Employer Liability. The Contractor will maintain workers' compensation insurance as required by Title 51, Revised Code of Washington, and will provide evidence of coverage to the Kitsap County Risk Management Division. If the contract is for over $50,000, then the Contractor will also maintain employer liability coverage with a limit of not less than $1 million.

7.17.5 The Contractor shall have insurance coverage and limits as follows:

7.17.5.1 Comprehensive Liability

Comprehensive General Liability Insurance and Comprehensive Automobile Liability Insurance with limits of not less than:

COVERAGE	**LIMITS OF LIABILITY**
Comprehensive General Liability Insurance	
a. Bodily Injury Liability	$1,000,000 each occurrence
b. Property Damage Liability	$1,000,000 each occurrence
OR	
c. Combined Bodily Injury/Property Damage Liability	$2,000,000 aggregate
Comprehensive Automobile Liability Insurance	
a. Bodily Injury Liability	$1,000,000 each person $1,000,000 each occurrence
b. Property Damage Liability	$1,000,000 each occurrence
OR	
c. Combined Single Limit Coverage of	$2,000,000

7.17.5.2 Professional Liability Insurance with limits of not less than:

Professional Liability Insurance $1,000,000 each occurrence.

7.18 **INTEGRATION**

This Contract, including Exhibits contains all the terms and conditions agreed upon by the parties. No other understandings, oral or otherwise, regarding the subject matter of this Contract shall be deemed to exist or to bind any of the parties hereto.

7.19 **MAINTENANCE OF RECORDS**

Provider shall prepare, maintain, and retain, accurate records, including appropriate medical records and administrative and financial records, related to this Contract and to Services provided hereunder in accordance with industry standards, applicable federal and state statutes and regulations, and state and federal sponsored health program requirements. Such records shall be maintained for the maximum period required by federal or state law. SBHASO shall have continued access to Provider's records as necessary for SBHASO to perform its obligations hereunder, to comply with federal and state laws and regulations, and to ensure compliance with applicable accreditation and HCA and CMS requirements.

Each party agrees that the terms set forth in this Agreement are strictly confidential and neither party shall disclose such terms to any person or entity for purposes other than the administration of the Agreement without receiving prior written consent of the other party, except as required by law or government programs, which may include being subject to the Public Records Act, RCW 42.56

Provider shall completely and accurately report encounter data to SBHASO and shall certify the accuracy and completeness of all encounter data submitted. Provider shall assure that it, and all of its subcontractors that are required to report encounter data, have the capacity to submit all data necessary to enable the SBHASO to meet the reporting requirements in the Encounter Data Transaction Guide published by HCA, or other requirements HCA may develop and impose on SBHASO or Provider.

Upon SBHASO's request, or under SBHASO's state and federal sponsored health programs and associated contracts, Provider shall provide to SBHASO direct access and/or copies of all information, encounter data, statistical data, and treatment records pertaining to Members who receive Services hereunder, or in conjunction with claims reviews, quality improvement programs, grievances and appeals and peer reviews.

7.20 **NO WAIVER OF RIGHTS**

A failure by either party to exercise its rights under this Contract shall not preclude that party from subsequent exercise of such rights and shall not constitute a waiver of any other rights under this Contract unless stated to be such in writing signed by an authorized representative of the party and attached to the original Contract.

Waiver of any breach of any provision of this Contract shall not be deemed to be a waiver of any subsequent breach and shall not be construed to be a modification of the terms and conditions of this Contract.

7.21 **ONGOING SERVICES**

Provider and its subcontractors shall ensure in the event of labor disputes or job actions, including work slowdowns, or other activities within its service BHA network, uninterrupted services shall be available as required by the terms of this Contract.

7.22 **OVERPAYMENTS**

In the event Provider fails to comply with any of the terms and conditions of this Contract and results in an overpayment, SBHASO may recover the amount due HCA, MCO, CMS, or other federal or state agency subject to dispute resolution as set forth in the contract. In the case of overpayment, Provider shall cooperate in the recoupment process and return to SBHASO the amount due upon demand.

7.22.1 Except in the case of fraud, SBHASO may not request a refund from Provider of payment previously made to satisfy a claim unless it does so in writing within 24 months after the date payment was made.

7.22.2 In the case of coordination of benefits, SBHASO must request a refund from Provider of payment previously made to satisfy a claim within 30 months after the date payment was made.

7.22.3 Except in the case of fraud, Provider may not request payment from SBHASO to satisfy a claim unless it does so in writing within 24 months after the date the claim was denied or payment intended to satisfy the claim was made.

7.22.4 In the case of coordination of benefits, the Provider must request from the SBHASO within 30 months after original payment was made for any additional balances owed.

7.23 **OWNERSHIP OF MATERIALS**

The parties to this Contract hereby mutually agree that if any patentable or copyrightable material or article should result from the work described herein, all rights accruing from such material or article shall be the sole property of SBHASO. The SBHASO agrees to and does hereby grant to the Provider, irrevocable, nonexclusive, and royalty-free license to use, according to law, any material or article and use any method that may be developed as part of the work under this Contract.

The foregoing products license shall not apply to existing training materials, consulting aids, checklists, and other materials and documents of the Provider which are modified for use in the performance of this Contract.

The foregoing provisions of this section shall not apply to existing training materials, consulting aids, checklists, and other materials and documents of the Provider that are not modified for use in the performance of this Contract.

7.24 **PERFORMANCE**

Provider shall furnish the necessary personnel, materials/behavioral health services and otherwise do all things for, or incidental to, the performance of the work set forth here and as attached. Unless specifically stated, Provider is responsible for performing or ensuring all fiscal and program responsibilities required in this contract. No subcontract will terminate the legal responsibility of Provider to perform the terms of this Contract.

7.25 **RESOLUTION OF DISPUTES**

The parties wish to provide for prompt, efficient, final and binding resolution of disputes and controversies that may arise under this Contract; therefore, establish this dispute resolution procedure. All claims, disputes and other matters in question between the parties arising out of, or relating to, this Contract shall be resolved by the following dispute resolution procedure unless the parties mutually agree in writing otherwise:

7.25.1 **Informal Resolution**

The parties shall use best efforts and will deal fairly and negotiate in good faith to informally resolve any disputes that may arise related to this Contract.

7.25.2 **Nonbinding Mediation**

If Provider is dissatisfied with SBHASO's final resolution of a contract dispute or if SBHASO fails to grant or reject Provider's request for review of a contract dispute within thirty (30) days after it is made, Provider may submit the contract dispute to nonbinding mediation pursuant to Chapter 7.07 of the Revised Code of Washington.

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.

7.25.5 **Washington Law.**

This Contract shall be governed by laws of the State of Washington, both as to interpretation and performance.

7.26 **SEVERABILITY AND CONFORMITY**

The provisions of this Contract are severable. If any provision of this Contract, including any provision of any document incorporated by reference is held invalid by any court, that invalidity shall not affect the other provisions of this Contract and the invalid provision shall be considered modified to conform to existing law.

7.27 **SINGLE AUDIT ACT**

Provider may not grant access to health information unrelated to enrollees covered under this agreement. If Provider grants access to medical records for audit purposes, the information provided will be limited to the minimum necessary to perform the audit.

If Provider or its subcontractor is a sub recipient of Federal awards as defined by OMB Uniform Guidance Subpart F, Provider and its subcontractors shall maintain records that identify all Federal funds received and expended. Such funds shall be identified by the appropriate OMB Catalog of Federal Domestic Assistance titles and numbers, award names, award numbers, and award years (if awards are for research and development), as well as names of the Federal agencies. Provider and its subcontractors shall make Provider and its subcontractor's records available for review or audit by officials of the Federal awarding agency, the General Accounting Office and DSHS. Provider and its subcontractors shall incorporate OMB Uniform Guidance Subpart F audit requirements into all contracts between Provider and its subcontractors who are sub recipients. Provider and its subcontractors shall comply with any future amendments to OMB Uniform Guidance Subpart F and any successor or replacement Circular or regulation.

If Provider/subcontractors are a sub recipient and expends $750,000 or more in Federal awards from any/all sources in any fiscal year, Provider and applicable subcontractors shall procure and pay for a single or program-specific audit for that fiscal year. Upon completion of each audit, Provider and applicable subcontractors shall submit to SBHASO the data collection form and reporting package specified in OMB Uniform Guidance Subpart F, reports required by the program-specific audit guide, if applicable and a copy of any management letters issued by the auditor.

For purposes of "sub recipient" status under the rules of OMB Uniform Guidance Subpart F, Medicaid payments to a sub recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part of the rule unless a State requires the fund to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.

7.28 **SUBCONTRACTS**

Provider may subcontract services to be provided under this Contract subject to the following requirements.

7.28.1 The Provider shall not assign or subcontract any portion of this Contract or transfer or assign any claim arising pursuant to this Contract without the written consent of

SBHASO. Said consent must be sought in writing by the Provider not less than fifteen (15) days prior to the date of any proposed assignment.

7.28.2 Provider shall be responsible for the acts and omissions of any subcontractor.

7.28.3 Provider must ensure the subcontractor neither employs any person nor contracts with any person or BHA excluded from participation in federal health care programs under either 42 USC 1320a-7 (§§1128 or 1128A SSA) or debarred or suspended per this Contract's General Terms and Conditions.

7.28.4 Provider shall require subcontractors to comply with all applicable federal and state laws, regulations and operational policies as specified in this Contract.

7.28.5 Provider shall require subcontractors to comply with all applicable SBHASO operational policies as applicable.

7.28.6 Subcontracts for the provision of behavioral health services must require subcontractors to provide individuals access to translated information and interpreter services.

7.28.7 Provider shall ensure a process is in place to demonstrate all third-party resources are identified and pursued.

7.28.8 Provider shall oversee, be accountable for and monitor all functions and responsibilities delegated to a subcontractor for conformance with any applicable statement of work in this Contract on an ongoing basis including written reviews.

7.28.9 Provider will monitor performance of the subcontractors on an annual basis and notify SBHASO of any identified deficiencies or areas for improvement requiring corrective action by Provider.

7.28.10 The Provider agrees to include the following language verbatim in every subcontract for services which relate to the subject matter of this Contract:

"To the fullest extent permitted by law, subcontractor shall indemnify, defend and hold harmless the SBHASO, Kitsap County, Jefferson County and Clallam County, and the elected and appointed officials, officers, employees and agents of each of them, from and against all claims resulting from or arising out of the performance of this contract, whether such claims arise from the acts, errors or omissions of subcontractor or its own subcontractors, the contractor, third parties, the SBHASO, Kitsap County, Jefferson County or Clallam County, or anyone directly or indirectly employed by any of them or anyone for whose acts, errors or omissions any of them may be liable. "Claim" means any loss, claim, suit, action, liability, damage or expense of any kind or nature whatsoever, including but not limited to attorneys'

fees and costs, attributable to personal or bodily injury, sickness, disease or death, or to injury to or destruction of property, including the loss of use resulting therefrom. Subcontractor's duty to indemnify, defend and hold harmless includes but is not limited to claims by subcontractor's officers, employees or agents. Subcontractor's duty, however, does not extend to claims arising from the sole negligence or willful misconduct of the SBHASO, Kitsap County, Jefferson County or Clallam County, or the elected and appointed officials, officers, employees and agents of any of them.

"For purposes of these indemnification provisions, subcontractor expressly waives its immunity under Title 51 of the Revised Code of Washington and acknowledges that this waiver was mutually negotiated.

"Subcontractor further expressly agrees that the SBHASO, Kitsap County, Jefferson County and Clallam County, and the elected and appointed officials, officers, employees and agents of each of them, are all third-party beneficiaries to this contract for this purpose and have the right to bring an action against subcontractor to enforce these defense and indemnification provisions.

"These defense and indemnification provisions shall survive the expiration or termination of this contract."

Those written subcontracts shall:

7.28.11 Require subcontractors to hold all necessary licenses, certifications/permits as required by law for the performance of the services to be performed under this Contract;

7.28.12 Require subcontractors to notify Provider in the event of a change in status of any required license or certification;

7.28.13 Include clear means to revoke delegation, impose corrective action, or take other remedial actions if the subcontractor fails to comply with the terms of the subcontract;

7.28.15 Require the subcontractor to correct any areas of deficiencies in the subcontractor's performance that are identified by Provider, SBHASO/MCO/HCA;

7.28.15 Require best efforts to provide written or oral notification within fifteen (15) business days of termination of a Primary Care Provider (PCP) to individuals currently open for services who had received a service from the affected PCP in the previous sixty (60) days. Notification must be verifiable in the individual's medical record at the subcontractor.

7.29 **SURVIVABILITY**

The terms and conditions contained in this Contract by their sense and context are intended to survive the expiration of this Contract and shall so survive. Surviving terms include but are not limited to: Financial Terms and Conditions, Single Audit Act, Contract Performance and Enforcement, Confidentiality of Client Information, Resolution of Disputes, Indemnification, Oversight Authority, Maintenance of Records, Ownership of Materials and Contract Administration Warranties and Survivability.

7.30 **TREATMENT OF INDIVIDUAL'S PROPERTY**

Unless otherwise provided in this Contract, Provider shall ensure any adult individual receiving services from Provider under this Contract has unrestricted access to the individual's personal property. Provider shall not interfere with any adult individual's ownership, possession, or use of the individual's property unless clinically indicated. Provider shall provide individuals under age eighteen (18) with reasonable access to their personal property that is appropriate to the individual's age, development and needs. Upon termination of this Contract, Provider shall immediately release to the individual and/or guardian or custodian all the individual's personal property.

7.31 **WARRANTIES**

The parties' obligations are warranted and represented by each to be individually binding for the benefit of the other party. Provider warrants and represents it is able to perform its obligations set forth in this Contract and such obligations are binding upon Provider and other subcontractors for the benefit of SBHASO.

