

**THIS DOCUMENT REPRESENTS ALL INCORPORATED AMENDMENTS, EXHIBITS  
AND ATTACHEMENTS FROM JULY 2018 THROUGH AMENDMENT #5.  
AMENDMENT #5 IS EFFECTIVE JULY 1, 2019.**

	<b>WASHINGTON APPLE HEALTH MANAGED CARE CONTRACT</b>	HCA Contract Number: «Contract» Contractor Contract Number: <input checked="" type="checkbox"/> Competition Exempt
<b>THIS AMENDED AND RESTATED CONTRACT</b> is between the Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."		
CONTRACTOR NAME «Organization_Name»		CONTRACTOR doing business as (DBA)
«Mailing_AddressSt_Address» «City», «State» «Zip_Code»		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»
HCA INDEX NUMBER		
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»	CONTRACTOR TELEPHONE «PhoneNo»	CONTRACTOR E-MAIL ADDRESS «EmailAddress»
HCA CONTACT NAME AND TITLE		HCA CONTACT ADDRESS Post Office Box 45502 Olympia, WA 98504-5502
HCA CONTACT TELEPHONE		HCA CONTACT E-MAIL ADDRESS
IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		CFDA NUMBER(S)
<b>CONTRACT START DATE</b> July 1, 2018		<b>CONTRACT END DATE</b> December 31, 2019
<b>PRIOR MAXIMUM CONTRACT AMOUNT</b> N/A	<b>AMOUNT OF INCREASE OR DECREASE</b> N/A	<b>TOTAL MAXIMUM CONTRACT AMOUNT</b> Per Member/Per Month
<b>PURPOSE OF AMENDMENT:</b> Contract for Apple Health Managed Care Services		
<b>EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:</b> <input checked="" type="checkbox"/> Exhibit(s) (specify): Exhibit A, Rates; Exhibit B, Access to Care Standards; Exhibit C, Designation of Behavioral Health Providers; Exhibit D, Value Based Purchasing; Exhibit E, Challenge Pool Value-Based Purchasing Incentives; Exhibit F, Instructions for Medical Loss Ratio (MLR) Reporting; Exhibit G, Data Use, Security and Confidentiality; Exhibit H, Health Home Provisions; and Exhibit I, Service Areas. <input checked="" type="checkbox"/> Attachment(s) (specify): Attachment 1 – Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D [removed 7/1/19]; Attachment 2, 2018 Performance Measures; Attachment 3, Monthly Certification Letter [removed 7/1/19]; and Attachment 4, Oral Health Connection Pilot. <input type="checkbox"/> No Exhibits		
Approval from the federal Centers for Medicare and Medicaid Services (CMS) is required for this Contract. Should CMS fail to approve this Amended and Restated Contract, it is null and void.		
The terms and conditions of this Contract 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 of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.		
CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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**Exhibits**

- Exhibit A-AHFAM, Apple Health Family
- Exhibit A-AHBD, Apple Health Blind Disabled
- Exhibit A-AHAC, Apple Health Adult Coverage
- Exhibit A-SCHIP, Apple Health State Children’s Health Insurance Program
- Exhibit A-COPES, Apple Health Community Options Program Entry System
- Exhibit B, Access to Care Standards
- Exhibit C, Designation of Behavioral Health Providers
- Exhibit D, Value Based Purchasing
- Exhibit E, Challenge Pool Value-Based Purchasing Incentives
- Exhibit F, Instructions for Medical Loss Ratio (MLR) Reporting
- Exhibit G, Data Use, Security and Confidentiality
- Exhibit H, Health Homes
- Exhibit I, Service Area Matrix

**Attachments**

- Attachment 1, Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D [removed]
- Attachment 2, 2018 Performance Measures
- Attachment 3, Monthly Certification Letter [removed]
- Attachment 4, Oral Health Connections Pilot

## 1 DEFINITIONS

In any subcontracts and in any other documents that relate to this Contract, the Contractor shall use the definitions as they appear in this Contract.

### 1.1 Access

“Access” as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by the Contractor’s successful demonstration and reporting on outcome information for the availability and timeliness elements defined in the Network Adequacy Standards and Availability of Services described in this Contract. (42 C.F.R. § 438.68, § 438.206, § 438.320).

### 1.2 Access to Care Standards (ACS)

“Access to Care Standards (ACS)” means minimum eligibility requirements for Medicaid eligible persons to access mental health services administered through the HCA.

### 1.3 Actuarially Sound Capitation Rates

“Actuarially Sound Capitation Rates” means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; and have been certified as meeting the requirements of 42 C.F.R. § 438.6(c) by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board (42 C.F.R. § 438.6(c)).

### 1.4 Administrative Day

“Administrative Day” means one or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate. (WAC 182-550-1050.)

### 1.5 Administrative Hearing

“Administrative Hearing” means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by chapter 34.05 RCW, the agency’s hearings rules found in Titles 388 or 182 WAC, or other law.

### 1.6 Advance Directive

“Advance Directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.3, 438.10, 422.128, and 489.100).

### 1.7 Adverse Benefit Determination

“Adverse Benefit Determination” means any of the following (42 C.F.R. § 438.400(b)):

- 1.7.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- 1.7.2 The reduction, suspension, or termination of a previously authorized service;

- 1.7.3 The denial, in whole or in part, of payment for a service;
- 1.7.4 The denial of request for “good cause” designation that would preclude usual third-party liability procedures;
- 1.7.5 The failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required timeframes;
- 1.7.6 The failure of the Contractor to act within the timeframes for resolution and notification of appeals and grievances;
- 1.7.7 The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities; and
- 1.7.8 For a rural area resident with only one Managed Care Organization (MCO) available, the denial of an Enrollee’s request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the Contractor’s network; or, for a plan’s denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the Enrollee seeks, when receiving all care in-network would subject the Enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

**1.8 All Payer Claims (APC) Database**

“All Payer Claims Database” means a centralized repository maintained by the Washington State Office of Financial Management and encompasses claims data submitted by MCOs.

**1.9 Allegation of Fraud**

“Allegation of Fraud” means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the individual, entity or provider. An allegation has yet to be proved or supported by evidence.

An allegation of fraud is an allegation, from any source, including but not limited to the following:

- 1.9.1 Fraud hotline complaints;
- 1.9.2 Claims data mining;
- 1.9.3 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

**1.10 Alternative Benefit Plan (ABP)**

“Alternative Benefit Plan (ABP)” means the Medicaid benefits for the newly eligible Medicaid expansion group of adults ages 19 through 64 with modified adjusted gross income that does not exceed 138 percent of the Federal Poverty Level (FPL) established by the federal Patient Protection and Affordable Care Act (ACA) of 2010. For the purposes of this Contract, we refer to this population as Apple Health Adult Coverage – Medicaid Expansion.

**1.11 Ancillary Services**

“Ancillary Services” means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to,

laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy (WAC 182-500-0010).

#### 1.12 **Appeal**

“Appeal” means review by the Contractor of an Adverse Benefit Determination.

#### 1.13 **Appeal Process**

“Appeal Process” means the Contractor’s procedures for reviewing an Adverse Benefit Determination.

#### 1.14 **Auxiliary Aids and Services**

“Auxiliary Aids and Services” means services or devices that enable persons with impaired sensory, manual, or speaking skills to have an equal opportunity to participate in the benefits, programs or activities conducted by the Contractor. Auxiliary Aids and Services includes:

- 1.14.1 Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;
- 1.14.2 Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;
- 1.14.3 Acquisition or modification of equipment or devices; and
- 1.14.4 Other similar services and actions.

#### 1.15 **Behavioral Health Agency**

“Behavioral Health Agency” means an entity licensed by the Department of Health to provide behavioral health services, including mental health disorders and Substance Use Disorders.

#### 1.16 **Behavioral Health Organization (BHO)**

“Behavioral Health Organization (BHO)” means a single or multiple-county authority or other entity operating as a prepaid inpatient health plan through which the agency or the agency’s designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area to Enrollees who meet Access to Care Standards.

#### 1.17 **Breach**

“Breach” means the acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of PHI, with the exclusions and exceptions listed in 45 C.F.R. § 164.402.

#### 1.18 **Business Associate Agreement**

“Business Associate Agreement” means an agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), between a HIPAA covered

entity HIPAA business associate. The agreement protects Protected Health Information (PHI) in accordance with HIPAA guidelines.

**1.19 Business Day**

“Business Day” means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the state of Washington.

**1.20 CAHPS® Database**

“CAHPS® Database ” (previously known as the National CAHPS® Benchmarking Database or NCBD) means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors. Data is compiled into a single national database, which enables CAHPS® Database participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages).

**1.21 Capacity Threshold**

“Capacity Threshold” means the capacity to serve at least sixty (60) percent of Apple Health eligible individuals in a service area in each of the following six critical provider types: hospital, mental health, primary care, pharmacy, obstetrical, and pediatricians.

**1.22 Care Coordination**

“Care Coordination” means an Enrollee’s healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Enrollee and the Enrollee’s caregivers, and works with the Enrollee to ensure that the Enrollee receives the most appropriate treatment, while ensuring that health care is not duplicated.

**1.23 Care Coordination Organizations (CCOs)**

“Care Coordination Organization (CCO)” means an organization that is responsible for delivering Health Home services to the participating Enrollee.

**1.24 Care Coordinator (CC)**

“Care Coordinator (CC)” means a health care professional or group of professionals, licensed in the state of Washington, who are responsible for providing Care Coordination services to Enrollees. Care Coordinators may be:

1.24.1 A Registered Nurse, Social Worker, Mental Health Professional or Chemical Dependency Professional employed by the Contractor or primary care provider or Behavioral Health agency; and/or

1.24.2 Individuals or groups of licensed professionals, or paraprofessional individuals working under their licenses, located or coordinated by the primary care provider/clinic/Behavioral Health agency.

Nothing in this definition precludes the Contractor or Care Coordinator from using allied health care staff, such as Community Health Workers or Certified Peer Counselors and others to facilitate the work of the Care Coordinator or to provide services to Enrollees who need assistance in accessing services but not Care Coordination services.

## 1.25 Care Management

“Care Management” means a set of services designed to improve the health of Enrollees. Care management includes a health assessment, development of a care plan and monitoring of Enrollee status, care coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the Enrollee to a less intensive level of population health management as warranted by Enrollee improvement and stabilization. Effective care management includes the following:

- 1.25.1 Actively assisting Enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
- 1.25.2 Utilization of evidence-based clinical practices in screening and intervention;
- 1.25.3 Coordination of care across the continuum of medical, behavioral health, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- 1.25.4 Ready access to integrated behavioral health and physical health services; and
- 1.25.5 Use of appropriate community resources to support individual Enrollees, families and caregivers in managing care.

## 1.26 Care Manager (CM)

“Care Manager (CM)” means an individual employed by the Contractor or a contracted organization who provides Care Management services. Care Managers shall be licensed as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists, social workers with a Masters in Social Work (MSW), or shall be social service or healthcare professionals with a Bachelors in Social Work or closely related field, Indian Health Service Community Health Representatives (CHR), or certified chemical dependency professionals.

## 1.27 Centers for Medicare and Medicaid Services (CMS)

“Centers for Medicare and Medicaid Services (CMS)” means the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children’s Health Insurance Program (CHIP), and health insurance portability standards.

## 1.28 Certified Electronic Health Record Technology (CEHRT)

“Certified Electronic Health Record Technology (CEHRT)” means systems that meet the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services and are certified by the Office of the National Coordinator for Health Information Technology (ONC) as meeting health IT standards, implementation specifications and certification criteria adopted by the Secretary.

## 1.29 Children’s Health Insurance Program (CHIP)

“Children’s Health Insurance Program (CHIP)” means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children’s Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and chapter 182-505 WAC.

### 1.30 **Children with Special Health Care Needs**

“Children with Special Health Care Needs” means children under 19 years of age who are any one of the following:

- 1.30.1 Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;
- 1.30.2 Eligible for Medicaid under section 1902(e)(3) of the Act;
- 1.30.3 In foster care or other out-of-home placement;
- 1.30.4 Receiving foster care or adoption assistance; and/or
- 1.30.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V of the Social Security Act.

### 1.31 **Chronic Condition**

“Chronic Condition” means a physical or behavioral health condition that is persistent or otherwise long lasting in its effects.

### 1.32 **Chronic Disease Self-Management Education (CDSME)**

“Chronic Disease Self-Management Education (CDSME)” means programs that enable individuals with multiple chronic conditions to learn how to manage their overall health, symptoms, and risk factors. An example is the Stanford University Chronic Disease Self-Management Program which has been shown in randomized trials to improve symptoms such as pain, shortness of breath and fatigue, improve ability to engage in everyday activities, reduce depression and decrease costly health care such as emergency department visits.

### 1.33 **Client**

“Client” means an individual who has been determined Medicaid-eligible by HCA but who has not enrolled in an Apple Health Managed Care program.

### 1.34 **Clinical Data Repository (CDR)**

“Clinical Data Repository (CDR)” means a tool HCA is using to advance Washington’s capabilities to collect, share and use integrated physical and behavioral health information from provider EHR systems. The CDR is a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient. It allows clinicians to retrieve data for a single patient rather than a population of patients with common characteristics. Typical data types which are often found within a CDR include: CCD, C-CDA, problem lists, clinical laboratory test results, patient demographics, pharmacy information, radiology reports and images, pathology reports, hospital discharge summaries, diagnosis, and progress notes. The use of standard data inputs helps manage the cost and complexity of data contributed by many different care providers. The CDR will be operated by the State Health Information Exchange (HIE) on behalf of sponsoring organizations. HCA will be the initial sponsoring organization. The CDR will also include claims and encounter information so that aggregate data can be provided for quality reporting and population health management. Once the CDR portal is open, any HIPAA covered entity with an HIE agreement, such as behavioral health providers or some housing providers, will be able to upload standardized documents for patient lives within the CDR. Electronic documents such as PDFs have more limited utility than discrete data that can be parsed into the record.



**1.35 Code of Federal Regulations (C.F.R.)**

“Code of Federal Regulations (C.F.R.)” means the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States.

**1.36 Cold Call Marketing**

“Cold Call Marketing” means any unsolicited personal contact by the Contractor or its designee, with a potential Enrollee or a current Enrollee of another Contracted managed care organization for the purposes of marketing (42 C.F.R. § 438.104(a)).

**1.37 Community Health Workers (CHW)**

“Community Health Workers (CHW)” means individuals who serve as a liaison and advocate between social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs include Community Health Representatives (CHR) in the Indian Health Service funded, Tribally contracted program.

**1.38 Comparable Coverage**

“Comparable Coverage” means an Enrollee has other insurance that HCA has determined provides a full scope of health care benefits.

**1.39 Complex Case Management (CCM)**

“Complex Case Management (CCM)” means Care Management services delivered to Enrollees with multiple or complex conditions to obtain access to care and services and coordination of their care. CCM services provided to Enrollees are in accordance with standards defined by the National Committee for Quality Assurance (NCQA).

**1.40 Concurrent Review**

“Concurrent Review” means the Contractor’s review of care and services at the time the event being reviewed is occurring. Concurrent review includes an assessment of the Enrollee’s progress toward recovery and readiness for discharge while the Enrollee is hospitalized or in a nursing facility; and may involve an assessment of the medical necessity of tests or procedures while the Enrollee is hospitalized or in a nursing facility.

**1.41 Confidential Information**

“Confidential Information” means information that is exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW or other federal or state law. Confidential Information includes, but is not limited to, Personal Information, medical records, and any other health and enrollment information that identifies a particular enrollee.

**1.42 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

“Consumer Assessment of Healthcare Providers and Systems (CAHPS®)” means a family of standardized survey instruments, including a Medicaid survey used to measure Enrollee experience of health care.

**1.43 Continuity of Care**

“Continuity of Care” means the provision of continuous care for chronic or acute medical conditions to maintain care that has started or been authorized in one setting as the Enrollee transitions between: facility to home; facility to facility; providers or service areas; managed

care Contractors; and Medicaid fee-for-service (FFS) and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice or medical home to another; and from substance use care to primary and/or mental health care.

#### 1.44 **Continuity of Care Document (CCD)**

“Continuity of Care Document (CCD)” means an electronic document exchange standard for sharing patient care summary information. Summaries include the most commonly needed pertinent information about current and past health status in a form that can be shared by all computer applications, including web browsers, electronic medical record (EMR) and electronic health record (EHR) software systems. The industry is already moving toward the Consolidated CDA (C-CDA) as the emerging industry standard and the clinical exchange of choice. For the purposes of the Clinical Data Repository requirements in this Contract this patient care summary is referred to as the CCDA.

#### 1.45 **Contract**

“Contract” means the entire written agreement between HCA and the Contractor, including any exhibits, documents, and materials incorporated by reference. The parties may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitutes as one agreement. E-mail (electronic mail) transmission of a signed copy of this Contract shall be the same as delivery of an original.

#### 1.46 **Contractor**

“Contractor” means the individual or entity performing services pursuant to this Contract and includes the Contractor’s owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted subcontract, “Contractor” includes any subcontractor and its owners, officers, directors, partners, employees, and/or agents.

#### 1.47 **Contracted Services**

“Contracted Services” means covered services that are to be provided by the Contractor under the terms of this Contract.

#### 1.48 **Copayment**

“Copayment” means a payment made by an Enrollee in addition to a payment made by a Managed Care Organization.

#### 1.49 **Covered Services**

“Covered Services” means health care services that HCA determines are covered for Enrollees.

#### 1.50 **Credible Allegation of Fraud**

“Credible Allegation of Fraud” means the Contractor has investigated an allegation of fraud and concluded that the existence of fraud is more probable than not. (42 C.F.R. § 455.2).

**1.51 Debarment**

“Debarment” means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds

**1.52 Department of Children, Youth and Families (DCYF)**

“Department of Children, Youth and Families (DCYF)” means the Washington State agency responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

**1.53 Department of Social and Health Services (DSHS)**

“Department of Social and Health Services (DSHS)” means the Washington State agency responsible for providing a broad array of health care and social services. DSHS administrations with which the Contractor may interface include, but are not limited to:

- 1.53.1 Aging and Long-Term Support Administration is responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens.
- 1.53.2 Developmental Disabilities Administration is responsible for providing a safe, high-quality array of home, community, and facility-based residential services and employment support for Washington citizens with disabilities.
- 1.53.3 Behavioral Health Administration (BHA) is responsible for providing mental health services in state psychiatric hospitals.

**1.54 Director**

“Director” means the Director of HCA. In his or her sole discretion, the Director may designate a representative to act on the Director’s behalf. Any designation may include the representative’s authority to hear, consider, review, and/or determine any matter.

**1.55 Duplicate Coverage**

“Duplicate Coverage” means an enrollee is covered by the Contractor on a third party basis at the same time the enrollee is covered by the Contractor for Apple Health.

**1.56 Durable Medical Equipment (DME)**

“Durable Medical Equipment (DME)” means equipment as defined in WAC 182-543-1000 that:

- 1.56.1 Can withstand repeated use;
- 1.56.2 Is primarily and customarily used to serve a medical purpose;
- 1.56.3 Generally is not useful for a person in the absence of illness or injury; and
- 1.56.4 Is appropriate for use in the Client’s place of residence.

**1.57 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

“Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)” means comprehensive screening, diagnostic and treatment services for children under the age of twenty-one (21), as defined in Section 1905(r) of the Social Security Act (SSA) , codified in 42 C.F.R § 441.50-441.62, and chapter 182-534 WAC and described in the HCA EPSDT and Provider Billing Guide.

**1.58 Electronic Health Record (EHR)**

“Electronic Health Record (EHR)” means a real-time patient health record with access to evidence-based decision support tools that can be used to aid clinicians in decision making. The EHR can automate and streamline a clinician's workflow, ensuring that all clinical information is communicated. It can also prevent delays in response that result in gaps in care. The EHR can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.

**1.59 Eligible Clients**

“Eligible Clients” means individuals certified eligible by HCA, living in the service area, and eligible to enroll for health care services under the terms of this Contract.

**1.60 Emergency Care for Mental Health Condition**

“Emergency Care for Mental Health Condition” means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to chapter 71.05 RCW.

**1.61 Emergency Department Information Exchange™ (EDIE)**

“Emergency Department Information Exchange™” means an internet-delivered service that enables health care providers to better identify and treat high users of the emergency department and special needs patients. When patients enter the emergency room, EDIE can proactively alert health care providers through different venues such as fax, phone, e-mail, or integration with a facility's current electronic medical records.

**1.62 Emergency Fill**

“Emergency Fill” means the dispensing of a prescribed medication to an Enrollee by a licensed pharmacist who has used his or her professional judgment in identifying that the Enrollee has an Emergency Medical Condition for which lack of immediate access to pharmaceutical treatment would result in (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

**1.63 Emergency Medical Condition**

“Emergency Medical Condition” means 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: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a)).

**1.64 Emergency Medical Transportation**

“Emergency Medical Transportation” means ambulance transportation during which a Client receives needed emergency medical services en-route to an appropriate medical facility (WAC 182-546-0001).

**1.65 Emergency Room Care**

“Emergency Room Care” means care received in a hospital that provides immediate treatment for acute illness or trauma.

**1.66 Emergency Services**

“Emergency Services” means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 C.F.R. § 438.114(a)).

**1.67 Encrypt**

“Encrypt” means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

**1.68 Enrollee**

“Enrollee” means an Eligible Client who is enrolled in managed care through a Managed Care Organization (MCO) having a contract with HCA (42 C.F.R. § 438.10(a)).

**1.69 Exception to Rule**

“Exception to rule” means a request by an Enrollee or a requesting provider for the Enrollee to receive a non-covered health care service according to WAC 182-501-0160.

**1.70 Excluded Benefit**

“Excluded Benefit” means a benefit that neither HCA nor the Contractor pays for because there is no funding for that benefit.

**1.71 External Quality Review (EQR)**

“External Quality Review (EQR)” means the analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to Enrollees (42 C.F.R. § 438.320).

**1.72 External Quality Review Organization (EQRO)**

“External Quality Review Organization (EQRO)” means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both (42 C.F.R. § 438.320).

**1.73 Facility**

“Facility” means but is not limited to: a hospital, an inpatient rehabilitation center, long-term and acute care (LTAC), skilled nursing facility, and nursing home.

**1.74 Family Connect**

“Family Connect” means enrolling a family member into the same Apple Health Managed Care plan that other family members are enrolled in.

**1.75 Federally Qualified Health Center (FQHC)**

“Federally Qualified Health Center” (FQHC) means a community-based organization that provides comprehensive primary care and preventive care, that may include health care,

dental and mental health/substance abuse services to people of all ages, regardless of their ability to pay or health insurance status.

**1.76 Foundation for Health Care Quality**

“Foundation for Health Care Quality” means a nonprofit organization that sponsors or conducts health care quality improvement programs and evaluation and measurement activities. Among the projects sponsored by the Foundation are: the Bree Collaborative, the Clinical Outcomes Assessment Program (COAP), the Surgery Clinical Outcomes Assessment Program (SCOAP), and the Obstetrics Clinical Outcomes Assessment Program (OBOCAP).

**1.77 Fraud**

“Fraud” means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law (42 C.F.R § 455.2).

**1.78 Grievance**

“Grievance” means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee’s rights.

**1.79 Grievance Process**

“Grievance Process” means the procedure for addressing Enrollees’ grievances (42 C.F.R. § 438.400(b)).

**1.80 Grievance and Appeal System**

“Grievance and Appeal System” means the processes the Contractor implements to handle appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them. (42 C.F.R. § 438.400 to § 438.424).

**1.81 Guideline**

“Guideline” means a set of statements by which to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice. By definition, following a guideline is never mandatory. Guidelines are not binding and are not enforced.

**1.82 Habilitation Services**

“Habilitation Services” means medically necessary services provided to assist the Enrollee in partially or fully attaining, learning, keeping, improving, or preventing deterioration of developmental-age appropriate skills that were never present as a result of a congenital, genetic, or early acquired health condition and required to maximize, to the extent practical, the Enrollee’s ability to function within his or her environment. (WAC 182-545-400).

**1.83 Habilitative Devices**

“Habilitative Devices” means prosthetics, orthotics and related supplies.

**1.84 Health Care Authority (HCA)**

“Health Care Authority (HCA)” means the 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.

**1.85 Health Care Professional**

“Health Care Professional” means a physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed certified social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist and certified respiratory therapy technician.

**1.86 Health Care Services**

“Health Care Services” means all Medicaid services provided by a managed care entity under contract with HCA in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

**1.87 Health Information Technology (HIT)**

“Health Information Technology” means the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making. Certified HIT (including certified EHR technology (CEHRT)) are systems that meet the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. Certification gives providers and patients confidence that the Health IT products and systems they use are secure and can work with other systems to share information (interoperability).

**1.88 Health Insurance**

“Health Insurance” means a contract to transfer risk from individuals to an insurance company. In exchange for a premium, the insurance company agrees to pay for losses covered under the terms of the policy.

**1.89 Health Technology Assessment (HTA)**

“Health Technology Assessment (HTA)” means a program that determines if health services used by Washington State government are safe and effective. The program examines scientific evidence for new technologies which is then reviewed by a committee of practicing clinicians. The purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. HTA contracts for scientific, evidence-based reports about whether certain medical devices, procedures and tests are safe and work as promoted.

**1.90 Healthcare Effectiveness Data and Information Set (HEDIS®)**

“Healthcare Effectiveness Data and Information Set (HEDIS®)” means a set of standardized performance measures designed to ensure that health care purchasers and consumers have

the information they need to reliably compare the performance of managed health care plans. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

**1.91 Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit Program**

“Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit Program” means a set of standards and audit methods used by an NCQA certified auditor to evaluate information systems (IS) capabilities assessment (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HD standards).

**1.92 Home Health Care**

“Home Health Care” means a range of services provided in an Enrollee’s home for treatment of an illness or injury. Examples of home health care include wound care, education, IV or nutrition therapy, injections, and monitoring health status.

**1.93 Hospice Services**

“Hospice Services” means services associated with an Enrollee’s terminal illness and related conditions.

**1.94 Hospitalization**

“Hospitalization” means an admission to a hospital for treatment.

**1.95 Hospital Outpatient Care**

“Hospital Outpatient Care” means medical care or treatment that does not require an overnight stay in a hospital or medical facility.

**1.96 Improper Payment**

“Improper Payment” means any payment made to a provider, contractor or subcontractor that was more or less than the sum to which the payee was legally entitled, including amounts in dispute.

**1.97 Indian Health Care Provider (IHCP)**

“Indian Health Care Provider (IHCP)” means the Indian Health Service and/or any Tribe, Tribal organization, or Urban Indian Health Program (UIHP) that provides Medicaid-reimbursable services.

**1.98 Individual with Special Health Care Needs**

“Individual with Special Health Care Needs” means an Enrollee who meets the diagnostic and risk score criteria for Health Home Services; or is a Child with Special Health Care Needs; or has a chronic or disabling condition that meets all of the following conditions:

- 1.98.1 Has a biologic, psychologic, or cognitive basis;
- 1.98.2 The Enrollee is likely to continue to have the chronic disease or disabling healthcare condition for more than one year; and
- 1.98.3 Produces one or more of the following conditions stemming from a disease:



- 1.98.4 Significant limitation in areas of physical, cognitive, or emotional functions; or
- 1.98.5 Dependency on medical or assistive devices to minimize limitations of function or activities.

#### **1.99 Interoperable Health IT**

“Interoperable Health IT” means the extent to which systems and devices can exchange data, and interpret the shared data. For two systems to be interoperable, they must be able to exchange data and subsequently present the data such that it can be understood by a user. Examples of Interoperable Health IT are certified EHR technologies.

#### **1.100 Large Rural Area**

“Large Rural Area” means areas with a population density of less than twenty (20) people per square mile.

#### **1.101 Limitation Extension (LE)**

“Limitation Extension (LE)” means a request by an Enrollee or the Enrollee’s health care provider to extend a covered service with a limit to the Enrollee according to WAC 182-501-0169.

#### **1.102 Limited English Proficient (LEP)**

“Limited English Proficient (LEP)” means Potential Enrollees and Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English (42 C.F.R. § 438.10).

#### **1.103 List of Excluded Individuals/Entities (LEIE)**

“List of Excluded Individuals/Entities (LEIE)” means an Office of Inspector General’s List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

#### **1.104 Managed Care**

“Managed Care” means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services.

#### **1.105 Managed Care Organization (MCO)**

“Managed Care Organization (MCO)” means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA managed care programs.

#### **1.106 Marketing**

“Marketing” means any promotional activity or communication with a potential Enrollee that is intended to increase a Contractor’s membership or to “brand” a Contractor’s name or organization. These activities are directed from the Contractor to a Potential Enrollee or Enrollee who is enrolled with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or to end their enrollment with another HCA-contracted MCO. Marketing communications

include: written, oral, in-person (telephonic or face-to-face) or electronic methods of communication, including email, text messaging, and social media (Facebook, Instagram and Twitter).

#### **1.107 Marketing Materials**

“Marketing Materials” means materials that are produced in any medium, including written or electronic, such as email, social media and text messaging, by or on behalf of the Contractor that can be reasonably interpreted as intended to market the Contractor to Potential Enrollees (42 C.F.R. § 438.104(a)).

#### **1.108 Material Provider**

“Material Provider” means a Participating Provider whose loss would negatively affect access to care in the service area in such a way that a significant percentage of Enrollees would have to change their Provider or Contractor, receive services from a non-participating Provider, or consistently receive services outside the service area.

#### **1.109 Maternity Support Services (MSS)**

“Maternity Support Services (MSS)” means a component of HCA’s First Steps program. This voluntary program is designed to increase access to prenatal care as early in the pregnancy as possible and improve birth outcomes, including low birth weight babies (chapter 182-533 WAC).

#### **1.110 Medicaid Fraud Control Division (MFCD)**

“Medicaid Fraud Control Division (MFCD)” also sometimes called the “Medicaid Fraud Control Unit (MFCU) means the Washington State Attorney General’s Office (AGO), Medicaid Fraud Control Division, which investigates and prosecutes abuse of clients or fraud committed by any entity, facility, agency, health care professional, health care provider, primary care provider, provider or individual.

#### **1.111 Medically Necessary Services**

"Medically Necessary" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this Contract, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

#### **1.112 Medical Loss Ratio (MLR)**

“Medical Loss Ratio” means the measurement of the share of Enrollee premiums that the Contractor spends on medical claims, as opposed to other non-claims expenses such as administration or profits. Additional clarification can be found in the Congressional Research Service report dated August 26, 2014, found here: <http://fas.org/sqp/crs/misc/R42735.pdf>

#### **1.113 Medication Assisted Treatment (MAT)**

“Medication Assisted Treatment” means the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.

