

CORE PROVIDER AGREEMENT

The Health Care Authority (HCA) administers medical assistance and medical care programs for eligible clients. HCA provides medical assistance or medical care to certain eligible clients by enrolling eligible providers of medical services.

HCA reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients. To be eligible for enrollment, a provider must:

- a. Agree to and sign this Core Provider Agreement (“Agreement”);
- b. Complete and sign a Medicaid Provider Disclosure Statement;
- c. Complete an online enrollment application
- d. Complete and sign a Debarment Statement;
- e. Be an eligible provider and meet the conditions contained in WAC 182-502-0010;
- f. Meet all the applicable state and/or federal licensure requirements to assure HCA of his/her qualifications to perform services under this Agreement. This includes maintaining professional licensure in good standing without any stipulation in the provider’s license.

This Agreement will be effective and a provider will be considered a participating provider once the provider completes the above requirements and signs this Agreement, and HCA issues a provider number.

As a participating provider in the medical assistance and medical care programs, hereafter known as Provider, the Provider agrees to the following:

1. **Governing Law and Venue.** This Agreement shall be governed by the laws of the state of Washington. The jurisdiction for all lawsuits in which the Provider alleges a breach of this Agreement shall be exclusively in the Superior Court for the state of Washington. Venue for any such lawsuits shall be in the Superior Court for Thurston County, Washington.

The medical assistance and medical care programs are authorized and governed by Title XIX of the Social Security Act, Title XXI of the Social Security Act, Chapter IV of Title 42 of the Code of Federal Regulations (CFR), Chapter 74.09 of the Revised Code of Washington (RCW), and Titles 182 and 388 of the Washington Administrative Code (WAC). The Provider is subject to and shall comply with all federal and state laws, rules, and regulations and all program policy provisions, including Pre-2012 Numbered Memoranda, Provider Notices, Medicaid Provider Guides, and other associated written HCA issuances in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

2. **License.** The Provider shall be licensed, certified, or registered as required by state and/or federal law. The Provider will notify HCA within seven (7) calendar days of learning of any adverse action initiated against the license, certification, or registration of the Provider or any of its officers, agents, or employees.
3. **Professional liability coverage.** By signing this agreement the provider organization or individual certifies that the organization or individual currently has and will maintain the professional liability insurance coverage so long as the organization or individual provider is providing services to Apple Health clients.
4. **Billing and Payment.** The Provider agrees:
 - a. To submit claims for services rendered to eligible clients, as identified by HCA, in accordance with rules and Medicaid Provider Guides in effect at the time the service is rendered.
 - b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the program, except where payment by the client is authorized by applicable rule. In no event shall HCA be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.

- c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to HCA. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.
5. **Disclosure.** At the time the provider enters into this Agreement, or renews this Agreement, or at any time upon request by HCA or the federal Department of Health and Human Services, the Provider agrees to submit full and complete disclosure of the following:
 - a. Ownership and control information as required by 42 CFR § 455.104;
 - b. Information related to business transactions as required by 42 CFR § 455.105;
 - c. Information on persons convicted of crimes as required by 42 CFR § 455.106; and
 - d. Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

At any time during the course of this Agreement, the Provider agrees to notify HCA of any material and/or substantial changes in information contained on the Medicaid Provider Disclosure Statement given to the HCA by the Provider. This notification must be made in writing within thirty (30) calendar days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

- a. Ownership;
 - b. Licensure;
 - c. Federal tax identification number;
 - d. Additions, deletions, or replacements in group membership; and
 - e. Any change in address or telephone number.
6. **False Claims Act Education.** If the Provider receives annual Medicaid payments of \$5 million or more, the Provider must comply with the requirements of 42 USC § 1396a(a)(68).
 7. **National Provider Identifier (NPI).** The Provider must provide its NPI to HCA (if eligible for an NPI) and include its NPI on all claims submitted.
 8. **Inspection; Maintenance of Records.** For six (6)-years from the date of services, or longer if required specifically by law, the Provider shall:
 - a. Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to HCA.
 - b. Make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within HCA or the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to HCA may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.
 9. **Audit or Investigation.** Audits or investigations may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and **supportive** materials until the audit is completed and all issues are resolved, even if the period of retention extends beyond the required 6-year period.
 10. **Disputes.** Any party may initiate a dispute concerning this Agreement under the dispute resolution processes in Titles 182 and 388 WAC applicable to the specific subject matter of the dispute.

Neither party may dispute a termination of this Agreement for convenience or for loss of funding under Section 10 Termination.

11. **Termination.** HCA shall deny or terminate this Agreement for cause according to applicable WAC. Either HCA or the Provider may terminate this agreement for convenience at any time upon 30 calendar days' written notification to the other. In the event that funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, HCA may terminate this Agreement. If this Agreement is

terminated for any reason, HCA shall pay only for services authorized and provided through the date of termination.

12. **Advance Directives.** Hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMOs must comply with the advance directive requirements as required by 42 CFR 489, Subpart I and 42 CFR 417.436.
13. **Provider Not Employee Or Agent.** The Provider or its directors, officers, partners, employees and agents are not employees or agents of HCA.
14. **Assignment.** The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement, to a third party without the written consent of HCA.
15. **Confidentiality.** The Provider may use personal information and other information gained by reason of this Agreement only for the purpose of this Agreement. The Provider shall not disclose, transfer, or sell any such information to any party, except as provided by law.
16. **Indemnification and Hold Harmless.** The Provider shall be responsible for and shall indemnify and hold HCA harmless from all liability resulting from the acts or omissions of the Provider or any subcontractor.
17. **Severability.** The provisions of the Agreement are severable. If any provision of the Agreement is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.
18. **Certification.** This is to certify that the information provided in support of this Agreement is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under federal and state laws. Willful misstatement of any material fact in the enrollment application may result in criminal prosecution. I acknowledge that this is being signed under the penalties of perjury and understand that HCA is relying on the accuracy of the information I have presented. I agree to abide by the terms of this Agreement including all applicable federal and state statutes, rules, and policies.
19. **Electronic Signatures.** Provider and HCA agree that each may treat executed faxes, scanned images, or photocopies as original documents.
20. **Signature Block.** If Provider is a legal entity other than a person, identify the organization in the first line of the signature block. The person signing this Core Provider Agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.

PROVIDER LEGAL ENTITY NAME		
SIGNATURE OF PROVIDER OR OWNER/MANAGER	TITLE	DATE
FULL NAME (PRINTED)	NPI	PROVIDER SPECIALTY

For additional information on Provider Enrollment go to:
<http://hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-provider>
 Questions? Toll-Free 1-800-562-3022, ext. 16137

To fax:

- Go to the New Provider Enrollment website at:
<http://hca.wa.gov/billers-providers/apple-health-medicaid-providers/enroll-billing-provider>
- Click on “document submission cover sheet” link in step 4
- Follow directions on cover sheet

To mail, send to:
 Provider Enrollment
 PO Box 45562
 Olympia, WA 98504-5562