7.32 **CONTRACT CERTIFICATION**

7.32.1 The terms and conditions of this Agreement are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings and communications, oral or otherwise regarding the subject matter for this Agreement between the parties. The parties signing below represent they have read and understand this Agreement, and have the authority to execute this Agreement. This Agreement shall be binding on SBHASO only upon signature by KitsapCounty.

IN WITNESS WHEREOF the Parties have signed this Agreement effective this ____ day of

_____, 2019.

Dated this ___ day of _____, 2019

SALISH BEHAVIROAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION, By KITSAP COUNTY BOARD OF COMMISSIONERS, Its Administrative Entity

_____

Dated this ___ day of _____, 2019

For [Contractor:]

_____

Edward E. Wolfe, Chair

Signature

Charlotte Garrido, Commissioner

Printed Name

Robert Gelder, Commissioner

Title

ATTEST:

Dana Daniels, Clerk of the Board

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit A
Schedule of Services
January 1, 2020 through December 31, 2020

Identification of Contracted Services

The Crisis Services Provider, [CONTRACTING ENTITY], shall provide covered services, as indicated in the Contracted Services Grid below, within the scope of Provider's business, licensure(s) and practice, in accordance with the Base Provider Agreement, SBHASO Policies and Procedures, [CONTRACTING ENTITY] Policies and Procedures, MCO and HCA standards, MCO Provider Manuals, the terms, conditions and eligibility outlined in Contract Exhibits, and the requirements of any applicable government sponsored program.

Contracted Services Grid

Crisis Services		
Contracted Service	**Service Type**	**SBHASO Policies and Procedures**
☐	Crisis Services (Includes Crisis Stabilization, Mobile Crisis Outreach, Behavioral Health Disaster Response, and Involuntary Treatment Act Evaluations)	Integrated Crisis System; Involuntary Treatment Act Services; Ensuring Care Coordination for Individuals
☐	Regional Behavioral Crisis Hotline	Integrated Crisis System; Toll-free Crisis Line Management

Salish Behavioral Health Administrative Services Organization (SBHASO)

EXHIBIT B – COMPENSATION SCHEDULE

Contractor: _____

NPI: _____

Time Period: January 1, 2020 – December 31, 2020

Payment Type	Service Detail	Monthly Base Medicaid	Monthly Additional Capacity Medicaid	Maximum Monthly Medicaid
Capacity	Schedule of Services, as described in Exhibit A	[$1 to $100,000] in increments of $1.00	[$1 to $100,000] in increments of $1.00	[$1 to $200,000] in increments of $1.00

- *Monthly Base* is compensation for all eligible crisis services up to [1 to 1,000] units.
    - Monthly Base payment is due and payable by SBHASO on the twentieth (20th) day of the month. If the 20th, is not a business day, the Monthly Base payment shall be due and payable on the next business day following the twentieth (20th) day of the month.
- *Monthly Additional Capacity* is compensation for services delivered in excess of [10 to 1,000] units
    - Each additional unit is compensated at [$10 to $200] per unit, to a maximum of [$1,000 to $50,000] per month.
    - Contractor shall generate invoice for Monthly Additional Capacity payment and submit to SBH-ASO by the fifteenth (15th) day of the month. If the fifteenth (15th) is not a business day, the Monthly Base payment shall be due and payable on the next business day following the fifteenth (15th) day of the month. SBHASO will render payment from clean invoice submissions to Contractor within 30 days of receipt of invoice.
- For toll-free crisis line provider, compensation is based on H0030 services.
- For all other crisis providers, compensation is based on H2011* services.

* H2011 services with HW modifier are excluded from Medicaid compensation.

EXHIBIT C
DELEGATION AGREEMENT

This Exhibit C: Sub-Delegation Agreement ("Exhibit C") is attached to and a part of the Administrative Services Agreement (the "Agreement") by and between Salish Behavioral Health Administrative Services Organization ("SBHASO"), and [Behavioral Health Agency] (Provider), and is effective as of the Effective Date.

This Exhibit C sets forth additional requirements applicable to Provider's performance and SBHASO's oversight of Provider's performance of all Subdelegated Functions under the Agreement.

1. **DEFINITIONS**. Capitalized terms not otherwise defined in this Exhibit C shall have the meanings given under the Agreement.

   1.1 **BH-ASO.** "Behavioral Health Administrative Services Organization" or "BH-ASO" means the entity selected by HCA to administer crisis behavioral health services and programs for residents in a defined regional services area, regardless of ability to pay, including Medicaid eligible individuals.

   1.2 **BH-ASO Contract. "**Behavioral Health Administrative Services Organization Contract" or "BH-ASO Contract" means (SBHASO's) contract with the HCA for the provision of BH-ASO services, including Members, in the Salish regional service area ("Region").

   1.3 **General Fund State.** "General Fund State" or "GFS" means the source of funding for services provided pursuant to *Apple Health – Fully Integrated Managed Care – Behavioral Health Services wrap-around contract*.

   1.4 **Grievance**. "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination, as defined under the applicable HCA Contract(s). Possible subjects for Grievances may include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect a Member's rights.

   1.5 **HEDIS**. "HEDIS" means the Healthcare Effectiveness Data and Information Set developed and published by the National Committee for Quality Assurance. HEDIS includes technical specifications for the calculation of performance measures.

   1.6 **NCQA Standards**. "NCQA Standards" means certain National Committee for Quality Assurance ("NCQA") standards and guidelines applicable to CSHCD SCRBH, Provider and/or the Services, published by NCQA and modified from time to time

1.7 **Program Documents**. "Program Documents" means, for each Subdelegated Function, SBHASO's comprehensive set of documents and materials that describe and govern one or more of the services or activities provided or performed by SBHASO in carrying out each Subdelegated Function. Program Documents shall, at a minimum: (i) define the purpose and objectives of each Delegated Function; (ii) a describe the manner in which the activities and services related to the Delegated Function are performed; (iii) roles and responsibilities related to performance and oversight of the Delegated Function; (iv) whether any of the activities or services will be subdelegated; and (v) SBHASO's processes, policies, desk procedures, job aides, and other information and materials, related to the performance of the Delegated Function.

1.8 **Provider Policies and Procedures.** Provider's Policies and Procedures shall contain information useful and applicable to credentialing, utilization management, prior authorization requirements, claims submissions, and Provider's online demographic information.

2. **SUBDELEGATED FUNCTIONS**.

2.1 For each Subdelegated Function, SBHASO shall ensure that all services and activities related to that Subdelegated Function are performed (i) in a professional manner and in accordance with industry standards; (ii) as outlined in the applicable exhibits and any attachments or other addenda thereto; (iii) in accordance with SBHASO's Program Documents; and (iv) in accordance with the Agreement.

2.2 **Joint Oversight**. Throughout the Term of the Agreement, the Managed Care Organizations (MCOs) and SBHASO shall conduct joint oversight to monitor and improve the Provider's performance of the Subdelegated Functions. Oversight activities will include, at a minimum: established roles and responsibilities related to oversight and reporting; SBHASO's timely preparation and the MCO's and SBHASO's review of regularly delivered reports; annual and ad hoc audits of [Behavioral Health Agency's] performance, including file and other documentation review; regular and ad hoc operational review and performance improvement meetings; and development and implementation of appropriate correctives actions, as needed and as set forth herein and in any attachments and addenda hereto.

3. **SPECIFIC DELEGATIONS/SUBDELEGATIONS**.

3.1 **Crisis Administration Services**. Crisis Administration Services are delegated to SBHASO by the Managed Care Organizations (MCOs), and shall be performed by SBHASO in accordance with MCO Exhibits and Attachments. Any Crisis Administration Services Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with the SBHASO policies and procedures

and Exhibit C and Attachment C-1. Attachment C-1 is attached to this Exhibit C and by this reference incorporated herein.

3.2 **Delegated/Subdelegated Provider Credentialing.** Credentialing activities related to SBHASO's subcontracted Crisis Services providers are delegated to SBHASO by the MCO's, and shall be performed by SBHASO in accordance with Attachment C-2, which is attached to this Exhibit C and by this reference incorporated herein. Any Credentialing activities Subdelegated by the SBHASO to Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-2, which is attached to this Exhibit C and by this reference incorporated herein.

3.3 **Delegated/Subdelegated Utilization Management.** Certain Utilization Management activities related to SBHASO's administration of Crisis Services are delegated to SBHASO in accordance with Attachment C-3, which is attached to this Exhibit C and by this reference incorporated herein. If applicable, Utilization Management activities Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachments C-3, which is attached to this Exhibit C and by this reference incorporated herein.

3.4 **Delegated/Subdelegated Encounter Data Services.** Encounter Data Services related to SBHASO's administration of Crisis Services are delegated to SBHASO in accordance with Attachment C-4, which is attached to this Exhibit C and by this reference incorporated herein. Any Encounter Data Services Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-4, which are attached to this Exhibit C and by this reference incorporated herein.

3.5 **Delegated/Subdelegated Quality Improvement Services.** Certain Quality Improvement activities related to SBHASO's administration of Crisis Services are delegated to SBHASO in accordance with Attachment C-5, which is attached to this Exhibit C and by this reference incorporated herein. If applicable, Quality Improvement activities Subdelegated by the SBHASO to the Provider shall be performed by the Provider in accordance with Exhibit C and Attachment C-5, which are attached to this Exhibit C and by this reference incorporated herein.

4. **PRE-CONDITIONS OF SUB-DELEGATION**. The delegation of any part of a Delegated Function is contingent upon SBHASO's determination that the Provider is capable of and willing to perform such Subdelegated Function(s), and all related services and activities, in a manner that complies with the Agreement, including this Exhibit C and all attachments and addenda hereto.

4.1 **Pre-Subdelegation Assessment and Corrective Actions**. SBHASO shall conduct a pre-subdelegation assessment to determine whether the Provider is capable of

performing each Delegated Function in accordance with applicable Compliance Requirements and SBHASO's established standards for quality and efficiency. If SBHASO's pre-subdelegation assessment indicates that Provider is unable to perform a Subdelegated Function in full compliance with the terms and conditions hereof, or otherwise fails to meet established standards, Provider shall submit, implement and comply with a Corrective Action Plan ("CAP"), acceptable to SBHASO within a mutually agreed upon time frame and prior to performing any part of the Subdelegated Function(s).

4.2 **Failure to Meet Pre-Conditions**. If Provider is not able to complete the CAP, or is otherwise unable to perform the Subdelegated Function(s) as required hereunder, to SBHASO's satisfaction, SBHASO may, in addition to any other available remedies, suspend or terminate Provider's performance under this Exhibit C or any attachment or addenda hereto.

5. **CONTACT WITH MEMBERS**.

5.1 **Definitions**. Consistent with the requirements of 42 C.F.R. §438.10(c)(4)(i), any managed care terms used by Provider in communications with Members shall have meanings consistent with the definitions of the managed care terms provided in Health Care Authority's model managed care contracts found here: https://www.hca.wa.gov/billers-providers/programs-and-services/model-managed-care-contracts.

5.2 **Member Rights.** In furnishing service to Apple Health Members under the Agreement, Provider shall take into account federal and state law pertaining to Member rights.

5.3 **Access to Member Records.** The MCOs and SBHASO shall have access to Provider's medical records, to the extent permitted by state and federal law.

5.4 **Confidentiality of Member Records.** Provider shall maintain the confidentiality of Member information and records in accordance with state and federal law.

5.5 **Equal Access**. Provider will provide all information, including both oral and written information, in a manner and format that is easily understood and readily accessible to the Member(s) receiving the information.

5.6 **Treatment Options.** Provider will freely communicate with Members about treatment options, including medication treatment options, regardless of benefit coverage limitations.

5.7 **Interpreter Services**. Provider shall access and utilize appropriate interpreter services for all interactions between Provider and a Member who is deaf or hearing impaired, or whose primary language is other than English.

5.8 **Written Information**. Provider shall ensure that all written information it provides to Members is accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at a sixth (6^{th}) grade reading level. Wherever appropriate or required, Provider shall use form letters and notices provided by the MCOs or SBHASO. Generally applicable written communications, including educational materials, must be reviewed and approved by the MCOs and SBHASO prior to use.

5.8.1 Generally available written communications must be translated into each language spoken by five percent (5%) of Members, or 1,000 Members, whichever is less. SBHASO will provide to Provider, a list of languages meeting this requirement upon request.

5.8.2 For Members whose primary language is not translated or whose need cannot be addressed by translation, Provider will use one of the following alternatives to address the Member's communication needs: (i) translating the material into the Member's primary reading language; (ii) providing the material in an audio format in the Member's primary language; (iii) having an interpreter read the material to the Member in the Member's primary language; (iv) providing the material in another alternative medium or format acceptable to the Member, in which case Provider shall document the Member's acceptance of the material in the alternative medium or format in the Member's record; or (v) providing the material in English, if Provider documents the Member's preference for receiving written materials in English.

5.9 **Telephonic Communication**. Provider may not use an automated call system to make outbound calls to Members for care coordination, or for calls related to behavioral health or prescription verification.

5.10 **Marketing**. Unless otherwise agreed to by the parties in writing, Provider shall not perform marketing activities on the MCO's or SBHASO's behalf or in manner that suggests Provider is acting under the authority or as a representative of the MCOs or SBHASO. The Parties acknowledge that door-to-door, telephonic and other cold-c, all marketing, are not permitted. Provider shall at all times comply 42 C.F.R. §§ 438.10 and 438.104 and HCA's Managed Care Marketing Guidelines.

6. **GRIEVANCES**. The MCOs and SBHASO maintain a Grievance Process consistent with applicable state and federal requirements, including those that apply to General Fund State-funded services. SBHASO retains, and does not delegate to Provider, responsibility for

responding to and resolving Grievances. Not later than the end of the next business day following the day of Provider's receipt, Provider shall transfer or refer to SBHASO any Grievance Provider receives, irrespective of whether such Grievance is related to Provider, SBHASO, a SBHASO subcontractor, including any Subdelegates, a provider, or the MCO. SBHASO shall provide the appropriate MCO information on the Grievance of a Medicaid Enrollee. The MCO of a Medicaid Enrollee shall undertake an initial review of all Grievances. After the MCO's initial review and upon the MCO's request, SBHASO and Provider shall provide all reasonable assistance to the MCO in its investigation and resolution of a Grievance that relates to a Service provided by Provider or a SBHASO subcontractor, or relates to or involves information held by Provider. The MCO shall be responsible for providing notice of the resolution of a Grievance to the affected Member or provider.