#### **1.114 Medication Management**

“Medication Management” means the prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face as able, by a person licensed to perform such services. Medication management includes only minimal psychotherapy.

#### **1.115 Mental Health Professional**

“Mental Health Professional” means:

- 1.115.1 A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;
- 1.115.2 A person who is licensed by the Department of Health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapy associate;
- 1.115.3 A person with a master’s degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional; or
- 1.115.4 A person who has an approved exception to perform the duties of a Mental Health Professional by the HCA/Division of Behavioral Health and Recovery (HCA/DBHR) before July 1, 2001.

#### **1.116 Multidisciplinary Team**

“Multidisciplinary Team” means a group of clinical and non-clinical staff, such as Primary Care Providers, Mental Health Professionals, chemical dependency treatment providers, and social workers, Community Health Workers, peer counselors or other non-clinical staff that facilitates the work of the Complex Care Manager. Optional team members may include nutritionists/dietitians, direct care workers, pharmacists, peer specialists, DCYF-contracted early childhood and family support providers, family members or housing representatives.

#### **1.117 National Correct Coding Initiative (NCCI)**

“National Correct Coding Initiative (NCCI)” means CMS-developed coding policies based on coding conventions defined in the American Medical Association’s CPT manual, national and local policies and edits.

#### **1.118 National Committee for Quality Assurance (NCQA)**

“National Committee for Quality Assurance (NCQA)” is an organization responsible for the accreditation of MCOs and other health care related entities and for developing and managing health care measures that assess the quality of care and services that managed care clients receive. HCA requires contracted MCOs to achieve and maintain NCQA accreditation.

#### **1.119 Network**

“Network” means physicians, hospitals, and other health care providers that have contracted to provide health care services to enrolled clients.

### **1.120 Network Adequacy**

“Network Adequacy” means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Enrollees without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, provider/patient ratios, geographic accessibility and travel distance. (42 C.F.R § 438.68 and § 438.206).

### **1.121 Neurodevelopmental Centers**

“Neurodevelopmental Centers” means a group of community non-profit and hospital-based agencies as designated by the Department of Health who provide therapy and related services to young children with neuromuscular or developmental disorders. Services may include speech, occupational, and physical therapies, along with other specialties such as nutrition, social work, and adaptive equipment.

### **1.122 New Individual**

“New Individual” means a person who was not enrolled in an Apple Health managed care program within the six (6) months immediately preceding enrollment, and who does not have a family member enrolled in Apple Health Managed Care.

### **1.123 Non-Participating Provider**

“Non-Participating Provider” means a person, health care provider, practitioner, facility or entity acting within their scope of practice and licensure, that does not have a written agreement with the Contractor to participate in a MCO’s provider network, but provides health care services to Enrollees.

### **1.124 Non-Quantitative Treatment Limits (NQTLs)**

“Non-Quantitative Treatment Limits (NQTLs)” means activities such as medical management standards, provider network admission standards and reimbursement rates, fail-first policies, and other limits on the scope or duration of benefits.

### **1.125 Office of Inspector General (OIG)**

“Office of Inspector General (OIG)” means the Office of Inspector General within the United States Department of Health and Human Services.

### **1.126 OneHealthPort (OHP)**

“OneHealthPort (OHP)” means the lead HIE organization for Washington State, designated under chapter 300, Laws of 2009 (SSB 5501). The HIE is operated by OneHealthPort under the oversight of HCA and an Oversight Board. The CDR is operated as a service of the HIE. The HIE also delivers connectivity services for a variety of Trading Partners in Washington State and other states. The HIE is the connectivity path for organizations transacting data with the CDR. Organizations transacting data with the CDR will be required to connect to the HIE in some manner.

### **1.127 Oral Health Connections Pilot**

“Oral Health Connection Pilot” means a project to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not

including Dual Eligible Clients) located in Cowlitz, Thurston or Spokane counties are those that qualify for this pilot. Attachment 4, Oral Health Connections Pilot.

#### **1.128 Outcomes**

“Outcomes” means changes in enrollee health, functional status, satisfaction or goal achievement that result from health care and/or supportive services.

#### **1.129 Overpayment**

“Overpayment” means any payment from HCA to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this Contract, including amounts in dispute.

#### **1.130 Participating Rebate Eligible Manufacturer**

“Participating Rebate Eligible Manufacturer” means any manufacturer participating in the Medicaid Drug Rebate Program and who has a signed National Drug Rebate Agreement with the Secretary of Health and Human Services.

#### **1.131 Participating Provider**

“Participating Provider” means a person, health care provider, practitioner, or entity, acting within their scope of practice and licensure, with a written agreement with the Contractor to provide services to Enrollees under the terms of this Contract.

#### **1.132 Partnership Access Line (PAL)**

“Partnership Access Line (PAL)” means a resource that provides access to consultation with a child psychiatrist to assist prescribers in meeting the needs of an enrolled child with a mental health diagnosis.

#### **1.133 Peer-Reviewed Medical Literature**

“Peer-Reviewed Medical Literature” means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

#### **1.134 Personal Information**

“Personal Information” means information identifiable to any person, including, but not limited to, information that relates to a person’s name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

#### **1.135 Physician Group**

“Physician Group” means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

#### **1.136 Physician Incentive Plan (PIP)**

“Physician Incentive Plan (PIP)” means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to Enrollees under the terms of this Contract.

#### **1.137 Physician’s Orders for Life Sustaining Treatment (POLST)**

“Physician’s Orders for Life Sustaining Treatment (POLST)” means a set of guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment (RCW 43.70.480).

#### **1.138 Physician Services**

“Physician Services” means health services provided by a licensed medical physician (M.D.) or doctor of osteopathic medicine (D.O.).

#### **1.139 Plan**

“Plan” means the pairing of health care benefits and payment structure in a product with provider networks and service area offered to Enrollees.

#### **1.140 Plan Reconnect**

“Plan Reconnect” means an individual who has regained eligibility for Apple Health Managed Care and who was enrolled in Apple Health Managed Care within the six (6) months immediately preceding reenrollment.

#### **1.141 Population Health Management Systems (PHMS)**

“Population Health Management Systems (PHMS)” means health information technology (HIT) and health information exchange (HIE) technologies that are used at the point-of-care, and to support service delivery. Examples of HIT tools include, but are not limited to, electronic health records (EHRs), OneHealthPort (OHP) Clinical Data Repository (CDR), registries, analytics, decision support and reporting tools that support clinical decision-making and care management. The overarching goal of PHMS is to expand interoperable HIT and HIE infrastructure and tools so that relevant data (including clinical and claims data) can be captured, analyzed, and shared to support VBP models and care delivery redesign.

#### **1.142 Post-service Review**

“Post-service review” means the Contractor’s review of health care services that have already been received by the Enrollee, but were not prior authorized according to Contractor policy.

#### **1.143 Post-stabilization Services**

“Post-stabilization Services” means contracted services, related to an emergency medical condition and emergency care for a mental health condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition (42 C.F.R. § 438.114 and 422.113).

#### **1.144 Potential Enrollee**

“Potential Enrollee” means any individual who HCA determines is eligible for enrollment in Apple Health Managed Care and who, at the time of HCA’s determination, is not enrolled with any Apple Health Managed Care Contractor (42 C.F.R. § 438.10(a)).

#### **1.145 Predictive Risk Intelligence System (PRISM)**

“Predictive Risk Intelligence System (PRISM)” means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next twelve (12) months based on the patient’s disease profile and pharmacy utilization.

#### **1.146 Premium**

“Premium” means the amount of money an individual or business pays to a managed care organization to maintain an insurance policy. In return, the insurer must provide coverage for claims made against the policy by the insured.

#### **1.147 Prescription Drug**

“Prescription Drug” means a pharmaceutical drug that legally requires a medical prescription to be dispensed.

#### **1.148 Prescription Drug Coverage**

“Prescription Drug Coverage” means health insurance or a plan that helps pay for prescription drugs and medications.

#### **1.149 Primary Care Provider (PCP)**

“Primary Care Provider (PCP)” means 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.

#### **1.150 Primary/Preferred Language**

“Primary/Preferred Language” means the language an Enrollee or potential Enrollee identifies as the language in which they wish to communicate verbally or in writing with HCA.

#### **1.151 Prior Authorization**

“Prior Authorization” means the requirement that a provider must request, on behalf of an Enrollee and when required by rule or HCA billing instructions, the HCA or the HCA’s designee’s approval to provide a health care service before the Enrollee receives the health care service, prescribed drug, device, or drug-related supply. The HCA or the HCA’s designee’s approval is based on medical necessity. Receipt of prior authorization does not

guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization (WAC 182-500-0085).

#### **1.152 Program Integrity**

“Program Integrity” means a system of reasonable and consistent oversight of the Medicaid program. Program Integrity effectively encourages compliance; maintains accountability; protects public funds; supports awareness and responsibility; ensures providers, contractors and subcontractors meet participation requirements; ensures services are medically necessary; and ensures payments are for the correct amount and for covered services. The goal of Program Integrity is to reduce and eliminate Fraud, Waste, and Abuse (FWA) in the Medicaid program. Program Integrity activities include prevention, algorithms, investigations, audits, reviews, recovery of improper payments, education, and cooperation with Medicaid Fraud Control Division (MFCDD), and other state and federal agencies. See chapter 182-502A WAC.

#### **1.153 Provider**

“Provider” means 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. (42 C.F.R. § 438.2).

#### **1.154 Provider Access Payment (PAP) Program**

“Provider Access Payment (PAP) Program” means a federally funded program that provides additional payments to eligible providers.

#### **1.155 Quality of Care**

“Quality of Care” means the degree to which a Contractor increases the likelihood of desired health outcomes of its Enrollees through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

#### **1.156 Quantitative Treatment Limitations**

“Quantitative Treatment Limitations (QTLs)” means limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits.

#### **1.157 Regional Service Area (RSA)**

“Regional Service Area (RSA)” means a single county or multi-county grouping formed for the purpose of health care purchasing.

#### **1.158 Regulation**

“Regulation” means any federal, state, or local regulation, rule, or ordinance.

#### **1.159 Rehabilitative Devices**

“Rehabilitation Devices” means weights, braces, slings, wraps, splints and supports designed to help an Enrollee improve their physical or mental strength, skills or functions.

#### **1.160 Rehabilitation Services**

“Rehabilitation Services” means services focused on improving an Enrollee’s physical and mental strength, skills or functions, lost or impaired due to illness, injury or disability.



Rehabilitation services include physical or occupational therapy and speech-language pathology.

**1.161 Revised Code of Washington (RCW)**

“Revised Code of Washington (RCW)” means the laws of the state of Washington.

**1.162 Risk**

“Risk” means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined in this Contract.

**1.163 Rural Area**

“Rural Area” means areas with a population density of at least twenty (20) and less than five hundred (500) people per square mile.

**1.164 Safety Net Assessment Fund (SNAF)**

“Safety Net Assessment Fund (SNAF)” means a program that increases payment for hospital claims for Medicaid clients, authorized under chapter 74.60 RCW.

**1.165 Screening, Brief Intervention and Referral for Treatment (SBIRT)**

“Screening, Brief Interventions and Referral to Treatment (SBIRT)” means a comprehensive, evidenced-based public health practice designed to identify through screening, adolescents and adults who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. If a person is found to be at risk of harm from their use, they receive several brief interventions to reduce their risk or if necessary, a referral for further evaluation for treatment. SBIRT services are provided in a wide variety of medical and community health care settings: primary care centers, hospital emergency rooms, and trauma centers.

**1.166 Second Opinion Network (SON)**

“Second Opinion Network (SON)” means an organization consisting of Agency recognized experts in the field of child psychiatry contracted with by HCA to perform peer-to-peer medication reviews with health care providers when psychotropic medications or medication regimens for children under eighteen (18) years of age exceed the medications review thresholds established for the HCA Medicaid mental health benefit.

**1.167 Secured Area**

“Secured Area” means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

**1.168 Security Incident**

“Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

**1.169 Service Areas**

“Service Areas” means the geographic areas in which the Contractor serves eligible clients as described in this Contract.

**1.170 Single Case Agreement**

“Single Case Agreement” means a written agreement between the Contractor and a nonparticipating provider to deliver services to an Enrollee.

**1.171 Specialist**

“Specialist” means a provider who is highly skilled in a specific and restrictive field.

**1.172 Subcontract**

“Subcontract” means any separate agreement or contract between the Contractor and an individual or entity (“Subcontractor”) to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

**1.173 Subcontractor**

“Subcontractor” means an individual or entity that has a contract with the Contractor that relates directly or indirectly with the performance of the Contractor’s obligations under this Contract.

**1.174 Substance Use Disorder (SUD)**

“Substance Use Disorder (SUD)” means a problematic pattern of use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home.

**1.175 Substantial Financial Risk**

“Substantial Financial Risk” means a physician or physician group as defined in this Section is at substantial financial risk when more than 25 percent of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 Enrollees’ arrangements that cause substantial financial risk include, but are not limited to, the following:

- 1.175.1 Withholds greater than 25 percent of total potential payments; or
- 1.175.2 Withholds less than 25 percent of total potential payments but the physician or physician group is potentially liable for more than 25 percent of total potential payments; or
- 1.175.3 Bonuses greater than 33 percent of total potential payments, less the bonus; or
- 1.175.4 Withholds plus bonuses if the withholds plus bonuses equal more .than 25 percent of total potential payments; or
- 1.175.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25 percent of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

#### **1.176 System for Award Management (SAM)**

“System for Award Management (SAM)” means the Official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS. Provider listed in the SAM should not be awarded a contract with the Contractor.

#### **1.177 Tracking**

“Tracking” means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

#### **1.178 Transitional Healthcare Services (THS)**

“Transitional Healthcare Services (THS)” means the mechanisms to ensure coordination and continuity of care as Enrollees transfer between different locations or different levels of care within the same location. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization or re-hospitalization, including recidivism following substance use disorder treatment.

#### **1.179 Transport**

“Transport” means the movement of Confidential Information from one entity to another, or within an entity, that:

- 1.179.1 Places the Confidential Information outside of a Secured Area or system (such as a local area network); and
- 1.179.2 Is accomplished other than via a Trusted System.

#### **1.180 Trauma-Informed Care**

“Trauma-Informed Care” means a service delivery system designed to include a basic understanding of how trauma affects the life of an Enrollee seeking services. Traditional service delivery approaches may exacerbate trauma related symptoms in a survivor of trauma. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities and triggers of trauma, so that these services and programs can be more supportive and avoid re-traumatization.

#### **1.181 Unique User ID**

“Unique User ID” means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase, or other mechanism, authenticates a user to an information system.

#### **1.182 Urgent Care**

“Urgent Care” means treatment of injury or illness requiring immediate care, but not serious enough to require an emergency room visit.

#### **1.183 Urgent Care Center**

“Urgent Care Center” means a clinic outside of a traditional hospital-based emergency room focused on the delivery of urgent, but not serious medical problems. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an emergency room visit.

**1.184 Urgent Medical Condition**

“Urgent Medical Condition” means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within 24 hours of the request, the person’s situation is likely to deteriorate to the point that Emergent Services are necessary.

**1.185 Validation**

“Validation” means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis (42 C.F.R. § 438.320).

**1.186 Washington Administrative Code (WAC)**

“Washington Administrative Code (WAC)” means the rules adopted by agencies to implement legislation.

**1.187 Washington Apple Health (AH)**

“Washington Apple Health (AH)” means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children’s Health Insurance program (CHIP), and the state-only funded health care programs.

**1.188 Washington Apple Health Foster Care (AHFC)**

“Washington Apple Health Foster Care (AHFC)” means an HCA managed care program that serves foster children and children receiving adoption support services.

**1.189 Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)**

“Washington Apple Health – Fully Integrated Managed Care (AH-FIMC)” means the program under which behavioral health services are added to the Apple Health Managed Care (AHMC) contract.

**1.190 Washington Healthplanfinder (HPF)**

“Washington Healthplanfinder (HPF)” means an online marketplace for individuals, families, and small businesses to compare and enroll in qualified health insurance plans.

## 2 GENERAL TERMS AND CONDITIONS

### 2.1 Amendment

Except as described below, an amendment to this Contract generally shall require the approval of both HCA and the Contractor. The following shall guide the amendment process:

- 2.1.1 Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.
- 2.1.2 HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.
- 2.1.3 The Contractor shall submit all feedback or questions to HCA at [contracts@hca.wa.gov](mailto:contracts@hca.wa.gov).
- 2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.
- 2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA Contracts Office.

### 2.2 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA.

### 2.3 Billing Limitations

- 2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.
- 2.3.2 HCA shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.
- 2.3.3 The Contractor must waive the timeliness rule for processing a claim and prior authorization requirements when HCA program integrity or MFCD activities result in recoupment of an improperly paid claim HCA paid but should have been paid by the Contractor:
  - 2.3.3.1 The Contractor shall pay for medically necessary services submitted beyond the standard claims payment timeframes in these circumstances. If the Contractor is unable to systematically identify and waive the timeliness rules in this scenario, it is acceptable for the Contractor to address the waiver of the timeliness rule within its provider payment dispute processes.
  - 2.3.3.2 The servicing provider must submit a claim to the Contractor within one hundred twenty (120) calendar days from HCA's notification of improper payment. The Contractor must have in place a process to administer these claims.
  - 2.3.3.3 If the Contractor is unable to waive the timeliness rule to process an

improperly paid claim identified by HCA, HCA may at any time request a refund from the Contractor of the improperly paid claim.

## 2.4 Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed (42 C.F.R. § 438.3). The provisions of this Contract that are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to, the following laws, as amended:

- 2.4.1 Title XIX and Title XXI of the Social Security Act;
- 2.4.2 Title VI of the Civil Rights Act of 1964;
- 2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities;
- 2.4.4 The Age Discrimination Act of 1975;
- 2.4.5 The Rehabilitation Act of 1973;
- 2.4.6 The Budget Deficit Reduction Act of 2005;
- 2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA);
- 2.4.8 The Anti-Kickback Statute 42 U.S.C. § 1320a-7b.
- 2.4.9 The Health Insurance Portability and Accountability Act (HIPAA);
- 2.4.10 The American Recovery and Reinvestment Act (ARRA);
- 2.4.11 The Patient Protection and Affordable Care Act (PPACA or ACA);
- 2.4.12 The Health Care and Education Reconciliation Act;
- 2.4.13 The Public Assistance Act, Title 74 RCW.
- 2.4.14 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;
- 2.4.15 All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:
  - 2.4.15.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.
  - 2.4.15.2 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;
- 2.4.15.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA);
- 2.4.15.4 Those specified in Title 18 RCW for professional licensing;
- 2.4.16 Industrial Insurance – Title 51 RCW;
- 2.4.17 Reporting of abuse as required by RCW 26.44.030 and chapter 74.34 RCW;
- 2.4.18 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2;
- 2.4.19 EEO Provisions;
- 2.4.20 Copeland Anti-Kickback Act;
- 2.4.21 Davis-Bacon Act;
- 2.4.22 Byrd Anti-Lobbying Amendment;
- 2.4.23 All federal and state nondiscrimination laws and regulations;
- 2.4.24 Americans with Disabilities Act of 1990, as amended: The Contractor shall make reasonable accommodation for Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining contracted services;
- 2.4.25 The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan; and
- 2.4.26 Any other requirements associated with the receipt of federal funds.

## 2.5 **Covenant Against Contingent Fees**

The Contractor certifies that no person or selling agent has been employed or retained to solicit or secure this Contract for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by the Contractor for the purpose of securing business. HCA shall have the right, in the event of breach of this clause by the Contractor, to terminate this Contract or, in its discretion, to deduct from amounts due the Contractor under the Contract recover by other means the full amount of any such commission, percentage, brokerage or contingent fee.

## 2.6 **Debarment Certification**

The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded in any Washington State or Federal department or agency from participating in transactions (debarred). The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accord with Subsection 2.38 of this Contract if the Contractor becomes debarred during the term hereof.

## 2.7 Defense of Legal Actions

Each party to this Contract shall advise the other as to matters that come to its attention with respect to potential substantial legal actions involving allegations that may give rise to a claim for indemnification from the other. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Contract by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

## 2.8 Disputes

When a dispute arises over an issue that pertains in any way to this Contract (other than overpayments or actions taken by MFCD, as described below), the parties agree to the following process to address the dispute:

- 2.8.1 The Contractor shall request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:
  - 2.8.1.1 The disputed issue(s).
  - 2.8.1.2 An explanation of the positions of the parties.
  - 2.8.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.
- 2.8.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within fifteen (15) calendar days after the Contractor receives notice of the disputed issue(s).
  - 2.8.2.1 The Director, in his or her sole discretion, will determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director will provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.
  - 2.8.2.2 The Director will consider all of the information provided at the conference and will issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she will notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.
  - 2.8.2.3 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the



disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

2.8.3 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.

2.8.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section. Disputes regarding other recoveries sought by the MFCD are governed by the authorities, laws and regulations under which the MFCD operates.

## 2.9 **Force Majeure**

If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

## 2.10 **Governing Law and Venue**

This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County. In the event that an action is removed to U.S. District Court, venue shall be in the Western District of Washington in Tacoma.

Nothing in this Contract shall be construed as a waiver by HCA of the State's immunity under the 11<sup>th</sup> Amendment to the United States Constitution.

## 2.11 **Independent Contractor**

The parties intend that an independent Contractor relationship will be created by this Contract. The Contractor and its employees or agents performing under this Contract are not employees or agents of the HCA or the state of Washington. The Contractor, its employees, or agents performing under this Contract will not hold himself/herself out as, nor claim to be, an officer or employee of the HCA or the state of Washington by reason hereof, nor will the Contractor, its employees, or agent make any claim of right, privilege or benefit that would accrue to such employee. The Contractor acknowledges and certifies that neither HCA nor the state of Washington are guarantors of any obligations or debts of the Contractor.

## 2.12 **Insolvency**

If the Contractor becomes insolvent during the term of this Contract:

2.12.1 The state of Washington and Enrollees shall not be, in any manner, liable for the debts and obligations of the Contractor (42 C.F.R. § 438.106(a) and 438.116(a)(1)).

2.12.2 In accord with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge Enrollees for Contracted services (42 C.F.R. § 438.106(b)(1)).

- 2.12.3 The Contractor shall, in accord with RCW 48.44.055 or RCW 48.46.245, provide for the continuity of care for Enrollees.
- 2.12.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

### 2.13 Inspection

The Contractor and its subcontractors shall permit the state of Washington, including HCA, MFCD and state auditor, and federal agencies, including but not limited to: CMS, Government Accountability Office, Office of Management and Budget, Office of the Inspector General, Comptroller General, and their designees, to access, inspect and audit any records or documents of the Contractor or its subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time.

- 2.13.1 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation identified in subsection 2.13. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or a shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access and inspect under this section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).

### 2.14 Insurance

The Contractor shall at all times comply with the following insurance requirements:

- 2.14.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.
- 2.14.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - \$1,000,000; General Aggregate - \$2,000,000.
- 2.14.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and

regulations.

- 2.14.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.
- 2.14.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA if requested.
- 2.14.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.
- 2.14.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a "Best's Reports" rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.
- 2.14.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.
- 2.14.9 Material Changes: The Contractor shall give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.
- 2.14.10 General: By requiring insurance, the state of Washington and HCA do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.
- 2.14.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this Section, will treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.
- 2.14.12 Privacy Breach Response Coverage. For the term of this Contract and three (3) years following its termination Contractor shall maintain insurance to cover costs

incurred in connection with a security incident, privacy Breach, or potential compromise of Data including:

- 2.14.12.1 Computer forensics assistance to assess the impact of a data breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach Notification Laws (45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; and WAC 284-04-625).
- 2.14.12.2 Notification and call center services for individuals affected by a security incident, or privacy Breach.
- 2.14.12.3 Breach resolution and mitigation services for individuals affected by a security incident, or privacy Breach, including fraud prevention, credit monitoring and identity theft assistance.
- 2.14.12.4 Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy law(s).

## 2.15 Records

- 2.15.1 The Contractor and its subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.
- 2.15.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of ten (10) years after final payment is made under this Contract. However, when an inspection, audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action (42 C.F.R. § 438.3(h)).
- 2.15.3 The Contractor and the Contractor's subcontractors shall retain, as applicable, Enrollee grievance and appeal records (42 C.F.R. § 438.416), base data (42 C.F.R. § 438.5(c)), MLR reports (42 C.F.R. § 438.8(k)), and the data, information, and documentation specified in 42 C.F.R. § 438.604, § 438.606, § 438.608, and § 438.610 for a period of no less than ten (10) years.
- 2.15.4 The Contractor acknowledges the HCA is subject to the Public Records Act (chapter 42.56 RCW). This Contract will be a "public record" as defined in chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as "public records" and therefore subject to public disclosure.

## 2.16 Mergers and Acquisitions

If the Contractor is involved in an acquisition of assets or merger with another HCA Contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each Contractor maintain its separate business lines for the remainder of the contract period. The Contractor does not have an automatic right to a continuation of the Contract after any such acquisition of assets or merger.

## 2.17 **Contractors Located Outside of the United States**

The Contractor assures HCA that it is not located outside the United States. The Contractor shall not include in its encounter data reporting to the HCA, or to HCA's contracted Actuary, any claims paid to any provider located outside the United States. (42 C.F.R. § 438.602(i))

## 2.18 **Notification of Organizational Changes**

The Contractor shall provide HCA with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor shall provide HCA notice of any changes to the Contractor's key personnel including, but not limited to, the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, HCA government relations contact, HCA Account Executive, Compliance Officer and Medical Director as soon as reasonably possible.

## 2.19 **Order of Precedence**

In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

- 2.19.1 Federal statutes and regulations applicable to the services provided under this Contract;
- 2.19.2 State of Washington statutes and regulations applicable to the services provided under this Contract;
- 2.19.3 Applicable state of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers;
- 2.19.4 General Terms and Conditions of this Contract;
- 2.19.5 Any other term and condition of this Contract and exhibits; and
- 2.19.6 Any other material incorporated herein by reference.

## 2.20 **Severability**

If any term or condition of this Contract is held invalid by any court of competent jurisdiction, and if all appeals have been exhausted, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

## 2.21 **Survivability**

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Fraud, Waste and Abuse (FWA); Notice of Overpayment; Overpayments or Underpayments of Premiums; Indemnification and Hold Harmless; Inspection; Access to Records; On-site inspections and Periodic Audits; Records; Constraints on Use of Data; Security of Data; Data Confidentiality and Non-Disclosure of Data; Data Breach Notification and Obligations; and Material Breach. After termination of this Contract, the Contractor remains obligated to:

- 2.21.1 Cover hospitalized Enrollees until discharge consistent with this Contract.
- 2.21.2 Submit all data and reports required in this Contract.
- 2.21.3 Provide access to records required in accord with the Inspection provisions of this

Section.

- 2.21.4 Provide the administrative services associated with Contracted services (e.g. claims processing, Enrollee appeals) provided to Enrollees prior to the effective date of termination under the terms of this Contract.
- 2.21.5 Repay any overpayments within sixty (60) calendar days of discovery by the Contractor or its subcontractors of the overpayment, or within sixty (60) calendar days of notification by HCA, MFCD, or other law enforcement agency, (42 U.S.C. 1320a-7k(d)) and that:
  - 2.21.5.1 Pertain to services provided at any time during the term of this Contract; and
  - 2.21.5.2 Are identified through an HCA audit or other HCA administrative review at any time on or before ten (10) years from the date of the termination of this Contract (42 C.F.R. § 438.3(h)); or
  - 2.21.5.3 Are identified through a fraud investigation conducted by the MFCD or other law enforcement entity, based on the timeframes provided by federal or state law.
- 2.21.6 Reimburse providers for claims erroneously billed to and paid by HCA within the twenty-four (24) months before the expiration or termination of this Contract.

## 2.22 **Waiver**

Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the Director of the HCA or his or her designee has the authority to waive any term or condition of this Contract on behalf of HCA.

## 2.23 **Contractor Certification Regarding Ethics**

The Contractor certifies that the Contractor is now, and shall remain, in compliance with chapter 42.52 RCW, Ethics in Public Service, throughout the term of this Contract.

## 2.24 **Health and Safety**

Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any HCA client with whom the Contractor has contact. The Contractor shall require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol™ developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other similar standards.

## 2.25 **Indemnification and Hold Harmless**

HCA and the Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful

misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party. The Contractor shall indemnify and hold harmless HCA from any claims by Participating or non-Participating Providers related to the provision of services to Enrollees according to the terms of this Contract. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

#### **2.26 Industrial Insurance Coverage**

The Contractor shall comply with the provisions of Title 51 RCW, Industrial Insurance. If the Contractor fails to provide industrial insurance coverage or fails to pay premiums or penalties on behalf of its employees, as may be required by law, HCA may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. HCA may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries, (L&I) Division of Insurance Services. This provision does not waive any of L&I's rights to collect from the Contractor.

#### **2.27 No Federal or State Endorsement**

The award of this Contract does not indicate an endorsement of the Contractor by the Centers for Medicare and Medicaid Services (CMS), the federal government, or the state of Washington. No federal funds have been used for lobbying purposes in connection with this Contract or managed care program.

#### **2.28 Notices**

Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if mailed by United States Postal Services, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

2.28.1 In the case of notice to the Contractor, notice will be sent to:

«CEO»  
«Organization\_Name»  
«Mailing\_AddressSt\_Address»  
«City», «State» «Zip\_Code»

2.28.2 In the case of notice to HCA, send notice to:

Contract Administrator  
HCA  
Division of Legal Services  
Contracts Office  
PO Box 42702  
Olympia, WA 98504-2702

2.28.3 Notices shall be effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage.

2.28.4 Either party may at any time change its address for notification purposes by mailing

a notice in accord with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

## **2.29 Notice of Overpayment**

- 2.29.1 If HCA determines it has made an overpayment to the Contractor, then HCA will issue a Notice of Overpayment to the Contractor.
- 2.29.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:
  - 2.29.2.1 Comply with all of the instructions contained in the Notice of Overpayment;
  - 2.29.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;
  - 2.29.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;
  - 2.29.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and
  - 2.29.2.5 Include a copy of the Notice of Overpayment.
- 2.29.3 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding. The adjudicative proceeding will be governed by the administrative procedure act, chapter 34.05 RCW, and chapter 182-526 WAC.
- 2.29.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment within sixty (60) calendar days from the date of receipt. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this contract; or any other collection action available to HCA to satisfy the overpayment debt.
- 2.29.5 Nothing in this Contract limits HCA's ability to recover overpayments under applicable law.

