cWashington Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

## As of the date of this Addendum, there are no applicable laws of this type.

# **General Insurance Laws**

## As required by Wash. Rev. Code § 48.43.515(7), carrier must cover services of a primary care Provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least 60 days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The Provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

## As required by Wash. Rev. Code § 48.43.600(4), to the extent the Agreement conflicts with the carrier overpayment recovery procedures contained in Wash. Rev. Code § 48.43.600(4), the provisions of Wash. Rev. Code § 48.43.600(4) shall prevail.

## As required by Wash. Admin. Code § 284-170-421(1), the Agreement or Provider Manual has established mechanism by which its participating Providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits.

## As required by Wash. Admin. Code § 284-170-421(2), nothing contained in the Agreement has the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the Agreement and a health plan, the benefits, terms, and conditions of the health plan must govern with respect to coverage provided to enrollees.

## As required by Wash. Admin. Code § 284-170-421(3), the following language is included in the Agreement:

(a) Provider hereby agrees that in no event, including, but not limited to nonpayment by [issuer] , [issuer’s] insolvency, or breach of this contract will [provider] bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other than [issuer] , 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 enrollees in accordance with the terms of the enrollee's health plan.

(b) Provider agrees, in the event of [issuer’s] insolvency, to continue to provide the services promised in this contract to enrollees of name of issuer for the duration of the period for which premiums on behalf of the enrollee were paid to [issuer] or until the enrollee's discharge from inpatient facilities, whichever time is greater.

(c) Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan.

(d) Provider may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where [issuer] denies payments because the [provider] has failed to comply with the terms or conditions of this contract.

(e) Provider further agrees (i) that the [above provisions a-d] shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of [issuer’s] enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between [provider] and enrollees or persons acting on their behalf.

(f) If Provider contracts with other providers or facilities who agree to provide covered services to enrollees of [issuer] with the expectation of receiving payment directly or indirectly from [issuer], such providers or facilities must agree to abide by the above provisions a-d.

## As required by Wash. Admin. Code § 284-170-421(4), Providers that willfully collect or attempt to collect an amount from an enrollee knowing that collection to be in violation of the Agreement constitutes a class C felony under Wash. Rev. Code § 48.80.030(5).

## As required by Wash. Admin. Code § 284-170-421(5), Provider is responsible to the health issuer’s applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

## As required by Wash. Admin. Code § 284-170-421(6), issuer has made all documents, procedures and other administrative policies and programs referenced in the Agreement available for review by Provider prior to contracting.

## As required by Wash. Admin. Code § 284-170-421(7), the following language is included in the Agreement:

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.

## As required by Wash. Admin. Code § 284-170-421(8), subject to applicable state and federal laws related to the confidentiality of medical or health records, participating Providers and facilities are required to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. Providers and facilities must cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

## As required by Wash. Admin. Code § 284-170-421(9), an issuer, participating Provider, and facility must provide at least 60 days' written notice to each other before terminating the Agreement without cause.

## As required by Wash. Admin. Code § 284-170-421(10), whether the termination was for cause, or without cause, the issuer must make a good faith effort to ensure written notice of a termination is provided at least 30 days prior to the effective date of the termination or immediately for a termination for cause that results in less than 30 days notice to a provider or carrier to all enrollees who are patients seen: (i) on a regular basis by a specialist; (ii) by a provider for whom they have a standing referral; or (iii) by a primary care Provider.

## As required by Wash. Admin. Code § 284-170-421(11), participating Providers and facilities must furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services, unless the Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

## As required by Wash. Admin. Code § 284-170-421(12), an issuer may not penalize a Provider because the Provider, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare or that may violate state or federal law.

## As required by Wash. Admin. Code § 284-170-421(13), the Agreement contains procedures for the fair resolution of disputes arising out of the Agreement and to the extent necessary to comply with Wash. Admin. Code § 284-170-421(13), incorporates applicable Provider Manual provisions.

## Any information which is required to be included in the Agreement under Wash. Admin. Code § 284-170-431(1) and which is not already included in the body of the Agreement but has been provided to the Provider separately shall be considered incorporated into the Agreement.

## As required by Wash. Admin. Code § 284-170-431(2):

### For health services provided to covered persons, a carrier shall pay Providers and facilities as soon as practical but subject to the following minimum standards: (A) 95% of the monthly volume of clean claims shall be paid within 30 days of receipt by the responsible carrier or agent of the carrier; and (B) 95% of the monthly volume of all claims shall be paid or denied within 60 days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

### The receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

### The carrier has established a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims, which is contained in the Provider Manual.

### If carrier fails to pay claims within the standard established under Wash. Admin. Code § 284-170-431(2), the carrier shall pay interest on undenied and unpaid clean claims more than 61 days old until the carrier meets the standard Wash. Admin. Code § 284-170-431(2). Interest shall be assessed at the rate of 1% per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the Provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

### When the carrier issues payment in either the Provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the Provider or facility first and the covered person second.

## As required by Wash. Admin. Code § 284-170-431(3), for subsections q. and r. of Section III of this Addendum, “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 Wash. Admin. Code § 284-170-431.

## As required by Wash. Admin. Code § 284-170-431(4), denial of a claim must be communicated to the Provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the Provider or facility must also promptly disclose the supporting basis for the decision.

## As required by Wash. Admin. Code § 284-170-431(5), carrier is responsible for ensuring that any person acting on behalf of or at the direction of the carrier or acting pursuant to carrier standards or requirements complies with billing and claim payment standards contained in Wash. Admin. Code § 284-170-431.