6.1 Provider and SBHASO shall promptly refer to the MCO any non-Grievance inquiries or requests it receives from Members or MCO providers that are unrelated to the Services provided by Provider under this Agreement.

7. **SBHASO OBLIGATIONS**.

7.1 **Ultimate Legal Responsibility and Oversight**. The MCOs shall at all times retain ultimate responsibility for and oversight of all Delegated Functions to SBHASO. SBHASO is responsible for oversight of all Subdelegate Functions to Provider.

7.1.1 The MCOs and SBHASO will review Provider's regular (e.g., daily, weekly, monthly, and semi-annual) reports related to each Delegated and Subdelegated Functions, identified in the attachments and addenda hereto.

7.1.2 At least annually, and more often as SBHASO deems reasonably necessary, SBHASO will conduct an audit of Provider's performance of each Subdelegated Function. Such audits will evaluate, at a minimum, the extent to which Provider's performance of each Subdelegated Function meets applicable Compliance Requirements. Where possible, SBHASO will provide Provider at least than thirty (30) days' written notice of an audit, including the scope and format of the audit.

7.2 **Termination of Provider's Responsibilities**. SBHASO retains the right to suspend or terminate a Subdelegate of SBHASO, if SBHASO reasonably determines that such Subdelegate's performance under the Agreement is deficient, non-compliant, or otherwise unsatisfactory, and SBHASO provides written notice to Provider regarding such deficiency, non-compliance, or dissatisfaction.

7.3 **HCA Reporting**. SBHASO shall be responsible for submitting reports or other information related to the Services to the MCOs which are responsible to submit reports and other information related to Services to HCA.

8. **SBHASO OBLIGATIONS.**

8.1 Provider shall employ, subcontract or otherwise arrange for sufficient staff to provide each Subdelegated Function in a manner which permits the parties to satisfy applicable Compliance Requirements.

8.2 Provider shall ensure that its other business relationships do not interrupt the continuity of services provided to MCO and SBHASO Members under this Exhibit C.

8.3 **NCQA Compliance**. The MCOs are accredited by NCQA and operate in accordance with the NCQA Standards. SBHASO and Provider shall comply with the most current version of the NCQA Standards and shall cooperate with and assist the MCOs in demonstrating SBHASO's and Provider's compliance with NCQA Standards.

8.4 **Record Keeping; Reporting.** Provider shall maintain a record keeping system or systems adequate to fully document its performance of each Subdelegated Function. Provider will prepare and timely submit to SBHASO regular (e.g., daily, weekly, monthly, and semi-annual) reports or other documentation as identified in the attachments or addenda hereto, related to each Subdelegated Function. Provider will investigate and, if necessary, correct any issues or concerns, including errors or inconsistencies, SBHASO or Provider identifies related to Provider's reports, and will resubmit corrected reports, as needed.

8.5 **Audits**. Provider shall promptly respond to and cooperate with all requests for information, including permitting reasonable access to facilities, and clinical, financial and/or administrative records related to the provision of Services under the Agreement from SBHASO related to audits and other oversight activities.

8.6 **Eligibility**. SBHASO and, where applicable, Provider, shall adhere to SBHASO's established protocols for determining an individual's eligibility for the Services. Provider shall ensure that patient funding information is updated upon a change to the funding source.

8.7 **HCA Compliance**. SBHASO and Provider shall comply with the applicable terms and conditions of the HCA Contracts. In the event HCA makes changes to the applicable terms and conditions of the HCA Contracts, SBHASO and Provider shall accept such changes without modification.

8.7.1 Provider shall cooperate with SBHASO's Quality Improvement program and provide open communication on quality improvement strategies.

8.7.2 Provider shall maintain a quality improvement system tailored to the nature and type of health care services rendered under the contract, and which affords quality control for the health care provided.

8.7.3 Provider shall cooperate with MCO-, SBHASO- and HCA-sponsored Quality Improvement activities.

8.7.4 Provider shall provide to SBHASO all information needed to support care coordination activities.

8.7.5 Provider shall participate in training as requested or required by an MCO, SBHASO or the HCA.

8.7.6 Provider shall respond to law enforcement inquiries regarding an individual's eligibility possess a firearm under RCW 9.41.040(2)(a), and shall concurrently provide to SBHASO a copy of the inquiry and response. SBHASO shall provide a copy of the inquiry and response to the appropriate MCO for Medicaid Enrollees.

8.8 **SBHASO Program Documents**. SBHASO will develop and maintain Program Documents related to each Subdelegated Function. At least sixty (60) days prior to commencement of Provider's performance of any Subdelegated Function hereunder, or a shorter period of time to which the parties agree, SBHASO shall provide Provider copies of its Program Documents. SBHASO shall provide Provider at least fifteen (15) business days advance written notice of any material change to SBHASO's Program Documents.

8.9 **Oversight of SBHASO's Subdelegates**. SBHASO shall obtain the MCO's written approval prior to subdelegating any portion of its performance hereunder. Subdelegation agreements must be in writing and comply with the requirements set forth in Section 3.6 of the MCO's Agreement. SBHASO shall provide, and document its provision of, active and ongoing oversight of any approved Subdelegate(s). SBHASO shall have a written oversight plan, including a process to evaluate, on at least an annual basis, each Subdelegate's performance relative to the applicable Compliance Requirements and the terms and conditions of the written sub-delegation agreement between SBHASO and the Subdelegate. SBHASO's written process must include a process for issuing a corrective action and revoking subdelegation. SBHASO shall maintain and provide to the MCOs, upon request, a record of its oversight of each Subdelegate's performance, including SBHASO's monitoring process and activities, and any finds or other results.

8.10 SBHASO shall provide written notification to the MCOs and Subdelegates at least thirty (30) days prior to implementing any change expected to materially alter SBHASO's performance of a Subdelegated Function.

8.11 **HCA Data Reporting**. Provider shall provide to SBHASO timely, complete, and accurate reports and data, including encounter data in accordance with the HCA's Encounter Data Transaction Guide. SBHASO shall ensure that its subcontractors, who are required to report data, have the capacity to submit all HCA required data to enable SBHASO to meet the reporting requirements under the MCO and HCA Contracts. SBHASO shall ensure that its subcontractor(s) comply with data submission requirements established by the HCA for all Services.

8.12 **Program Integrity.** Where possible, SBHASO shall perform ongoing analysis of utilization and claims, billing, or encounter data to detect overpayments or other errors or inconsistencies. Such oversight will include audits and investigations of SBHASO's subcontractors, including provider entities, and a process to verify that services billed by providers were actually provided to Members.

8.13 **Authorizations and Coverage Decision.** If the Subdelegated Functions include authorizations, SBHASO shall comply with 42 C.F.R. § 438.210, Chapters 182-538 and 182-550 WAC, WACs 182-501-0160, 182-501-0169, and WAC 284-43-410, and applicable terms of SBHASO's HCA Contracts. Where applicable, SBHASO shall follow the coverage decision of the Washington Health Technology Assessment program.

9. **PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTIONS**.

9.1 **Deficiencies and Non-Compliances**. If SBHASO reasonably determines that Provider's performance of a Subdelegated Function, including any service or activity related thereto, does not meet applicable Compliance Requirements or is otherwise deficient, SBHASO shall provide Provider written notice describing the non-compliances and/or deficiencies. In addition to its other remedies available under this Agreement, SBHASO may take one or more of the following steps to address a non-compliance or deficiency:

9.1.1 Audit. Upon reasonable notice to Provider, conduct an audit of Provider's performance of the non-compliant or deficient Subdelegated Function, service or activity to further investigate the nature, source and extent of the non-compliance or deficiency.

9.1.2 Corrective Action Plan(s). Following notice of a non-compliance or deficiency, require Provider to prepare and submit to SBHASO, within a reasonable time-frame, a corrective action plan ("CAP") designed to correct the identified non-compliance or deficiency. Such CAP shall be in the form of a written response to SBHASO's notice of non-compliance or deficiency and shall detail Provider's process for correcting the identified issue(s) within a proposed time period, not to exceed thirty (30) days, including implementation and completion, or such

other period as is reasonable given the nature or severity of the non-compliance or deficiency. SBHASO shall review and approve each CAP prior to Provider's implementation.

9.1.3 **Suspension of Performance, Compensation.** If, in SBHASO's sole judgment, Provider's non-compliance or deficiency poses unreasonable risk to the well-being of Members, the timely provision of medically necessary health care and other services, or otherwise materially jeopardizes the quality or continuity of SBHASO operations, then SBHASO may suspend part or all of Provider's performance of the non-compliant or deficient Subdelegated Function until such time as Provider has corrected the non-compliance or deficiency to SBHASO's satisfaction. In such event, SBHASO reserves the right to suspend Provider's compensation related to the suspended Subdelegated Function(s) until such time as the non-compliance or deficiency has been resolved to SBHASO's satisfaction.

9.2 **CAP Implementation and Completion**. SBHASO shall oversee Provider's implementation of a CAP to ensure that the instance(s) of non-compliance or deficiency is fully resolved. At the earlier of Provider's completion of the CAP or the time-frame for correction stated in the CAP, SBHASO shall review evidence of Provider's implementation and/or completion of the CAP.

9.2.1 Upon SBHASO's finding that all issues related to the CAP are resolved, SBHASO shall provide written notice to Provider of closure of the CAP.

9.2.2 SBHASO may, in its sole discretion, permit Provider additional time to provide satisfactory evidence of CAP completion.

9.3 **Suspension or Termination of Delegation.** If, in SBHASO's reasonable judgment, Provider's performance remains non-compliant or deficient after the agreed-to time-frame for correction, SBHASO may suspend or terminate part or all Provider's performance of the non-compliant or deficient Subdelegated Function, or take any other remedial action permitted under this Exhibit C or the Agreement. In the event SBHASO suspends Provider's performance of all or part of a Subdelegated Function, SBHASO reserves the right to suspend Provider's compensation related to the suspended Subdelegated Function(s) until such time as the non-compliance or deficiency has been resolved to SBHASO's satisfaction. In the event SBHASO revokes delegation and terminates Provider's performance of all or part of a Subdelegated Function, Provider acknowledges and agrees that it has no right to and shall not seek any compensation related to the revoked Subdelegated Function(s) as of the effective date of revocation.

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-1: Crisis Services Additional Requirements Delegation Grid

The purpose of this Crisis Services Delegation Grid is to specify the responsibilities of [Behavioral Health Agency] ("Sub-Delegate") under the Agreement with respect to the specific activities that are sub-delegated for Crisis Services, including reporting requirements.

"Crisis Services," as defined by the HCA, means evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional.

The delegation grid may be amended from time to time during the term of this Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate's performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit C, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Delegate's Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the delegate does not fully meet Compliance Requirements.

If SBHASO determines that Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of sub-delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited sub-delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the sub-delegation agreement and scope, or revoke the sub-delegation agreement all together.

Subdelegation

It may be allowable for the SBHASO to Sub-Delegate specific activities that relate to Crisis Services. As provided for under the Agreement and as set forth herein, sub-delegation requires the prior written approval of the Managed Care Organizations. In addition to the requirements for sub-delegation set forth in the Agreement, SBHASO will submit to the MCOs a Delegation Chart. If a sub-delegation is approved, the SBHASO will be responsible for ongoing oversight of the Sub-Delegate's performance and will be required to report performance results to the Managed Care Organizations.

Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
HCA CONTARCT REQUIREMENTS				
24-7 Availability	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis Services shall be available 24-7-365, including regional crisis hotline that provides screening and referral services	Weekday submissions of Member crisis interventions and outcomes	Submit Member crisis interventions and outcomes to the appropriate MCO
Immediate Access	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis Services shall be available to Members without the need for the member to complete an intake evaluation or other screening or assessment processes or prior authorization.		

Function	Sub-Delegation Status	Sub-Delegate Activities	Reporting: Data, Frequency, & Submission	SBHASO Activities
Encounter Data	☒ Sub-Delegated ☐ Not Sub-Delegated	Require submission of complete and accurate encounter data related to the provision of Crisis Services in HCA-prescribed formats	Weekly basis provide to SBHASO batches of such data	Weekly basis provide batches of such data to appropriate MCO.
WASHINGTON ADMINISTRATIVE CODE REQUIREMENTS				
Crisis Services standards	☒ Sub-Delegated ☐ Not Sub-Delegated	Crisis services shall be performed in accordance with all state agency requirements, including Washington Department of Health and HCA regulatory requirements, applicable to Crisis Services and Crisis Services providers		Annual Monitoring of Sub-Delegate's Policies and Procedures and Clinical Records

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-2: Credentialing (CR) Delegation Grid

The purpose of the following grid is to specify the responsibilities of [Behavioral Health Agency] ("Sub-Delegate") under the Agreement with respect to the specific activities that are Sub-Delegated for Credentialing. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the sub-delegation of Credentialing for Crisis Services by the SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate's performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit C, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Sub-Delegate's Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all Sub-Delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the Sub-Delegate does not fully meet Compliance Requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the Sub-Delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited Sub-Delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements

and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for the SBHASO to Sub-Delegate specific activities that relate to Credentialing. As provided for under the Agreement and as set forth herein, sub-delegation requires the prior written approval of the Managed Care Organizations. In addition to the requirements for sub-delegation set forth in the Agreement, SBHASO will submit to the MCOs a Delegation Chart. If a sub-delegation is approved, the SBHASO will be responsible for ongoing oversight of the Sub-Delegate's performance and will be required to report performance results to the Managed Care Organizations.