## **2.30 Proprietary Data or Trade Secrets**

- 2.30.1 Except as required by law, regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.
- 2.30.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that



is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) business days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.

- 2.30.3 Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

### **2.31 Ownership of Material**

HCA recognizes that nothing in this Contract shall give HCA ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by HCA during the performance of this Contract.

### **2.32 Solvency**

- 2.32.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21A, 48.44 or 48.46 RCW, as amended.
- 2.32.2 The Contractor agrees that HCA may at any time access any information related to the Contractor's financial condition, or compliance with the Office of the Insurance Commissioner (OIC) requirements, from OIC and consult with OIC concerning such information.
- 2.32.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC or National Association of Insurance Commissioners (NAIC) per the HCSC required filing checklist for financial reports. The Contractor's routine quarterly and annual statements submitted to the OIC and NAIC are exempt from this requirement. The Contractor shall also deliver copies of related documents, reports, and correspondence (including, but not limited to, Risk-Based Capital (RBC) calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC or NAIC.
- 2.32.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.
- 2.32.5 The Contractor shall notify HCA within 24 hours after any action by the OIC which may affect the relationship of the parties under this Contract.

2.32.6 The Contractor shall notify HCA if the OIC requires enhanced reporting requirements within fourteen (14) calendar days after the Contractor's notification by the OIC. The Contractor agrees that HCA may, at any time, access any financial reports submitted to the OIC in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

### 2.33 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (42 C.F.R. § 438.3(f)(2)).

### 2.34 Reservation of Rights and Remedies

A material default or breach in this Contract will cause irreparable injury to HCA. In the event of any claim for default or breach of this Contract, no provision in this Contract shall be construed, expressly or by implication, as a waiver by the state of Washington to any existing or future right or remedy available by law. Failure of the state of Washington to insist upon the strict performance of any term or condition of this Contract or to exercise or delay the exercise of any right or remedy provided in this Contract or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and shall not be deemed a waiver of any right of the state of Washington to insist upon the strict performance of this Contract. In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach.

### 2.35 Termination by Default

2.35.1 **Termination by Contractor.** The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice, as described in the Notices section of the General Terms and Conditions, specifying the default. For purposes of this Section, "default" means failure of HCA to meet one or more material obligations of this Contract. In the event it is determined that HCA was not in default, HCA may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

2.35.2 **Termination by HCA.** HCA may terminate this Contract if HCA determines:

2.35.2.1 The Contractor did not fully and accurately make any disclosure required under 42 C.F.R. § 455.106(a).

2.35.2.2 The Contractor failed to timely submit accurate information required under 42 C.F.R. § 455, Subpart E. (42 C.F.R. § 455.416(d)).

2.35.2.3 One of the Contractor's owners failed to timely submit accurate information required under 42 C.F.R. § 455, Subpart E. (42 C.F.R. §

455.416(d)).

- 2.35.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R. § 455.416(d)).
- 2.35.2.5 One of the Contractor's owners did not cooperate with any screening methods required under 42 C.F.R. 455, Subpart E.
- 2.35.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years. (42 C.F.R. § 455.416(b)).
- 2.35.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program. (42 C.F.R. § 455.416(c)).
- 2.35.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) calendar days of a CMS or HCA request. (42 C.F.R. § 455.416(e); 42 C.F.R. § 455.450(d)).
- 2.35.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits under 42 C.F.R. § 455.432. (42 C.F.R. § 455.416(f)).
- 2.35.2.10 The Contractor has falsified any information provided on its application. (42 C.F.R. § 455.416(g)).

## 2.36 Termination for Convenience

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second day after the mailing, terminate this Contract in whole or in part when it is in the best interest of HCA, as determined by HCA in its sole discretion. If this Contract is so terminated, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.

## 2.37 Termination due to Federal Impact

Notwithstanding any provision in this Contract to the contrary, if HCA does not receive Centers for Medicare and Medicaid Services (CMS) approval of this Contract, HCA shall provide at least thirty (30) calendar days' prior written notice of termination of this Contract to the Contractor. The effective date of any such termination hereunder shall be the earliest date that is at least thirty (30) calendar days following the date the notice is sent and occurs on the last day of a calendar month. HCA shall not be relieved of its obligation under this Contract, including payment to the Contractor, for the period from the contract effective date through the effective date of termination.

### 2.38 Terminations: Pre-termination Processes

Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices section of the General Terms and Conditions of this Contract, of the intent to terminate this Contract and the reason for termination.

HCA shall provide written notice to the Contractor's Enrollees of the decision to terminate the Contract and indicate whether the Contractor may appeal the decision. The notice shall also inform Enrollees that they may change MCOs without cause if they wish to do so, effective the first of the following month.

- 2.38.1 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes section of this Contract.
- 2.38.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA shall:
  - 2.38.2.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;
  - 2.38.2.2 Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and
  - 2.38.2.3 For an affirming decision, give Enrollees notice of the termination and information consistent with 42 C.F.R. § 438.10 on their options for receiving Medicaid services following the effective date of termination.

### 2.39 Savings

In the event funding from any state, federal, or other sources is withdrawn, reduced, or limited in any way after the date this Contract is signed and prior to the termination date, HCA may, in whole or in part, suspend or terminate this Contract upon fifteen (15) calendar days' prior written notice to Contractor or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. At HCA's sole discretion the Contract may be renegotiated under the revised funding conditions. If this Contract is so terminated or suspended, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date.

### 2.40 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within 365 calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to Enrollees (42 C.F.R. § 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

### 2.41 Administrative Simplification

The Contractor shall comply with the requirements of RCW 70.14.155 and chapter 48.165 RCW.

- 2.41.1 To maximize understanding, communication, and administrative economy among

all managed care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:

- 2.41.1.1 Current Procedural Terminology (CPT)
  - 2.41.1.2 International Classification of Diseases (ICD)
  - 2.41.1.3 Healthcare Common Procedure Coding System (HCPCS)
  - 2.41.1.4 CMS Relative Value Units (RVUs)
  - 2.41.1.5 CMS billing instructions and rules
  - 2.41.1.6 NCPDP Telecommunication Standard D.O.
  - 2.41.1.7 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.
- 2.41.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding that leads to inappropriate payments. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing Medicaid claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.
- 2.41.3 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.
- 2.41.4 Drug database requirements are specific to values used as reference file in adjudication of pharmacy claims and storage of pharmacy claim data. Drug databases used for other purposes are not subject to this requirement and do not require approval.
- 2.41.5 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

### 3 MARKETING AND INFORMATION REQUIREMENTS

#### 3.1 Marketing

- 3.1.1 All marketing materials must be reviewed by and have written approval of HCA prior to distribution (42 C.F.R. § 438.104(b)(1)(i)). Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by the HCA. Marketing materials include any items developed by the Contractor for distribution to Enrollees or Potential Enrollees that are intended to provide information about the Contractor's benefit administration, including:
  - 3.1.1.1 Print media;
  - 3.1.1.2 Websites; and
  - 3.1.1.3 Electronic Media (Television/Radio/Internet/Social Media).
- 3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 C.F.R. § 438.104(b)(2)).
- 3.1.3 Marketing materials must be distributed in all service areas the Contractor serves (42 C.F.R. § 438.104(b)(1)(ii)).
- 3.1.4 Marketing materials must not contain an invitation, implied or implicit, for an Enrollee to change from one Apple Health MCO to the Contractor, or imply that the Contractor's benefits are substantially different from any other Apple Health MCO. This does not preclude the Contractor from distributing state-approved communications to Enrollees regarding the scope of their own value-added benefits.
- 3.1.5 Marketing materials must be in compliance with the Equal Access for Enrollees and Potential Enrollees with Communication Barriers provisions of this Section.
  - 3.1.5.1 Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as identified by HCA.
  - 3.1.5.2 HCA may determine, in its sole judgment, if materials that are primarily visual, auditory, or tactile meet the requirements of this Contract.
- 3.1.6 The Contractor shall not offer or accept (other than the payment by HCA) anything of value as an inducement to enrollment.
- 3.1.7 The Contractor must not seek to influence enrollment in conjunction with the sale or offering of any other insurance (42 C.F.R. § 438.104(b)(1)(iv)).
- 3.1.8 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 C.F.R. § 438.104(b)(1)(v)).
- 3.1.9 The Contractor must not make any assertion or statement, whether written or oral, in marketing materials that a potential Enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits (42 C.F.R. § 438.104(b)(2)(i)).
- 3.1.10 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the federal or state government or similar entity (42 C.F.R. § 438.104(b)(2)(ii)).

- 3.1.11 The Contractor may participate in community events, including health fairs, educational events, and booths at other community events.

### 3.2 Information Requirements for Enrollees and Potential Enrollees

- 3.2.1 The Contractor shall provide to potential Enrollees and new Enrollees the information needed to understand benefit coverage and obtain care in accord with the provisions of this Section (42 C.F.R. § 438.10(b)(3) and 438.10(f)(3)). The information shall be provided at least once a year, upon request and within fifteen (15) business days after the Contractor was notified of enrollment.

The Contractor shall notify Enrollees of their ability to request the information at any time. If the Enrollee or potential Enrollee is not able to understand written information, the Contractor will provide at no cost the necessary information in an alternative language or format that is understandable to the Enrollee or potential Enrollee.

- 3.2.2 The Contractor shall use and disseminate the HCA produced managed care handbook to Enrollees and potential Enrollees. The HCA-produced template and HCA-approved Contractor handbook will provide sufficient, accurate and current written information to assist potential Enrollees in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932(d)(2) and 42 C.F.R. § 438.10 and 438.104(b)(1)(iii)).

- 3.2.3 The Contractor shall provide to each Enrollee, and to each potential Enrollee who requests it, the HCA-approved managed care handbook.

- 3.2.3.1 The Contractor shall provide the HCA-approved managed care handbook in a translated version or through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and potential Enrollees with disabilities or limited English proficiency.

- 3.2.3.2 The Contractor shall develop content for the managed care handbook in the sections labeled for Contractor use in the template.

- 3.2.4 The Contractor may develop supplemental materials specific to the Contractor's programs, in addition to the managed care handbook that is sent to newly enrolled and assigned Enrollees. The supplemental, plan-specific material shall be incorporated into the managed care handbook template as instructed by HCA. The supplemental, plan-specific material will not include mandatory materials such as NCQA-required materials and the annual notices that the Contractor is required to send to Enrollees.

- 3.2.4.1 Supplemental plan-specific materials may not duplicate information, such as covered benefits, contained in the HCA's approved handbook template and the Contractor's approved managed care handbook, but may include contact numbers for Contractor's customer service, information about the Contractor's authorization processes, network providers and/or Value Added Benefits that the Contractor may provide.

- 3.2.5 The Contractor shall include with all written materials a tagline and information on how the Enrollee can request Auxiliary Aids and Services including the provision of information in an alternative language and format that is understandable to the

Enrollee. If the Enrollee requests the tagline in large print, the Contractor shall provide it to the Enrollee in either paper form or electronically within five (5) business days.

- 3.2.6 The Contractor shall submit branding materials developed by the Contractor that specifically mention Medicaid, AH or the specific benefits provided under this Contract for review and approval. No such materials shall be disseminated to Enrollees, potential Enrollees, providers or other members of the public without HCA's approval.
- 3.2.7 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions AH or the specific benefits provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval, including any Enrollee materials regarding Utilization Management activities that are developed by the Contractor or its delegates. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.
- 3.2.8 The Contractor shall notify all new Health Home-eligible Enrollees of their eligibility for the Health Home program. The notice shall include all of the following:
  - 3.2.8.1 A description of the benefits of the program;
  - 3.2.8.2 Confirmation that program participation is voluntary and not a condition for the Enrollee's receipt of any other covered service;
  - 3.2.8.3 Information about how to file grievances and appeals;
  - 3.2.8.4 A statement that a participant has the right to change care coordination providers and the procedure for doing so; and
  - 3.2.8.5 How to obtain more information about the program.
- 3.2.9 The Contractor shall notify all known pregnant Enrollees about their eligibility to participate and receive Maternity Support Services (MSS) through the HCA First Steps program.
  - 3.2.9.1 The Contractor must use the HCA MSS informational letter template to notify these clients. HCA will provide the template to the Contractor. No later than the twentieth of each month, the Contractor shall submit to HCA a list of all Enrollees who are newly identified within the preceding month as pregnant or are within sixty (60) calendar days postpartum. The Contractor shall submit the list to HCA using the HCA First Steps Maternity Support Services report template. HCA will provide the Support Services report template to the Contractor.
- 3.2.10 The Contractor shall communicate changes to state or federal law to Enrollees no more than ninety (90) calendar days after the effective date of the change and Enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the Enrollees' quality of or access to care, which may include changes to: enrollment rights, grievance and hearing procedures, benefits, authorizations or coverage of emergency services. HCA shall notify the Contractor in writing of any significant change (42 C.F.R. § 438.10(f)(4)).



- 3.2.11 The Contractor shall create a link on the front page of its website for providers and Enrollees that directs said providers and Enrollees to a mental health website. The mental health website shall:
- 3.2.11.1 Contain information on how to access mental health services;
  - 3.2.11.2 Connect to the provider directory that displays a current list of contracted mental health professionals specifying those which are contracted to serve children and youth;
  - 3.2.11.3 Include information on how to contact the Contractor should the provider or Enrollee have difficulty accessing such care; and
  - 3.2.11.4 Include information about the behavioral health resource line (chapter 74.09 RCW).
- 3.2.12 The Contractor will have a written process for development, review, and approval of all marketing and Enrollee information including those provided by a third party. This process shall be provided to HCA upon request. It must include the names of the approving source for all internal and third party documents. All documents must be approved by the Contractor as meeting all contract terms, and federal, state, and local laws prior to submission to HCA.

### 3.3 **Equal Access for Enrollees and Potential Enrollees with Communication Barriers**

The Contractor shall assure equal access for all Enrollees and Potential Enrollees when oral or written language communications creates a barrier to such access. (42 C.F.R. § 438.10 and 45 C.F.R. § 92.8).

#### 3.3.1 Oral Information

- 3.3.1.1 The Contractor shall assure that interpreter services are provided for Enrollees and Potential Enrollees with a primary language other than English or who are deaf or hearing impaired, free of charge. This includes oral interpretation, American Sign Language, and the use of Auxiliary Aids and Services as defined in this Contract. (42 C.F.R. § 438.10(d)(4)). Interpreter Services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and the Contractor or any of its providers including, but not limited to:
- 3.3.1.1.1 Customer service;
  - 3.3.1.1.2 All interactions with any provider for any covered service;
  - 3.3.1.1.3 Emergency services; and
  - 3.3.1.1.4 All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535 and chapter 284-43 WAC).
- 3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters, including, but not limited to, handling Enrollee Grievances and Appeals.
- 3.3.1.3 HCA is responsible for payment of interpreter services provided when

the interpreter service is requested through, authorized, and provided by the HCA's Interpreter Services program vendor and complies with all program rules.

3.3.1.4 Hospitals are responsible for payment for interpreter services during inpatient stays.

3.3.1.5 Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

### 3.3.2 Written Information

3.3.2.1 The Contractor shall provide all generally available and Enrollee-specific written materials through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and Potential Enrollees (42 C.F.R. § 438.10(d)(1) and 438.10(d)(6)(iii)). For the purposes of this subsection, the Enrollee's preferred language may not be the same as their primary language. The Contractor must translate materials into the Enrollee's preferred language.

3.3.2.1.1 HCA shall provide to the Contractor a sample tagline in the languages into which HCA translates Enrollee materials. The Contractor shall use this tagline for all mailings to Enrollees and Potential Enrollees, and shall maintain the ability to provide materials to all Enrollees in their preferred language.

3.3.2.1.2 The Contractor shall include with all written material a large print tagline and information on how the Enrollee or Potential Enrollee can request Auxiliary Aids and Services, including the provision of information in an alternative language and format that is understandable to the Enrollee or Potential Enrollee.

3.3.2.1.3 If 5 percent or 1,000, whichever is less of the Contractor's Enrollees speak a language other than English, generally available materials, including the Contractor's handbook must be translated into that language.

3.3.2.1.4 For Enrollees whose primary language is not translated or whose need cannot be addressed by translation under the preceding subsection as required by the provisions of this Section, the Contractor may meet the requirement of this Section by doing any of the following:

3.3.2.1.4.1 Translating the material into the Enrollee's or Potential Enrollee's preferred language.

3.3.2.1.4.2 Providing the material in an audio format in the Enrollee's or Potential Enrollee's preferred language.

- 3.3.2.1.4.3 Having an interpreter read the material to the Enrollee or Potential Enrollee in the Enrollee's primary preferred language.
  - 3.3.2.1.4.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Enrollee or Potential Enrollee. The Contractor shall document the Enrollee's or Potential Enrollee's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).
  - 3.3.2.1.4.5 Providing the material in English, if the Contractor documents the Enrollee's or Potential Enrollee's preference for receiving material in English.
- 3.3.2.2 The Contractor shall ensure that all written information provided to Enrollees or potential Enrollees is: accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth (6th) grade reading level, provided in a font size no smaller than 12 point, and fulfills other requirements of the Contract as may be applicable to the materials (42 C.F.R. § 438.10(d)(6)).
- 3.3.2.3 HCA may make exceptions to the sixth grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for sixth (6th) grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.
- 3.3.2.4 Educational materials about topics such as preventative services or other information used by the Contractor for health promotion efforts must be submitted to HCA within thirty (30) calendar days of use, but do not require HCA approval as long as they do not specifically mention AH or the benefits provided under this Contract.
- 3.3.2.5 Educational materials that are not developed by the Contractor or developed under contract with the Contractor are not required to meet the sixth grade reading level requirement and do not require HCA approval.
- 3.3.2.6 All other written materials must have the written approval of HCA prior to use. For Enrollee-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.
- 3.3.2.7 The Contractor may provide the Enrollee handbook information in any of the following ways:
- 3.3.2.7.1 Mailing a printed copy of the information to the Enrollee's mailing address;

- 3.3.2.7.2 Providing the information by email after obtaining the Enrollee's agreement to receive the information by email;
  - 3.3.2.7.3 Posting the information on its website and advising the Enrollee in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided Auxiliary Aids and Services upon request at no cost; or
  - 3.3.2.7.4 Providing the information by any other method that can reasonably be expected to result in the Enrollee receiving the information.
- 3.3.3 If the Contractor provides this information electronically, it must meet the following requirements:
- 3.3.3.1 The format is readily accessible and takes into consideration the special needs of Enrollees and Potential Enrollees with disabilities or limited English proficiency;
  - 3.3.3.2 The information is placed in a location on the Contractor's website that is prominent and readily accessible;
  - 3.3.3.3 The information is provided in an electronic form which can be electronically retained and printed;
  - 3.3.3.4 The information is consistent with the content and language requirements of 42 C.F.R. § 438.10; and
  - 3.3.3.5 The Enrollee must be informed that the information is available in paper form without charge within five (5) business days of Enrollee request.

#### 3.4 **Electronic Outbound calls**

The Contractor may use an interactive, automated system to make certain outbound calls to Enrollees.

- 3.4.1 The Contractor must submit call scripts to HCA no less than thirty (30) calendar days prior to the date the automated calls will begin. Approvable reasons for automated calls include:
  - 3.4.1.1 Recertification of eligibility;
  - 3.4.1.2 Outreach to new Enrollees;
  - 3.4.1.3 Reminders of events such as flu clinics;
  - 3.4.1.4 Initial Health Screening (IHS);
  - 3.4.1.5 Surveys;
  - 3.4.1.6 Appointment reminders/immunizations/well child appointments; and
  - 3.4.1.7 Notification of new programs or assistance offered.
- 3.4.2 Under no circumstances will the Contractor use automated calls for care coordination activities, behavioral health-related calls or prescription verifications.

3.4.3 The Contractor shall ensure that if this service is provided by a third party, that either a subcontract or a Business Associate Agreement is in place and is submitted to HCA for review.

### 3.5 Medication Information

The Contractor shall provide information to Enrollees about which generic and name brand medications are covered and whether they are preferred or non-preferred. The information may be provided in paper form or electronically.

3.5.1 If provided electronically, the information must be provided on the Contractor's website in a place that is prominent and readily accessible, in a machine readable file and format that can be retained and printed.

3.5.2 Information must be consistent with content and language requirements.

3.5.3 The Contractor shall notify Enrollees that the information is available in paper form without charge, upon request. If an Enrollee requests the information in paper form, the Contractor must provide the information to the Enrollee within five (5) business days.

### 3.6 Conscience Clause

The Contractor shall notify Enrollees at least sixty (60) calendar days before the effective date when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections. (42 C.F.R. § 438.102(b)(1)(ii)(B); 1932(b)(3)(B)(ii); RCW 48.43.065.)

## **4 ENROLLMENT**

### **4.1 Service Areas**

The Contractor's policies and procedures related to Enrollment shall ensure compliance with the requirements described in this Section.

- 4.1.1 The Contractor's service areas are described in Exhibit I, Service Areas. The HCA may modify Exhibit I, for service area changes as described in this Section.

### **4.2 Service Area Changes**

- 4.2.1 With the written approval of HCA, and upon execution of a formal contract amendment, the Contractor may either expand into an additional service area (an "Area Expansion") or increase its level of client assignments in a service area if it is already receiving voluntary enrollment, in that service area (an "Area Increase").

- 4.2.2 To obtain an Area Expansion or an Area Increase, the Contractor must give written notice to HCA, along with evidence, as HCA may require, demonstrating the Contractor's ability to support the Area Expansion or Area Increase.

- 4.2.2.1 HCA may withhold approval of an Area Expansion or an Area Increase if, in HCA's sole judgment, the request is not in the best interest of HCA.

- 4.2.2.2 If approved, the timing of the Area Expansion or Area Increase will be at HCA's sole discretion.

- 4.2.3 The Contractor may not decrease its service areas or its level of participation in any service area except during contract renewal, i.e., when the Contract is extended as provided herein.

- 4.2.4 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

- 4.2.5 HCA shall determine, in its sole judgment, which zip codes fall within each service area.

- 4.2.6 HCA will use the Enrollee's residential zip code to determine whether an Enrollee resides within a service area.

### **4.3 Eligible Client Groups**

The HCA shall determine eligibility for enrollment under this Contract. The HCA will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Apple Health (AH) managed care. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract.

- 4.3.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving AH Family and clients who are not eligible for cash assistance who remain eligible for medical services under Medicaid.

- 4.3.2 Clients receiving Medicaid under the provisions of the ACA effective January 1, 2014.

- 4.3.3 Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.

- 4.3.4 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.
- 4.3.5 Children eligible for the Children's Health Insurance Program (CHIP).
- 4.3.6 Categorically Needy - Blind and Disabled Children and Adults who are not eligible for Medicare.

#### 4.4 **Client Notification**

HCA shall notify eligible clients of their rights and responsibilities as managed care Enrollees at the time of initial eligibility determination, after a break in eligibility greater than twelve (12) months or at least annually.

#### 4.5 **Exemption from Enrollment**

A client may request exemption from enrollment for cause at any time. Each request for exemption will be reviewed by HCA pursuant to chapter 182-538 WAC. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a termination of enrollment request consistent with the Termination of Enrollment provisions of this Section.

- 4.5.1 If the Contractor receives an exemption request from an Enrollee or potential Enrollee, the Contractor shall forward the request to the Medical Assistance Customer Service Center (MACSC) within two (2) business days of receipt of the request.

#### 4.6 **Enrollment Period**

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one AH managed care plan to another without cause, each month except as described in the Patient Review and Coordination (PRC) provisions of this Contract.

#### 4.7 **Enrollment Process**

- 4.7.1 Enrollees certifying or renewing Medicaid eligibility through the Health Benefit Exchange, Healthplanfinder may select an MCO available in the Enrollee's service area.
- 4.7.2 HCA will assign the clients who do not select a plan.
- 4.7.3 HCA will assign all eligible family members, to the same AH managed care contractor consistent with this Contract.
- 4.7.4 An Enrollee may change his or her MCO, with or without cause, at any time. The effective date of the change in MCO shall be consistent with HCA's established enrollment timelines.
- 4.7.5 The client, the client's representative or responsible parent or guardian must notify the HCA if they want to choose another health plan.
- 4.7.6 The HCA will attempt to enroll all family members with the same AH managed care plan unless the following occurs:
  - 4.7.6.1 A family member is placed into the Patient Review and Coordination (PRC) program by the Contractor or the HCA. The PRC placed family

member shall follow the enrollment requirements described in the PRC provisions of this Contract. The remaining family members shall be enrolled with a single AH managed care plan of their choice.

- 4.7.6.2 The HCA grants an exception because the family members have conflicting medical needs that cannot be met by a single AH managed care contractor.

#### 4.8 **Effective Date of Enrollment**

- 4.8.1 Except for a newborn whose mother is enrolled in an AH MCO, HCA shall enroll all newly eligible Medicaid clients subject to this Contract into Apple Health Managed Care effective the first day of the month, if both the date of initial Medicaid eligibility and the managed care enrollment take place in the current month. A newborn whose mother already is enrolled in an Apple Health MCO will be enrolled with that MCO as of the date of birth.
- 4.8.2 The Contractor is responsible for payment, medical necessity determinations and service authorizations for all services provided on and after the effective date of enrollment except as provided under subsections 4.11.7 and 16.4 of this Contract.
- 4.8.3 No retroactive coverage is provided under this Contract, except as described in this Section or by mutual, written agreement by the parties.

#### 4.9 **Newborns Effective Date of Enrollment**

Newborns whose mothers are Enrollees on the date of birth shall be deemed Enrollees and enrolled in the same plan as the mother as follows:

- 4.9.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur, effective when the newborn is reported to the HCA.
- 4.9.2 If the newborn does not receive a separate client identifier from HCA, the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.
- 4.9.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from HCA, the newborn's enrollment shall end the last day of the month in which the twenty-first (21st) day of life occurs or when the mother's enrollment ends, whichever is sooner, except as provided in the provisions of the Enrollee Hospitalized at Termination of Enrollment of the Benefits Section of this Contract.
- 4.9.4 A newborn, whose mother is not covered by Apple Health or any comparable coverage, and the newborn is determined eligible for Apple Health Medicaid prior to discharge from their initial birth hospitalization shall be enrolled according to HCA enrollment rules. The Contractor will be responsible for hospital costs for the newborn starting from the month of enrollment.
- 4.9.5 A newborn whose mother is receiving services fee-for-service (FFS) when the baby is born will be enrolled in AHMC and assigned to an MCO according to system rules (Early Enrollment).
- 4.9.6 When a newborn is placed in foster care, the newborns will remain enrolled with the Contractor for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month following



placement of the newborn.

#### 4.10 Enrollment Data and Requirements for Contractor's Response

The HCA will provide the Contractor with data files with the information needed to perform the services described in this Contract.

- 4.10.1 Data files will be sent to the Contractor at intervals specified within the HCA 834 Benefit Enrollment and Maintenance Companion Guide, published by the HCA and incorporated by reference into this Contract.
- 4.10.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 C.F.R. § 162.103).
- 4.10.3 The data file will be transferred per specifications defined within the HCA Companion Guides.
- 4.10.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify the HCA in writing of the refusal of an application for enrollment or any discrepancy regarding the HCA's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the HCA. The effective date of enrollment specified by the HCA shall be considered accepted by the Contractor and shall be binding if the notice is not timely or the HCA does not agree with the reasons stated in the notice. Subject to the HCA approval, the Contractor may refuse to accept an Enrollee for the following reasons:
  - 4.10.4.1 The HCA has enrolled the Enrollee with the Contractor in a service area the Contractor is not contracted.
  - 4.10.4.2 The Enrollee is not eligible for enrollment under the terms of this Contract.

#### 4.11 Termination of Enrollment

##### 4.11.1 Voluntary Termination of Enrollment

- 4.11.1.1 Enrollees may request termination of enrollment for cause by submitting a written request to terminate enrollment to the HCA or by calling the HCA toll-free customer service number (42 C.F.R. § 438.56(d)(1)(i)). If the Contractor receives a termination request from an Enrollee, the Contractor shall direct the Enrollee to contact HCA.
- 4.11.1.2 For the purposes of this Section, the following are cause for disenrollment (42 C.F.R. § 438.56(d)(2)):
  - 4.11.1.2.1 The Enrollee moves out of the Contractor's service area;
  - 4.11.1.2.2 The Contractor does not, because of moral or religious objections, deliver the service the Enrollee seeks;
  - 4.11.1.2.3 The Enrollee needs related services (for example, birth and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Enrollee's primary care provider or another provider

- determines that receiving the services separately would subject the Enrollee to unnecessary risk;
- 4.11.1.2.4 Other reasons, including but not limited to: Poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the Enrollee's health care needs.
  - 4.11.1.3 Enrollees denied disenrollment for cause or a plan change may request an appeal of the decision through a state hearing.
  - 4.11.1.4 Except as provided in chapter 182-538 WAC, the enrollment for Enrollees whose enrollment is terminated will be prospectively ended. The Contractor may not request voluntary termination of enrollment on behalf of an Enrollee.
  - 4.11.2 Involuntary Termination of Enrollment Initiated by the HCA for Ineligibility.
    - 4.11.2.1 The enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for enrollment due to a change in eligibility status.
  - 4.11.3 When an Enrollee's enrollment is terminated for ineligibility, the termination shall be effective:
    - 4.11.3.1 The first (1<sup>st</sup>) day of the month following the month in which the enrollment termination is processed by the HCA if it is processed on or before the HCA cut-off date for enrollment or the Contractor is informed by the HCA of the enrollment termination prior to the first (1<sup>st</sup>) day of the month following the month in which it is processed by the HCA.
    - 4.11.3.2 Effective the first (1<sup>st</sup>) day of the second month following the month in which the enrollment termination is processed if it is processed after the HCA cut-off date for enrollment and the Contractor is not informed by the HCA of the enrollment termination prior to the first (1<sup>st</sup>) day of the month following the month in which it is processed by the HCA.
  - 4.11.4 Newborns placed in foster care before discharge from their initial birth hospitalization shall have their Apple Health Managed Care enrollment terminated and be enrolled in Apple Health Foster Care (AHFC) effective the first of the month after placement in foster care. Subject to the terms in Subsection 16.4, Enrollee in Facility at Enrollment, the Contractor is responsible for hospital costs until the newborn is discharged from the birth hospitalization.
  - 4.11.5 Involuntary Termination Initiated by the Contractor
    - 4.11.5.1 To request involuntary termination of enrollment of an Enrollee, the Contractor shall send written notice to HCA at [hcamcprograms@hca.wa.gov](mailto:hcamcprograms@hca.wa.gov).
      - 4.11.5.1.1 HCA shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) business days of HCA's receipt of such notice and the documentation

required to substantiate the request. HCA shall approve the request for involuntary termination of the Enrollee when the Contractor has substantiated in writing any of the following (42 C.F.R. § 438.56(b)(1)):

- 4.11.5.1.1.1 The Enrollee purposely puts the safety or property of the Contractor, or the Contractor's staff, providers, patients, or visitors at risk, and the Contractor's attempts to address this behavior with reasonable accommodations of any disability of the Enrollee have not been successful; and continued enrollment would seriously impair the Contractor's ability to furnish services to the Enrollee or any other Enrollees;
  - 4.11.5.1.1.2 The Enrollee engages in intentional misconduct, including refusing without good cause to provide information to the Contractor about third party insurance coverage; or
  - 4.11.5.1.1.3 The Enrollee received written notice from the Contractor of its intent to request the Enrollee's termination of enrollment, unless the requirement for notification has been waived by HCA because the Enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the Enrollee shall include the Enrollee's right to use the Contractor's grievance process to review the request to end the Enrollee's enrollment.
- 4.11.5.2 The Contractor shall continue to provide services to the Enrollee until HCA has notified the Contractor in writing that enrollment is terminated.
- 4.11.5.3 HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).
- 4.11.5.4 The Contractor shall have in place, and provide upon HCA's request, written methods by which it assures it does not request disenrollment for reasons other than those permitted under this Contract (42 C.F.R. § 438.56(b)(3)).
- 4.11.6 An Enrollee whose enrollment is terminated for any reason, other than

incarceration, at any time during the month is entitled to receive contracted services, at the Contractor's expense, through the end of that month.