## As required by Wash. Admin. Code §§ 284-170-431(6) and (7), the billing and claim payment standards contained in Wash. Admin. Code § 284-170-431 do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Providers, facilities or covered persons, or instances where the carrier has not been granted reasonable access to information under the Provider's or facility's control. Additionally, Providers, facilities and carriers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

## As required by Wash. Admin. Code § 284-170-433(1), health carrier shall reimburse Provider for a health care service provided to a covered person through telemedicine or store and forward technology if: (i) the plan provides coverage of the health care service when provided in person by the Provider; (ii) the health care service is medically necessary; (iii) the health care service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, and Wash. Rev. Code §§ 48.43.005 and 48.43.715; (iv) the health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information; and (v) for audio-only telemedicine, the covered person has an established relationship with the Provider.

## As required by Wash. Admin. Code § 284-170-433(2), a carrier must reimburse a Provider for a health care service provided to a covered person through telemedicine as provided in Wash. Rev. Code § 48.43.735(1) or Wash. Admin. Code § 284-170-433(1) the same amount of compensation the carrier would pay the Provider if the health care service was provided in person by the Provider; except, hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more Providers may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services. For purposes of this subsection, the number of Providers in a provider group refers to all providers within the group, regardless of a Provider's location. For purposes of this section, reimbursement of store and forward technology is available only for those covered services specified in the negotiated agreement between the health carrier and the health care Provider.

## As required by Wash. Admin. Code § 284-170-433(3), an originating site for a telemedicine health care service subject to Wash. Admin. Code § 284-170-433(1) must include a: (i) hospital; (ii) rural health clinic; (iii) federally qualified health center; (iv) physician's or other Provider's office; (v) licensed or certified behavioral health agency; (vi) skilled nursing facility; (vii) home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under Wash. Rev. Code § 18.64 or a school-based health center as defined in Wash. Rev. Code § 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a Provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the Provider and the provider licensure laws of the other state; or (viii) renal dialysis center, except an independent renal dialysis center. Except for subsection (vii) and a hospital that is an originating site for an audio-only telemedicine encounter, any originating site under this subsection may charge a facility fee for infrastructure and preparation of the patient. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the health carrier. A distant site, a hospital that is an originating site for an audio-only telemedicine encounter, or any other site not identified in this subsection may not charge a facility fee.

## As required by Wash. Admin. Code § 284-170-433(4), health carrier may not distinguish between originating sites that are rural and urban in providing the coverage required in Wash. Admin. Code § 284-170-433(1).

## As required by Wash. Admin. Code § 284-170-433(5), health carrier may subject coverage of a telemedicine or store and forward technology health service under Wash. Admin. Code § 284-170-433(1) to all terms and conditions of the plan in which the covered person is enrolled including, but not limited to, utilization review, prior authorization, deductible, copayment, or coinsurance requirements that are applicable to coverage of a comparable health care service provided in person.

## As required by Wash. Admin. Code § 284-170-433(6), if a Provider intends to bill a covered person or the covered person's health plan for an audio-only telemedicine service, the Provider must obtain patient consent from the covered person for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent. A covered person's consent must be obtained prior to initiation of the first audio-only encounter with a provider and may constitute consent to such encounters for a period of up to 12 months. If audio-only encounters continue beyond an initial 12-month period, consent must be obtained from the covered person for each prospective 12-month period. Consent to be billed for audio-only telemedicine services must be obtained by the Provider or auxiliary personnel under the general supervision of the Provider. A covered person may consent to a Provider billing them or their health plan in writing or verbally. Consent to billing for an audio-only telemedicine encounter may be obtained and documented by the Provider or auxiliary personnel under the general supervision of the Provider as part of the process of making an appointment for an audio-only telemedicine encounter, recorded verbally as part of the audio-only telemedicine encounter record or otherwise documented in the patient record. Consent must be documented and retained by the Provider for a minimum of 5 years. As needed, a carrier also may request documentation of the covered person's consent as a condition of claim payment. A patient may revoke consent granted under this subsection. Revocation of the patient's consent must be communicated by the patient or their authorized representative to the Provider or auxiliary personnel under the general supervision of the Provider verbally or in writing and must be documented and retained by the Provider for a minimum of 5 years. Once consent is revoked, the revocation must operate prospectively.

## As required by Wash. Admin. Code § 284-170-433(7), a carrier may not deny, reduce, terminate or fail to make payment for the delivery of health care services using audio and visual technology solely because the communication between the patient and Provider during the encounter shifted to audio-only due to unanticipated circumstances. In these instances, a carrier may not require a Provider to obtain consent from the patient to continue the communication. A carrier has no obligation to reimburse a Provider for both an audio-visual and an audio-only encounter when both means of communication have been used during the encounter due to unforeseen circumstances.

## As required by Wash. Admin. Code § 284-170-433(9), access to telemedicine services is inclusive for those patients who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with carriers' obligations under Wash. Rev. Code §§ 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

## Any information which is required to be included in the Agreement under Wash. Admin. Code § 284-170-480(7) and which is not already included in the body of the Agreement but has been provided to the Provider separately shall be considered incorporated into the Agreement.

# **Health Maintenance Organization (HMO)/Managed Care Organization (MCO) Specific Laws**

## As required by Wash. Rev. Code § 48.46.243(1), in the event the HMO fails to pay for health care services as set forth in the Agreement, the enrolled participant shall not be liable to the Provider for any sums owed by the HMO. This subsection shall survive termination of the Agreement.