DELEGATION GRID				
Function	**Sub-Delegation Status**	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**SBHASO Activities**
CR 7: Assessment of Organizational Providers	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	N/A	ALL
Decision Making	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	At least monthly standard reporting in electronic format to designated MCO Staff/email	Agency: Approved, Denied, Terminated, Pending. All verifications have 180 days freshness from date of decision SBHASO has the right to approve, suspend and terminate individual practitioners, providers and sites
Ongoing Monitoring	☐ Sub-	State Exclusion	Completed by	Collected at

	Delegated ☒ Not Sub-Delegated	Website OIG SAM For Behavioral Health Agency employees, volunteers, interns, practicum students, leadership and board members	15th of Month-Sub-Delegate is to maintain documentation	initial contracting and 36 months after or if any changes. SBHASO completes all ongoing monitoring.
Disclosure and/or Ownership Form	☒Sub-Delegated ☐ Not Sub-Delegated	Complete Disclosure and/or Ownership Form prior to execution of each contract and 36 months after or if any changes	N/A	Collected at initial contracting and 36 months after or if any changes

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-3: Utilization Management (UM) Delegation Grid

The purpose of the following grid is to specify the responsibilities of [Behavioral Health Agency] ("Sub-Delegate") under the Agreement with respect to the specific activities that are sub-delegated for Utilization Management. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the sub-delegation of Behavioral Health Utilization Management for Crisis Services by SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate's performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit C, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Delegate's Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the delegate does not fully meet Compliance Requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of sub-delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective

action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for SBHASO to sub-delegate specific activities that relate to Behavioral Health Utilization Management for Crisis Services. As provided for under the Agreement and as set forth herein, sub-delegation requires the prior written approval of the Managed Care Organizations. In addition to the requirements for sub-delegation set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart. If a sub-delegation is approved, the SBHASO will be responsible for ongoing oversight of the sub-delegate's performance and will be required to report performance results to the Managed Care Organizations.

DELEGATION GRID				
Function	**Sub-Delegation Status**	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**SBHASO Activities**
Members and practitioners can access staff to discuss UM issues *[UM 3]*	☐ Delegated ☒ Not Delegated	-Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. *[UM 3.A.1]* -Staff can receive inbound communication regarding UM issues after normal business hours. *[UM 3.A.2]* -Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues. *[UM 3.A.3]* -TDD/TTY services for members who need them. *[UM 3.A.4]* - Language assistance for members to discuss UM issues. *[UM 3.A.5]*	None.	Manager of Delegation will oversee services to ensure they meet standards during annual audit.

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-4: Claims and Encounters Delegation Grid

The purpose of the following grid is to specify the responsibilities of [Behavioral Health Agency] ("Sub-Delegate") under the Agreement with respect to the specific activities that are Sub-Delegated regarding Claims and Encounter Data. The grid also describes the reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the sub-delegation of Claims Processing and Payment and Encounter Data Submission by the SBHASO to Sub-Delegate.

The delegation grid may be amended from time to time during the term of the Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate's performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit C, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Sub-Delegate's Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all Sub-Delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Sub-Delegate to implement corrective action plans if the Sub-Delegate does not fully meet Compliance Requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the Sub-Delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited Sub-Delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual and ad hoc audits of documentation, processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification standards, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements

and categories. If Sub-Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for the SBHASO to Sub-Delegate specific activities that relate to Claims and Encounter Data. As provided for under the Agreement and as set forth herein, sub-delegation requires the prior written approval of the Managed Care Organizations. In addition to the requirements for sub-delegation set forth in the Agreement, SBHASO will submit to the MCOs a Delegation Chart. If a sub-delegation is approved, the SBHASO will be responsible for ongoing oversight of the Sub-Delegate's performance and will be required to report performance results to the Managed Care Organizations.

CLAIMS/ENCOUNTER BUSINESS REQUIREMENTS				
Function	**Sub-Delegation Status**	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**SBHASO Activities**
1. Encounter Data Definition of Encounter Data	☒ Sub-Delegated ☐ Not Sub-Delegated	Encounter Data means records of physical or behavioral health care services submitted as electronic data files created by the SBHASO's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.	N/A	N/A
2. Encounter Data Dedicated Resource	☒ Sub-Delegated ☐ Not Sub-Delegated	Designate a person dedicated to work collaboratively with SBHASO on quality control and review of encounter data submitted to HCA.	N/A	SBHASO resource will partner with the behavioral health agency resource for quality control and review of encounter data.
3. Encounter Data Reporting requirements	☒ Sub-Delegated ☐ Not Sub-	Submit complete, accurate, and timely data for all services for which the SBHASO has	Weekly	SBHASO will provide oversight of the behavioral health agency encounter data.

	Delegated	incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA.		
4. Encounter Data Expected turnaround time reporting encounter data	☒ Sub-Delegated ☐ Not Sub-Delegated	Encounter data must be submitted to SBHASO at a minimum weekly, and no later than thirty (30) calendar days from the end of the month in which the SBHASO paid the financial liability. Date of Service, or receipt of third party notification (if applicable).	Weekly	SBHASO will monitor turnaround.
5. Encounter Data Submission and edits	☒ Sub-Delegated ☐ Not Sub-Delegated	Submitted encounters and encounter records must pass all system edits with a disposition of accept and listed in the Encounter Data Reporting Guide, Health Care Authority Service Encounter Reporting Instructions, SBHASO Data Dictionary, or sent out in communications from HCA to the SBHASO.	N/A	N/A
6. Encounter Data		Submitted	N/A	N/A

Duplicates	☒ Sub-Delegated ☐ Not Sub-Delegated	encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.		
7. Encounter Data RCW 42.56.270(11)	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	N/A	The SBHASO must report the paid date, paid unit, and paid amount for each encounter. The "paid amount" data is considered the SBHASO's proprietary information and is protected from public disclosure. "Paid amount" is defined as the amount paid for the service, or zero pay for cost based/invoice payments.
8. Encounter Data 42 C.F.R. § 438.606 Attestations	☒ Sub-Delegated ☐ Not Sub-Delegated	The behavioral health provider shall send attestation to SBHASO to certify the accuracy and completeness of all encounter data concurrently with each file upload.	Weekly	SBHASO will receive monthly attestations from the behavioral health provider. SBHASO will review and complete a monthly attestation and sent to the MCOs. The MCOs will review and complete the monthly certification letter and send to the HCA.
9. Encounter Data 837 Requirements	☒ Sub-Delegated ☐ Not Sub-	The behavioral health provider must be able to meet the requirements	N/A	N/A

	Delegated	outlined in the attached requirements document.		
10. Encounter Data Quality Assurance	☒ Sub-Delegated ☐ Not Sub-Delegated	The behavioral health provider must validate the accuracy and completeness of all encounter data for behavioral health care services compared to the year-to-date general ledger of paid claims for the health care services.	Quarterly	The SBHASO will oversee the quality assurance of behavioral health provider encounters. The SBHASO must validate the accuracy and completeness of all encounter data for behavioral health care services compared to the year-to-date general ledger of paid claims for the health care services. The MCOs will oversee the quality assurance of the SBHASO encounters.
11. Encounter Data Form D	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	Quarterly	Within sixty (60) calendar days of the end of each calendar quarter, the SBHASO shall provide aggregate totals of all encounter data submitted and accepted during that quarter on the Apple Health - Integrated Managed Care Quarterly Encounter/General Ledger Reconciliation (Form D). SBHASO shall reconcile the cumulative encounter data submitted and accepted for the quarter and contract year with the general ledger paid claims for the quarter. The SBHASO shall provide justification for

				any discrepancies. SBHASO will complete Form D and send to MCOs. MCO will submit Form D to HCA. HCA will approve or reject the discrepancy justifications and notify the MCOs of the decision 120 calendar days of the end of each calendar quarter.
12. Claims Payment Standards Section 1902(a)(37) of the Social Security Act 42 C.F.R. § 447.46 WAC 284-170-431	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	Monthly	The SBHASO shall meet the timeliness of payment standards. These standards shall also be applicable to State-only and federal block grant fund payments. To be compliant with payment standards the SBHASO 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 95 percent of clean claims within ninety (90) calendar days of receipt. The SBHASO shall provide a monthly report to the MCO of claims timeliness results. If standard is not met, provide root cause and corrective action until performance expectation is met.

13. Claims processing Top Claims Denials Reporting	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	Quarterly	The SBHASO shall produce and submit a quarterly claims denial analysis report. The first report due May 31st 2020 for services processed January – March 2020. The report shall include the following data: Total number of approved claims for which there was at least one denied line. Completely denied claims. Total number of claims adjudicated in the reporting claim. Total number of behavioral health claims denied by claim line. Summary by reason and type of claims denied. The total number of denied claims divided by the total number of claims. For each of the five network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated. Total number of Behavioral Health claims received, that were not

				approved upon initial submission. The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted. The top five reasons for behavioral health claims being rejected upon initial submission. The report shall include a narrative, including the action steps planned to address. The top five (5) reasons for denial, including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of denied claims and actions to address them. MCOs will review denials, and may report up to the HCA.
14. TPL Reporting	☒ Sub-Delegated ☐ Not Sub-Delegated	The behavioral health agency shall report all third party revenue for each submitted claim to the SBHASO.	Monthly	The SBHASO shall submit a quarterly *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as claims that the SBHASO denies due to TPL coverage. The report shall include recoveries or denied claim payments for any

				covered service. The SBHASO shall calculate cost savings in categories. The SBHASO shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data. The report is due by the sixtieth (60th) calendar day following the end of the quarter. The SBHASO shall submit to the MCO on the 15th of the month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care insurance coverage with any carrier, including the SBHASO. The SBHASO shall submit to the MCO on the 20th of the following month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the SBHASO newly becomes aware of a cause of action to recover health care costs for which the SBHASO has paid under the Agreement.

				MCO will review and report outcome to the HCA.
15. Participating and Non-Participating Reporting	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A		The SBHASO shall track and record all payments to Participating Providers and Non-Participating Providers in a manner that allows for reporting to the MCO the number, amount, and percentage of claims paid to Participating Providers and Non-Participating Providers separately. The SBHASO shall identify the type of providers and Subspecialty. The SBHASO shall also track, document and report to the MCO any known attempt by Non-Participating Providers to balance bill Enrollees. The SBHASO shall provide annual reports to the MCO for the preceding state fiscal year (July 1 through June 30). The reports shall indicate the proportion of services provided by the SBHASO's Participating Providers and Non-Participating Providers, by county, and including hospital-based physician services. SBHASO shall submit the reports to the MCO no later than August 15 of each year.

				MCO will monitor, and may report up to the HCA.
16. Sub-delegation Agreements SBHASO sub-delegation agreements with a vendor	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A		The SBHASO will notify the MCO of sub-delegation vendor agreements the SBHASO has; what duties do they perform, and how often.
17.Claims/Encounter Delegation Oversight Audit Quality Assurance Audits	☐ Sub-Delegated ☒ Not Sub-Delegated	N/A	Annual	MCO is required to perform an annual oversight delegation audit of encounter data reporting/ claims processing. The objective of this audit is to assess the effectiveness of key internal controls by ensuring the accuracy, completeness, and timeliness of the encounter/claims processing functions. SBHASO will provide MCO claims data set for specified time period. MCO will review the claims data set for the following: • Review encounter/claims universe sample of all claims paid or denied for 1 year; • Verify the member was eligible for benefits on the dates of service;

				• Review encounter submission and reconciliation to ensure requirements are met; • Review claim payment calculations and verify that claims were paid accurately; • Verify claims were submitted by the provider within 365 days of dates of service; •Review responses to audit questionnaire to ensure compliance.

Salish Behavioral Health Administrative Services Organization (SBHASO)
Exhibit C-5: Quality Improvement (QI) Delegation Grid

The purpose of the following grid is to specify the responsibilities of [Behavioral Health Agency] ("Sub-Delegate") under the Agreement with respect to the specific activities that are sub-delegated for Quality Improvement. The grid also describes the semi-annual reporting requirements, which are in addition to any applicable reporting requirements stated in the Agreement. The grid below applies to the sub-delegation of Behavioral Health Telephone Access for Crisis Services by SBHASO to Sub-Delegate.

SBHASO does not formally sub-delegate the responsibility for performing quality management and improvement activities on behalf of SBHASO. However, SBHASO does require Sub-Delegates to maintain a quality improvement and management program pertaining to sub-delegated activities, and to participate and cooperate in SBHASO's quality improvement program, collect data for SBHASO quality improvement activities, and carry out corrective actions as required by SBHASO.

The delegation grid may be amended from time to time during the term of this Agreement by SBHASO to reflect changes in delegation standards; delegation status; performance measures; reporting requirements; and other provisions.

The sections that follow describe the process by which SBHASO evaluates Sub-Delegate's performance and the remedies available to SBHASO if Sub-Delegate does not fulfill its obligations. The statements below shall not supersede any term or condition of Exhibit C, the Delegation Agreement, and all obligations and remedies set forth in the parties' Agreement remain in full force and effect. In the event of a conflict between the descriptions below and any term or condition of the Agreement, including Exhibit C, the terms and conditions of the Agreement shall prevail.

Process of Evaluating Delegate's Performance

SBHASO will require routine reports and documentation as listed in the delegation grid and will use this documentation to evaluate Sub-Delegate performance on an ongoing basis. In addition, SBHASO will:

- Conduct an annual audit to ensure all sub-delegated activities comply with applicable Compliance Requirements,
- Provide written feedback on the results of the annual audit, and
- Require Delegate to implement corrective action plans if the delegate does not fully meet Compliance Requirements.

If SBHASO determines that Sub-Delegate has failed to adequately perform the delegated activities, SBHASO may:

- Change or revoke the scope of delegation if corrective action is not adequate; and/or
- Discontinue contracting with Sub-Delegate.

Ongoing performance of accredited delegates is evaluated through the semi-annual and routine monitoring of reports. SBHASO reserves the right to conduct annual or ad hoc audits of documentation,

processes and files in order to ensure service levels, quality and compliance with regulatory requirements.