- 4.11.7 In no event will an Enrollee be entitled to receive services and benefits under this Contract after the last day of the month, in which his or her enrollment is terminated, except:
  - 4.11.7.1 When the Enrollee is hospitalized or in another inpatient facility covered by this Contract at termination of enrollment and continued payment is required in accord with the provisions of this Contract.
  - 4.11.7.2 For the provision of information and assistance to transition the Enrollee's care with another provider.
  - 4.11.7.3 As necessary to satisfy the results of an appeal or hearing.
- 4.11.8 Regardless of the procedures followed or the reason for termination, if a disenrollment request is granted, or the Enrollee's enrollment is terminated by HCA for one of the reasons described in Subsection 4.11.5 of this Contract, the effective date of the disenrollment will be no later than the first day of the second month following the month the request was made. If HCA fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

## 5 PAYMENT AND SANCTIONS

### 5.1 Rates/Premiums

Subject to the Sanctions provisions of this Section, HCA shall pay a monthly premium for each Enrollee in full consideration of the work to be performed by the Contractor under this Contract. HCA will only pay monthly premium payments for Medicaid Enrollees in the eligible client groups detailed in Subsection 4.3 of this Contract. HCA shall pay the Contractor, on or before the fifteenth (15th) calendar day of the month based on the HCA list of Enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 C.F.R. § 438.726(b) or 42 C.F.R. § 438.730(e).

### 5.2 Monthly Premium Payment Calculation

The monthly premium payment for each Enrollee will be calculated as follows:

**Premium Payment = Base Rate X Age/Sex Adjustment Factor X Risk Adjustment Factor X Regional Adjustment Factor X Withhold Factor**

Additional premium payments include Delivery Case Payment Rates and Low Birth Weight Baby Case Payment Rates, as described in Subsections 5.7 through 5.8 of this Contract.

- 5.2.1 The Base Rate is established by HCA and will vary between the Apple Health (AH) Family Adult, AH Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry System (COPEs), Developmental Disability Administration (DDA) and Apple Health Adult Coverage – (AHAC) populations. The base rates will initially be the same for all contractors, but may vary based on ACA related taxes and/or fees.
- 5.2.2 The Age/Sex Adjustment factors are established by HCA and will vary between the AH Family Adult, AH Family Child, SCHIP, AHBD, COPEs, DDA and AHAC populations. The age/sex factors will be the same for all contractors.
- 5.2.3 The Regional Adjustment Factors are recalculated by HCA annually to reflect changes in the relative cost of providing care in different regional service areas of the State. The Regional Adjustment Factors and geographic service areas are the same for all contractors but may vary between AH Family, SCHIP, AHBD, COPEs, DDA and AHAC populations.
- 5.2.4 The Risk Adjustment Factors will be as established for the rates effective January 1, 2018 by HCA for the AH Family Adult, AH Family Child, SCHIP, AHBD, COPEs, DDA and AHAC populations to reflect differences in the relative health status of the populations enrolled with the Contractors. The Risk Adjustment Factors are calculated by region and by Contractor.
- 5.2.5 The Withhold Factor is intended to hold back a percentage amount, as identified in Exhibit D, Value-Based Purchasing, of the capitation payments excluding any administrative, WSHIP, SNAF, PAP, IMD or FQHC/RHC enhancement funding. A calculated portion of the amount withheld from the monthly premium payment will be released upon demonstrated improvement towards the quality measure benchmarks and physician incentive agreements defined in Exhibit D, Value-Based

Purchasing.

- 5.2.6 HCA shall automatically generate newborn premiums upon enrollment of the newborn. For newborns whose premiums HCA does not automatically generate, the Contractor shall submit a premium payment request to HCA within 365 calendar days of the date of birth. HCA shall pay within sixty (60) calendar days of receipt of the premium payment request.
- 5.2.7 HCA shall make a full monthly payment to the Contractor for the month in which an Enrollee's enrollment is terminated except as otherwise provided in this Contract.
- 5.2.8 The Contractor shall be responsible for contracted services provided to the Enrollee in any month for which HCA paid the Contractor for the Enrollee's care under the terms of this Contract.

### 5.3 Annual Fee on Health Insurance Providers

- 5.3.1 The Contractor is subject to a fee (the "Annual Fee") imposed by the federal government under Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (124 Stat. 1029 (2010)) (collectively, "PPACA"), unless specifically exempt under federal law.
- 5.3.2 If the Contractor is responsible for payment of a percentage of the Annual Fee for all health insurance providers, the Contractor's obligation is determined by the ratio of the Contractor's net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Annual Fee for the same year.
- 5.3.3 The amount of the Annual Fee attributable to the Contractor and attributable specifically to the Contractor's premiums under this Contract ("Contractor's Allocated Fee") could affect the actuarial soundness of the premiums received by the Contractor from HCA for the contract year during which the Annual Fee is assessed.
- 5.3.4 A dollar amount reflecting the Contractor's Allocated Fee, which shall also include an adjustment for the impact of non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's Adjusted Fee"), shall be payable to the Contractor under this Contract, unless the Contractor is exempt from the Annual Fee under federal law.
- 5.3.5 HCA shall consult with the Contractor and determine an estimated amount of the Contractor's Adjusted Fee based on the pro rata share of the preliminary notice of the fee amount, as transmitted by the United States Internal Revenue Service to the Contractor, attributable to the Contractor's net written premiums under this Contract.
- 5.3.6 Capitation payments for the period to which the tax applies will be retroactively adjusted to account for this fee. The net aggregate change in capitation payments for the period based on the retroactive rate change will be paid to the Contractor.
- 5.3.7 HCA shall make a good-faith effort to make the estimated payment to the Contractor thirty (30) calendar days before the deadline for payment by the

Contractor.

- 5.3.8 The adjustment shall be reconciled, no later than ninety (90) calendar days following the receipt of the final notice of the fee from the United States Internal Revenue Service, through a retroactive adjustment to the capitation rates for the applicable period and an additional payment to the Contractor, or a refund from the Contractor, as applicable, once the complete data is available to calculate the Contractor's Adjusted Fee.
- 5.3.9 The Contractor agrees to not pursue any legal action whatsoever against HCA or its officers, employees, or agents with respect to the amount of the Contractor's Allocated Fee or Contractor's Adjusted Fee.

#### 5.4 **Medical Loss Ratio (MLR) Report**

- 5.4.1 In accordance with 42 C.F.R. § 438.8, MCOs must report a Medical Loss Ratio (MLR) calculation to HCA on an annual basis.
  - 5.4.1.1 Using the instructions provided in Exhibit F, Instructions for MLR Reporting, and in accordance with 42 C.F.R. § 438.8, the Contractor shall complete the MLR reporting template available in MC-Track for the MLR reporting year beginning January 1, 2018, and submit to HCA no later than May 31, 2019.

#### 5.5 **Gain Share Program**

- 5.5.1 MCOs must report MLR experience calculated in accordance with 42 C.F.R. § 438.8. Any settlements which result from the gain share program calculation will be limited such that the Contractor's minimum MLR will not be less than 85 percent when the settlement amount is included in the MLR calculation.
- 5.5.2 HCA will perform gain share calculations on an annual basis for AH Family Adult, AH Family Child, SCHIP, AHBD, COPEs, DDA, and AHAC populations. Separate calculations of Gain Sharing are done due to differences in assumed administrative loads included in the rates for each program. Upon completion of the separate calculations, the results for the seven populations will be aggregated to determine any net Gain Share payment. Gain Sharing is calculated separately for each Contractor.
- 5.5.3 The following methods will be used to calculate the Gain Share components:
  - 5.5.3.1 Total Revenue is the sum of all Pre-Tax Capitation Rates, Delivery Case Rate Payments and Low Birth Weight Case Payments. Total Revenue also assumes full recovery by the Contractor of Value-Based Purchasing withheld funds, regardless of whether those funds were actually recovered under the capitation withhold arrangement described in Exhibit D, Value-Based Purchasing. Pre-tax capitation rates means that the AH-PDL payments, Health Insurer Fee, and Premium Tax related revenue will be excluded from this (Gain Share) computation.
  - 5.5.3.2 Total Net Revenue is equal to Total Revenue, net of any SNAF, PAP, and WSHIP components (also referred to in aggregate as "supplemental payments") of the capitation revenue.
  - 5.5.3.3 Revenue for Health Care Expenses is defined as the Total Net Revenue

less an assumed administrative load. [(Revenue-supplemental payments) x (1- administrative load)] Actual administrative expenses will not be included in the computation. The administrative load varies by population and rate period. The assumed administrative load is shown on Exhibit A.

- 5.5.3.4 Net Health Care Expenses will be based on the actual medical service expenses incurred during the contract year less any reimbursements from third-party reimbursements (including but not limited to pharmacy rebates, overpayment recoveries from providers, net reinsurance costs or third-party liability offsets) and less supplemental payments plus direct Medical Management costs as defined by NAIC and GAAP guidelines and excluding any overhead allocations. Upon request by HCA, the Contractor will report its health care expenses for the year with any adjustments and run out claims as specified in the request from HCA. The template for providing the data and due date for the report will be included in the request from HCA.
- 5.5.3.5 Contractor's Gain/Loss will be calculated for each population using the following formula: Revenue for **Health Care Expenses - Net Health Care Expenses** (based on the actual incurred expenses for health care) = **Net Gain/Loss** (for the health care services provided by population).
- 5.5.3.6 The net gain/loss divided by the Total Net Revenue will provide a percentage of the gain/loss which will be compared to the gain sharing thresholds established by HCA.
- 5.5.4 Under the Gain Share Program, HCA will share in a significant excess of the Total Net Revenue for Health Care Expenses over the Net Health Care Expenses experienced by the Contractor as defined in subsection 5.5.5 of this Contract. Six (6) months following the end of the calendar year, using the financial reports provided by the Contractor, a simple profit and loss statement will be developed for the health services portion for each of the seven populations.
- 5.5.5 After aggregating the results for all seven populations, if the Contractor experiences gain exceeding 3 percent), HCA will share equally in the gain between 3 percent and 5 percent. HCA will recover all gains exceeding 5 percent. The Contractor will only be required to reimburse HCA if it experiences an actual gain above 3 percent.

## 5.6 Recoupments

- 5.6.1 Unless mutually agreed by the parties in writing, HCA shall only recoup premium payments and retroactively terminate enrollment for an individual Enrollee:
  - 5.6.1.1 With duplicate coverage as defined in this Contract.
  - 5.6.1.2 Who is deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the Enrollee's date of death.
  - 5.6.1.3 Who retroactively has their enrollment terminated consistent with this Contract.
  - 5.6.1.4 Who has been found ineligible for enrollment with the Contractor,



provided HCA has notified the Contractor before the first day of the month for which the premium was paid.

5.6.1.5 Who is an inmate at a correctional facility in any full month of enrollment.

5.6.1.6 Who is residing in an Institute for Mental Disease (IMD) for more than fifteen (15) calendar days within a single calendar month.

5.6.1.7 When an audit determines that payment or enrollment was made in error.

5.6.2 When HCA recoups premium payments and retroactively terminates enrollment for an individual Enrollee, the Contractor's submitted encounter record(s) for the terminated Enrollee for the affected member month(s) are no longer valid. When this occurs, the Contractor:

5.6.2.1 Shall void the invalid encounters;

5.6.2.2 May recoup payments made to providers.

5.6.2.2.1 If the Contractor recoups said payments:

5.6.2.2.1.1 The Contractor must issue proper notice to the provider indicating the reason for the recoupment.

5.6.2.2.1.2 The Contractor's issuance of the notice must be in a timely manner to ensure the provider has the ability to bill the recouped claim(s) to another payer or government entity, if appropriate.

5.6.2.2.1.3 The Contractor's providers may submit appropriate claims for payment to the HCA through its FFS program, with the Contractor's notice of recoupment, if the Enrollee was eligible for covered services.

5.6.3 Retroactive recoupments are determined on an individual Enrollee basis, and not on a family basis. Recouping premiums for one family member does not necessarily mean there will be recoupments taken for other family members.

## 5.7 Delivery Case Rate Payment

A one-time payment shall be made to the Contractor for labor and delivery expenses for AH Family, SCHIP and AHAC Enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if the Contractor has incurred and paid direct costs for labor and delivery based on encounter data received and accepted by HCA. AHBD, DDA, and COPEs Enrollees are not eligible for these payments. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy.

HCA shall not pay the Delivery Case Rate payment for Enrollees who have comparable Third Party Insurance coverage.

## 5.8 Low Birth Weight Baby Case Payment (LBW-BCP)

A one-time payment shall be made to the Contractor for Low Birth Weight Baby related expense for AH Family and SCHIP Enrollees enrolled with the Contractor during the month of a qualifying low birth event. The LBW-BCP payment shall be paid to the Contractor if the following conditions are met:

- 5.8.1 HCA determines the Contractor incurred and paid direct costs for a qualifying low birth weight event based on valid encounter data received and accepted by HCA.
- 5.8.2 Qualifying events that derive one of the following APR-DRG codes: 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 630, 631, 633, 634, 636, or 639 shall qualify for the LBW-BCP.
- 5.8.3 The qualifying claim must have a Contractor paid amount of more than \$75,000.
- 5.8.4 The LBW-BCP is not modified by any rate adjustment factors.
- 5.8.5 The HCA will pay a maximum of 300 LBW-BCP for the contract year. The maximum number of payments is for all contractors, under both AHMC and FIMC contracts, combined.
- 5.8.6 In the event that the maximum number of payments has been reached, the ProviderOne submitted date and time of the qualifying encounter will determine the order of the claims for payment.

## 5.9 Targeted Service Enhancements

The per member per month premium amounts established by HCA will include additional funding for targeted services for the Hospital Safety Net (Safety Net). The Provider Access Payment (PAP) is a directed payment.

- 5.9.1 Provider Access Payment (PAP) Program
  - 5.9.1.1 On a quarterly basis, HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.
  - 5.9.1.2 On a one-time basis, PAP payments paid via the pass-through payment methodology from January 1, 2019 through June 30, 2019 will be reconciled with the directed payment methodology and HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.
  - 5.9.1.3 On a yearly basis, PAP payments for the calendar year will be reconciled with mature encounter data to ensure participating providers PAP payments do not exceed the programs allowable amounts. HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.
- 5.9.2 Hospital Safety Net (Safety Net)
  - 5.9.2.1 HCA will increase the per member premium payments to support increased payment for hospital services provided by Washington hospitals to Medicaid Enrollees. Computation of these amounts included covered services provided in psychiatric and rehabilitation

hospitals.

- 5.9.2.2 HCA will calculate the per member premium based on the estimated funding to be collected and the estimated member month premiums to be paid over the contracted period.

## 5.10 Apple Health Preferred Drug List Payment

- 5.10.1 The cost of all outpatient pharmacy products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form, including prescription drugs on the AH-PDL described in subsection 17.3.3.1 of this Contract, have been excluded from the Base Rates described in subsection 5.2.1 of this Contract for the AH Family Adult, AH Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry System (COPES), Developmental Disability Administration (DDA) and Apple Health Adult Coverage – (AHAC) populations.
- 5.10.2 The Contractor shall continue to administer the outpatient prescription drug program and submit paid encounters for pharmacy products in the National Council for Prescription Drug Programs (NCPDP) Batch format as required in subsection 5.12.
- 5.10.3 HCA shall reimburse the Contractor for the expenditures for outpatient prescription drugs.
  - 5.10.3.1 The Contractor shall be reimbursed for qualifying accepted National Council for Prescription Drug Programs (NCPDP) pharmacy encounters including an administrative fee of \$1.50 by generating a Service Based Enhancement (SBE) payment beginning July 1, 2019. During the first full week of each month from February 2018 through July 2018, HCA will extract the encounter data submitted by the Contractor during the prior month with dates of service on or after January 1, 2018, for paid claims for drugs on the AH-PDL. Starting in August 2018, the data extract will include all outpatient pharmacy products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form with dates of service on or after on or after July 1, 2018. As of July 1, 2019 dates of service, the data extract will only include encounters submitted January 1, 2018 to June 30, 2019. This manual data extract and process will account for encounters that have had a business status change and have not been paid.
  - 5.10.3.2 The encounter data files will be provided to the Contractor via the HCA Secure File Transfer (SFT) sites for the encounters submitted by the Contractor. HCA will send notification to the Contractor via e-mail when the files have been posted to the SFT sites.
  - 5.10.3.3 The Contractor shall review the data files provided within five business days of the date they receive notification of their availability. If the Contractor identifies any discrepancies between the Contractor's records and the data provided, the discrepancies shall be reported to

HCA by the close of business on the fifth day.

- 5.10.3.4 If adjustments are made to the data files, HCA will provide a final version of the data files to the Contractor within five business days.
- 5.10.3.5 HCA will initiate payment via ProviderOne Gross Adjustment to the Contractor for the total paid amount in each final version of the encounter plus the applicable administrative fee within five (5) business days of the finalization of the encounter.

#### 5.11 **Overpayments or Underpayments of Premium**

At its sole discretion, if HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractor, or other causes there are material errors or omissions in the development of the rates, HCA may make prospective and/or retrospective modifications to the rates, as necessary and approved by Centers for Medicare and Medicaid Services (CMS). If HCA determines that it will adjust the rates paid to the Contractor, HCA will provide the Contractor with all underlying data related to the change. The Contractor will have thirty (30) calendar days to review and comment on the underlying data provided by HCA prior to HCA's implementation of the rate change. At the explicit written approval of HCA and CMS, the Contractor can elect to make a lump sum or similar arrangement for payment in lieu of modifications to the rate.

#### 5.12 **Encounter Data**

- 5.12.1 For purposes of this Subsection:
  - 5.12.1.1 "Encounter" means a single health care service or a period of examination or treatment.
  - 5.12.1.2 "Encounter data" means records of health care services submitted as electronic data files created by the Contractor's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.
  - 5.12.1.3 "Encounter record" means the number of service lines or products submitted as line items in the standard 837 format or the National Council for Prescription Drug Programs (NCPDP) Batch format.
  - 5.12.1.4 "Duplicate Encounter" means multiple encounters where all fields are alike except for the ProviderOne Transaction Control Numbers (TCNs) and the Contractors Claim Submitter's Identifier or Transaction Reference Number.
- 5.12.2 The Contractor shall submit and maintain accurate, timely, and complete encounter data to facilitate appropriate rate development and development of enhanced payment amounts that are dependent upon accurate and complete encounter data. The Contractor shall comply with all of the following:
  - 5.12.2.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of encounter data submitted to HCA.
  - 5.12.2.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with

current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:

- 5.12.2.2.1 Encounter data must be submitted to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability;
  - 5.12.2.2.2 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor;
  - 5.12.2.2.3 Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Contractor; and
  - 5.12.2.2.4 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.
- 5.12.2.3 These data quality standards are listed within this Contract and incorporated by reference into this Contract. The Contractor shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended.
- 5.12.3 The Contractor must report the paid date, paid unit, and paid amount for each encounter. The "paid amount" data is considered the Contractor's proprietary information and is protected from public disclosure under RCW 42.56.270(11). Paid amount shall not be utilized in the consideration of a Contractor's assignment percentage or in the evaluation of a Contractor's performance.
- 5.12.4 HCA shall perform encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.
- 5.12.5 The Contractor must certify the accuracy and completeness of all encounter data concurrently with each file upload (42 C.F.R. § 438.606). The certification must affirm that:
- 5.12.5.1 The Contractor has reported to HCA for the month of (indicate month and year) all paid claims for all claim types;
  - 5.12.5.2 The Contractor has reviewed the claims data for the month of submission; and
  - 5.12.5.3 The Contractor's Chief Executive Officer, Chief Financial Officer, or an

individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer attest that based on best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and they hereby certify that no material fact has been omitted from the certification and submission.

- 5.12.6 The Contractor shall submit a signed Monthly Certification Letter, a template is available through MC-Track. This letter must include a list of all submitted encounter data files and is due within five business days from the end of each month. The purpose of this letter is to certify that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful in accordance with 42 C.F.R. § 438.606 and this Contract.
- 5.12.7 The Contractor must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims.
  - 5.12.7.1 Within sixty (60) calendar days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounter data submitted and accepted within required timing in subsection 5.12.2.2 of this Section during that quarter using the Apple Health Quarterly Encounter/General Ledger Reconciliation (Form D), available through MC-Track, and 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 Contractor shall provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the Contractor of the decision 120 calendar days of the end of each calendar quarter.
  - 5.12.7.2 The Contractor's encounter data submitted and accepted on Form D will be validated against submitted and accepted data captured within HCA's ProviderOne System and must be within 1 percent of what HCA captured.
    - 5.12.7.2.1 If the Contractor's encounter data submitted and accepted on Form D is not within 1 percent of the submitted and accepted encounter data captured within HCA's ProviderOne System, HCA will provide the Contractor a list of ProviderOne TCNs and associated Contractor's Transaction Reference Numbers. The Contractor must explain the difference in the encounter data provided by HCA with the encounter data submitted and accepted on Form D for that quarter. HCA will approve or reject the Contractor's explanation. If approved, the reconciliation process will use the submitted and accepted encounter data on the Contractor's Form D. If rejected, the reconciliation process will use the submitted and accepted encounter data captured within HCA's ProviderOne System.
  - 5.12.7.3 Following the completion of the quarterly validation process described in

5.12.7.1 through 5.12.7.2 of this Subsection, HCA may charge the Contractor \$25,000 for nonperformance if the Contractor fails to demonstrate that the encounter data submitted and accepted within required timing reconciles to the general ledger amounts within 1 percent. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

5.12.8 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other program integrity activities, federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies.

5.12.9 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract:

5.12.9.1 HCA may change the Encounter Data Reporting Guide with ninety (90) calendar days' written notice to the Contractor.

5.12.9.2 The Encounter Data Reporting Guide may be changed with less than ninety (90) calendar days' notice by mutual agreement of the Contractor and HCA.

5.12.9.3 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

#### **5.13 Retroactive Premium Payments for Enrollee Categorical Changes**

Enrollees may have retroactive changes in their eligibility category. With the exception of the Recoupment categories listed in Subsection 5.6, such changes will only affect premium payments prospectively.

#### **5.14 Renegotiation of or Changes in Rates**

The rates set forth herein shall be subject to renegotiation during the contract period only if HCA, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation. If HCA, in its sole judgment, determines there is a change in benefits during the term of the Contract that will have a material impact on Contractor costs, HCA may change rates to allow for the benefit change.

#### **5.15 Reinsurance/Risk Protection**

The Contractor may obtain reinsurance for coverage of Enrollees provided that the Contractor remains ultimately liable to HCA for the services rendered.

#### **5.16 Provider Payment Reform**

HCA intends to reform provider payment. The Contractor shall collaborate and cooperate with HCA on provider payment reform. The Contractor will provide in a timely manner any information necessary to support HCA's analyses of provider payment.

## 5.17 Experience Data Reporting

The Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. The experience information shall be provided directly to an actuary designated by HCA. The designated actuary will determine the timing, content, format and medium for such information. HCA requires this information in order to be able to set actuarially sound managed care rates.

## 5.18 Payments to Hospitals

5.18.1 Payments must be made to hospitals subject to the Hospital Safety Net Assessment in accord with chapter 74.60 RCW as follows:

5.18.1.1 HCA will provide information to the Contractor to facilitate its payments to the hospitals subject to the Hospital Safety Net Assessment.

5.18.2 The Contractor will pay all hospitals for services delivered under the Inpatient and Outpatient service categories at rates no less than those published by HCA for its FFS program, including the administrative day rate which is applicable through the date of discharge, regardless of the level of service being provided.

5.18.3 Fourteen-Day Readmission Review Program

5.18.3.1 The Contractor shall conduct review of inpatient admissions that occur within fourteen (14) calendar days of a prior inpatient admission to determine if that readmission is medically necessary. Readmission deemed not medically necessary shall not be reimbursed.

5.18.3.2 The Contractor shall conduct post-pay review of inpatient admissions that occur within fourteen (14) calendar days of a prior inpatient admission to determine if that readmission was potentially preventable. The readmission must be clinically related to the prior admission and avoidable.

5.18.3.2.1 The Contractor shall consider a readmission to be avoidable if there is a reasonable expectation it could have been prevented by the provider through one or more of the following actions:

5.18.3.2.1.1 Providing quality care in the prior admission. A specific quality concern, identified and documented during the first admission which then resulted in the readmission, must be identified;

5.18.3.2.1.2 Completing adequate discharge planning with the prior admission;

5.18.3.2.1.3 Implementing adequate post-discharge follow-up of the prior admission; or

5.18.3.2.1.4 Coordinating between inpatient and outpatient health care teams to provide required care post discharge of the prior admission.



- 5.18.3.3 The Contractor shall not classify a readmission as avoidable or within the provider's ability to affect, if the readmission is:
  - 5.18.3.3.1 At a Critical Access Hospital (CAH);
  - 5.18.3.3.2 Unrelated to conditions or care from the prior admission;
  - 5.18.3.3.3 A planned readmission or necessary for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, burn therapy, dialysis, or other planned inpatient treatment documented in the record or as indicted using patient discharge status "81"-planned readmission;
  - 5.18.3.3.4 A planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case;
  - 5.18.3.3.5 A same-day planned admission to a different hospital unit for continuing care (can include mental health/SUD transfers, rehab transfers, etc. which may be technically coded as discharge/admission for billing reasons);
  - 5.18.3.3.6 An admission for required treatments for cancer including treatment-related toxicities, or care for advanced-stage cancer;
  - 5.18.3.3.7 End of life and hospice care;
  - 5.18.3.3.8 Obstetrical readmissions for birth after an antepartum admission;
  - 5.18.3.3.9 Admissions with a primary diagnosis of mental health or SUD issue;
  - 5.18.3.3.10 Neonatal readmissions;
  - 5.18.3.3.11 Transplant readmissions within 180 days of transplant;
  - 5.18.3.3.12 Readmissions when the index admission occurred in a different hospital system;
  - 5.18.3.3.13 To complete care for an Enrollee who left Against Medical Advice from a prior admission;
  - 5.18.3.3.14 Due to Enrollee non-adherence despite appropriate discharge planning and supports. This also includes cases where the recommended discharge plan was refused by the Enrollee, and a less appropriate alternative plan was made to accommodate Enrollee preferences; this must be clearly documented in the record; or
  - 5.18.3.3.15 Because the Contractor did not fulfill its responsibility for post discharge services that would have prevented the readmission.

- 5.18.3.4 The Contractor shall work with its providers to assure they understand

their role and take the following actions to prevent the occurrence of a readmission within fourteen (14) calendar days of a prior admission:

- 5.18.3.4.1 Create a discharge summary including summary of diagnoses, care provided, medication list, and follow up plan;
  - 5.18.3.4.2 Determine the Enrollee's needs to support a safe discharge and write orders accordingly;
  - 5.18.3.4.3 Ensure the discharge summary is sent to the PCP or follow-up provider;
  - 5.18.3.4.4 Provide all required prescriptions and educate the Enrollee about appropriate use of the medication(s);
  - 5.18.3.4.5 Provide written discharge instructions, accompanied by an explanation, to the Client and family/guardian;
  - 5.18.3.4.6 Provide appropriate contact telephone numbers to Enrollee or family/guardian to call for discharge related questions; and
  - 5.18.3.4.7 Document clearly in a readable format the content of discussion with the Contractor (call, fax, etc.).
- 5.18.3.5 The Contractor shall share responsibility with its providers to successfully manage the discharge to prevent a readmission. The Contractor shall coordinate with the provider to remove any barriers the provider may face in implementing the discharge plan and the elements of care.
- 5.18.3.6 In addition to the services required in the Transitional Services section of this Contract, the Contractor shall:
- 5.18.3.6.1 Resolve any barriers to implementing ordered services;
  - 5.18.3.6.2 Ensure a follow-up appointment is scheduled according to the discharge instructions (typically seven (7) calendar days);
  - 5.18.3.6.3 Educate the Enrollee about the importance of attending the follow-up appointment, and provide assistance to the Enrollee in getting to the appointment, including helping with transportation arrangements;
  - 5.18.3.6.4 Assure implementation of DME or non-durable supply orders, and the Enrollee is given appropriate education on use;
  - 5.18.3.6.5 Assess the need for and arrange, as indicated, an in-home safety assessment with appropriate follow up as needed;
  - 5.18.3.6.6 Assess and address relevant financial and social needs of the Enrollee;

- 5.18.3.6.7 Respond timely to implement any changes required in the discharge plan to sustain a successful discharge; and
- 5.18.3.6.8 Provide case management services, as needed, to prevent readmission.
- 5.18.3.7 If a readmission occurs because of the Contractor's failure to fulfill its responsibilities, or a component of its shared responsibilities, the Contractor shall not deny payment for the readmission.
- 5.18.3.8 The Contractor shall use the template letters created with the HCA to support this program.
- 5.18.3.9 The Contractor must provide a first and second level re-review to the hospital or physician if the Contractor has deemed the provider failed to provide the level of care described above and was responsible for the readmission.
  - 5.18.3.9.1 After exhausting the Contractor's first and second level re-review process, the hospital may request HCA to conduct a review if a dispute between the Contractor and the provider still exists about payment and assignment of responsibility. The Contractor shall appeal to HCA for a "Potentially Preventable" case review when the Contractor and the hospital or attending physician are unable to agree on assignation of responsibility for the readmission and the provider continues to dispute the Contractor's determination.
  - 5.18.3.9.2 The Contractor and the hospital or attending physician will each present a written summary of their position and supporting clinical documentation to HCA. The Contractor shall collect the information and request submitted by the hospital or physician as well as the Contractor's information to HCA within fourteen (14) calendar days of the hospital's request. HCA shall convene an internal panel to review the documents and make a final assignment of responsibility.
- 5.18.3.10 The Contractor shall respond within fourteen (14) calendar days to any request from HCA for readmission review information and data required in response to a concern for a pattern of inappropriate adjudication presented to HCA by a hospital.
- 5.18.3.11 The Contractor shall submit a quarterly report, due thirty (30) days after the end of each quarter (April, July, October) with a comprehensive annual report for the previous year, by January 31 of each year. The report must include:
  - 5.18.3.11.1 Total number of patients readmitted to any hospital within fourteen (14) days of discharge from a prior hospitalization (regardless of preventability);

- 5.18.3.11.2 Number of readmissions reviewed by the Contractor for determination of Provider Potentially Preventable Readmission (PPPR) status;
  - 5.18.3.11.3 Number of readmissions identified as PPPR with recoupment requested from the hospital;
  - 5.18.3.11.4 For each readmission identified in 5.18.3.11.3 above:
    - 5.18.3.11.4.1 Recouped amount;
    - 5.18.3.11.4.2 Hospital;
    - 5.18.3.11.4.3 Primary and secondary diagnosis of admission; and
    - 5.18.3.11.4.4 Rationale for denial (brief narrative description of what criteria were used to determine that the readmission was preventable and how the case met these criteria).
  - 5.18.3.11.5 Number of cases contested by hospitals, how these were handled, and outcome of dispute; and
  - 5.18.3.11.6 Estimated Contractor staffing time for PPPR process.
- 5.18.4 Treatment of Inpatient Hospital Claims for Certified Public Expenditure (CPE) Hospitals.
- 5.18.4.1 Because HCA can leverage additional federal funds for FFS inpatient claims at CPE facilities, these expenditures were carved out of the premium payments for the blind and disabled populations moved from FFS to Apple Health Managed Care beginning July 1, 2012. HCA will separately identify the Enrollees subject to the carve-out. If an Enrollee's eligibility category changes to AHBD while he or she is an inpatient at a CPE hospital:
    - 5.18.4.1.1 The Contractor is responsible for the claim when the AHBD eligibility does not cover the entire hospitalization.
    - 5.18.4.1.2 HCA is responsible for the inpatient claim when the Enrollee's AHBD eligibility covers the entire hospitalization.
  - 5.18.4.2 While premiums are net of CPE inpatient hospital claims, the Contractor does remain at risk for these FFS claims if they exceed expectations. CPE inpatient hospital expenditure benchmarks will be computed on a per-member-per month (PMPM) basis, and will vary by category, age, gender and region.
  - 5.18.4.3 After the end of each calendar year, HCA will compute aggregate CPE hospital FFS expenditures attributable to the Contractor, based upon actual enrollment. Actual CPE hospital expenditures for all Contractor enrolled member months will be compared to the Contractor specific benchmarks that take into account changes in utilization and risk. If

actual expenditures exceed the established benchmarks, the Contractor will reimburse the State for the amount of the excess. The State will not make payments to any MCO if expenditures are below benchmark amounts.

5.18.4.4 The following is a list of CPE Hospitals:

5.18.4.4.1 University of Washington Medical Center

5.18.4.4.2 Harborview Medical Center

5.18.4.4.3 Cascade Valley Hospital

5.18.4.4.4 Evergreen Hospital and Medical Center

5.18.4.4.5 Kennewick General Hospital

5.18.4.4.6 Olympic Medical Center

5.18.4.4.7 Samaritan Hospital – Moses Lake

5.18.4.4.8 Skagit County Hospital District #2 – Island

5.18.4.4.9 Skagit Valley Hospital

5.18.4.4.10 Valley General Hospital – Monroe

5.18.4.4.11 Valley Medical Center - Renton

5.18.4.5 The Contractor shall authorize inpatient services at CPE hospitals. The HCA shall honor the Contractor's authorizations for the Contractor's provision of services related to inpatient claims.

5.18.4.6 The HCA shall provide reports to the Contractor detailing CPE hospital payments on a quarterly basis. The Contractor shall conduct quarterly audits of CPE hospital payments to confirm Contractor authorization of CPE hospital stays. The Contractor shall provide a quarterly report to HCA of all CPE hospital stays not authorized by the Contractor, including the recommended payment amount of CPE hospital recoupments. The Contractor shall submit its quarterly reports to HCA within thirty (30) business days of receiving the quarterly payment reports from the HCA.

#### 5.19 **Payment for Services by Non-Participating Providers**

5.19.1 The Contractor shall limit payment for emergency services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid FFS program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).

5.19.2 Except as provided herein for emergency services, the Contractor shall coordinate with and pay a non-participating provider that provides a service to Enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the state. For the purposes of this subsection, "contracts with similar providers in the state" means the Contractor's contracts with similar providers to provide services under the managed care program when the payment is for services received by a managed care Enrollee.

- 5.19.3 The Contractor shall track and record all payments to participating providers and non-participating providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating providers and non-participating providers separately. The Contractor shall identify the type of providers and subspecialty according to specifications provided by HCA. The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill Enrollees.
- 5.19.4 The Contractor shall provide annual reports to the HCA for the preceding state fiscal year July 1 through June 30. The reports shall indicate the proportion of services provided by the Contractor's participating providers and non-participating providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to HCA no later than August 15 of each year, or as required by HCA.

## 5.20 Data Certification Requirements

Any information and/or data required by this Contract and submitted to HCA shall be certified by the Contractor as follows (42 C.F.R. § 438.242(b)(2) and 438.600 through 438.606):

- 5.20.1 Source of certification: The information and/or data shall be certified by one of the following:
  - 5.20.1.1 The Contractor's Chief Executive Officer.
  - 5.20.1.2 The Contractor's Chief Financial Officer.
  - 5.20.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.
- 5.20.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.
- 5.20.3 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.
- 5.20.4 HCA will identify the specific data that requires certification.

## 5.21 Sanctions

- 5.21.1 If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, HCA may impose sanctions by withholding from the Contractor up to five percent of its scheduled payments or may suspend or terminate assignments and re-enrollments (defined as connecting an Enrollee who lost eligibility with the Contractor which he or she was enrolled in when he or she lost enrollment).
- 5.21.2 HCA shall notify the Contractor of any default in writing, and shall allow a cure period of up to thirty (30) calendar days, depending on the nature of the default. If the Contractor does not cure the default within the prescribed period, HCA may withhold payment, assignments, or re-enrollments from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

- 5.21.2.1 HCA will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in the Disputes provisions of the General Terms and Conditions Section of this Contract, if the Contractor disagrees with HCA's position.
- 5.21.2.2 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with applicable law, including but not limited to 42 C.F.R. § 438.700, 42 C.F.R. § 438.702, 42 C.F.R. § 438.704, 45 C.F.R. § 92.36(i)(1), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210 against the Contractor for:
  - 5.21.2.2.1 Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an Enrollee covered under this Contract.
  - 5.21.2.2.2 Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.
  - 5.21.2.2.3 Acting to discriminate against Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an Enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services.
  - 5.21.2.2.4 Misrepresenting or falsifying information that it furnishes to CMS, HCA, an Enrollee, potential Enrollee, or any of its subcontractors.
  - 5.21.2.2.5 Failing to comply with the requirements for physician incentive plans.
  - 5.21.2.2.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or materially misleading information.
  - 5.21.2.2.7 Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.
- 5.21.2.3 HCA may base its determinations regarding Contractor conduct on findings from onsite surveys, Enrollee or other complaints, financial status, or any other source.
- 5.21.2.4 Except for matters and penalties covered under chapters 74.09 and 74.66 RCW, intermediate sanctions may include:
  - 5.21.2.4.1 Civil monetary sanctions in the following amounts:

- 5.21.2.4.1.1 A maximum of \$25,000 for each determination of failure to provide services; distribution of marketing materials that have not been approved by HCA, or that contain false or misleading information, misrepresentation or false statements to Enrollees, potential Enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.
- 5.21.2.4.1.2 A maximum of \$100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or HCA.
- 5.21.2.4.1.3 A maximum of \$15,000 for each potential Enrollee HCA determines was not enrolled because of a discriminatory practice subject to the \$100,000 overall limit.
- 5.21.2.4.1.4 A maximum of \$25,000 or double the amount of the charges, whichever is greater, for charges to Enrollees that are not allowed under managed care. HCA will deduct from the penalty the amount charged and return it to the Enrollee.
- 5.21.2.4.2 Appointment of temporary management for the Contractor as provided in 42 C.F.R. § 438.706. HCA will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033 or other applicable law.
- 5.21.2.4.3 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA shall notify current Enrollees of the sanctions and that they may terminate enrollment at any time.
- 5.21.2.4.4 Suspension of payment for Enrollees enrolled after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

## 5.22 Payment to FQHCs/RHCs

- 5.22.1 HCA will pay to the Contractor a lump sum monthly amount intended to provide funding to supplement the Contractor's payment to each of its contracted Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) to ensure that each FQHC/RHC receives its entire, specific encounter rate for each qualifying encounter. This monthly amount to be paid to the Contractor in a lump sum and



subsequently disbursed to each FQHC/RHC as directed by HCA is called an enhancement payment.

5.22.1.1 The lump sum payment to the Contractor for its contracted FQHC/RHC will continue to be based on a prior month's client assignments. The total amount of enhancement payment to be made to each Contractor will be based on the Contractor's correct and timely reporting and submission of client assignment roster files to HCA on a monthly basis. For purposes of this Section, the "client assignment roster file" is the electronic file submitted monthly by the Contractor to HCA that is intended to identify the FQHC/RHC to which a Managed Care client has been assigned by the Contractor. The client assignment roster file is specific to client assignment and the resulting per-client enhancement payment only, and it is a separate and distinct process from encounter claim submission. It is this per-client enhancement payment, or capitation payment, that is aggregated by FQHC/RHC and paid to the Contractor for disbursement to the individual FQHC/RHC. The amount due to each FQHC/RHC will be provided to the Contractor by HCA.

5.22.1.1.1 The Contractor shall submit its client assignment roster files to HCA no later than the 15th of the month for the current month of enrollment. HCA will pay to the Contractor a lump sum enhancement payment in the following month. Without exception, any client assignment roster file data received after the 15th of the month will be included in the next payment cycle for HCA's payment to the Contractor.

5.22.1.1.2 Incorrectly submitted client assignment roster files and/or data records within the client assignment roster files will not be included in any payment to the Contractor and must be corrected and re-submitted by the Contractor to HCA before payment is made. Corrected client assignment roster files received after the 15th of the current month will be included in the following month's cycle for payment purposes. Retroactive enrollment and disenrollment shall follow the same timeline and procedure and will be processed no differently than client assignment roster files for the current month.

5.22.1.1.3 Using correctly submitted client assignment roster files, HCA will base the total enhancement payment due to the Contractor on the number of successfully loaded client records multiplied by the specific enhancement rate of each contracted FQHC/RHC. Thus, payment due to each Contractor will be the aggregated amount of all capitation payments for each contracted FQHC/RHC

5.22.1.2 HCA will provide the Contractor with the monthly enhancement payment

funds separately from the monthly premium payments.

- 5.22.1.2.1 These supplemental payments will include the load for the 2 percent premium tax as shown on Exhibit A-AHFQHC and A-AHRHC of this Contract. The premium tax is retained by the Contractor and is not paid to the FQHC/RHC.
- 5.22.1.2.2 The enhancement payments will be calculated separately and apart from the risk-based capitation payments made to the Contractor by HCA and at no time will the Contractor be at risk for or have any claim to the enhancement payments.
- 5.22.2 The FQHC/RHC is entitled to its specific, full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Section 1902(bb) of the Social Security Act (42 USC § 1396a(bb)). The full encounter rate shall be at least equal to the Prospective Payment System (PPS) rate specific to each FQHC/RHC and applies to FQHC/RHC reimbursed under the Alternative Payment Methodology (APM) rate methodology and to FQHC/RHC reimbursed under the PPS rate methodology. The encounter rates and enhancement rates for each contracted FQHC/RHC will be provided by HCA to the Contractor on a quarterly basis or sooner if any changes or corrections are needed. The rate files will be published to this location (<http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>), according to the following schedule: January 1, April 1, July 1 and October 1. Any changes that occur during the quarter will be included in the next file and will specify the effective date of the change.
- 5.22.3 To ensure that each FQHC/RHC receives its entire encounter rate for each qualifying encounter, the Contractor shall pay each contracted FQHC/RHC in one (1) of the ways described below:
  - 5.22.3.1 Under the first payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to payment of claims for services made at standard rates paid to the FQHC/RHC by the Contractor. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA.
  - 5.22.3.2 Under the second payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to any monthly capitation rates for services. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA.
  - 5.22.3.3 Within the third payment method, for participating RHCs only, the Contractor shall pay the clinic their full encounter rate for encounter-

eligible RHC services. For these RHCs, the Contractor will not pass the enhancement payments through to the clinics. MCOs will use the funds for the sole purpose of paying RHCs their full encounter rate at the time the claim is processed. HCA will notify the Contractor of participating RHC NPIs.

- 5.22.3.4 The Contractor must ensure that all encounter-eligible services as defined in HCA's "Rural Health Clinic Billing Guide" are paid at the RHC encounter rates to participating RHCs. RHCs encounter rates are published quarterly and are available at: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides>. The Contractor shall make changes or correction to any systems or processes as needed to comply with HCAs guidelines for billing RHC encounter claims.
- 5.22.4 For all RHCs under the payment method described in subsection 5.22.3.4 HCA will perform an annual reconciliation with the Contractor. Reconciliations will ensure that each participating RHC received its full encounter rate for each qualifying claim and that MCOs are not put at risk for, or have any right to, the enhancement portion of the claim. Reconciliations will be conducted in the second half of the calendar year following the calendar year for which enhancements were made.
  - 5.22.4.1 Claims included in RHC encounter reconciliations between the Contractor and HCA will include:
    - 5.22.4.1.1 An eligible RHC encounter service as outlined in the RHC Billing Guide (found at: <https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides#>);
    - 5.22.4.1.2 A T1015 procedure code; and
    - 5.22.4.1.3 A certified RHC Billing NPI (participating NPIs will be shared by HCA with MCOs at least annually).
  - 5.22.4.2 HCA will base reconciliation findings on the Contractor's timely submission of encounter data, as specified in subsection 5.12 of this Contract. Actual payment amounts will be used for each RHC reconciliation, except for the RHCs that receive payment from the Contractor under a capitated model. Reconciliation for the RHCs that are capitated will utilize a FFS equivalency methodology.
  - 5.22.4.3 For any underpayment in which the Contractor did not receive sufficient monthly supplemental payments in the previous year, HCA shall pay the Contractor the amount due. For any overpayment in which the MCO received more than its sufficient monthly supplemental payment in the previous year, HCA shall recoup the amount due from the Contractor.
  - 5.22.4.4 Following HCA's notification of reconciliation results, the Contractor shall have thirty (30) calendar days to review and respond to the outcome and provide justification for any discrepancies or findings. The Contractor will address any findings outlined by the HCA including any instances in which an RHC was not paid appropriately. Following the

review period, the Contractor shall make these payments to the FQHC/RHC as designated by HCA within the next thirty (30) calendar days.

- 5.22.5 For RHCs that have arranged to receive the full encounter payment the Contractor shall ensure clinics receive their full encounter payments for global maternity visits.
- 5.22.6 The Contractor shall ensure it has sufficiently trained staff to handle calls and/or inquiries from providers regarding the reimbursement process and client assignment.

### 5.23 **Payment of Physician Services for Trauma Care**

The Contractor shall pay physician services an enhancement for severe trauma care. If all criteria are met, the trauma enhancement must be at least 275 percent of the Contractor's standard rate for the service.

- 5.23.1 To qualify for the trauma care enhancement, a service must meet all of the following criteria:
  - 5.23.1.1 The service must be provided by a physician or clinician;
  - 5.23.1.2 The service must be hospital-based, with a billed place of service 21, 22, 23, 24, 51, 52, or 56;
  - 5.23.1.3 The service must be provided in a Department of Health designated or recognized trauma service center; and
  - 5.23.1.4 The provider has indicated that the injury severity score (ISS) criteria has been met by billing with modifier ST in any position. The ISS must be:
    - 5.23.1.4.1 Thirteen (13) or greater for clients age 15 and older;
    - 5.23.1.4.2 Nine (9) or greater for clients younger than age 15;
    - 5.23.1.4.3 Zero (0) or greater when the service is provided at a Level I, II, or III trauma service center when the trauma case is received as a transfer from another facility.
- 5.23.2 Rehabilitation and surgical services provided within six months of the date of an injury that meets all criteria in subsection 5.23.1 may also receive the enhancement rate if all of the following criteria are met:
  - 5.23.2.1 The follow-up procedures are directly related to the qualifying traumatic injury;
  - 5.23.2.2 The follow-up procedures were planned during the initial acute episode of care, i.e. the inpatient stay; and
  - 5.23.2.3 The plan for the follow-up procedure(s) is clearly documented in the medical record of the client's initial hospitalization for the traumatic injury.
- 5.23.3 Exemptions. The following services are never subject to trauma care enhancements:

5.23.3.1 Laboratory and pathology services; or

5.23.3.2 Technical component only (TC) charges

**5.24 Payment to Freestanding Birthing or Childbirth Centers**

The Contractor will pay all Freestanding Birthing or Childbirth Centers licensed by the Department of Health a facility fee at a rate no less than those published by HCA for its FFS Planned Home Births & Births in Birthing Center program.

**5.25 Nonpayment for Provider Preventable Conditions**

The Contractor shall comply with WAC 182-502-0022, on Provider Preventable Conditions (PPCs) – Payment Policy. The Contractor shall deny or recover payments to healthcare professionals and inpatient hospitals for care related to the treatment of the consequences of Healthcare Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), also known as Serious Adverse Events.

5.25.1 The Contractor shall require all providers to report PPC associated with claims for payment or Enrollee treatments for which payment would otherwise be made. (42 C.F.R § 434.6(a)(12)).

**5.26 Billing for Services Provided by Residents**

The Contractor shall allow teaching physicians to submit claims for primary care services provided by interns and residents under supervision of the teaching physician as described in HCA's Physician's Billing Guide.

## **5.27 Funding for Enrollees Residing in an Institute for Mental Disease (IMD)**

- 5.27.1 Federal funds may not be used to cover the cost of care for an Enrollee when the Enrollee resides in an IMD for more than fifteen (15) calendar days in a single calendar month.
- 5.27.2 HCA will take-back each per-member, per-month (PMPM) premium payment for Enrollees who had resided in an IMD for more than fifteen (15) calendar days within one (1) calendar month in the 365-day period preceding the reconciliation period (described below).
- 5.27.3 On an annual basis, HCA will provide a report to the Contractor for each Enrollee who had an IMD stay of more than fifteen (15) calendar days within one calendar month during the preceding 365-day period. HCA will post the reports to the Contractor's Secure File Transfer (SFT) site during the reconciliation period. Using instructions provided by HCA, the Contractor will have thirty (30) calendar days following the posting date to review and comment on the underlying data provided by HCA. Within ten (10) business days after the Contractor has the opportunity to review and comment on the underlying data, HCA will recover the PMPM premium for identified IMD stays. As of July 1, 2018, this process excludes IMD stays that are attributable to Substance Use Disorders, because this experience is included in the behavioral health rate.
- 5.27.4 HCA will pay the Contractor a separate physical health IMD state funds only monthly premium payment for each Enrollee. The Contractor will use these funds for the cost of physical health claims paid on behalf of an IMD Enrollee during the calendar month for which HCA recovered the PMPM premium. HCA will issue monthly manual payments via the ProviderOne gross adjustment process for adults enrolled in AHMC. The IMD rates for each program will be included in Exhibit A.
- 5.27.5 Using the enrollment data from the monthly premium payment files for the AHMC contract, HCA will calculate the total IMD amount due to each MCO by multiplying the applicable IMD rate by the Enrollee count for each program. Once the batch payments have been initiated, HCA will send the Contractor the summary level files used for the calculations and an email with the payment amount by contract and managed care program, indicating the batch date for the payment.
- 5.27.6 When HCA recovers a premium payment for an Enrollee in accordance with this Section, the Contractor must adjust the paid claims and capitated payments made for the affected month of service to reflect that the claims were paid from the IMD funds described in this Section.

## **5.28 Challenge Pool Value-Based Purchasing Incentives**

The Contractor is eligible to receive annual Challenge Pool funds for timely reporting of data under Exhibit D, Value-Based Purchasing in this Contract, for demonstrating achievement in adopting Alternative Payment Methodologies in its contracts with providers, and for high performance on quality metrics defined by HCA. The conditions under which the Contractor may earn these funds are defined in Exhibit E, Challenge Pool Value-Based Purchasing Incentives.

## 5.29 **Payment for 2017 Ground Emergency Medical Transport (GEMT) Services**

- 5.29.1 During the 2019 calendar year contract period, funds will be provided to the Contractor by HCA for payment of eligible services that occurred between January 1, 2017 and December 31, 2017.
- 5.29.2 The Contractor shall pay GEMT participating provider emergency transports for eligible services that occurred between January 1, 2017 and December 31, 2017 at the provider's individual cost based rate as provided by HCA on a provider-specific GEMT fee schedule, based on the following criteria:
  - 5.29.2.1 The provider must be a participating publicly owned or operated ground emergency medical transport provider as defined in 42 C.F.R. § 433.50. This is a voluntary program and eligible providers will be determined by the HCA and a list of eligible providers will be provided to the Contractor prior to payment;
  - 5.29.2.2 The transport being billed must be for a Title XIX client;
  - 5.29.2.3 The transport must be an emergency medical transportation as defined in WAC 182-546-0001: "ambulance transportation during which a client receives needed emergency medical services en-route to an appropriate medical facility";
  - 5.29.2.4 The transport must be provided by a Department of Health credentialed and recognized ambulance provider, and defined in WAC 182-546-0300;
  - 5.29.2.5 The provider has attested that the transport meets all state and federal policies and statutes; and
  - 5.29.2.6 The transport occurred between January 1, 2017 and December 31, 2017.

## 5.30 **Mental Health Payer**

The Contractor shall follow the rules for payer of responsibility set forth in the chart labelled "How do providers identify the correct payer" in the Washington Apple Health (Medicaid) Mental Health Billing Services Guide.

## 6 ACCESS TO CARE AND PROVIDER NETWORK

### 6.1 Network Capacity

- 6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to provide adequate access to all services covered under the Contract for all Enrollees, including those with limited English proficiency or physical or mental disabilities (42 C.F.R. § 438.206(b)(1)).
- 6.1.2 On a quarterly basis, no later than the 15<sup>th</sup> of the month following the last day of the quarter, the Contractor shall provide documentation of its provider network, including the six critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.9 of this Section to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private providers to allow Enrollees a choice of service systems or clinics. The report shall include information regarding the Contractor's maintenance, monitoring and analysis of the network. The quarterly reports shall include a one page narrative describing the contracting activities in border communities and service areas.
- 6.1.3 The Contractor shall have written policies and procedures for selection and retention of network providers that, at a minimum, meet the requirements of 42 C.F.R. § 438.214.
- 6.1.4 In addition to the quarterly reports required under this Subsection, the Contractor shall also submit updated provider network information within ten (10) business days when requested by HCA or in the following circumstances:
  - 6.1.4.1 At the time it enters into a contract with HCA;
  - 6.1.4.2 At any time there has been a change in the Contractor's network or operations that, in the sole judgement of HCA, would materially affect capacity and/or the Contractor's ability to provide services (42 C.F.R. § 438.207(b and c)), including:
    - 6.1.4.2.1 Changes in services, benefits, geographic service area or payments; or;
    - 6.1.4.2.2 Enrollment of a new population in the Contractor.
- 6.1.5 Provider network information will be reviewed by HCA for:
  - 6.1.5.1 Completeness and accuracy;
  - 6.1.5.2 The need for HCA provision of technical assistance;
  - 6.1.5.3 Removal of providers who no longer contract with the Contractor; and
  - 6.1.5.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this Section.
- 6.1.6 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure timely access to necessary care, including inpatient



and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.

- 6.1.7 Inaccurate or Incomplete Submissions: For each quarterly network submission that is not submitted in the HCA-developed format as described in the submission Data Definitions that accompany the contract submission documents, HCA may charge the Contractor \$5,000 for nonperformance. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.
- 6.1.7.1 If the submission must be returned to the Contractor for corrections, and the submission contained errors that reflect a material loss of providers in a service area, the Contractor's assignments shall be suspended for that service area. Suspension of assignments shall continue until the quarter in which the Contractor submits an accurate submission for that service area.
- 6.1.8 Late Submissions: For each quarterly network submission that is not submitted by the due date and does not have written approval from HCA prior to the due date for the late submission, HCA may charge the Contractor \$1,000 for the first day, and \$100 per day thereafter for nonperformance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.
- 6.1.9 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of providers in any contracted service area including all critical provider types: Primary Care Providers, Hospitals, Pharmacy, Mental Health, Obstetrician/Gynecologist, and Pediatrician and high volume specialties identified by the Contractor, for two consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area.
- 6.1.10 The Contractor shall provide contracted services through non-participating providers, at a cost to the Enrollee that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.
- 6.1.11 The Contractor shall maintain an online provider directory that meets the requirements listed below and include information about available interpreter services, communication, and other language assistance services. Information must be provided for each of the provider types covered under this Contract: physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers as appropriate. The Contractor shall make all information in the online provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary. The Contractor

shall also make copies of all provider information in the online provider directory available to Enrollees in paper form upon request. The online provider directory must meet the following requirements:

- 6.1.11.1 Maintain a link on the front page of the Contractor's website that immediately links users to the Contractor's online, searchable provider directory.
- 6.1.11.2 Include a list of all clinics and primary and specialty providers, including street addresses, telephone numbers, and URLs, as available.
- 6.1.11.3 Include any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges, or provider groups with which a provider is a member.
- 6.1.11.4 Includes a description of each primary and specialty provider's languages spoken, including American Sign Language, and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili", and whether the provider has completed cultural competence training.
- 6.1.11.5 Includes information about whether the Contractor's network providers' office/facilities have accommodations for people with physical disabilities, including offices, exam room(s), and equipment.
- 6.1.11.6 Indicates whether each primary and specialty provider, including mental health professionals (MHPs) are accepting new patients. Pediatric MHPs must be listed separately from adult MHPs.
  - 6.1.11.6.1 Search capability to locate providers contracted to provide mental health services to children and youth who are accepting new patients (chapter 74.09 RCW).
- 6.1.11.7 Include a list of hospitals, pharmacies, and DME providers.
- 6.1.11.8 Include a specific description of any telemedicine services available from a listed provider and at what facilities.
- 6.1.11.9 Update the provider directory within thirty (30) calendar days of a change in the Contractor's network that would affect adequate capacity in a service area, or the Contractor receives updated provider information, including providers who are no longer under contract with the Contractor. (42 C.F.R § 438.10(h)(3)).
  - 6.1.11.9.1 If the Contractor chooses to provide paper provider directories, they must be updated monthly.
- 6.1.11.10 The Contractor shall have in place a process for Enrollees, Potential Enrollees and other individuals to identify and report potential inaccurate, incomplete, or misleading information in the Contractor's online directory. The Contractor shall provide a dedicated email address and either a form on the website or a telephone number so that errors can be reported directly through the website. Errors must be

corrected within ten (10) business days.

- 6.1.11.11 Contractor program staff shall provide assistance to Enrollees and Potential Enrollees in conducting provider searches based on office or facility location, provider discipline, provider capacity, and available languages.

## 6.2 Service Delivery Network

In the maintenance, monitoring and reporting of its network, the Contractor must consider the following (42 C.F.R. § 438.206(b)):

- 6.2.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.
- 6.2.2 Adequate access to all services covered under this Contract.
- 6.2.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the population represented by the Contractor's Enrollees and potential Enrollees.
- 6.2.4 The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services, including mental health providers by provider type.
- 6.2.5 The number of network providers who are not accepting new Enrollees or who have placed a limit, or given the Contractor notice of the intent to limit their acceptance of Enrollees.
- 6.2.6 The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees or potential Enrollees, and whether the location provides physical access for the Contractor's Enrollees with disabilities.
- 6.2.7 The cultural, racial/ethnic composition and language needs of Enrollees and the ability of network providers to communicate with limited English proficient Enrollees in their preferred language.
- 6.2.8 The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
- 6.2.9 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visit, and other evolving and innovative technological solutions.

## 6.3 Timely Access to Care

The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services (42 C.F.R. § 438.206(b) and (c)). The Contractor shall ensure that:

- 6.3.1 Network providers offer access comparable to that offered to commercial Enrollees or, if the Contractor serves only Medicaid Enrollees, comparable to Medicaid FFS.
- 6.3.2 Mechanisms are established to ensure compliance by providers.
- 6.3.3 Providers are monitored regularly to determine compliance.

6.3.4 Corrective action is initiated and documented if there is a failure to comply.

#### 6.4 **Hours of Operation for Network Providers**

The Contractor must require that network providers offer hours of operation for Enrollees that are no less than the hours of operation offered to any other patient (42 C.F.R. § 438.206(c)(1)(iii)).

#### 6.5 **24/7 Availability**

The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services may be provided directly by the Contractor or may be delegated to subcontractors (42 C.F.R. § 438.206(c)(1)(iii)).

6.5.1 Medical or mental health advice for Enrollees from licensed Health Care Professionals.

6.5.2 Triage concerning the emergent, urgent or routine nature of medical and mental health conditions by licensed Health Care Professionals.

6.5.3 Authorization of urgent and emergency services, including emergency care for mental health conditions and services provided outside the Contractor's service area.