Corrective Action Plans

If Sub-Delegate fails to meet any of its responsibilities, including contracted responsibilities and NCQA accreditation or certification requirements, SBHASO will work with Sub-Delegate to create a corrective action plan to identify areas of improvement and actions plans to ensure compliance with all elements and categories. If Delegate does not take corrective action, or fails to meet improvement goals, SBHASO reserves the right to revise the delegation agreement and scope, or revoke the delegation agreement altogether.

Subdelegation

It may be allowable for a SBHASO to sub-delegate specific activities that relate to Crisis Services telephone operations. As provided for under the Agreement and as set forth herein, sub-delegation requires the prior written approval of the Managed Care Organizations. In addition to the requirements set forth in the Agreement, SBHASO will submit to MCO a Delegation Chart. If a sub-delegation is approved, the SBHASO will be responsible for ongoing oversight of the sub-delegate's performance and is required to report performance results to the Managed Care Organizations.

DELEGATION GRID				
Function	**Sub-Delegation Status**	**Sub-Delegate Activities**	**Reporting: Data, Frequency, & Submission**	**SBHASO Activities**
Behavioral Health Telephone Access *[QI 4.B.1 and QI 4.B.2*]	☒ Sub-Delegated ☐ Not Sub-Delegated	Telephones are answered by a live voice within 30 seconds with an abandonment rate within 3 percent.	Submission to SBHASO staff of a monthly summary report that includes total calls, call answer time and abandonment rate. Reports provided in electronic or hard copy.	Manager of Sub-Delegation will receive and review monthly reports for performance review. Quality and Compliance Committee will review monthly reports on a quarterly basis.

Salish Behavioral Health Administrative Services Organization (SBHASO)

Exhibit D
BUSINESS ASSOCIATE AGREEMENT

This **BUSINESS ASSOCIATE AGREEMENT** ("***Agreement***") is entered into on this _____day of _____, 2019 (the "***Effective Date***") by and between the Salish Behavioral Health Administrative Services Organization (SBHASO) (***"Covered Entity***") for its benefit, the benefit of its affiliates, and _____ on behalf and for the benefit of itself and its affiliates ("***Business Associate***") (each, a "Party" and collectively, the "Parties").

WHEREAS, Covered Entity has affiliates (each, a Covered Entity "affiliate) that create, receive, transmit, maintain and/or disclose (collectively, "Use") "***Protected Health Information***" or "***PHI***" (as such terms are defined at 45 C.F.R. Section 164.500 et seq.), and Covered Entity and/or one or more of its affiliates desire to obtain services from Business Associate and/or the affiliates of Business Associate (each, a Business Associate "affiliate") that will result in the Use of such PHI by Business Associate and/or its affiliates pursuant to a contract (in effect as of, or after, the effective date of this Agreement) between Business Associate and/or any of its affiliates, on one hand, and Covered Entity and/or any of its affiliates, on the other hand (each contract, a "***Services Agreement***");

WHEREAS, irrespective of the Covered Entity affiliates and the Business Associate affiliates that are parties to any Services Agreement, Covered Entity and Business Associate desire this Agreement to govern the Use of all PHI by and between the Parties and their respective affiliates and to supersede all other agreements (including all other business associate agreements) between such entities regarding the Use of PHI; and

WHEREAS, pursuant to the authorities set forth above, Business Associate and its affiliates may Use PHI only in accordance with this Agreement.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. **Definitions**.

1.1 The Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***"), the Health Information Technology for Economic and Clinical Health Act ("***HITECH***"), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (the "***Privacy Rule***") and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (the "***Security Rule***"), and the requirements of the final modifications to the HIPAA Privacy Rule, Security, Rule, et al., issued on January 25, 2013 and effective March 26, 2013, as may be amended from time to time, shall collectively be referred to herein as the "***HIPAA Authorities***." All other capitalized terms hereunder shall have the meaning ascribed to them elsewhere in this Agreement, or, if no such definition is specified herein, shall have the meaning set forth in the HIPAA Authorities.

1.2 "Affiliate" (capitalized or not) means any entity that controls, is controlled by or is under common control with a Party as well an any entity that is a subsidiary of an entity that controls a Party.

1.3 "Personally Identifiable Information" or "PII" shall include any data elements that identify an individual or that could be used to identify an individual, including but not limited to an individual's first name or initial and last name, all geographic subdivisions smaller than a state, all elements of dates (except year) for dates directly related to an individual including birth date, admission date, discharge date, date of death, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate or driver's license numbers, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and

serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, code, or combination that allows identification of an individual.

1.4 "Protected Health Information" or "PHI" shall collectively refer to Protected Health Information, Electronic Protected Health Information ("ePHI"), each as defined by the HIPAA Authorities, and "Personal Identifiable Information" as defined above.

1.5 "Data Use, Security and Confidentiality" are required by the Health Care Authority Contract for all Contractors and Subcontractors providing PHI.

2. **Interpretation of Provisions of this Agreement; Application of Agreement**.

2.1 In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Authorities, the terms of the HIPAA Authorities shall prevail. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with the HIPAA Authorities. A reference in this Agreement to a section in the HIPAA Authorities means the section in effect or as amended. Titles or headings are used in this Agreement for reference only and shall not have any effect on the interpretation of this Agreement.

2.2 This Agreement governs the Use of all PHI that exists or arises in connection with a Services Agreement irrespective of the Covered Entity affiliate and Business Associate affiliate that may be parties to such Services Agreement. Each Party hereto represents and warrants that (i) it is validly existing under the laws of the state of its formation; (ii) it has the full right, authority, capacity and ability to enter into this Agreement for the benefit and, in the case of Business Associate, on the behalf of itself and each of its affiliates and to carry out its and its affiliates' obligations hereunder; (iii) this Agreement is a legal and valid obligation binding upon it and it shall cause all of its affiliates that Use PHI pursuant to a Services Agreement to comply with the obligations hereunder of such Party; and (iv) its execution, delivery and performance of this Agreement does not conflict with any agreement, instrument, obligation or understanding to which it or any of its affiliates are bound.

3. **Obligations of Business Associate**.

3.1 Limits on Use and Disclosure. Business Associate agrees to not use or further disclose PHI other than as permitted by this Agreement or as Required by Law. Business Associate further agrees that to the extent it is carrying out one or more of the Covered Entity's obligations under the Privacy Rule, it shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.

3.2 Safeguards. Business Associate agrees to use reasonable and appropriate administrative, physical and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement. More specifically, as also provided for in the Security Rule Requirements section 0 in this agreement, Business Associate agrees to establish, implement and maintain appropriate safeguards, and comply with the Security Rule with respect to Electronic PHI, as necessary to prevent any use or disclosure of PHI other than as provided for by this Agreement.

3.3 Mitigation of Harm. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement or the HIPAA Authorities and shall take prompt steps to prevent the recurrence of any Incident, including any action required by applicable federal and state laws and regulations. All such efforts will be subject to Covered Entity's prior written approval. In the event of an Incident (as defined below), Business Associate shall promptly develop and provide to Covered Entity a written correction action plan which describes the measures to be taken to halt and/or contain such Incident.

3.4 Report of Improper Use or Disclosure. "Incident" means (i) any successful Security Incident, (ii) Breach of Unsecured PHI, or (iii) any loss, destruction, alteration or other event in which PHI cannot be accounted for. Successful Security Incidents shall not include pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI. Business Associate agrees to notify Covered Entity, in writing immediately upon discovery, but not later than one business day from the day of discovery of any Incident (by Business Associate or by a Subcontractor) involving the acquisition, access, use or disclosure of the PHI not provided for by this Agreement of which Business Associate becomes aware. As soon as reasonably possible thereafter, in no case more than five (5) business days following discovery of the Incident, Business Associate shall provide Covered Entity with a written report which shall include but not be limited to: i) a description of the circumstances under which the Incident occurred; ii) the date of the Incident and the date that the Incident was discovered; iii) a description of the types of PHI involved in the Incident; iv) the identification of each Individual whose PHI is known or is reasonably believed by the Business Associate to have been affected; and v) any recommendations that the Business Associate may have, if any, regarding the steps that Individuals may take to protect themselves from harm. To the extent that Covered Entity reasonably determines that such Incident necessitates the notification of Individuals by Covered Entity under HITECH, Business Associate agrees that it shall immediately reimburse Covered Entity for the reasonable expenses of such notification process. Business Associate shall cooperate with any investigation (and/or risk assessment) of such Incident conducted by Covered Entity in connection with any report made pursuant to this Section. Business Associate shall make itself and any subcontractors and agents assisting Business Associate in the performance of its obligations available to Covered Entity to testify as witnesses, or otherwise, in the event of an Incident.

3.5 Subcontractors.

(a) Prior to the date on which any Subcontractor (including any affiliate that is a Subcontractor) creates, receives, maintains or transmits PHI on behalf of Business Associate in connection with Business Associate's obligations under the Services Agreement, Business Associate agrees to enter into a written agreement with any Subcontractor ("***Subcontractor Agreement***") to whom Business Associate provides PHI that requires them: (i) to comply with the same HIPAA Authorities that apply to Business Associate under the Agreement; and (ii) to comply with the same restrictions and conditions that apply to Business Associate through this Agreement with respect to such PHI.

(b) Upon Business Associate's knowledge of a material breach of the Subcontractor Agreement by Subcontractor, Business Associate shall immediately notify Covered Entity of such material breach in writing and, at its option (unless otherwise directed by Covered Entity), shall: (i) provide an opportunity for Subcontractor to cure the breach or end the violation and terminate this Agreement if Subcontractor does not cure the breach or end the violation within the cure period identified in the Data Breach Notification Section of this Agreement; (ii) immediately terminate this Agreement if Subcontractor has breached a material term of this Agreement and Business Associate (or Covered Entity) deems cure by the Subcontractor not to be possible; or (iii) if neither termination nor cure are feasible, report the violation to the Covered Entity.

(c) Business Associate agrees to provide Covered Entity with a list of any and all such Subcontractors and, in the event of an Incident, employees that create, receive, maintain or transmit PHI on behalf of Business Associate in in connection with Business Associate's obligations under the Service Agreement with Covered Entity within thirty (30) days of such a request.

3.6 Access to Records. At the request of Covered Entity and within ten (10) calendar days of such request and in a reasonable manner designated by Covered Entity, Business Associate shall provide access to PHI

in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in a manner compliance with 45 CFR §164.524 and/or other applicable provisions of the HIPAA Authorities.

3.7 Amendments to PHI. At the request of Covered Entity, or, as directed by Covered Entity, at the request of an Individual, Business Associate shall make, within fifteen (15) calendar days of such request and in a reasonable manner designated by Covered Entity, any amendment(s) to PHI in a Designated Record Set to which the Covered Entity has agreed pursuant to 45 CFR §164.526, or shall otherwise assist Covered Entity in complying with Covered Entity's obligations under 45 CFR §164.526.

3.8 Availability of Internal Practices, Books and Records. Business Associate shall make its internal practices, books and records available to Covered Entity or the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity or the Secretary, as applicable. Covered Entity reserves the right to request, and Business Associate shall provide, additional satisfactory assurances that Business Associate is meeting its applicable obligations under the HIPAA Privacy and Security Rules. Such requests may include, but are not limited to; an onsite audit, conducted by Covered Entity or its designee, access to policies and procedures, risk assessment documentation, incident logs or information related to the Business Associate's Subcontractors compliance with their applicable obligations under the HIPAA Privacy and Security Rules.

3.9 Accounting of Disclosures. Business Associate shall document such disclosures of PHI and information related to such disclosures (i.e., (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Such documentation shall be maintained with regard to all disclosures of PHI, except for those disclosures that are expressly exempted from the documentation requirement under the HIPAA Authorities (see, e.g., 45 CFR §§164.502; 164.508; 164. 510; 164.512, etc.). Documentation required to be collected by the Business Associate under this Section shall be retained for a minimum of ten 10) years, unless otherwise provided under the HIPAA Authorities. Business Associate shall further provide the information collected pursuant to this Section to Covered Entity or an Individual, within twenty (20) calendar days of the applicable request and in a reasonable manner designated by Covered Entity, as necessary to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or other applicable provision of the HIPAA Authorities.

3.10 Disclosure of Minimum PHI. Business Associate agrees that it shall request, use and/or disclose only the amount and content of PHI that is the Minimum Necessary for Business Associate to fulfill its obligations under the terms and conditions of this Agreement. Business Associate acknowledges that such Minimum Necessary standard shall apply with respect to uses and disclosures by and among members of Business Associate's workforce as well as by or to third parties as permitted hereunder.

3.11 Notification of Claims. Business Associate shall promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("***Actions***") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for any covered entity, regardless of whether Covered Entity and/or Business Associate are named as parties to such Actions.

3.12 Security Rule Requirements. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. Additionally, Business Associate shall comply with the security and privacy requirements described in the attached Data Use, Security and Confidentiality Addendum and the Security & Privacy Addendum. Not more than once per calendar year, Business Associate shall within ten (10) days after request from Covered Entity truthfully complete and duly execute the Annual Attestation that is attached hereto or, alternatively, notify Covered Entity in writing of any facts or

events that would render untrue any statement within the Annual Attestation. Business Associate shall document policies and procedures that implement the foregoing requirements and shall, upon request, provide them to Covered Entity, who may further disclose them to any governmental entity with regulatory oversight over Covered Entity. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Agreement or the HIPAA Authorities of which it becomes aware, including any Incident. Accordingly, as also provided in the Report of Improper Use or Disclosure section of this Agreement, Business Associate agrees to report any Incident of which it becomes aware to Covered Entity immediately, but not later than one business day from the day of discovery of the Incident. All reports required of the Business Associate pursuant to this Section shall be provided as specified in the Report of Improper Use or Disclosure section of this Agreement, including the actions and the mitigation steps, if any, taken by Business Associate in response to the Incident(s).

3.13 Compliance with HIPAA Authorities. Requirements of the HIPAA Authorities that are made applicable with respect to business associates, or any other provision required to be included in this Agreement pursuant to the HIPAA Authorities, are incorporated into this Agreement by this reference.