6.5.4 The Contractor must notify HCA five (5) business days in advance of any non-scheduled closure during scheduled business days, except in the case when advanced notification is not possible due to emergency conditions.

6.5.5 The Contractor shall either cover emergency fills without authorization, or guarantee authorization and payment after the fact for any emergency fill dispensed by a contracted pharmacy.

6.5.5.1 The Contractor shall post the Emergency Fill policy on its website to be visible and easy to access for providers.

#### 6.6 **Customer Service**

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., Pacific Time, Monday through Friday, year round and shall provide customer service on all dates that are recognized as work days for state employees. HCA may authorize exceptions to this requirement if the Contractor provides HCA with written assurance that its providers will accept enrollment information from HCA. Toll free numbers shall be provided at the expense of the Contractor.

6.6.1 The Contractor shall report by December 1 of each year its scheduled non-business days for the upcoming calendar year.

6.6.2 The Contractor and its subcontracted pharmacy benefit manager, provider help desks, authorization lines, and Enrollee customer service centers, if any, shall comply with the following customer service performance standards:

6.6.2.1 Telephone abandonment rate – standard is less than 3 percent.

6.6.2.2 Telephone response time - average speed of answer within 30 seconds.

## 6.7 Appointment Standards

The Contractor shall comply with appointment standards that are no longer than the following (42 C.F.R. § 438.206(c)(1)(i)):

- 6.7.1 Transitional healthcare services by a primary care provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.
- 6.7.2 Transitional healthcare services by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the Enrollee's primary care provider or as part of the discharge plan.
- 6.7.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the Enrollee's PCP or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.
- 6.7.4 Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the Enrollee's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
- 6.7.5 Urgent, symptomatic office visits shall be available from the Enrollee's PCP or another provider within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not emergent.
- 6.7.6 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
- 6.7.7 Second opinion appointments described in subsection 16.2.1 must occur within thirty (30) calendar days of the request, unless the Enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days.
- 6.7.8 Failure to meet appointment standards may, at the HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

## 6.8 Provider Database

The Contractor shall have, maintain and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the Contractor shall obtain the following information: the identity, location, languages spoken (when this information is supplied by the provider), qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 C.F.R. § 438.242(b)(1)).

## 6.9 Provider Network - Distance and Drive Time Standards

6.9.1 The Contractor's network of providers shall meet the distance and drive time standards in this subsection in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation. The Contractor's ability to receive enrollment and/or assignment is based on the assignment provisions in this Contract. "Rural area" is defined as any area other than an "urban area" as defined in 42 C.F.R. § 412.62(f)(1)(ii).

### 6.9.2 Distance Standards

#### 6.9.2.1 PCP

6.9.2.1.1 Urban: 2 within 10 miles.

6.9.2.1.2 Non-urban: 1 within 25 miles.

#### 6.9.2.2 Obstetrics

6.9.2.2.1 Urban: 2 within 10 miles.

6.9.2.2.2 Non-urban: 1 within 25 miles.

#### 6.9.2.3 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

6.9.2.3.1 Urban: 2 within 10 miles.

6.9.2.3.2 Non-urban: 1 within 25 miles.

#### 6.9.2.4 Hospital

6.9.2.4.1 Urban/Non-urban: 1 within 25 miles.

#### 6.9.2.5 Pharmacy

6.9.2.5.1 Urban: 1 within 10 miles.

6.9.2.5.2 Non-urban: 1 within 25 miles.

#### 6.9.2.6 Mental Health Professionals

6.9.2.6.1 Urban/non-urban: 1 within 25 miles.

### 6.9.3 Drive Time Standards

The Contractor must ensure that when Enrollees travel to service sites, the drive time to the closest provider of the service the Enrollee is seeking is within a standard of not more than:

6.9.3.1 In Urban Areas, service sites are accessible by public transportation with the total trip, including transfers, not to exceed ninety minutes each way;

6.9.3.2 In Rural Areas, a thirty-minute drive from the Enrollee's primary residence to the service site; and

6.9.3.3 In Large Rural Geographic Areas, a ninety-minute drive from the

Enrollee's primary residence to the service site.

These travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages or delayed ferry service).

- 6.9.4 HCA may, in its sole discretion, grant exceptions to the distance and drive time standards. HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as HCA may require supporting the request. If the closest provider of the type subject to the standards in this Section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.

#### **6.10 Assignment of Enrollees**

- 6.10.1 HCA has the sole and exclusive right to determine the methodology and procedures by which Enrollees are assigned to the Contractor or reassigned to any other Apple Health Managed Care contractors (MCOs).
- 6.10.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or Enrollees.
- 6.10.3 HCA will count New Individuals, Family Connects, and Plan Reconnects as part of an MCO's enrollment in all service areas.
- 6.10.4 Reassignment of Enrollees
- 6.10.4.1 HCA may, at its sole discretion reassign Enrollees to the Contractor and an individual may choose to voluntarily enroll with the Contractor if the Contractor is eligible to receive enrollment in the individual's service area, consistent with this Subsection.
- 6.10.5 Assignment of New Individuals
- 6.10.5.1 The number of New Individuals assigned to the Contractor and to all other MCOs depends on (a) the number of MCOs eligible to receive assignments in a service area; (b) the number of New Individuals eligible for assignment in a service area; and (c) the performance of the Contractor and all other MCOs on the Clinical Performance Measures and the Administrative Measures described in this Section.
- 6.10.5.2 HCA will assign New Individuals to an eligible MCO in the individual's service area. Once assigned, HCA will notify the Enrollee of his or her assignment and provide information on how the individual can change enrollment to another MCO available in the service area, if any. The effective date of enrollment will be consistent with the enrollment provisions of this Contract.
- 6.10.6 Service area assignment process:
- 6.10.6.1 HCA, in its sole discretion, shall determine whether the Contractor's

provider network meets the required capacity.

- 6.10.6.1.1 To receive New Individual assignments and voluntary enrollments in a service area, the Contractor must attain a Capacity Threshold as described in this Subsection.
- 6.10.6.1.2 If at any time during the term of this Contract the Contractor's provider network no longer meets the minimum Capacity Threshold in any service area, HCA may, in its sole discretion, reassign all Enrollees covered by the Contractor to another MCO in the service area.
  - 6.10.6.1.2.1 Upon HCA's request, the Contractor shall provide a list of current Enrollees and their assigned PCP.
  - 6.10.6.1.2.2 The Contractor shall assist HCA in the orderly transition of Enrollees to another MCO, consistent with the Care Coordination and Transitional Healthcare Services provisions of this Contract.
- 6.10.6.1.3 HCA recognizes that a full complement of critical provider types may not be available in a service area; therefore, HCA may, at its sole discretion, make exceptions to network adequacy standards to provide coverage for that service area.
- 6.10.6.1.4 The levels of service area participation are described in the following table:



<b>Capacity Threshold</b>	<b>Number of critical provider types meeting capacity</b>	<b>Assignment of New Individuals And/Or Voluntary Enrollment</b>	<b>Family Connects or Plan Reconnects</b>
80% or more	6/6	Assignment and voluntary enrollment	Yes
80% or more	5/6	No assignment; voluntary enrollment only	Yes
60% or above, but below 80%	6/6	No assignment; voluntary enrollment only	Yes
Below 60%.	N/A	No assignment or voluntary enrollment	None

6.10.6.2 Enrollments for each month covered by this Contract will be set by HCA based on the performances of the Contractor and all other MCOs under the Clinical Performance Measures and the Administrative Measure described in this Section.

6.10.6.3 HCA will calculate the Contractor's assignment percentages of New Individuals for January and July of each contract year based on a normed and weighted average of two Clinical Performance measures and one Administrative measure.

6.10.6.3.1 Clinical Performance Measures: The Contractor's reported HEDIS® Clinical Performance measures for the previous contract year:

6.10.6.3.1.1 Childhood Immunization Combo 10 Status.

6.10.6.3.1.2 Comprehensive diabetes care: retinal eye exam.

6.10.6.3.2 Administrative Measure (Initial Health Screen (IHS)): The Contractor shall submit quarterly reports of its performance on completing IHSs on all New Individual, Family Connect, and Plan Reconnect Enrollees. Assignments will be based on the September and March submissions as described in subsection 6.10.7.

6.10.7 Administrative Measure (Initial Health Screen) calculation:

- 6.10.7.1 The Contractor shall calculate and report its performance on completing IHSs on all New Individual, Family Connect and Plan Reconnect Enrollees on a quarterly basis.
- 6.10.7.2 To calculate the quarterly screening performance:
  - 6.10.7.2.1 The numerator is the total number of New Individuals, Family Connects, and Plan Reconnects that have received an IHS.
  - 6.10.7.2.2 The denominator is the total number of New Individuals, Family Connects, and Plan Reconnects.
  - 6.10.7.2.3 The Contractor shall report its screening performance numerator, denominator and rate (expressed as a percentage) according to the following schedule:
    - 6.10.7.2.3.1 January, February and March – Submitted June 15 of each contract year;
    - 6.10.7.2.3.2 April, May and June – Submitted September 15 of each contract year;
    - 6.10.7.2.3.3 July, August and September – Submitted December 15 of each contract year; and
    - 6.10.7.2.3.4 October, November and December – Submitted March 15 of each contract year.

**6.11 Distance Standards for High Volume Specialty Care Providers**

The Contractor shall establish, analyze and meet measurable distance standards for high volume specialty care providers, subject to HCA approval. At a minimum the Contractor shall establish, analyze and meet distance standards for Cardiologists, Dermatologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Endocrinologists, Otolaryngologists, Mental health professionals with prescribing authority and Specialists in Physical Medicine, Rehabilitation.

The Contractor shall ensure pediatric specialists are noted in this list. The Contractor shall analyze performance against standards at minimum, annually and provide a report to HCA upon request detailing the outcomes of this analysis along with the Contractor’s analysis of Primary Care Providers.

**6.12 Contracts with Mental Health Professionals**

The Contractor shall contract with mental health providers as described in Exhibit C, Designation of Behavioral Providers to ensure that Enrollees have access to the provider that most appropriately meets their mental health needs.

**6.13 Standards for the Ratio of Primary Care and Specialty Providers to Enrollees**

The Contractor shall establish and meet measurable standards for the ratio of both PCPs and high volume Specialty Care Providers to Enrollees. The Contractor shall analyze performance against standards at minimum, annually.

#### **6.14 Access to Specialty Care**

- 6.14.1 The Contractor shall provide all medically necessary specialty care for Enrollees in a service area. If an Enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, or who is not available to provide the medically necessary services required by the Enrollee within the timeframe described in this Contract, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's provider network, who is willing to see the Enrollee.
- 6.14.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor's available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

#### **6.15 Enrollees Residing in Rural Areas**

If an Enrollee resides in a rural area in which there is mandatory enrollment, the following requirements apply:

- 6.15.1 The Enrollee must have a choice of two Primary Care Providers when there is a single plan in the area (42 C.F.R. § 438.52(b)(2)(i));
- 6.15.2 The Enrollee may seek care from a non-participating provider when the service or type of provider (in terms of training, experience and specialization) is not available within the Contractor's network or when the service or type of provider is available in the Contractor's network, but an appointment with a participating provider cannot be scheduled to provide the service within the time frames listed in Subsection 6.3 of this Contract (42 C.F.R. § 438.52(b)(2)(ii)(A));
- 6.15.3 The Enrollee may seek a service from a non-participating provider when Enrollee's primary care provider or other provider determines that the Enrollee needs related services that would subject the individual to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available from a participating provider. (42 C.F.R. § 438.52(b)(2)(ii)(D)); and
- 6.15.4 The Enrollee may seek a service from a non-participating provider when the state determines that circumstances warrant out-of-network treatment. (42 C.F.R. § 438.52(b)(2)(ii)(E)).

#### **6.16 Order of Acceptance**

- 6.16.1 The Contractor shall provide care to all Enrollees who voluntarily choose the Contractor and all Enrollees assigned by HCA.
- 6.16.2 Enrollees will be accepted in the order in which they apply.
- 6.16.3 HCA shall enroll all eligible clients with the Contractor of their choice except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.
- 6.16.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of Subsections 6.9 Provider Network – Distance and Drive Time

Standards, and 6.10 Assignment of Enrollees. The Contractor shall submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.

- 6.16.5 The Contractor may request in writing that HCA suspend voluntary enrollment and/or assignments in any service area. HCA will approve the temporary suspension when, in the sole judgment of HCA, it is in the best interest of HCA and/or its clients. The Contractor shall submit any information HCA requires to make a final decision on this request.
- 6.16.6 The Contractor shall accept clients who are enrolled by HCA in accord with this Contract and chapter 182-538 WAC.
- 6.16.7 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or behavioral condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.3(d)).

#### **6.17 Provider Network Changes**

- 6.17.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accord with the Notices provisions of the General Terms and Conditions Section of this Contract, of the loss of a material provider.
- 6.17.2 The Contractor shall make a good faith effort to provide written notification to Enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 C.F.R. § 438.10(f)(5)). Enrollee notices shall have prior approval of HCA. If the Contractor fails to notify affected Enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected Enrollees to continue to receive services from the terminating provider, at the Enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies Enrollees or the Enrollee's effective date of enrollment with another plan.
- 6.17.3 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material subcontractor from a service area. This reimbursable expense shall be in addition to any other provisions of this Contract.
- 6.17.4 HCA reserves the right to impose Sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this Section.
  - 6.17.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a material provider.

#### **6.18 Network Submissions for Washington Healthplanfinder**

The Contractor shall maintain provider network data. The Contractor shall submit provider network data to the Health Benefit Exchange (HBE) in a format specified by HBE. The

provider network data will support Enrollee plan selection and will include a provider directory. In addition to the provider network data and directory, the Contractor shall submit to public reporting of performance measure data such as HEDIS® and CAHPS® results. The data will be used by consumers to select an Apple Health Managed Care Contractor. HBE will develop a detailed implementation schedule to include specific dates for Contractor submission of information. In addition, the Contractor may be required to participate in testing of provider network and directory functionality. The provider network and directory submissions required under this Subsection are in addition to and do not supersede or replace any other provider network or provider directory submissions or reports due to HCA under this Contract.

#### **6.19 Enrollee PCP Assignment Files**

6.19.1 As part of HCA's ongoing efforts to improve population health management activities, the Contractor shall send current Enrollee PCP assignment files to HCA on a monthly basis, or upon request by HCA. The Contractor shall send assignment files by the 15th of each month for the current month through Secure File Transfer (SFT) and Pretty Good Privacy (PGP) encryption protocols. Assignment files must include, at a minimum:

- 6.19.1.1 ProviderOne Client ID number;
- 6.19.1.2 Primary Care Provider (PCP) name;
- 6.19.1.3 PCP National Provider Identifier (NPI); and
- 6.19.1.4 PCP assignment effective date.

## 7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

### 7.1 Quality Assessment and Performance Improvement (QAPI) Program

- 7.1.1 The Contractor shall have and maintain one quality assessment and performance improvement (QAPI) program for all services it furnishes to its Enrollees that meets the provisions of 42 C.F.R. § 438.330.
  - 7.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.
  - 7.1.1.2 The QAPI program structure shall include the following elements:
    - 7.1.1.2.1 Assessment of the quality of care received by Enrollees, as measured by HEDIS® and other quality performance measures;
    - 7.1.1.2.2 Goals and interventions to improve the quality of care and received, including primary care and behavioral health bi-directional clinical integration;
    - 7.1.1.2.3 Assessment of health equity, including identification of health disparities;
    - 7.1.1.2.4 Service to a culturally and linguistically diverse membership;
    - 7.1.1.2.5 Service to members with complex health issues and special health care needs;
    - 7.1.1.2.6 Patient safety initiatives and tracking of the critical incident management system;
    - 7.1.1.2.7 Inclusion of Enrollee voice and experience, which may include consumer surveys, grievances, and feedback from Ombuds process;
    - 7.1.1.2.8 Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, provider appeals and surveys;
    - 7.1.1.2.9 Involvement of designated physician in the QI program, including involvement of designated behavioral health care provider;
    - 7.1.1.2.10 A quality improvement committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:
      - 7.1.1.2.10.1 Include practicing provider participation;
      - 7.1.1.2.10.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement;

- 7.1.1.2.10.3 Institute actions to address performance deficiencies, including policy recommendations; and
- 7.1.1.2.10.4 Ensure appropriate follow-up.
- 7.1.1.2.11 A written QAPI program description shall include the following:
  - 7.1.1.2.11.1 A listing of all quality-related committee(s);
  - 7.1.1.2.11.2 Descriptions of committee responsibilities and oversight;
  - 7.1.1.2.11.3 Contractor staff and practicing provider committee participant titles;
  - 7.1.1.2.11.4 Meeting frequency;
  - 7.1.1.2.11.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate; and
  - 7.1.1.2.11.6 All contractually required elements of the QAPI program structure as outlined above.
- 7.1.1.2.12 An annual quality work plan is due March 1. The work plan shall contain:
  - 7.1.1.2.12.1 Goals and objectives for the year, including objectives for patient safety, serving a geographically, culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization;
  - 7.1.1.2.12.2 Timeframe to complete each activity;
  - 7.1.1.2.12.3 Identification of a responsible person for each activity;
  - 7.1.1.2.12.4 Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs as defined in HCA's Quality Strategy; and
  - 7.1.1.2.12.5 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.
- 7.1.1.2.13 An annual written QAPI Program Evaluation due June 1, of the overall reporting of the effectiveness of the Contractor's QAPI program. (42 C.F.R. § 438.330(c)(2)(i) and (ii)). The report shall reflect on required QI program

structure and activities in the Work Plan and shall include at minimum:

- 7.1.1.2.13.1 Analysis of and actions taken to improve health equity.
- 7.1.1.2.13.2 Inclusion of consumer voice.
- 7.1.1.2.13.3 Contractually required HEDIS® performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid NCQA 90th percentile and Washington State average. Both clinical and non-clinical performance measures must be trended and evaluated in the MCO report.
- 7.1.1.2.13.4 Accompanying written analysis of performance, including data comparisons to the Medicaid NCQA 90th percentile and Washington State average.
- 7.1.1.2.13.5 Findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health (42 C.F.R. § 438.330(b)(3)). The following minimum measure set shall be reported on in the annual QAPI program evaluation about over and under-utilization:
  - 7.1.1.2.13.5.1 Preventable hospitalizations, including readmissions;
  - 7.1.1.2.13.5.2 Avoidable emergency department visits;
  - 7.1.1.2.13.5.3 EDSDT or well-child care;
  - 7.1.1.2.13.5.4 Childhood and adolescent immunizations;
  - 7.1.1.2.13.5.5 Mental health treatment penetration;
  - 7.1.1.2.13.5.6 Children and Adult Access to Primary Care;
  - 7.1.1.2.13.5.7 Prenatal and postpartum care; and



- 7.1.1.2.13.5.8 Comprehensive Diabetes Care.
- 7.1.1.2.13.6 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.
- 7.1.1.2.13.7 A written assessment of the success of contractually required performance improvement projects.
- 7.1.2 Upon request, the Contractor shall make available to providers, Enrollees, or the HCA, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.
- 7.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:
  - 7.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.
  - 7.1.3.2 Evaluation of the delegated organization prior to delegation.
  - 7.1.3.3 An annual evaluation of the delegated entity.
  - 7.1.3.4 Evaluation of regular delegated entity reports.
  - 7.1.3.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

## 7.2 Performance Improvement Projects

- 7.2.1 The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. PIPs identified by the Contractor are subject to review and approval of HCA including, but not limited to area of focus, design and implementation, and evaluation methodologies. The Contractor shall conduct the following PIPs:
  - 7.2.1.1 One clinical PIP piloting a behavioral health intervention that is evidence-based, research-based or Promising Practice recognized by the Washington State Institute for Public Policy (WSIPP). (See current WSIPP Report Inventory (and Updated Inventory report) of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Behavioral Health <http://www.wsipp.wa.gov/Reports>);
  - 7.2.1.2 One clinical PIP, conducted in partnership between the Department of Health and the Contractor, which will be a statewide PIP on improving well-child visit rates in infants, young children, and adolescents described in this Contract; and
  - 7.2.1.3 One non-clinical PIP of the Contractor's own choosing.
- 7.2.2 Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction and must include the following elements.

- 7.2.2.1 Measurement of performance using objective quality indicators.
- 7.2.2.2 Implementation of interventions to achieve improvement in the access to and quality of care.
- 7.2.2.3 Evaluation of the effectiveness of the interventions based on the performance measures.
- 7.2.2.4 Planning and initiation of activities for increasing or sustaining improvement.
- 7.2.3 The Contractor shall report the status and results of all required clinical and non-clinical performance improvement projects to HCA. (42 C.F.R. § 438.330(c)(3)).
  - 7.2.3.1 The Contractor must annually submit current year PIP proposals to HCA no later than March 15.
  - 7.2.3.2 Each completed project shall be documented on a PIP Worksheet found in the CMS protocol entitled “Conducting Performance Improvement Projects”.
- 7.2.4 The Contractor shall collaborate with peer Medicaid managed care organizations, DOH and other entities as appropriate to conduct one clinical statewide PIP to improve well-child visit rates in infants, young children and adolescents. This group shall be called the Well-Child Visit Workgroup and shall perform the following work:
  - 7.2.4.1 Appoint a workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating MCOs.
  - 7.2.4.2 Provide adequate funding, resources and staff to plan, execute and evaluate the PIP.
  - 7.2.4.3 Coordinate with existing state efforts such as the DOH Pediatric Transforming Clinical Practice Improvement Initiative to improve well-child visit rates.
  - 7.2.4.4 Set an improvement goal for the next year’s HEDIS® rates for the following HEDIS® well-child visit measures:
    - 7.2.4.4.1 Well-Child Visits in the first fifteen (15) months of life (W15);
    - 7.2.4.4.2 Well-Child Visits in the third, fourth, fifth and sixth years of life (W34); and
    - 7.2.4.4.3 Adolescent Well-Care Visits (AWC).
  - 7.2.4.5 Define the target populations and scope of the PIP.
  - 7.2.4.6 Define intervention(s) used in the PIP. Interventions shall be robust and innovative in nature, intended to increase the number of children receiving well-child visits and to educate and assist providers.
  - 7.2.4.7 Evaluate the success of interventions to improve well-child visit rates by the workgroup set goal in the three child measures using available

Contractor Well-Child Visit data.

- 7.2.4.8 Submit quarterly progress reports on the status of Well-Child Visit PIP Workgroup activities. Reports shall be submitted to HCA on the third Friday of the month following the end of the quarter in January; April; July; and October.
- 7.2.4.9 Submit a PIP Worksheet annually, upon request, to HCA.
- 7.2.5 The Contractor shall provide financial support to the DOH to conduct the ongoing Well-Child Visit Collaborative PIP Workgroup, Health Care Disparity Workgroup and other quality improvement efforts, as described in the following manner:
  - 7.2.5.1 The Contractor shall make semi-annual payments, due to DOH no later than June 28, 2019 and December 27, 2019 based on total Apple Health MCO enrollment on December 1, 2018.
    - 7.2.5.1.1 If the Contractor's combined statewide Medicaid managed care enrollment is less than 25,000, the Contractor shall make two payments of \$25,000 each to support the PIP.
    - 7.2.5.1.2 If the Contractor's combined statewide Medicaid managed care enrollment is 25,000 or more but less than 100,000, the Contractor shall make two payments of \$50,000 each to support the PIP.
    - 7.2.5.1.3 If the Contractor's combined statewide Medicaid managed care enrollment is 100,000 or greater, the Contractor shall make two payments of \$100,000 each to support the PIP.
- 7.2.6 CMS, in consultation with HCA and other stakeholders, including the Contractor, may specify performance measures and topics for performance improvement projects to be conducted as part of this Contract and AHMC.
- 7.2.7 Integrated Patient Record/Clinical Data Repository Project.

The Contractor shall collaborate with peer AH MCOs, HCA, and the State HIE to conduct a multi-year, statewide project to establish and maintain a longitudinal integrated patient record for Apple Health-Managed Care Enrollees assigned to Contractor.

The integrated patient record will be housed in a Clinical Data Repository (CDR) using a service connected to the State HIE and set up by HCA. HCA will invest in the technical infrastructure necessary to set up, prepare, and source the CDR with patient demographic and other relevant administrative data for all Enrollees.

The integrated patient record has the capacity to bring together physical, dental, behavioral health, and social service data currently stored in disparate provider EHR systems and other state and local data sources across the health care delivery system. HCA encourages transmission of interoperable documents to enable the efficient reuse of content by providers and others.

The CDR will connect and leverage the power of information and federal, state, and private investments in EHR technology to enable Care Coordination and increased communication among providers across multiple disciplines and organizations. This effort will provide access to data sets that are not broadly available to authorized clinicians, care teams, communities, plans, and purchasers that can be used to improve care.

- 7.2.7.1 The Contractor shall appoint a representative to provide input into the CDR project plan, and an evaluation of the project.
- 7.2.7.2 The Contractor shall pay the operational costs to maintain an integrated health record for each of its Enrollees as billed by the State HIE in two installments each year with estimated due dates of January 31 and July 1.
  - 7.2.7.2.1 If the total AH contracts enrollment is less than 1,200,000 covered lives, the Contractor shall pay the operational costs at the rate of \$1.05 per year per Enrollee to maintain an integrated health record for each of its AH Enrollees. If the total covered lives enrolled under the AH contract exceeds 1,200,000, the Contractor shall pay the operational costs at the rate of \$1.02 per year per Enrollee to maintain an integrated health record for each of its AH Enrollees, and subsequent semi-annual payments will be adjusted accordingly.
  - 7.2.7.2.2 HCA will use the HIPAA 834 monthly audit files to report the Contractor's total enrollment to the State HIE. The State HIE will bill the Contractor for the maintenance of its Enrollees' integrated health records in two installments each year with estimated due dates of January 31 and July 1.
  - 7.2.7.2.3 The Contractor shall pay the State HIE in full by the due date indicated on the billings.
  - 7.2.7.2.4 If the Contractor fails to pay the State HIE within thirty (30) calendar days of the due date on the billing, HCA will withhold the amount due from the next available scheduled monthly AH premium payment to the Contractor.
  - 7.2.7.2.5 Costs to the Contractor to connect to the HIE to access data are the responsibility of the Contractor.
  - 7.2.7.2.6 Costs to the subcontractors to program EHR systems or connect to the HIE are the responsibility of individual entities.
  - 7.2.7.2.7 The Contractor shall coordinate with HCA and the state HIE efforts to facilitate readiness activities intended to prepare for the secure exchange of high value health information among subcontractors identified by HCA

through participation in communication and readiness activities organized by HCA and HIE.

- 7.2.7.2.8 The Contractor shall reinforce state expectations that subcontracted providers with certified EHR systems begin ongoing submission of automated exports of standard CCD/CCDA from their EHR to the CDR via the HIE each time an Apple Health Managed Care Enrollee is seen. The Contractor will include contract language during the next round of contract activities with subcontractors.
- 7.2.7.3 The Contractor shall participate in quality measurement activities related to the CDR.
  - 7.2.7.3.1 When a subcontracted provider is required to participate in the CDR per 7.2.7.2.8 above, the Contractor will require a clinical document to be submitted for a minimum of 80 percent of submitted claims.
  - 7.2.7.3.2 The Contractor will provide a Provider Compliance report annually to the HCA by July 1 detailing provider compliance with 7.2.7.2.8 and 7.2.7.3.1 above.
- 7.2.7.4 The Contractor shall participate in business process improvement activities related to the CDR.
  - 7.2.7.4.1 The Contractor will review prior authorization processes that require subcontracted providers to submit clinical documentation (“chart notes”) for the applicability of utilizing CDR data.
  - 7.2.7.4.2 The Contractor will provide a Prior Authorization report annually to the HCA by July 1 detailing the number of prior authorizations which utilized CDR data.
- 7.2.8 The Contractor shall make pay-for-performance payments to Critical Access Hospitals participating in the Washington Rural Health Access Preservation (WRHAP) Pilot created by the Legislature (Substitute House Bill 1520) (2017), upon the achievement by the hospitals of specified benchmarks on quality measures. The amounts and frequency of the payments shall be no less than the minimums specified below. Additional funds have been appropriated by the Legislature as part of the WRHAP Pilot to help the participating hospitals transition to a new payment methodology and will not extend beyond the anticipated 3-year pilot period. The total amount of additional funds available for the period of July 1, 2019 through December 31, 2019 to support this performance improvement initiative is \$1,417,000. Each of the 13 participating hospitals, if it achieves all of the specified benchmarks, will need to receive a total of no less than \$109,000 from all of the MCOs with which it has contracts in order to successfully implement the service changes needed to achieve the benchmarks. In order to accomplish this, the Contractor shall pay each hospital with which it has contracts amounts greater than or equal to the amounts listed in subsection 7.2.8.3 if and when the hospital achieves the specified quality benchmarks.

7.2.8.1 List of participating hospitals and service regions:

<b>WRHAP CAHs</b>	<b>Public Hospital District</b>	<b>Region</b>
Cascade Medical Center	Chelan County PHD #1	R1- North Central
Columbia Basin Hospital	Grant County PHD #3	R1- North Central
Dayton/Columbia County Health System	Columbia County PHD	R9-Greater Columbia
East Adams Rural Healthcare	Adams County PHD #2	R11-Spokane
Ferry County Memorial	Ferry County PHD #1	R11-Spokane
Forks Community Hospital	Clallam County PHD #1	R9-Salish
Garfield Co. Public	Garfield County PHD	R9-Greater Columbia
Mid-Valley	Okanogan County PHD #3	R11-Spokane
Morton General	Lewis County PHD #1	R15-Great Rivers
Odessa Memorial	Lincoln County PHD #1	R11-Spokane
Willapa Harbor	Pacific County PHD #2	R15-Great Rivers
North Valley	Okanogan County PHD #3	R11-Spokane
Three River	Okanogan-Douglas Counties PHD #1	R11-Spokane & R1-North Central

7.2.8.2 The Contractor shall contract with each participating Hospital District to make pay-for-performance payments based on the quality measures and benchmarks described in 7.2.8.2.1 and 7.2.8.2.2. Each participating Hospital District (Participant) has selected previously whether the payments will be made for its work on either (a) Behavioral Health services or (b) Care Coordination services. The Participant shall collect data for the quality measures using an EHR, registry, or manually collected data. When the Participant achieves one of the specified benchmarks, it must receive a payment equal to or greater than the applicable amount specified in 7.2.8.3 in addition to any other payments to which it may be entitled. The following are the quality measures and the benchmarks to be achieved during this contract period:

7.2.8.2.1 If the Participant indicates that the majority of the new services delivered will be behavioral health services (including psychiatric collaborative care services), the Participant submits a report on the behavioral health quality measure (Patients Screened for Clinical Depression and Follow-Up Plan - NQF 0418/MIPS 134) for a three month period that shows the Participant has met the benchmark for that period. To meet the benchmark, the Participant shall have screened a minimum of 53 percent of total clinic patients for each three-month period. The first three-month period begins July 1, 2019 and ends September 30, 2019. The second three-month period begins October 1, 2019 and ends December 31, 2019. The measure shall be calculated by the Participant as follows:

**Numerator:** Number of Enrollees screened for depression on the date of the visit using an age-appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen that includes either a referral to a practitioner who is qualified to diagnose and treat depression, a pharmacological intervention, or another documented intervention.