4. **Permitted Uses and Disclosures by Business Associate**.

4.1 Use or Disclosure to Perform Functions, Activities, or Services. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform those functions, activities, or services that Business Associate performs for, or on behalf of, Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not violate the Privacy Rule, or the policies and procedures of Covered Entity relating to the "Minimum Necessary Standard," if done by Covered Entity. Any such use or disclosure shall be limited to those reasons and those Individuals as necessary to meet the Business Associate's obligations under the Services Agreement.

4.2 Appropriate Uses of PHI. Except as may be otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3 Confidentiality Assurances and Notification. Except as may be otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that such PHI will remain confidential and used or further disclosed only as Required by Law or for the purpose for which such PHI was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

4.4 Data Aggregation Services. As applicable, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), except as may be otherwise provided by this Agreement.

5. **Indemnification**. Each party (the "***Indemnitor***") shall indemnify and hold harmless the other party (the "***Indemnitee***") against, and reimburse such Indemnitee for, any expense, loss, damages, fees, costs, claims or liabilities of any kind arising out of or related to any Actions asserted or threatened by a third party arising out of or related to the Indemnitor's acts and omissions associated with its obligations under this Agreement or its use or disclosure of PHI or, when the Indemnitor is the Business Associate, the Use of PHI by a Subcontractor or affiliate of Business Associate. Such indemnification shall include, but not be limited to, the payment of all reasonable attorney fees associated with any such Action.

6. **Obligations of Covered Entity**.

6.1 Notice of Privacy Practices. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI**.**

6.2 Change or Revocation of Permission. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's permitted or required uses and disclosures of PHI. Business Associate shall comply with any such changes or revocations.

6.3 Restrictions on Use or Disclosure. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI. Business Associate shall comply with any such restrictions. Business Associate shall immediately notify Covered Entity of any request for a restriction on the use or disclosure of an Individual's PHI that Business Associate receives from such Individual.

6.4 No Request to Use or Disclose in Impermissible Manner. Except as necessary for the Data Aggregation Services or management and administrative activities of the Business Associate as allowed herein, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

7. **Term and Termination**

7.1 Term. This Agreement shall be effective as of the earlier of the date first documented above or the effective date of the Services Agreement, and shall terminate upon termination of the Services Agreement for any reason or as otherwise provided in this Agreement.

7.2 Termination with Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, or its Subcontractors, Covered Entity shall, at its option: (i) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the cure period identified in the Data Breach Notification Section of this Agreement; (ii) immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity deems cure by Business Associate not to be possible; or (iii) if neither termination nor cure are feasible, report the violation to the Secretary.

7.3 Effect of Termination.

(a) Except as provided in this Section, upon termination of this Agreement for any reason, Business Associate shall return or destroy (at Covered Entity's election), and shall retain no copies of, all PHI in the possession of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written approval, which shall not be unreasonably withheld, Business Associate may retain the PHI, but shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. **Standards for Electronic Transactions**. In connection with the Services to be provided to Covered Entity pursuant to this Agreement, Business Associate agrees that if it (or a Subcontractor) conducts an electronic transmission for which the Secretary has established a "standard transaction" under 45 C.F.R. Part 164, Subparts A, C, D and E, as applicable (the "*Electronic Transactions Standards*"), Business Associate (or its Subcontractor) shall comply with the requirements of the Electronic Transactions Standards. Business Associate specifically represents that it has obtained such compliance. Business Associate agrees that, in connection with the transmission of standard transactions, it will not (and will not permit any Subcontractor

with which it might contract to): (i) change the definition, data condition, or use of a data element or segment in a standard; (ii) add any data elements or segments to the maximum defined data set; (iii) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification; or (iv) change the meaning or intent of the standard's implementation specification(s). Business Associate understands that Covered Entity reserves the right to request an exception from the uses of a standard as permitted by 45 CFR § 162.940, and, if such an exception is sought, Business Associate agrees to participate in a test modification.

9. **Confidentiality of Business Information**.

9.1 Business Information. In the event the parties have not agreed to alternative confidentiality language with respect to business information in the Services Agreement or elsewhere, the following provisions will apply. Neither party will disclose to any third party any information related to this Agreement or to the business operations of the other party, or any proprietary information belonging to the other party (collectively, "***Confidential Business Information***") without the prior written consent of the other party, except as may be required under law or this Agreement; provided that a party required by law to disclose Confidential Business Information shall inform the other party in order that the other party may contest such requirement. Each party hereby agrees that all Confidential Business Information communicated to it by the other party, whether oral or written, and whether before or after execution of this Agreement, was and will be received in strict confidence and will be used only for purposes set forth in the Services Agreement. Upon termination of this Agreement, each party shall, upon the request of the providing party, promptly return all such Confidential Business Information to the providing party or, at the providing party's option, shall destroy such Confidential Business Information and certify as to its destruction, except that each party shall be permitted to retain copies of Confidential Business Information as is reasonably necessary for its internal compliance and auditing purposes, provided the terms of this Section shall continue to apply with respect to such retained Confidential Business Information for so long as it is retained. This obligation of confidentiality shall not apply to information i) which was known by the recipient without the obligation of confidentiality prior to its receipt of such information; ii) is or becomes publicly available without breach of this Agreement; or iii) is received from a third party without an obligation of confidentiality and without breach of this Agreement. This paragraph shall not apply to uses and disclosures of PHI, which shall be governed by the remaining provisions of this Agreement.

9.2 Response to Subpoena. Business Associate shall be permitted to disclose PHI and Confidential Business Information that Business Associate is required to disclose pursuant to court order, subpoena or other compulsory legal process, provided that prior to making any disclosure thereunder, Business Associate shall provide Covered Entity within five (5) calendar days prior written notice (or as much notice as reasonably practicable under the circumstances) of the intended disclosure, specifying the basis and nature of the same.

10. **Miscellaneous**.

10.1 Assignment; Waiver. This Agreement shall be binding upon and inure to the benefit of the respective legal successors of the parties. Neither this Agreement nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other party. Except as provided herein, this Agreement shall create no independent rights in any third party or make any third party a beneficiary hereof. No failure or delay by either party in exercising its rights under this Agreement shall operate as a waiver of such rights, or of any prior, concurrent, or subsequent breach.

10.2 Property Rights. All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

10.3 Right to Cure. Business Associate agrees that in the event Business Associate fails to cure a breach of this Agreement pursuant to this Agreement, Covered Entity has the right, but not the obligation, to cure the same. Expenses, costs or fines reasonably incurred in connection with Covered Entity's cure of Business Associate's breach(es) shall be borne solely by Business Associate.

10.4 Injunctive Relief. Business Associate agrees that breach of the terms and conditions of this Agreement shall cause irreparable harm for which there exists no adequate remedy at law. Covered Entity retains all rights to seek injunctive relief to prevent or stop any breach of the terms of this Agreement, including but not limited to the unauthorized use or disclosure of PHI by Business Associate or any Subcontractor, contractor or third party that received PHI from Business Associate.

10.5 Survival; Severability. The respective rights and obligations of Business Associate under this Agreement, including but not limited to Business Associate's indemnification obligations, shall survive the termination of this Agreement. The parties agree that if a court determines that any of the provisions of this Agreement are invalid or unenforceable for any reason, such determination shall not affect the enforceability or validity of the remaining provisions of this Agreement.

10.6 Entire Agreement; Amendment. This document, together with any written Schedules, amendments and addenda, constitutes the entire agreement of the parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity and Business Associate to comply with the requirements of the HIPAA Authorities. Any modifications to this Agreement shall be valid only if such modifications are in accordance with the HIPAA Authorities, are made in writing, and are signed by a duly authorized agent of both parties.

10.7 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Washington to the extent that the HIPAA Authorities do not preempt the same.

10.8 Notice. Any notice required or permitted to be given by either party under this Agreement shall be sufficient if in writing and hand delivered (including delivery by courier) or sent by postage prepaid certified mail return receipt requested, to the following address:

If Covered Entity:		**If Business Associate:**	
Name:	_____	Name:	_____
Title:	Administrator	Title:	_____
Company:	SBHASO	Company:	_____
Address:	614 Division St, MS-23	Address	_____
	Port Orchard, WA 98366		_____
Phone:	(360) 337-4422	Phone:	_____

10.9 Independent Contractors. For purposes of this Agreement, Covered Entity and Business Associate, and Covered Entity and any Subcontractor of Business Associate, are and will act at all times as independent contractors. None of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties.

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement, and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

Signatures on the next page

COVERED ENTITY	**BUSINESS ASSOCIATE**
By: _____	By: _____
Title: _____	Title: _____
Date: _____	Date: _____

DATA USE, SECURITY AND CONFIDENTIALITY ADDENDUM

1. Definitions: The definitions below apply to this Addendum:

1.1 **"Authorized User"** means an individual or individuals with an authorized business need to access SBHASO's Confidential Information under this Agreement.

1.2 **"Breach"** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Agreement that compromises the security, confidentiality or integrity of the Data.

1.3 **"Data"** means the information that is disclosed or exchanged as described by this Agreement. For purposes of this Addendum, Data means the same as "Confidential Information."

1.4 **"Disclosure"** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

1.5 **"Hardened Password"** after July 1, 2019 means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.

1.5.1 Passwords for external authentication must be a minimum of 10 characters long.

1.5.2 Passwords for internal authentication must be a minimum of 8 characters long.

1.5.3 Passwords used for system service or service accounts must be a minimum of 20 characters long.

1.6 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 ("ARRA"), Sec. 13400 - 13424, H.R. 1 (2009) (HITECH Act).

1.7 **"HIPAA Rules"** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.

1.8 **"Portable/Removable Media"** means any Data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).

1.9 **"Portable/Removable Devices"** means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PC's, flash memory devices (e.g. USB flash drives, personal media players); and laptops/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant.

1.10 **"Protected Health Information" or "PHI"** means information that relates to the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or past, present or future payment for provision of health care to an individual. 45 C.F.R. §160 and 164. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. 45 C.F.R. § 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 C.F.R. § 164.501. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g(a)(4)(b)(iv).

1.11 **"ProviderOne"** means the Medicaid Management Information System, which is the State's Medicaid payment system managed by HCA.

1.12 **"Transmitting"** means the transferring of data electronically, such as via email, SFTP, web-services, AWS Snowball, etc.

1.13 **"Trusted System(s)"** means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2)

United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

1.14 **"U.S.C."** means the United States Code. All references in this Addendum to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at http://uscode.house.gov/

1.15 **"Use"** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2. Data Classification

2.1 The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4 of this Addendum, Data Security, of Securing IT Assets Standards No. 141.10 in the State Technology Manual at https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.

The Data that is the subject of this Agreement is classified as Category 4 - Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:

2.1.1 Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;

2.1.2 Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

3. Constraints on Use of Data

3.1 This Agreement does not constitute a release of the Data for the Business Associate's discretionary use. Business Associate must use the Data received or accessed under this Agreement only to carry out the purpose of this Agreement. Any ad hoc analyses or other use or reporting of the Data is not permitted without SBHASO's prior written consent.

3.2 Any disclosure of Data contrary to this Agreement is unauthorized and is subject to penalties identified in law.

3.3 The Business Associate must comply with the Minimum Necessary Standard, which means that Business Associate will use the least amount of PHI necessary to accomplish the Purpose of this Agreement.

3.3.1 Business Associate must identify:

3.3.1.1 For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.

3.3.2 Business Associate must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Agreement.

4. Security of Data

4.1 Data Protection

4.1.1 The Business Associate must protect and maintain all Confidential Information gained by reason of this Agreement, information that is defined as confidential under state or federal law or

regulation, or Data that SBHASO has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Business Associate to employ reasonable security measures, which include restricting access to the Confidential Information by:

4.1.1.1 Allowing access only to staff that have an authorized business requirement to view the Confidential Information.

4.1.1.2 Physically securing any computers, documents, or other media containing the Confidential Information.

4.2 Data Security Standards

4.2.1 Business Associate must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.) The Security Standard 141.10 is hereby incorporated by reference into this Agreement.

4.2.2 Data Transmitting

4.2.2.1 When transmitting Data electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (http://csrc.nist.gov/publications/PubsSPs.html). This includes transmission over the public internet.

4.2.2.2 When transmitting Data via paper documents, the Business Associate must use a Trusted System.

4.2.3 Protection of Data. The Business Associate agrees to store and protect Data as described.

4.2.3.1 Data at Rest:

4.2.3.1.1 Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Systems that contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

4.2.3.2 Data stored on Portable/Removable Media or Devices

4.2.3.2.1 Confidential Information provided by SBHASO on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.

4.2.3.2.2 SBHASO's Data must not be stored by the Business Associate on Portable Devices or Media unless specifically authorized within the Agreement. If so authorized, the Business Associate must protect the Data by:

4.2.3.2.2.1 Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;

4.2.3.2.2.2 Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;

4.2.3.2.2.3 Keeping devices in locked storage when not in use;

4.2.3.2.2.4 Using check-in/check-out procedures when devices are shared;

4.2.3.2.2.5 Maintaining an inventory of devices; and

4.2.3.2.2.6 Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

4.2.3.3 Paper Documents. Any paper records containing Confidential Information must be protected by storing the records in a Secured Area that is accessible only to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

4.2.4 Data Segregation

4.2.4.1 SBHASO Data received under this Agreement must be segregated or otherwise distinguishable from non-SBHASO Data. This is to ensure that when no longer needed by the Business Associate, all of SBHASO's Data can be identified for return or destruction. It also aids in determining whether SBHASO's Data has or may have been compromised in the event of a security breach.

SBHASO's Data must be kept in one of the following ways:

4.2.4.1.1 On media (e.g. hard disk, optical disc, tape, etc.) which contains only SBHASO Data;

4.2.4.1.2 In a logical container on electronic media, such as a partition or folder dedicated to SBHASO's Data;

4.2.4.1.3 In a database that contains only SBHASO Data;

4.2.4.1.4 Within a database – SBHASO data must be distinguishable from non-SBHASO Data by the value of a specific field or fields within database records;

4.2.4.1.5 Physically segregated from non-SBHASO Data in a drawer, folder, or other container when stored as physical paper documents.

4.2.4.2 When it is not feasible or practical to segregate SBHASO's Data from non-SBHASO data, both SBHASO's Data and the non-SBHASO data with which it is commingled must be protected as described in this Addendum.

4.3 Data Disposition

4.3.1 Upon request by SBHASO, at the end of the Agreement term, or when no longer needed, Confidential Information/Data must be returned to SBHASO or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

Media are to be destroyed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

4.3.2 For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 4.2.3, above. Destruction of the Data as outlined in this section of this Addendum may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

5. Data Confidentiality and Non-Disclosure

5.1 Data Confidentiality.

5.1.1 The Business Associate will not use, publish, transfer, sell or otherwise disclose any Confidential

Information gained by reason of this Agreement for any purpose that is not directly connected with the purpose of this Agreement, except:

5.1.1.1 as provided by law; or

5.1.1.2 with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

5.2 Non-Disclosure of Data

5.2.1 The Business Associate will ensure that all employees or their Subcontractors who will have access to the Data described in this Agreement (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Addendum before gaining access to the Data identified herein. The Business Associate will ensure that any new employee is made aware of the use restrictions and protection requirements of this Addendum before they gain access to the Data.

5.2.1.1 The Business Associate will ensure that each employee or their Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and nondisclosure requirements of Data under this Agreement. The Business Associate must retain the signed copy of employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Business Associate will make this documentation available to SBHASO upon request.

5.3 Penalties for Unauthorized Disclosure of Data

5.3.1 The Business Associate must comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.

5.3.2 The Business Associate accepts full responsibility and liability for any noncompliance with applicable laws or this Agreement by itself, their employees, and their Subcontractors.

6. Data Shared with Subcontractors

If Data access is to be provided to a Business Associate's Subcontractor under this Agreement, the Business Associate must include all of the Data security terms, conditions and requirements set forth in this Addendum in any such Subcontract. However, no subcontract will terminate the Business Associate's legal responsibility to SBHASO for any work performed under this Agreement nor for oversight of any functions and/or responsibilities it delegates to any subcontractor.

7. Data Breach Notification

7.1 The Breach or potential compromise of Data must be reported to the SBHASO HIPAA Privacy and Security Officer within one (1) business days of discovery. If the Business Associate does not have full details, it will report what information it has, and provide full details within five (5) business days of discovery. To the extent possible, these reports must include the following:

7.1.1 The identification of each Medicaid individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;

7.1.2 The nature of the unauthorized use or disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;

7.1.3 A description of the types of PHI involved;

7.1.4 The investigative and remedial actions the Business Associate or its Subcontractor took or will

take to prevent and mitigate harmful effects, and protect against recurrence;

7.1.5 Any details necessary for a determination of the potential harm to Individuals whose PHI is believed to have been used or disclosed and the steps those Individuals should take to protect themselves; and

7.1.6 Any other information SBHASO reasonably requests.

7.2 The Business Associate must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or SBHASO including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.

7.3 The Business Associate must notify SBHASO in writing, as described in 7.1 of this Addendum, within two (2) business days of determining notification must be sent to Medicaid individuals.

7.4 At SBHASO's request, the Business Associate will provide draft Enrollee notification to SBHASO at least five (5) business days prior to notification, and all SBHASO and HCA an opportunity to review and comment on the notifications.

7.5 At SBHASO's request, the Business Associate will coordinate its investigation and notifications with HCA and the Office of the state of Washington Chief Information Officer (OCIO), as applicable.

8. HIPAA Compliance

8.1 The Business Associate must perform all of its duties, activities, and tasks under this Agreement in compliance with HIPAA, the HIPAA Rules, and all applicable regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable. The Business Associate and Business Associate's subcontracts must fully cooperate with SBHASO efforts to implement HIPAA requirements.

8.2 Within ten business days, Business Associate must notify the SBHASOHIPAA and Privacy Security Officer of any complaint, enforcement, or compliance action initiated by the Office for Civil Rights based on an allegation of violation of HIPAA or the HIPAA Rules and must inform SBHASO of the outcome of that action. Business Associate bears all responsibility for any penalties, fines, or sanctions imposed against Business Associate for violations of HIPAA or the HIPAA Rules and for any sanction imposed against their Subcontractors or agents for which it is found liable.

9. Inspection

9.1 SBHASO reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by Business Associate during the terms of this Agreement. All SBHASO representatives conducting onsite audits of Business Associate agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

10. Material Breach

10.1 The Business Associate must indemnify and hold SBHASO and its employees harmless from any damages related to the Business Associate's or their Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.

* * * * *

1. Business Continuity, Enterprise Resilience, and Disaster Recovery

1.1 Business Impact Analysis:

1.1.1 Critical IT systems and components must be identified and documented, including recovery time objective and recovery point objective.

1.2 Recovery Strategies

1.2.1 The data center must maintain a back-up site(s).

1.2.2 Mission critical information must be fully backed-up on a weekly basis and incremental changes must be backed up daily.

1.2.3 Backed-up information must be stored encrypted with FIPS 140-2 compliant encryption protocols.

1.2.4 Backed-up information must be stored in a secure off-site facility.

1.2.5 Backed-up information must be stored off-line.

1.2.6 Testing of restoration of critical data back-ups must be no less than semi-annually (every 6 months).

1.2.7 Contracts for outsourced services must include disaster recovery agreements.

1.3 Recovery Plans and Procedures, and Maintenance

1.3.1 A documented business continuity plan for business functions must be updated and maintained.

1.3.2 The business continuity plan must be stored off-site in a secure location.

1.3.3 SBHASO must be alerted of any deficiencies discovered in the business continuity plan that would adversely affect SBHASO.

1.3.4 A documented disaster recovery plan for information technology must be updated and maintained.

1.3.5 The disaster recovery plan must be stored off-site in a secure location.

1.3.6 The disaster recovery plan must include policies and procedures for facility access during a disaster.

1.4 Testing and Exercising

1.4.1 The business continuity plan for business functions must be tested periodically. The disaster recovery plan for information technology must be tested periodically.

1.5 Escalation and Crisis Management

1.5.1 The business continuity plan must contain notification procedures to alert SBHASO of service disruptions including off-hour and weekend coverage.

1.5.2 The disaster recovery plan must have notification procedures to alert SBHASO of service disruptions including off-hour and weekend coverage.

2 IT Risk and Compliance Management

2.1 Regulatory and Standards Implementation

2.1.1 The Business Associate must remain in compliance with HIPAA and all other applicable national and state privacy and security regulations.

2.1.2 Confidential information, including PHI and ePHI, must never be stored outside of the United States.

2.1.3 An information security officer must be assigned.

2.1.4 An on-going and documented security awareness program must be established and communicated to all users to make them aware of the confidentiality of information, the Business Associate's security policies, standards, and good security practices.

2.1.5 Information Security awareness information must be distributed to all users on a periodic basis.

2.1.6 A privacy officer must be assigned.

2.1.7 An on-going and documented privacy awareness program must be established and communicated to all users to make them aware of the company's privacy policies and the requirements to protect the confidentiality of information.

2.1.8 Privacy awareness information must be distributed to all users on a periodic basis.

2.1.9 Mandatory privacy training must be delivered to, managed, and validated for all users on no less than an annual periodic basis.

2.1.10 All users are required to sign confidentiality and non-disclosure agreements.

2.2 Risk and Compliance Assessments

2.2.1 An accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI is conducted at least annually.

2.2.2 All users are required to have a nationally recognized criminal background check, and a local court background check for the past seven (7) years.

2.3 Policies, Standards, and Procedure Management

2.3.1 A documented risk management function and/or program supported by executive management must exist.

2.3.2 A documented information security function and/or program supported by executive management must exist.

2.3.3 A documented privacy function and/or program supported by executive management must exist.

2.3.4 The information security function/program must establish security policies and standards that are enforced through automated systems and administrative procedures that are maintained and updated as needed.

2.3.5 The privacy function/program must establish confidentiality policies which are maintained and updated as needed.

2.4 Issue and Corrective Action Management

2.4.1 Controls are implemented to reduce risks and vulnerabilities to a reasonable and appropriate level

2.4.2 A documented process must exist and be adhered to in order to report security issues affecting SBHASO to SBHASO's Information Security Officer.

2.4.3 A documented process must exist and be adhered to in order to report privacy issues affecting SBHASOPHI and ePHI to SBHASO's Privacy Officer.

2.5 Exception Management

2.5.1 Disciplinary measures for violations must be included in the Information Security and Privacy Program.

2.5.2 A documented security incident response plan must exist to ensure incidents are tracked, monitored, and investigated until closure is achieved.

2.5.3 A documented privacy incident response plan must exist to ensure that incidents are tracked, monitored, investigated and reported internally and to Covered Entity until remediation and closure is achieved.

3. Data Protection

3.1 Data Classification & Inventory

3.1.1 A documented information classification scheme must be utilized to ensure proper protection, use and destruction of SBHASO's data.

3.2 Data Lifecycle Analysis

3.2.1 Systems containing confidential information, including PHI and ePHI, have been documented, including security and privacy controls.

3.2.2 Documents showing the flow of sensitive data through systems and business processes must exist.

3.3 Data Encryption & Obfuscation

3.3.1 Confidential information, including PHI and ePHI, must be encrypted during storage on all devices including handhelds, laptops, workstations, and removable media with FIPS 140-2 compliant encryption protocols.

3.3.2 Information containing PHI and ePHI must be encrypted during storage on servers with FIPS 140-2 compliant encryption protocols.

3.3.3 Confidential information, including PHI and ePHI, must be encrypted during transmission over public or untrusted networks, including wireless or email transmissions, with FIPS 140-2 compliant encryption protocols.

3.3.4 Business to business communications with confidential information, including PHI and ePHI, must be encrypted.

3.4 Data Loss Prevention

3.4.1 A documented policy and process must exist with regard to the removal or movement of confidential information, including PHI and ePHI to unsecured systems or media.

3.4.2 Confidential information, including PHI and ePHI, stored on removable media must be secured with restricted access to those with a business need.

3.4.3 Technical controls must exist to prevent transmission of confidential information, including PHI and ePHI to unauthorized recipients.

3.4.4 Technical controls must exist to prevent storage of confidential information, including PHI and ePHI, on unsecured systems.

3.5 Data Retention and Destruction

3.5.1 A documented policy and process must exist with regard to the removal or destruction of confidential information, including PHI and ePHI. When appropriate, confidential information,

including PHI and ePHI, must be purged or destroyed using a NIST 800-88 approved process when no longer needed.

4. Third Party Risk Management

4.1 Evaluation & Selection

4.1.1 A documented process must exist to evaluate the privacy and security controls for the Business Associate's agents, subcontractors and outsourced services prior to entering into any such approved subcontracts.

4.2 Contract & Service Initiation

4.2.1 Any subcontracts shall contain all privacy and security requirements and protections as set forth in the Data Security Requirements Addendum as well as this Security and Privacy Addendum.

4.2.2 Information containing PHI or ePHI must only be disclosed to third parties when a Business Associate Agreement (BAA) and non-disclosure agreement are in effect.

4.3 Security & Compliance Review

4.3.1 A documented process exists to review the privacy and security controls of agents, subcontractors and outsourced services on a periodic basis to reasonably assure they are maintaining the required level of protection.

4.4 Third Party Monitoring

4.4.1 Agents, subcontractors, and outsourced services that perform critical services that support this agreement have been identified and documented.

4.4.2 Agents, subcontractors, and outsourced services that are identified as providing critical services or that are handling PHI must be monitored on an ongoing basis for compliance with this Agreement.

5. Identity & Access Management

5.1 User Account Management

5.1.1 Access to systems and applications must require a unique identifier (e.g. user ID) and at minimum a password or equivalent control.

5.1.2 User IDs must be locked after 5 consecutive unsuccessful login attempts.

5.1.3 User IDs must be disabled after 60 days or less of inactivity.

5.1.4 Passwords must be issued to users in a secure manner and be changed at first login

5.1.5 Password policies at a minimum must include minimum password length, alphanumeric composition, retention of password history, and password change frequency.

5.1.6 Passwords cannot be displayed on screens or on reports.

5.1.7 Passwords must be encrypted in transmission and storage.

5.2 Access Management

5.2.1 Access to confidential information, including PHI and ePHI, must be restricted to individuals that have a business need and access control mechanisms must be implemented that limit access to confidential information.

5.2.2 Security administration procedures must include procedures for access requests for a new user, changing access, prompt deletion of users involving terminations, user transfers and periodic verification of users and access rights.

5.2.3 All user access requests must be documented with management approval including privileged users.

5.2.4 Documented remote access policies must exist and be enforced.

5.3 Privileged User Management

5.3.1 All default supplied user IDs must be disabled, renamed, or deleted wherever possible.

5.3.2 System IDs must be documented describing their functions and risks.

5.3.3 System IDs must be required to have passwords and documented risk analysis if password change frequency is not enforced.

5.3.4 System ID passwords must be stored in encrypted files.

5.3.6 System IDs are not allowed to be scripted into the application.

5.3.7 System IDs must not be able to be accessed by an individual user for interactive use.

5.3.8 All vendor-supplied default passwords must be changed.

5.4 Data Platform Integration

5.4.1 All systems containing confidential information, including PHI and ePHI, have system access controls to prevent unauthorized disclosure or modification.

5.4.2 Single sign on technologies are leveraged wherever possible to eliminate the need for multiple access controls systems.

5.5 Access Reporting and Audit

5.5.1 All user access to systems containing confidential data, including PHI and ePHI, must be revalidated at least annually based on mutually agreed upon and reasonable procedures.

5.5.2 All User IDs and System IDs with privileged authorities must be revalidated at least annually based on mutually agreed upon and reasonable procedures.