**Denominator:** Number of Enrollees who visit the Participant's Rural Health Clinic or primary care clinic during the performance period. If there is no RHC or primary care clinic, the focus will be Enrollees who visit the Participant's Emergency Department. Enrollees with an active diagnosis of depression or bipolar disorder, who refuse to participate, or are in an urgent or emergent situation where time is of the essence and delaying treatment would jeopardize the patient's health status, or have limitations on functional capacity or motivation to improve that may impact the accuracy of results of standardized assessment tools are excluded from the program.

7.2.8.2.2 If the Participant indicates that the majority of the new services delivered will be chronic care management or care coordination services (other than psychiatric collaborative care management services), the Participant submits a report on the care coordination quality measure (percent of residents with phone contact or face-to-face visit within seven (7) calendar days of ED or hospital discharge) that shows the Participant has met the benchmark for that period. To meet the benchmark, the Participant must make contact with a minimum of 40 percent of patients for each three-month period. The first three-month period begins July 1, 2019 and ends September 30, 2019. The second three-month period begins October 1, 2019 and ends December 31, 2019. The measure shall be calculated by the Participant as follows:

**Numerator:** Number of Enrollees with a phone contact or face-to-face visit with the care coordinator or a primary care provider within seven (7) calendar days following discharge from the ED or the hospital where the Enrollee was admitted following the ED visit. For a contact to have occurred: (1) A phone or face-to-face visit within seven calendar days of ED or hospital discharge must occur OR, (2) an attempted contact where the first attempt is initiated within the first 48 to 72

hours of discharge and there are a minimum three daily attempts within the seven days following discharge.

**Denominator:** Number of Enrollees who (1) visit the Emergency Department operated by the Public Hospital District, and (2) are discharged alive to their homes following the ED visit or following a hospital admission resulting from the ED visit during the performance period (calendar quarter).

7.2.8.3 The Contractor shall award a pay-for-performance payment to a Participant as soon as possible after they submit a report showing that they have achieved one of the benchmarks specified in subsection 7.2.8.2. The minimum amount to be paid to each Participant for each benchmark is listed below and is based on the number of MCOs the hospital has contracted with in the region. The Contractor has the discretion to make additional payments for higher performance on the quality measures and to make additional payments more frequently than quarterly.

<b>WRHAP CAHs</b>	<b>* Benchmark 1 Minimum Rate</b>	<b>* Benchmark 2 Minimum Rate</b>
Cascade Medical Center	\$18,167	\$18,167
Columbia Basin Hospital	\$18,167	\$18,167
Dayton/Columbia County Health	\$13,625	\$13,625
East Adams Rural Healthcare	\$18,167	\$18,167
Ferry Community Hospital	\$18,167	\$18,167
Forks Community Hospital	\$10,900	\$10,900
Garfield County Public	\$13,625	\$13,625
Mid-Valley	\$18,167	\$18,167
Morton General	\$10,900	\$10,900
Odessa Memorial	\$18,167	\$18,167
Willapa Harbor	\$10,900	\$10,900
North Valley	\$18,167	\$18,167
Three River	\$18,167	\$18,167
*Rates are based on the 2019 contract arrangements between CAHs and MCOs and may be subject to change to reflect contractual arrangement for the remaining 2019 contract period. If changes occur, HCA will communicate them directly with the Contractor in writing.		

7.2.8.4 The Contractor shall submit to HCA a written quarterly WRHAP status report due forty-five (45) calendar days after the end of each quarter, on the performance improvement project (including copies of documentation received from the hospital demonstrating successful completion of the measures) and proof of payment to the hospital. Capitation payments for the period to which these payments apply will be retroactively adjusted by HCA within sixty (60) calendar days



following confirmation of payment.

### 7.3 Performance Measures

- 7.3.1 The Contractor shall report all required HEDIS® measures using the 2019 HEDIS® Technical Specifications and official corrections published by NCQA, to NCQA and HCA annually, unless directed otherwise in writing by HCA. The Contractor shall use administrative and hybrid data collection methods specified in the current HEDIS® Technical Specifications and required by HCA (42 C.F.R. § 438.240(b)(2)). Attachment 2, 2019 Performance Measures is the 2019 list of HCA required HEDIS® performance measures to be submitted to NCQA and HCA.
- 7.3.2 Attachment 2, 2019 HEDIS® Performance Measures is the 2019 list of HCA required HEDIS® performance measures to be submitted to NCQA and HCA. If “Hybrid” is noted in the “Notes” column of Attachment 2, the Contractor is contractually required to report using this methodology. If the Contractor is unable to report using this methodology, the Contractor is required to notify HCA within five (5) business days with the reason.
- 7.3.3 In addition to reporting all required HEDIS® data to NCQA, the Contractor will publicly report performance measure data including MCO name through the Quality Compass reporting mechanism, whether public reporting is required or not by NCQA.
- 7.3.4 No later than the date in June of each year as specified by the audit team, HEDIS® measures shall be submitted electronically to the HCA contracted EQRO according to instructions provided by HCA or the HCA designated EQRO.
- 7.3.5 The following performance measures shall be produced by HCA, in partnership with the DSHS/Research and Data Analysis Division (RDA), and delivered to the Contractor in reporting year 2019; for the data collection period January 1, 2018, through December 31, 2018.
  - 7.3.5.1 Substance use treatment penetration;
  - 7.3.5.2 Substance Use Disorder treatment initiation and engagement; (Washington Circle version)
  - 7.3.5.3 Mental Health treatment penetration;
  - 7.3.5.4 Thirty (30) day psychiatric inpatient readmissions;
  - 7.3.5.5 Number of Nulliparous Transverse Singleton Vertex (NTSV) C-Sections (cesarean births); and
  - 7.3.5.6 The proportion of person-months receiving long-term services and supports (LTSS) associated with receipt of services in home- and community-based settings during the measurement year.
- 7.3.6 The Contractor shall submit raw HEDIS® data to HCA electronically for all measures, no later than June 30 of each year. The Contractor shall submit the Raw HEDIS®/Member Level Data report according to specifications provided by HCA.
- 7.3.7 All HEDIS® measures including the CAHPS® sample frame, shall be audited by a

designated certified HEDIS® Compliance Auditor, a licensed organization in accord with methods and timelines described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures and the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures Protocol found at <https://www.medicaid.gov/medicaid/quality-of-care/index.html>. HCA will fund and the designated EQRO will conduct the audit.

- 7.3.8 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.
  - 7.3.8.1 Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the CMS Validating Performance Measures protocol identified by HCA designated EQRO.
- 7.3.9 The Contractor shall rotate HEDIS® measures only with HCA's advance written approval. The Contractor may request approval to rotate measures by making a written request to the HCA MC Programs mailbox. Any measures rotated by the Contractor without written permission from the HCA shall be subject to the sanctions language described in this Contract.
- 7.3.10 Health Care Disparities Workgroup. The Contractor shall collaborate with peer MCOs and the DOH to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure. The Health Care Disparities Workgroup shall perform the following work:
  - 7.3.10.1 Appoint a Workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating managed care organizations.
  - 7.3.10.2 Collect and examine data on ethnicity, race, and language markers as provided by HCA on all Enrollees and augmented by MCOs.
  - 7.3.10.3 Cooperate with the Department of Health to complete the analysis of one performance measure no later than June 30.
  - 7.3.10.4 Define interventions to address observed disparities.
  - 7.3.10.5 Implement defined interventions aimed at addressing disparities.
  - 7.3.10.6 Evaluate the effectiveness of interventions to reduce health care disparities.
  - 7.3.10.7 Provide adequate funding, resources, and staff to plan, execute, and evaluate the project.
  - 7.3.10.8 Submit quarterly progress reports providing an update on the status of the Health Care Disparity Workgroup activities. Reports shall be submitted to HCA quarterly on the third Friday of the month of January,

April, July, and October.

**7.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

- 7.4.1 In 2019, the Contractor shall conduct a CAHPS® Child 5.0H Medicaid with Chronic Conditions survey for FIMC and AHMC Enrollees.
  - 7.4.1.1 The Contractor shall contract with an NCQA-certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the HCA designated EQRO:
    - 7.4.1.1.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name, and CAHPS® primary vendor contact by January 2019.
    - 7.4.1.1.2 Timeline for implementation of vendor tasks upon request.
  - 7.4.1.2 The Contractor shall ensure the survey sample frame consists of all AHMC and FIMC members 17 years and younger with Washington State addresses. In administering the CAHPS®, the Contractor shall:
    - 7.4.1.2.1 Submit the eligible sample frame file(s) for certification by the HCA designated EQRO, a Certified HEDIS® Auditor, by the second Friday in January 2019, or the date otherwise specified by the audit team.
    - 7.4.1.2.2 Receive written notice of the sample frame file(s) compliance audit certification from the HCA designated EQRO by the January deadline listed in the NCQA HEDIS® Audit timeline for 2019.
    - 7.4.1.2.3 HCA EQRO shall review each MCOs questionnaire format, questions, and question placement, using the most recent HEDIS® version of the Medicaid CAHPS® survey (currently 5.0H), plus approved supplemental questions as determined by HCA.
    - 7.4.1.2.4 HCA will add supplemental questions to the Contractor's survey as determined by HCA and approved by NCQA.
    - 7.4.1.2.5 Conduct the mixed methodology (two questionnaires and two reminder postcards with telephone follow-up of at least three telephone attempts) for CAHPS® survey administration.
    - 7.4.1.2.6 Submit a copy of the final NCQA data submission report to the HCA designated EQRO by the date in June each year as specified by HCA or the HCA designated EQRO.
    - 7.4.1.2.7 Submit a copy of the Washington State Child Medicaid response data set according to 2019 NCQA/CAHPS® standards to the HCA designated EQRO by the date in June each year as specified by HCA or the HCA-designated EQRO.

7.4.1.3 The HCA requires the Contractor to submit its 2019 CAHPS® data to the CAHPS® Database by the submission deadline set by the CAHPS® Database.

7.4.2 The Contractor shall notify HCA in writing if the Contractor cannot conduct the CAHPS® survey because of limited total enrollment or sample size. The written statement shall provide enrollment and sample size data to support the Contractor's inability to meet the requirement.

## 7.5 NCQA Accreditation

7.5.1 The Contractor shall have and maintain NCQA accreditation at a level of "accredited" or better.

7.5.2 The Contractor shall provide authorization to NCQA with a copy of the authorization to HCA within thirty (30) calendar days of request by HCA for copies of the Contractor's most recent accreditation review, including accreditation status, survey type, level of accreditations, results of the review, recommended actions or improvements, corrective action plans and summaries of findings and expiration date of the accreditation (42 C.F.R. § 438.332(b)).

7.5.3 Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final NCQA report and may result in termination of the contract in accordance with the terms and conditions set forth in this Contract.

7.5.4 If the Contractor fails to obtain accreditation at a level of "accredited" or better or fails to maintain accreditation thereafter, the Contractor shall be considered in breach of this Contract. HCA shall terminate the Contract in accordance with the Termination by Default subsection of this Contract.

## 7.6 External Quality Review

7.6.1 Validation Activities: The Contractor's quality program shall be examined using a series of required validation procedures. The examination shall be implemented and conducted by HCA, its agent, or an EQRO.

7.6.2 The following required activities will be validated (42 C.F.R. § 438.358(b)(1)):

7.6.2.1 Performance improvement projects.

7.6.2.2 Performance measures.

7.6.2.3 A monitoring review of standards established by HCA and included in this Contract to comply with 42 C.F.R. § 438.358(b)(1)(iii) and a comprehensive review conducted within the previous three-year period.

7.6.3 HCA reserves the right to include additional optional activities described in 42 C.F.R. § 438.358 if additional funding becomes available and as mutually negotiated between HCA and the Contractor.

7.6.4 The Contractor shall submit reports, findings, and other results obtained from a Medicare or private accreditation review (e.g., CMS, NCQA, EValue8, URAC, etc.) if requested by HCA. HCA may, at its sole option, use the accreditation review results in lieu of an assessment of compliance with any Federal or State standards and the review conducted by HCA of those standards.

- 7.6.5 The Contractor shall submit to annual monitoring reviews by HCA and EQRO. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 C.F.R. § 438.358).
- 7.6.6 The Contractor shall, during an HCA annual monitoring review of the Contractor's compliance with contract standards or upon request by HCA or its External Quality Review Organization (EQRO) Contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, Enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to Enrollees.
- 7.6.7 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Annual Report (EQRAR). The EQRAR is a detailed technical report that describes the manner in which the data from all activities described in External Quality Review provisions of this Section and conducted in accord with C.F.R. § 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.
- 7.6.8 HCA will provide a copy of the EQRAR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, Enrollees and potential Enrollees of the Contractor, Enrollee advocacy groups, and members of the general public. HCA must make this information available in alternative formats for persons with sensory impairments, when requested.
- 7.6.9 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA and Washington State Department of Health (DOH) as needed to reduce duplicated work for both the Contractor and the state.

## **7.7 Provider Complaints and Appeals**

- 7.7.1 The Contractor shall have a system in place to process, track, and record provider complaints and appeals. The Contractor shall accept, record, and process provider complaints forwarded by HCA. The Contractor's provider complaint and appeal process should include a quality improvement process. The Contractor shall provide provider complaint and appeal data to HCA on a quarterly Provider Complaints and Appeals Report. The report is due by the last business day of the month following the end of the quarter. (42 C.F.R. § 438.66(c)(3)).

## **7.8 Critical Incident Management System**

The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, reporting protocols and oversight responsibilities. The Contractor shall increase intervention for an Enrollee when incident behavior escalates in severity or frequency.

The Contractor shall designate a Critical Incident Manager responsible for administering the incident management system and ensuring compliance with the requirements of this Section.

#### 7.8.1 Individual Critical Incident Reporting

The Contractor shall submit an individual Critical Incident report for the following incidents:

- 7.8.1.1 Homicide or attempted homicide by an Enrollee;
- 7.8.1.2 A major injury or major trauma that has the potential to cause prolonged disability or death of a client that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services;
- 7.8.1.3 An unexpected death of a client that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services;
- 7.8.1.4 Abuse, neglect or exploitation of an Enrollee (not to include child abuse);
- 7.8.1.5 Violent acts allegedly committed by an Enrollee to include:
  - 7.8.1.5.1 Arson;
  - 7.8.1.5.2 Assault resulting in serious bodily harm;
  - 7.8.1.5.3 Homicide or attempted homicide by abuse;
  - 7.8.1.5.4 Drive-by shooting;
  - 7.8.1.5.5 Extortion;
  - 7.8.1.5.6 Kidnapping;
  - 7.8.1.5.7 Rape, sexual assault or indecent liberties;
  - 7.8.1.5.8 Robbery; and
  - 7.8.1.5.9 Vehicular homicide.
- 7.8.1.6 Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions; and
- 7.8.1.7 Any event involving an Enrollee that has attracted or is likely to attract media attention.

7.8.2 The Contractor shall report Critical Incidents within one business day in which the Contractor becomes aware of the event. The report shall include:

- 7.8.2.1 The date the Contractor becomes aware of the incident;
- 7.8.2.2 The date of the incident;
- 7.8.2.3 A description of the incident;
- 7.8.2.4 The name of the facility where the incident occurred, or a description of

the incident location;

- 7.8.2.5 The name(s) and age(s) of Enrollees involved in the incident;
- 7.8.2.6 The name(s) and title(s) of facility personnel or other staff involved;
- 7.8.2.7 The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;
- 7.8.2.8 The Enrollee's whereabouts at the time of the report if known (i.e. home, jail, hospital, unknown, etc.) or actions taken by the Contractor to locate the Enrollee;
- 7.8.2.9 Actions planned or taken by the Contractor to minimize harm resulting from the incident; and
- 7.8.2.10 Any legally required notifications made by the Contractor.

7.8.3 The Contractor shall report Critical Incidents using the HCA Incident Reporting System at <https://fortress.wa.gov/hca/ics/>. If the system is unavailable the Contractor shall report Critical Incidents to [HCAMCPrograms@hca.wa.gov](mailto:HCAMCPrograms@hca.wa.gov).

#### 7.8.4 Individual Critical Incident Resolution and Closure

The Contractor shall submit follow-up reports using the Incident Reporting System and close the case within forty-five (45) calendar days after the Critical Incident was initially reported. A case cannot be closed until the following information is provided:

- 7.8.4.1 A summary of any debriefings;
- 7.8.4.2 Whether the Enrollee is in custody (jail), in the hospital or in the community;
- 7.8.4.3 Whether the Enrollee is receiving services and include the types of services provided;
- 7.8.4.4 If the Enrollee cannot be located, the steps the Contractor has taken to locate the Enrollee using available, local resources; and
- 7.8.4.5 In the case of the death of an Enrollee, verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Contractor shall document all attempts to retrieve it.

#### 7.8.5 Population Based Reporting

The Contractor shall submit a semi-annual report of all Critical Incidents tracked by the Contractor. At minimum, the report shall include an analysis of the following incidents:

- 7.8.5.1 Incidents identified through the Individual Critical Incidents process;
- 7.8.5.2 A credible threat to Enrollee safety;
- 7.8.5.3 Any allegation of financial exploitation of an enrollee;
- 7.8.5.4 Suicide and attempted suicide; and
- 7.8.5.5 Other incidents as defined in the Contractor's Policies and Procedures.

The following elements shall be included in the analysis: The number and types of Critical Incidents and comparison of changes over time; analysis of Critical Incidents that repeat; trends found in the population (i.e. regional differences, demographic groups, vulnerable populations); analysis of the effectiveness of the Critical Incident Management System; and action taken by the Contractor to reduce incidents.

The report is due no later than the last business day of January and July for the prior six (6) month period.

The Contractor shall also include a data file of all Critical Incidents from which the analysis is made using a template provided by HCA.

#### **7.9 Mental Health Evidence-Based Practices (EBPs)**

7.9.1 The Contractor shall cooperate and collaborate with HCA on the collection of data related to mental health evidence-based practices (EBPs). Contractor actions shall include, but are not limited to all of the following:

- 7.9.1.1 Participation in planning meetings;
- 7.9.1.2 Developing methods to collect data; and
- 7.9.1.3 Reporting of data on the uptake in use of EBPs over time to satisfy HCA requirements and state law.

7.9.2 The Contractor shall submit to HCA a quarterly report that details the delivery of mental health Evidence/Research Based Practices (E/RBPs) provided to Clients under the age of twenty one (21) years old by a qualified medical provider. The quarterly reports are due to HCA the last business day of January, April, July, and October. The report shall include the following data:

- 7.9.2.1 The number of children receiving E/RBP services;
- 7.9.2.2 The number of mental health encounters using these services; and
- 7.9.2.3 The percentage of mental health encounters using these services.

#### **7.10 Home Health/Private Duty Nursing Services**

On a quarterly basis, the Contractor shall submit to HCA a utilization review report of all Enrollees for whom Private Duty Nursing or Home Health services were requested. The report shall be due on the last business day of the month: in June when reporting for January-March; in September for April-June; in December for July-September; and in March for October-December. The report shall include:

- 7.10.1 Enrollee name;
- 7.10.2 Enrollee Date of Birth;



- 7.10.3 ProviderOne ID;
- 7.10.4 Type of Service (Private Duty Nursing or Home Health)
- 7.10.5 Name of Provider;
- 7.10.6 Provider NPI;
- 7.10.7 Date request for services received;
- 7.10.8 Number of units requested, indicated days or 15 minute increments;
- 7.10.9 Number of units approved;
- 7.10.10 Number of units paid; and
- 7.10.11 Date decision made.

#### 7.11 Practice Guidelines

- 7.11.1 The Contractor shall adopt physical and behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements (42 C.F.R. § 438.236):
  - 7.11.1.1 Are based upon the following:
    - 7.11.1.1.1 Valid and reliable clinical scientific evidence;
    - 7.11.1.1.2 In the absence of scientific evidence, on professional standards; or
    - 7.11.1.1.3 In the absence of both scientific evidence and professional standards, a consensus of health care professionals in the particular field.
- 7.11.2 The Contractor shall develop guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or the Substance Abuse and Mental Health Services Administration (SAMSHA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:
  - 7.11.2.1 Be age-appropriate to address the special needs or considerations that are driven by age.
  - 7.11.2.2 Consider the needs of Enrollees and support client and family involvement in care plans.
  - 7.11.2.3 Be adopted in consultation with contracting health care professionals within the state of Washington or, when applicable, are adopted in consultation with the behavioral health professionals in the Contractor's contracted network.
  - 7.11.2.4 Be reviewed and updated at least every two years and more often if national guidelines change during that time.
  - 7.11.2.5 Be disseminated to all affected providers and, upon request, to HCA,

Enrollees and potential Enrollees (42 C.F.R. § 438.236(c)).

- 7.11.2.6 Be distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers.
- 7.11.2.7 Be the basis for and consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).
- 7.11.3 The Contractor shall develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor shall:
  - 7.11.3.1 Conduct outreach to Enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.
  - 7.11.3.2 Report on preventive care utilization through required performance measure reporting.
  - 7.11.3.3 In collaboration with peer managed care organizations, disaggregate data on at least one preventive care measure and examine the data for racial/ethnic disparities.
  - 7.11.3.4 In collaboration with peer managed care organizations, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on utilization patterns.

## 7.12 Health Information Systems

The Contractor shall maintain, and shall require subcontractors to maintain, a health information system that complies with the requirements of 42 C.F.R. § 438.242 and provides the information necessary to meet the Contractor's obligations under this Contract. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The health information system must:

- 7.12.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility.
- 7.12.2 Ensure data received from providers is accurate and complete by:
  - 7.12.2.1 Verifying the accuracy and timeliness of reported data;
  - 7.12.2.2 Screening the data for completeness, logic, and consistency; and
  - 7.12.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.
- 7.12.3 The Contractor shall make all collected data available to HCA and the Center for Medicare and Medicaid Services (CMS) upon request.

## 7.13 Clinical Data Repository

- 7.13.1 HCA shall develop and the Contractor shall publish guidelines for participation in

the Clinical Data Repository, along with the contacts and resources to support provider organizations through the readiness activities.

The Contractor shall require that when subcontracted provider organizations with certified EHRs see an Apple Health Managed Care Enrollee, the provider sends a care summary (CCDA) from the provider's EHR to the Clinical Data Repository..

#### **7.14 Data Submission to Collective Medical Technologies (CMT)**

The Contractor shall submit enrollment, encounter and provider data to Collective Medical Technologies on a monthly basis. The data will be used to improve the ability of Emergency Room physicians to make informed decisions about Enrollees, improve care coordination and ensure Enrollee safety. HCA will provide a list of required data elements to ensure consistency.

The Contractor shall maintain a record of submission and record any errors or issues that occur during submission.

7.14.1 The Contractor will report to HCA in a form and manner to be determined by HCA, within five (5) calendar days of any issues that prevent or delay submission of data to CMT. The report will include any actions the Contractor will take to resolve the issue including any requests for HCA assistance.

7.14.2 The Contractor will provide a summary report for each calendar year to HCA within thirty (30) business days upon request showing confirmation of submission and any errors that occurred by month.

#### **7.15 Technical Assistance**

The Contractor may request technical assistance for any matter pertaining to this Contract by contacting HCA.

#### **7.16 Annual Diabetes Report**

7.16.1 The Contractor shall prepare an annual report on the prevalence of Diabetes and utilization of diabetes education services among Contractor Enrollees. The report is due each year no later than the last business day of December and shall include data from the first business day of October of the previous calendar year through the last business day of September of the current calendar year.

7.16.2 The Annual Diabetes Report shall be no more than four (4) pages in length, excluding attachments, and shall describe:

7.16.2.1 The total number of Contractor Enrollees with Type 1 and Type 2 diabetes.

7.16.2.2 The number of Contractor Enrollees with Type 1 and Type 2 diabetes in the following age groupings:

7.16.2.2.1 Ages less than 18 years of age;

7.16.2.2.2 Ages 18-64 years of age; and

7.16.2.2.3 Ages greater than 65 years of age.

- 7.16.2.3 The gender distribution of Enrollees with Type 1 and Type 2 diabetes.
- 7.16.2.4 The geographic distribution of Enrollees with Type 1 and Type 2 diabetes using the Enrollee's county of residence, rolled up into the *Healthier Washington* regional map found at: <http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach>
- 7.16.2.5 The total number of Enrollees with a diagnosis of Type 1 and Type 2 diabetes who received a diabetes education encounter.
- 7.16.2.6 The proportion of Enrollees with a diagnosis of diabetes Type 1 and Type 2 diabetes who received a diabetes education encounter.
- 7.16.2.7 A narrative description of how:
  - 7.16.2.7.1 Enrollees are referred to diabetes education, and a description of any role that the plan plays in these referrals.
  - 7.16.2.7.2 Diabetes education is promoted to Enrollees including links to Diabetes educational materials.
  - 7.16.2.7.3 Diabetes education providers enroll with the Contractor if interested in joining the Contractor's network of providers.
- 7.16.2.8 A list of:
  - 7.16.2.8.1 Available Diabetes education providers including, name of diabetes educator, physical address, zip code, county and *Healthier Washington* region.
  - 7.16.2.8.2 Any potential gaps in the network of diabetes educators, and measures the Contractor may take to address gaps in network providers.

**7.17 Value-Based Purchasing: Paying for Value Survey**

- 7.17.1 Each year the Contractor will complete all portions of HCA's annual Paying for Value Survey located in MC-Track, as appropriate based on the Contractor's non-Apple Health contracting in Washington State. The Contractor's survey response is due at the end of the month following HCA's release of the survey (e.g. survey is released July 1, 2019, Contractor's response is due August 31, 2019).

## **8 POLICIES AND PROCEDURES**

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to the HCA for review and approval in accordance with 8.2 of this Section, Assessment of Policies and Procedures.

### **8.1 Contractor's Policies and Procedures**

The Contractor's Policies and Procedures shall:

- 8.1.1 Direct and guide the Contractor's employees, subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements;
- 8.1.2 Fully articulate the Contractor's understanding of the requirements;
- 8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training;
- 8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training; and
- 8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

### **8.2 Assessment of Policies and Procedures**

- 8.2.1 The Contractor shall provide a list of its policies and procedures related to this Contract to HCA. The format for the list will be provided by HCA. The Contractor shall complete and submit the list no later than June 30, 2019; and in response to corrective action, any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor shall also submit copies of policies and procedures upon request by HCA.

## **9 SUBCONTRACTS**

### **9.1 Contractor Remains Legally Responsible**

Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract. However, no subcontract, or other agreement delegating any authority or performance of obligations under this Contract, shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor (42 C.F.R. § 434.6(c) and 438.230(b)).

### **9.2 Solvency Requirements for Subcontractors**

For any subcontractor at financial risk, as defined in the Substantial Financial Risk provision, or of the Risk provision found in the Definitions section of this Contract, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

### **9.3 Provider Nondiscrimination**

9.3.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold (42 C.F.R. § 438.12(a)(1)).

9.3.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision (42 C.F.R. § 438.12(a)(1)).

9.3.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 C.F.R. § 438.214(c)).

9.3.4 Consistent with the Contractor's responsibilities to the Enrollees, this Section may not be construed to require the Contractor to:

9.3.4.1 Contract with providers beyond the number necessary to meet the needs of its Enrollees (42 C.F.R. § 438.12(b)(1)).

9.3.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty (42 C.F.R. § 438.12(b)(2)).

9.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 C.F.R. § 438.12(b)(3)).

### **9.4 Required Provisions**

Subcontracts shall be in writing and be consistent with the provisions of 42 C.F.R. § 434.6, § 438.230 and § 438.214, as applicable. All subcontracts shall contain applicable provisions contained in Subsections 9.5 and 9.6 of this Contract and the following provisions:

9.4.1 Identification of the parties of the subcontract and their legal basis for operation in the state of Washington.

9.4.2 A process for monitoring the subcontractor's performance and a periodic schedule

for formally evaluating performance, consistent with industry standards or State managed care laws and regulations.

- 9.4.3 Procedures and specific criteria for terminating the subcontract and for any other remedies the Contractor provides if HCA or the Contractor determines that the subcontractor has not performed satisfactorily (42 C.F.R. § 438.230(c)(1)(iii)).
- 9.4.4 Identification of the services to be performed and reports to be provided by the subcontractor and which of those services may be subcontracted by the subcontractor. If the Contractor allows the subcontractor to further subcontract, all subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered subcontracts.
- 9.4.5 Reimbursement rates and procedures for services provided under the subcontract.
- 9.4.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.
- 9.4.7 The requirement to permit the state of Washington, including HCA, MFCD and state auditor, and federal agencies, including but not limited to: CMS, Government Accountability Office, Office of Management and Budget, Office of the Inspector General, Comptroller General, and their designees, to access, inspect, audit, and evaluate any records or documents of the Contractor or its subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time.
- 9.4.8 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation identified in subsection 9.4.7. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).
- 9.4.9 The requirement to completely and accurately report encounter data, and to certify the accuracy and completeness of all encounter data submitted to the Contractor. The Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the reporting requirements in the Encounter Data Guide published by HCA.
- 9.4.10 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.
- 9.4.11 No assignment of a subcontract shall take effect without HCA's written agreement.
- 9.4.12 The subcontractor shall comply with the applicable state and federal statutes, rules, and regulations including, but not limited to, the laws identified in Subsection 2.4 of this Contract, 42 U.S.C. § 1396a(a)(43), 42 U.S.C. § 1396d(r), and 42 C.F.R. § 438.3(l) and 438.230(c)(2).