5.6 Access Governance

5.6.1 User access must be defined by job roles to ensure segregation of duties.

5.6.2 User access must be logged and tracked to an individual for accountability.

5.7 Federation

5.7.1 Access to systems by agents, subcontractors, or outsourced services are subject to the same Identity Management requirements as the Business Associate's personnel.

6. Secure Development Lifecycle

6.1 Security and Risk Requirements

6.1.1 A documented process exists to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI, as part of the System Development Life Cycle.

6.1.2 Security controls are considered throughout the System Development Life Cycle.

6.2 Security Design & Architecture

6.2.1 Security controls are designed to eliminate a single point of failure.

6.2.2 Systems are designed to use a common security architecture.

6.2.3 Production, test, and development environments must be physically and/or logically separated.

6.3 Application Role Design and Access Privileges

6.3.1 Application security controls are designed to ensure users can access only information for which they have an authorized business need.

6.3.2 Access is controlled by a common access methodology or single sign on wherever feasible.

6.4 Secure Coding Guidelines

6.4.1 Secure coding principles and practices are documented and followed.

6.4.2 Web application controls must be configured to prevent printing or downloading data to unauthorized workstation and/or mobile devices.

6.4.3 Production information must not be used in development and test environments unless such environments are secured to the same level as production, or data has been de-identified as specified in HIPAA (45 CFR 164.514).

6.5 Secure Build

6.5.1 New server and network equipment deployment procedures must ensure implementation of security configuration settings.

6.6 Security Testing

6.6.1 All security controls must be tested prior to implementing new systems or upgrades into production.

6.6.2 Where feasible, automated tools are used for code review.

6.7 Roll-out and Go-live Management

6.7.1 Staff other than developers are responsible for moving systems or applications into production environment to retain separation of duties.

6.7.2 All non-standard access paths are removed prior to move into production.

6.8 Application Security Administration

6.8.1 Development staff requires management approval to access production systems.

6.8.2 Technical staff must not have access to production data, programs, or applications unless required to perform their jobs.

7 Infrastructure, Operations and Network Security/Cyber Threat and Vulnerability Management

7.1 Antivirus (AV) & Malware protection

7.1.1 A documented policy and procedures exist for guarding against, detecting, and reporting malicious software.

7.2 Intrusion Detection and Prevention

7.2.1 Intrusion detection and prevention systems must be implemented for critical components of the network.

7.3 Network Access Controls

7.3.1 A documented policy and procedures exist to prevent unauthorized/unsecured devices from accessing the network.

7.4 Network and Application Firewalls

7.4.1 Firewalls must be implemented and configured to deny all except authorized documented business services.

7.4.2 Firewalls must be configured to fail in a prevent state.

7.5 Proxy/Content Filtering

7.5.1 A documented policy and procedures exist to prevent confidential information, including PHI and ePHI, from being transmitted to unauthorized recipients or stored in unauthorized locations.

7.6 Remote Access Controls

7.6.1 Two-factor authentication is implemented for all remote network access (e.g. VPN, Citrix, etc.).

7.7 Security Monitoring

7.7.1 A documented policy and procedures exist to monitor networks, systems, and applications for potential security events.

7.7.2 A documented process exists to respond to potential security events on a 24x7x365 basis.

7.7.3 All significant computer security relevant events must be securely logged.

7.7.4 Computer systems handling confidential information, including PHI and ePHI, must securely log all significant computer security relevant events including the following: (a) unauthorized attempts to enter the system, (b) unauthorized attempts to access protected information or resources, (c) all attempts to issue restricted commands, (d) security activities, (e) special privileged user activities and (f) violation activities.

7.7.5 All logs of computer security relevant events must be traceable to specific individuals wherever possible.

7.8 Wireless Security Controls

7.8.1 A documented policy and procedures exist to prevent unauthorized wireless access to production systems.

7.9 Database Security

7.9.1 A documented policy and procedures exist to prevent unauthorized updates to databases.

7.9.2 All database access must be traceable to specific individuals.

7.10 Network Device Security

7.10.1 All network devices supporting business critical systems have physical and logical access controls.

7.10.2 All network devices supporting business critical systems have secured out-of-band management.

8 Cyber Threat and Vulnerability Management

8.1 OS Hardening & Secure Configuration

8.1.8 Required security configuration settings must be selected and documented.

8.1.2 Documented processes must exist to periodically verify security configuration settings.

8.1.3 Any and all Workstations able to access any confidential information must actively and automatically blank the screen or enable a screen saver and require re-authentication after fifteen (15) minutes of inactivity or less.

8.2 Patch Management

8.2.1 A documented patch management process must exist and be enforced.

8.2.2 Prompt application of security patches, service packs, & hot fixes is required for all systems that store, process, manage, or control access to sensitive data, including PHI and ePHI.

8.3 Vulnerability Management

8.3.1 A documented process and procedures exist to identify, quantify, prioritize, track, and remediate vulnerabilities.

8.4 Recurring Vulnerability Assessments and Penetration Testing

8.4.1 Periodic third party penetration tests must be conducted from outside and within the network.

8.4.2 Vulnerability assessment must be performed at least quarterly.

8.5 Incident and Problem Management

8.5.1 A documented problem management system must exist.

8.5.2 Audit logs must be implemented on all systems storing or processing critical or confidential information.

8.5.3 Audit logs must be retained for a minimum of twelve (12) months

8.5.4 Audit logs must be protected from unauthorized access and resistant to attacks including deactivation, modification or deletion.

8.5.5 Audit logs must be reviewed for inappropriate activities in a timely manner and appropriate actions must be taken to protect SBHASO associates, assets, systems, and data.

8.6 Capacity Management

8.6.1 A documented policy and process exists to evaluate current capacity against projected requirements.

8.7 Configuration and Change Management

8.7.1 A three-tiered architecture must be deployed to isolate web applications from production information in the “internal” network.

8.8 Release Management

8.8.1 Segregation of duties between change management, developer, and infrastructure staff must be maintained.

8.8.2 Developers must not be able to update production resources without proper change management procedures for production updates/fixes.

8.8.3 All production systems and application resources must be changed through an enforced and documented change management process which includes appropriate reviews, testing, and management approvals.

8.8.4 Production code and systems must not allow undocumented changes or updates.

8.9 Asset and Configuration Management

8.9.1 Documented network diagrams must exist.

8.9.2 An auditable and documented inventory of information technology assets must exist in case of loss or theft.

9 Physical Security

9.1 Policies, Standards, and Procedure Management

9.1.1 A documented physical security function and/or program must exist.

9.1.2 The physical security function/program must establish physical security policies and be enforced through automated systems and administrative procedures.

9.1.3 All servers storing or processing confidential information, including PHI and ePHI, must be located in a secure data center or equivalent secure facility.

9.2 Facility Access Controls

9.2.1 Employees must be required to wear identification badges at all times in sensitive facilities.

9.2.2 Visitors must be required to be identified, sign in, wear temporary visitor badges, and be escorted in facilities containing SBHASO data.

9.2.3 Data center access to sensitive areas, such as a computer room, must require two levels of authentication.

9.2.4 Data center and other sensitive facilities access must be periodically reviewed to ensure that access is still valid.

9.2.5 Facility access logs must be retained for at least six (6) months and be reviewed as needed.

9.3 Issue and Corrective Action Management

9.3.1 Any known HIGH risk physical security vulnerabilities affecting SBHASO, or SBHASO's data, must be communicated to SBHASO's Information Security Officer.

9.3.2 The Data Center facility must be equipped and maintained with fire detection/suppression, surge and brown-out, air conditioning, and other computing environment protection systems necessary to assure continued service for critical computer systems.

9.3.3 Policies and procedures must be in place to document repairs and modifications to physical components of facilities where PHI and ePHI are stored, which are related to security (for example, hardware, walls, doors and locks).

9.3.4 All hardware and electronic media containing PHI and ePHI must be identified and tracked during movement.

9.3.5 A retrievable exact copy of PHI and ePHI must be created from equipment before being moved.

10 Changes

10.1 SBHASO may change the above security requirements by providing new requirements in writing to Business Associate. Business Associate shall comply with such new security requirements within the specified time period and by the due date stated in the change notice. In the event Business Associate's compliance with the new requirements materially increases its cost to provide services under the Services Agreement(s), if service agreements are applicable to this Agreement, Business Associate shall notify SBHASO of the amount Business Associate believes is necessary to reimburse Business Associate for its actual and reasonable additional costs. If SBHASO elects not to reimburse Business Associate for such costs, then SBHASO may terminate this Agreement and/or any or all of the Services Agreements, in whole or in part, by sending written notice to Business Associate indicating which Services Agreements are being terminated and the effective date of termination. Such termination shall be without charge to CSHCD SCRBH, except that SBHASO shall pay for all services under such terminated Services Agreement(s) that were properly rendered until the effective date of termination.

* * * * *

PROGRAM INTEGRITY ADDENDUM

1. Standards of Conduct and Conflicts of Interest:

1.1 Business Associate shall either adopt SBHASO's Rules for Job Performance and Conduct policy (https://www.spokanecounty.org/3139/Policies-Procedures), or implement its own for its board members, employees, temporary employees, volunteers/interns, consultants, contractors and downstream entities, and subcontractors. These same individuals directly associated with the Business Associate, will attest that they have read and understand the Standards of Conduct and the attestations will be stored by the Business Associate.

1.2 Business Associate shall identify and address conflicts of interest for board members, employees, temporary employees, volunteers/interns, consultants, contractors and downstream entities on at least an annual basis and maintains documentation of all conflict of interest questionnaires, responses, and follow-up activities.

1.3 At the request of SBHASO and within ten (10) calendar days of such request and in a reasonable manner designated by SBHASO, Business Associate shall provide access to documentation regarding Standards of Conduct and Conflicts of Interest for the purpose of compliance validation.

2. General Compliance and Fraud, Waste and Abuse (FWA) Training:

2.1 Business Associate shall ensure training for all board members, employees, temporary employees, volunteers/interns, consultants, contractors and downstream entities, and subcontractors will specifically include the following Medicare Parts C and D General Compliance Training (GCT) and Medicare Parts C and D Fraud, Waste and Abuse (FWA) training. These same individuals directly associated with the Business Associate, will attest that they have completed these two trainings and the training attestations will be stored by the Business Associate.

2.1.1 Medicare Parts C and D General Compliance Training: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

2.1.2 Combatting Medicare Parts C and D Fraud, Waste, and Abuse: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CombMedCandDFWAdownload.pdf.

2.2 At the request of SBHASO and within ten (10) calendar days of such request and in a reasonable manner designated by SBHASO, Business Associate shall provide access to documentation regarding General Compliance and Fraud, Waste and Abuse training for the purpose of compliance validation.

* * * * *

ANNUAL ATTESTATION

(“Business Associate”) entered into this certain Business Associate Agreement (the "Agreement") with the Salish Behavioral Health Administrative Services Organization (SBHASO). Business Associate submits this attestation to SBHASO based on Business Associate's best knowledge, information and belief after having made a diligent inquiry.

1. For the period commencing from the later of (i) the Agreement's effective date or (ii) the date of the last Annual Attestation through the execution date of this Attestation set forth below, Business Associate has:

    a. Promptly notified SBHASO in writing of all Incidents involving it, its affiliates and Subcontractors involving the PHI of any individual Business Associate and its affiliates have Used in connection with a Services Agreement.

    b. Adhered to the data use, security and confidentiality standards contained in the Agreement.

    c. Adhered to the privacy and security standards and requirements contained in the Agreement.

    d. Adhered to the program integrity requirements contained in the Agreement.

    e. Incorporated into the contractual arrangement with any Subcontractor that Uses PHI the provisions required by the Agreement including executing a Business Associate Agreement between Business Associate and its business associate(s).

2. Business Associate has documented data use, security and confidentiality standards, and a security and privacy compliance program that complies with the requirements of (i) the HIPAA Authorities, (ii) applicable state security and privacy requirements, and (iii) all additional standards and obligations established by SBHASO pursuant to the Agreement and the Services Agreement(s) (if services agreements are applicable).

3. Business Associate has documentation of all board members, employees, temporary employees, volunteers/interns, consultants, contractors and subcontractor’s Standards of Conduct, Conflict of Interest, CMS General Compliance Training, and CMS Fraud, Waste and Abuse Training.

4. Capitalized terms in this Attestation shall have the meaning ascribed to them in the Agreement unless defined otherwise herein.

[Business Associate]

_____	_____
Signature of Officer	Title of Signing Officer
_____	_____
Printed Name of Signing Officer	Date

A signature below indicates that Business Associate **no longer** conducts the activities outlined in the Services Agreement(s) that require the Use of PHI and, consistent with state and federal law, has properly destroyed or returned to SBHASO all PHI in accordance with the Services Agreement(s) and the Agreement.

_____	_____
Signature of Officer	Title of Signing Officer
_____	_____
Printed Name of Signing Officer	Date

Statement of Variability- Salish Services Agreement

A corresponding Not-For-Public filing has been submitted. Variables are used in the Compensation Schedule and are outlined below.

Contracted Services Grid

Payment Type	Service Detail	Monthly Base Medicaid	Monthly Additional Capacity Medicaid	Maximum Monthly Medicaid
Crisis Services				
Capacity	Schedule of Services as described in Exhibit A	[$1 to $125,000] in increments of $1.00	[$1 to $100,000] in increments of $1.00	[$1 to $225,000] in increments of $1.00

- *Monthly Base* is compensation for all eligible crisis services up to [0-1,200] units in increments of 1.
- *Monthly Additional Capacity* is compensation for services delivered in excess of [10-5,000] units in increments of 1.

UNITED HEALTHCARE OF WASHINGTON, INC. ("United")
Washington State Programs Regulatory Requirements Appendix
Exhibit F

This Exhibit references most current *Washington State Programs Regulatory Requirements Appendix* as approved.

WASHINGTON STATE PROGRAMS

REGULATORY REQUIREMENTS APPENDIX

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") 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, 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 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.

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.

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.