- 9.4.13 Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract (42 C.F.R. § 438.6).
- 9.4.14 The Contractor shall provide the following information regarding the Grievance and Appeal System to all subcontractors (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)):
  - 9.4.14.1 The toll-free numbers to file oral grievances and appeals.
  - 9.4.14.2 The availability of assistance in filing a grievance or appeal.
  - 9.4.14.3 The Enrollee's right to request continuation of Medicaid benefits during an appeal or hearing and, if the Contractor's Adverse Benefit Determination is upheld, that the Enrollee may be responsible to pay for the cost of the benefits received for the first sixty (60) calendar days after the appeal or hearing request was received.
  - 9.4.14.4 The Enrollee's right to file Grievances and Appeals and their requirements and timeframes for filing.
  - 9.4.14.5 The Enrollee's right to a hearing, how to obtain a hearing, and representation rules at a hearing.
  - 9.4.14.6 The Subcontractor may file a Grievance or request an adjudicative proceeding on behalf of an Enrollee in accordance with subsection 13.2.1.
- 9.4.15 The process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
- 9.4.16 A process to identify deficiencies and take corrective action for both the Contractor and subcontractor.
- 9.4.17 The process whereby the subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the Enrollee's needs.
- 9.4.18 Prior to delegation, the Contractor shall evaluate any prospective subcontractor's ability to perform the activities for which that subcontractor is contracting, including the subcontractor's ability to perform delegated activities described in the subcontracting document.
- 9.4.19 The requirement to refer credible allegations of fraud to HCA and the MFCD as described in Subsection 12.6 of this Contract. (42 C.F.R § 455.23).
- 9.4.20 An exception request process for underpaid pharmacy claims must be available online for pharmacies on both the Contractor's website and the PBM's website. The process may require the pharmacy to provide an invoice documenting the actual acquisition cost of the medication and reasons why the product was not available for purchase at the reimbursement rate set by the PBM.

## 9.5 Health Care Provider Subcontracts

The Contractor's subcontracts, including those for facilities and pharmacy benefit management, shall also contain the following provisions:



- 9.5.1 A quality improvement system consistent with the Contractor's obligations under Subsections 7.1 through 7.3, tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.
- 9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Assessment and Performance Improvement (QAPI) activities required by Section 7 of this Contract.
- 9.5.3 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including QAPI, Utilization Management, Member Rights and Responsibilities, and Credentialing and Re-credentialing.
- 9.5.4 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:
  - 9.5.4.1 Assigned responsibilities
  - 9.5.4.2 Delegated activities
  - 9.5.4.3 A mechanism for evaluation
  - 9.5.4.4 Corrective action policy and procedure
- 9.5.5 Information about Enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.
- 9.5.6 The Subcontractor accepts payment from the Contractor as payment in full. The Subcontractor shall not request payment from HCA or any Enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-0160 requirements applicable to providers.
- 9.5.7 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors (42 C.F.R. § 438.230(b)(2)).
- 9.5.8 If the subcontract includes physician services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.
- 9.5.9 If the subcontract includes physician services, provisions that inform the provider of any HCA determined appeal rights to challenge the failure of the Contractor to cover a service. (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)(xi)).
- 9.5.10 A ninety (90) day termination notice provision.
- 9.5.11 A specific termination provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.
- 9.5.12 The Subcontractor agrees to comply with all relevant provisions of this Contract,

including but not limited to, the appointment wait time standards and the obligation to report accurately the information required for the Contractor's provider directory and any changes thereto. The subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards (42 C.F.R. § 438.206(c)(1)).

- 9.5.13 A provision that informs the provider of a reasonably accessible on-line location of the policies and procedures listed in Section 8 of this Contract.
- 9.5.14 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three (3) years and must identify deficiencies or areas for improvement and provide for corrective action (42 C.F.R. § 438.230(b)).
  - 9.5.14.1 Upon request by HCA, the Contractor will provide a copy of the monitoring policy, process and any results of identified health care providers.
- 9.5.15 The Contractor shall document and confirm in writing all Single Case Agreements with providers. The agreement shall include:
  - 9.5.15.1 The description of the services;
  - 9.5.15.2 The authorization period for the services, including the begin date and the end date for approved services;
  - 9.5.15.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and
  - 9.5.15.4 Any other specifics of the negotiated rate.
- 9.5.16 The Contractor must supply documentation to the Subcontractor no later than five (5) business days following the signing of the agreement. Updates to the Single Case Agreement, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).
- 9.5.17 The Contractor shall maintain a record of the Single Case Agreements for a period of six (6) years.
- 9.5.18 The Contractor shall provide a copy of the Health Care Provider subcontract template and any contract samples upon request by HCA.

## 9.6 **Health Care Provider Subcontracts Delegating Administrative Functions**

- 9.6.1 Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:
  - 9.6.1.1 For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.
  - 9.6.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct

provision of services to Enrollees and include, but are not limited to, utilization/medical management, claims processing, Enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

- 9.6.1.3 How frequently and by what means the Contractor will monitor compliance with solvency requirements and subcontractor performance related to any administrative function delegated in the subcontract.
  - 9.6.1.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 C.F.R. § 438.230(c)(1)(iii)).
  - 9.6.1.5 Whether referrals for Enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.
  - 9.6.1.6 Prior to delegation, an evaluation of the subcontractors ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.
- 9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees assigned or serviced by the delegated entity to the HCA by March 1 of each year applicable to this Contract and upon request by the HCA.

## 9.7 Health Homes

The Contractor shall provide health home services as a qualified health home lead organization, or may delegate Health Home services by contracting with other qualified Health Home lead organizations to deliver health home services for Enrollees meeting the eligibility criteria for the Health Home program. The Contractor shall subcontract with community based Care Coordination Organizations sufficient in quantity and type and may also provide Health Home services as a Care Coordination Organization.

Network adequacy for a Care Coordination Organization (CCO) network will be determined by evidence of signed subcontracts with at least five of the CCOs described below. Two of the five subcontracts must be with an organization that provides mental health services and an organization that provides long-term services and supports. The Contractor must assign at least 35 percent of their Health Home Enrollee population to the subcontracted CCO when providing Health Home services in each coverage area.

The following CCOs meet the requirement for "sufficiency" of a Health Home network:

- 9.7.1 Federally Qualified Health Centers
- 9.7.2 Area Agencies on Aging
- 9.7.3 Rural Health Clinics
- 9.7.4 Community Mental Health Agencies
- 9.7.5 Mental Health clinics or counseling services
- 9.7.6 Substance Use Disorder Treatment Agencies or counseling services
- 9.7.7 Hospitals

9.7.8 Behavioral Health Organizations

9.7.9 Medical or specialty clinics

9.7.10 Pediatric clinics

9.7.11 Social Service organizations'

## 9.8 Home Health Providers

The Contractor may not subcontract with a home health agency unless the home health agency is in compliance with the surety bond requirements of federal law (Section 4708(d) of the Balanced Budget Act of 1997 and 42 C.F.R. § 441.16).

## 9.9 Physician Incentive Plans

Physician Incentive Plans, as defined herein, are subject to the conditions set forth in this Section and in federal regulations (42 C.F.R. § 438.6, 42 C.F.R. § 422.208, and 42 C.F.R. § 422.210). The Contractor shall provide written notification to HCA on an annual basis (due March 1) that its physician incentive plans, if any, comply with federal regulations.

9.9.1 Prohibited Payments: The Contractor shall make no payment to a physician or Physician Group, directly or indirectly, under a Physician Incentive Plan as an inducement to reduce or limit Medically Necessary Services provided to an individual Enrollee.

9.9.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or Physician Groups are subject to review and approval by HCA. Prior to entering into, modifying, or extending the risk sharing arrangement in a subcontract at any tier, the Contractor shall provide the following information about its Physician Incentive Plan, and the Physician Incentive Plans of its Subcontractors to HCA:

9.9.2.1 A description of the incentive plan including whether the incentive plan includes referral services.

9.9.2.2 If the incentive plan includes referral services, the information provided to HCA shall include:

9.9.2.2.1 The type of incentive plan (e.g. withhold, bonus, capitation).

9.9.2.2.2 For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

9.9.2.2.3 Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.

9.9.2.2.4 The panel size and, if commercial members and Enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or Physician Group's panel may be pooled provided the terms of risk for the pooled Enrollees and commercial members are comparable, and the incentive payments are not

calculated separately for pooled Enrollees. Commercial members include military members.

- 9.9.3 If the Contractor, or any Subcontractor, places a physician or Physician Group at Substantial Financial Risk, the Contractor shall assure that all physicians and Physician Groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or Physician Group.
- 9.9.3.1 If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services that exceed 25 percent of maximum potential payments under the subcontract.
  - 9.9.3.2 If stop-loss protection is based on a per-member limit, it must cover 90 percent of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.
    - 9.9.3.2.1 1,000 members or fewer, the threshold is \$3,000 for professional services and \$10,000 for institutional services, or \$6,000 for combined services.
    - 9.9.3.2.2 1,001 - 5,000 members, the threshold is \$10,000 for professional services and \$40,000 for institutional services, or \$30,000 for combined services.
    - 9.9.3.2.3 5,001 - 8,000 members, the threshold is \$15,000 for professional services and \$60,000 for institutional services, or \$40,000 for combined services.
    - 9.9.3.2.4 8,001 - 10,000 members, the threshold is \$20,000 for professional services and \$100,000 for institutional services, or \$75,000 for combined services.
    - 9.9.3.2.5 10,001 - 25,000 members, the threshold is \$25,000 for professional services and \$200,000 for institutional services, or \$150,000 for combined services.
    - 9.9.3.2.6 25,001 members or more, there is no risk threshold.
  - 9.9.3.3 The Contractor shall provide the following information regarding its Physician Incentive Plans to any Enrollee who requests it:
    - 9.9.3.3.1 Whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;
    - 9.9.3.3.2 The type of incentive arrangement; and
    - 9.9.3.3.3 Whether stop-loss protection is provided

## 9.10 Provider Education

The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction from the training process.

- 9.10.1 The Contractor shall keep participating providers informed about:

- 9.10.1.1 Covered Services for Enrollees served under this Contract.
- 9.10.1.2 Coordination of care requirements.
- 9.10.1.3 HCA and the Contractor's policies and procedures as related to this Contract.
- 9.10.1.4 Health Homes.
- 9.10.1.5 HCA First Steps Program - Maternity Support Services (MSS). The Contractor shall notify providers about HCA's First Steps program, MSS, using the HCA MSS informational letter template that includes the HCA First Steps program website and Provider Directory.
- 9.10.1.6 Interpretation of data from the Quality Improvement program.
- 9.10.1.7 Practice guidelines as described in the provisions of this Contract.
- 9.10.1.8 Mental health services through the Contractor. The Contractor shall provide a link to the provider directory annually to all Primary Care Providers, including its contracted mental health and children's mental health professionals. The Contractor shall provide the link to its Primary Care Providers no later than January 31.
- 9.10.1.9 Mental health services through Behavioral Health Organizations (BHOs) including a list of BHOs and contact information in counties served by the Contractor.
- 9.10.1.10 Behavioral Health resource line (chapter 74.09 RCW).
- 9.10.1.11 DSHS substance use disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by the Contractor.
- 9.10.1.12 Contractor care management staff for assistance in care transitions and care management activity.
- 9.10.1.13 Program Integrity requirements.
- 9.10.1.14 DSHS long-term care services, including availability of home and community based care (chapter 388-106 WAC).
- 9.10.1.15 DSHS developmental disability services including community-based care (chapter 388-823 to -850 WAC).
- 9.10.1.16 DCYF services for children and families, including, but not limited to, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention Services (ECLIPSE), and Early Childhood and Education Assistance Program (ECEAP) and Head Start programs using the informational letter template jointly developed by DCYF and HCA.
- 9.10.1.17 Perinatal Psychiatry Consultation Line (PAL for Moms) offered through University of Washington Medicine.
- 9.10.1.18 Partnership Access Line Plus (PAL Plus) program available in Benton

and Franklin counties.

9.10.1.19 Educational opportunities for Primary Care Providers, such as those produced by the Washington State Department of Health Collaborative, the Washington State Medical Association, or the Washington State Hospital Association, etc.

## 9.11 Claims Payment Standards

9.11.1 The Contractor shall meet the timeliness of payment standards specified for Medicaid FFS in Section 1902(a)(37) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-170-431. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to 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. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.11.1.1 A claim is a bill for services, a line item of service or all services for one Enrollee within a bill.

9.11.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

9.11.1.3 The date of receipt is the date the Contractor receives the claim from the provider.

9.11.1.4 The date of payment is the date of the check or other form of payment.

9.11.2 The Contractor shall allow providers 365 days to submit claims for services provided under this Contract unless the provider has agreed or agrees to a shorter timely filing timeframe in their contract with the Contractor.

## 9.12 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor shall provide HCA with information related to subcontracted federally qualified health centers (FQHC) and rural health clinics (RHC), as required by HCA Federally Qualified Health Center and Rural Health Clinic Billing Guides, published by HCA and incorporated by reference into this Contract.

## 9.13 Screening and Enrollment of Providers

9.13.1 The Contractor shall ensure that all network providers are enrolled with the state as Medicaid providers consistent with federal disclosure, screening and enrollment requirements.

9.13.2 HCA shall screen, enroll and periodically revalidate all network providers as Medicaid providers, in accordance with Part 455, Subparts B and E of chapter 42 C.F.R.

9.13.3 The Contractor may execute network provider agreements, pending the outcome of screening, enrollment and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from HCA that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of

the provider, and must notify affected Enrollees.

#### 9.14 **Provider Credentialing**

The Contractor's policies and procedures shall be in writing and meet NCQA requirements related to the credentialing and recredentialing of health care professionals who have signed contracts or participation agreements with the Contractor. The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract (42 C.F.R. § 438.214).

- 9.14.1 The Contractor's policies and procedures shall ensure compliance with the following requirements described in this Section.
  - 9.14.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.
  - 9.14.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.
- 9.14.2 The Contractor's credentialing and recredentialing program shall include:
  - 9.14.2.1 Identification of the type of providers credentialed and recredentialed, including but not limited to, acute, primary, behavioral, substance use disorder and LTSS providers, as appropriate (42 C.F.R. § 438.214(b)).
  - 9.14.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.
  - 9.14.2.3 A process for provisional credentialing that affirms that:
    - 9.14.2.3.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and
    - 9.14.2.3.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.
    - 9.14.2.3.3 Provisional credentialing shall include an assessment of:
      - 9.14.2.3.3.1 Primary source verification of a current, valid license to practice;
      - 9.14.2.3.3.2 Primary source verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and
      - 9.14.2.3.3.3 A current signed application with attestation.
  - 9.14.2.4 Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.
  - 9.14.2.5 A detailed description of the Contractor's process for delegation of



credentialing and recredentialing.

- 9.14.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.
- 9.14.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:
  - 9.14.3.1 Review materials.
  - 9.14.3.2 Correct incorrect or erroneous information.
  - 9.14.3.3 Be informed of their credentialing status.
- 9.14.4 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.
- 9.14.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.
- 9.14.6 The Contractor's process to ensure confidentiality.
- 9.14.7 The Contractor's process to ensure listings in provider directories for Enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.
- 9.14.8 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.
- 9.14.9 The Contractor's process to ensure that offices of all health care professionals meet office site standards established by the Contractor.
- 9.14.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.(42 C.F.R. § 455.101).
- 9.14.11 The Contractor's process and criteria for assessing and reassessing organizational providers.
- 9.14.12 The criteria used by the Contractor to credential and recredential practitioners shall include (42 C.F.R. § 438.214(b)):
  - 9.14.12.1 Evidence of a current valid license to practice;
  - 9.14.12.2 A valid DEA or CDS certificate if applicable;
  - 9.14.12.3 Evidence of appropriate education and training;
  - 9.14.12.4 Board certification if applicable;
  - 9.14.12.5 Evaluation of work history;
  - 9.14.12.6 A review of any liability claims resulting in settlements or judgments paid

- on or on behalf of the provider; and
- 9.14.12.7 A signed, dated attestation statement from the provider that addresses:
- 9.14.12.7.1 The lack of present illegal drug use;
  - 9.14.12.7.2 A history of loss of license and criminal or felony convictions;
  - 9.14.12.7.3 A history of loss or limitation of privileges or disciplinary activity;
  - 9.14.12.7.4 Current malpractice coverage;
  - 9.14.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and
  - 9.14.12.7.6 Accuracy and completeness of the application.
- 9.14.12.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.
- 9.14.13 The Contractor shall ensure that subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled through the Medicare system, which requires a criminal background check as part of the enrollment process. Using <https://www.medicare.gov> or an enrollment verification letter from Medicare issued after March 23, 2011, the Contractor shall ensure that providers defined as "high categorical risk" are enrolled through the Medicare system. The Contractor shall document use of the Medicare.gov website when using it to verify the subcontracted provider's status. The Contractor shall ensure that contracted providers defined as "high categorical risk" revalidate their Medicare enrollment every five (5) years in compliance with 42 C.F.R. § 424.515.
- 9.14.13.1 If a "high categorical risk" subcontracted provider is not enrolled in the Medicare system and delivers a service that is not commonly delivered to a Medicare covered subscriber, e.g. someone under twenty-one (21) years of age, the above requirement to submit a letter from Medicare as part of the Contractor's credentialing process is waived. However, the provider must successfully complete the Contractor's credentialing process, which could include a background check.
- 9.14.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, fraud; integrity; or quality (42 C.F.R. § 455.101).
- 9.14.15 The Contractor shall notify HCA in accord with the Notices section of this contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, subcontractor or subcontractor employee.
- 9.14.16 The Contractor shall require providers defined as "high categorical risk" for potential fraud as defined in 42 C.F.R. § 424.518 to be enrolled and screened by Medicare.

9.14.17 The Contractor's policies and procedures shall be consistent with 42 C.F.R. § 438.12, and the process shall ensure the Contractor does not discriminate against particular health care professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

## 10 ENROLLEE RIGHTS AND PROTECTIONS

### 10.1 General Requirements

- 10.1.1 The Contractor shall comply with any applicable Federal and State laws that pertain to Enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Enrollees (WAC 182-503-0100; 42 C.F.R. § 438.100(a)(2)).
- 10.1.2 The Contractor shall have in place written policies that guarantee each Enrollee the following rights (42 C.F.R. § 438.100(b)(2)):
  - 10.1.2.1 Receive information on Apple Health Managed Care in general and the Contractor's Apple Health program in particular, including information about how to contact the person or entity designated as primarily responsible for coordinating the services accessed by the Enrollee.
  - 10.1.2.2 To be treated with respect and with consideration for their dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)).
  - 10.1.2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's ability to understand (42 C.F.R. § 438.100(b)(2)(iii)).
  - 10.1.2.4 To participate in decisions regarding their health care, including the right to refuse treatment (42 C.F.R. § 438.100(b)(2)(iv)).
  - 10.1.2.5 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 C.F.R. § 438.100(b)(2)(iv)).
  - 10.1.2.6 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164 (42 C.F.R. § 438.100(b)(2)(vi)).
  - 10.1.2.7 Each Enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the Enrollee (42 C.F.R. § 438.100(c)).

### 10.2 Cultural Considerations

- 10.2.1 The Contractor shall promote access to and delivery of services that are provided in a culturally competent manner to all enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
- 10.2.2 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (42 C.F.R. § 438.206(c)(2)).
- 10.2.3 At a minimum, the Contractor shall:

- 10.2.3.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. (CLAS Standard 4);
- 10.2.3.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);
- 10.2.3.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. (CLAS Standard 6);
- 10.2.3.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);
- 10.2.3.5 Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);
- 10.2.3.6 Establish culturally and linguistically appropriate goals. (CLAS Standard 9);
- 10.2.3.7 Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. (CLAS Standard 10);
- 10.2.3.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and
- 10.2.3.9 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).

**10.3 Advance Directives and Physician Orders for Life Sustaining Treatment (POLST)**

- 10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this Section.
- 10.3.2 The Contractor's advance directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, potential Enrollees.
  - 10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing advance directives.
  - 10.3.2.2 The Contractor's policies and procedures respecting the implementation of advance directives and POLST rights shall be included in the Enrollee handbook at a location designated in its template by HCA, and shall be featured on the Contractor's website in the member/enrollee section.
- 10.3.3 The Contractor's written policies respecting the implementation of advance directive

POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience (42 C.F.R. § 422.128). At a minimum, this statement must do the following:

- 10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.
  - 10.3.3.2 Identify the state legal authority permitting such objection.
  - 10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.
- 10.3.4 If an Enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive or received a POLST, the Contractor may give advance directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.
- 10.3.5 The Contractor must require and ensure that the Enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive or received a POLST.
- 10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an advance directive or received a POLST.
- 10.3.7 The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives or POLSTs.
- 10.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives or POLSTs.
- 10.3.9 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts (42 C.F.R. § 438.6(i)(3)).
- 10.3.10 The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

10.3.11 The Contractor shall inform Enrollees that they may file a grievance with the Contractor if the Enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and procedures. The Contractor shall also inform Enrollees that they may file a grievance with the Washington State Department of Health if they believe the Contractor is non-compliant with advance directive and POLST requirements.

#### **10.4 Enrollee Choice of PCP**

10.4.1 The Contractor must implement procedures to ensure each Enrollee has a source of primary care appropriate to their needs (42 C.F.R. § 438.208(b)(1)).

10.4.2 The Contractor shall allow, to the extent possible and appropriate, each new Enrollee to choose a participating PCP (42 C.F.R. § 438.3(l)).

10.4.3 In the case of newborns, the parent shall choose the newborn's PCP.

10.4.4 In the case of Alaska Native or American Indian Enrollees, the Enrollee may choose a tribal clinic as his or her PCP, whether or not the tribal clinic is a network provider.

10.4.5 If the Enrollee does not make a choice at the time of enrollment, the Contractor shall assign the Enrollee to a PCP or clinic, within reasonable proximity to the Enrollee's home, no later than fifteen (15) business days after coverage begins.

10.4.6 Contractor shall provide a list of assigned Enrollees to PCP upon request by the PCP or by HCA.

10.4.7 The Contractor shall allow an Enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the Enrollee's request for the change (WAC 182-538-060 and WAC 284-170-360).

10.4.8 The Contractor may limit an Enrollee's ability to change PCP's in accord with the Patient Review and Coordination provisions of this Contract.

#### **10.5 Prohibition on Enrollee Charges for Covered Services**

10.5.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including non-participating providers, charge Enrollees for covered services as described in the (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 C.F.R. § 438.106(c), 438.6(1), 438.230, 438.204(a) and WAC 182-502-0160).

10.5.2 Prior to authorizing services with non-participating providers, the Contractor shall assure that non-participating providers fully understand and accept the prohibition against balance billing Enrollees.

10.5.3 The Contractor shall require providers to report when an Enrollee is charged for services. The Contractor shall maintain a central record of the charged amount, Enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an Enrollee is charged for services, whether or not those charges are appropriate.

10.5.4 If an Enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee fail, the Contractor will

repay the Enrollee the inappropriately charged amount.

10.5.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees from being billed for contracted services.

10.5.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee for covered services including other insurer's copayments and coinsurance.

#### **10.6 Provider/Enrollee Communication**

The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient, for the following (42 C.F.R. § 438.102(a)(1)(i)):

10.6.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 C.F.R. § 438.102(a)(1)(i)).

10.6.2 Any information the Enrollee needs in order to decide among all relevant treatment options (42 C.F.R. § 438.102(a)(1)(ii)).

10.6.3 The risks, benefits, and consequences of treatment or non-treatment (42 C.F.R. § 438.102(a)(1)(iii)).

10.6.4 The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 C.F.R. § 438.102(a)(1)(iv)).

#### **10.7 Enrollee Self-Determination**

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (chapter 70.122 RCW) and state and federal Medicaid rules concerning advance directives (WAC 182-501-0125 and 42 C.F.R. § 438.6(m)); and, when appropriate, inform Enrollees of their right to make anatomical gifts (chapter 68.64 RCW).

#### **10.8 Women's Health Care Services**

The Contractor must provide female Enrollees with direct access to a women's health practitioners within the Contractor's network for covered care necessary to provide women's routine and preventive health care services, including prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-170-350 and 42 C.F.R. § 438.206(b)(2).

#### **10.9 Maternity Newborn Length of Stay**

The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

#### **10.10 Enrollment Not Discriminatory**

10.10.1 The Contractor will not discriminate against Enrollees due to an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, diminished mental



capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

- 10.10.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or mental condition, functional impairment or chemical dependency, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).
- 10.10.3 The Contractor will not exclude from participation in any health program or activity, deny benefits to, or discriminate against Enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability (42 C.F.R. § 438.3(d)(4)) and 42 U.S.C. 18116.

## **11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES**

### **11.1 Prior Authorization Administrative Simplification Initiative**

The Contractor shall actively participate and assign a representative to the Prior Authorization Simplification Initiative coordinated by the OIC according to RCW 48.165.030. The Contractor shall implement the recommendations made in the "Best Practices Recommendations" deliverable produced by the OIC's prior authorization simplification workgroup in order to meet the expectations found in chapter 48.165 RCW, unless HCA has agreed that to do so is in violation of C.F.R.

### **11.2 Utilization Management General Requirements**

The Contractor shall follow the Utilization Management (UM) requirements described in this Section and educate UM staff in the application of UM protocols, communicating the criteria used in making UM decisions. UM protocols shall recognize and respect the cultural needs of diverse populations.

#### **11.2.1 Drug Utilization Review (DUR) Program**

11.2.1.1 The Contractor shall operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K.

11.2.1.2 The Contractor shall provide a detailed description of its drug utilization review program by December 31 of each calendar year for the prior federal fiscal year (October 1 through September 30). The first report is due no later than December 31, 2018.

11.2.1.3 Contractor must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists, and Enrollees.

#### **11.2.2 Prospective Drug Utilization Review (Pro-DUR)**

11.2.2.1 Contractor must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, drug refill too soon, and clinical abuse/misuse.

#### **11.2.3 Retrospective Drug Utilization Review (Retro-DUR)**

11.2.3.1 Contractor must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, and abuse such as gross overuse, excessive filling or inappropriate or medically unnecessary care among physicians, pharmacists and members.

11.2.3.2 Contractor shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not

limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

- 11.2.3.3 Contractor shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.
- 11.2.4 The Contractor shall demonstrate that all UM staff making service authorization decisions have been trained and are competent in working with the specific area of service for which they have authorization and management responsibility, and that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health or long-term services and supports needs (42 C.F.R 438.210(b)(3)).
- 11.2.5 The Contractor's policies and procedures related to (UM) shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this Section.
- 11.2.6 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and behavioral services it furnishes its Enrollees. The UMP description shall include:
  - 11.2.6.1 The definition of the Contractor's UMP structure and assignment of responsibility for UMP activities to appropriate individuals.
  - 11.2.6.2 Identification of a designated physician responsible for program implementation, oversight and evaluation, and evidence of the physician's and a behavioral health practitioner's involvement in program development and implementation.
  - 11.2.6.3 Identification of the type of personnel responsible for each level of UM decision-making.
  - 11.2.6.4 The use of board-certified consultants to assist in making medical necessity determinations.
  - 11.2.6.5 Assurance that a physician, doctoral level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any behavioral health denial based on medical necessity.
  - 11.2.6.6 A written description of all UM-related committee(s).
  - 11.2.6.7 Descriptions of committee responsibilities.
  - 11.2.6.8 Committee participant titles, including UM subcontract, subcontractor representatives and practicing providers.
  - 11.2.6.9 Meeting frequency.
  - 11.2.6.10 Maintenance of signed meeting minutes reflecting decisions made by

each committee, as appropriate.

11.2.6.11 Behavioral healthcare benefits to include at a minimum:

11.2.6.11.1 Benefit structure and description;

11.2.6.11.2 Triage and referral procedures and protocols, if any, (i.e., clearly describe how Enrollees access behavioral healthcare services);

11.2.6.11.3 UM activities and staff roles and responsibilities;

11.2.6.11.4 Coordination activities with behavioral healthcare system;

11.2.6.11.5 Monitoring and oversight of the behavioral health program; and

11.2.6.11.6 Strategies to foster integration of physical health and behavioral health.

11.2.6.12 Annual evaluation and update of the UMP.

11.2.7 UMP behavioral health and non-behavioral health policies and procedures at minimum, shall address the following requirements:

11.2.7.1 Assurance that each Enrollee's needs are monitored and that appropriate referrals are made for care coordination or Health Home services consistent with Section 14 of this Contract.

11.2.7.2 Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-2000(2)).

11.2.7.3 Written policies for applying UMP decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; and the availability of services in the local delivery system.

11.2.7.4 Mechanisms for providers and Enrollees on how they can obtain the UM decision-making criteria upon request, including UM Adverse Benefit Determination or denial determination letter template language reflecting the same (WAC 284-43-2000(2)).

11.2.7.5 Mechanisms to facilitate communication between UMP staff and providers and Enrollees.

11.2.7.6 Mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

11.2.7.7 Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and

current, non-restricted license.

- 11.2.7.8 Mechanisms to verify that claimed services were actually provided.
- 11.2.7.9 Mechanisms to detect both underutilization and over-utilization of services, including pharmacy underutilization and over-utilization.
- 11.2.8 The Contractor shall ensure documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance and Appeal System Section of this Contract.
- 11.2.9 The Contractor shall implement the coverage decisions of the Health Technology Clinical Committee (HTCC) (chapter 182-55 WAC) as directed by HCA (See Health Technology Assessment (HTA) resources: <http://www.hca.wa.gov/about-hca/health-technology-assessment>).
- 11.2.10 Prior Authorization Administrative Simplification Workgroup. The Contractor shall participate in the statewide Prior Authorization Administrative Simplification Workgroup convened by the OIC (RCW 48.165.030). The Contractor will abide by best practice recommendations agreed to the Prior Authorization Administrative Simplification Workgroup unless otherwise directed by HCA.
- 11.2.11 Opioid Crisis Engagement. The Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to collaborate on approaches to the opioid crisis. Contractor activities developed in collaboration with peer managed care organizations and the HCA medical directors to address this health and safety concern may include, but are not limited to: Identification and management of Enrollees taking high-dose opioids for non-cancer pain; prescriber and Enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, use of naloxone, requesting second opinions from a pain management specialist, preauthorization of opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or substance use disorder programs for assessment.
- 11.2.12 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Enrollee (42 C.F.R. § 438.210(e)).
- 11.2.13 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service.

### 11.3 Prescription Drug Authorization Decisions and Timeframes

- 11.3.1 Contractor must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will, apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using

codes such as the Healthcare Common Procedure Coding System (HCPCS).

- 11.3.2 Contractor must respond to a prior authorization request for a covered outpatient drug or over-the-counter drug by telephone or other telecommunication device within twenty-four (24) hours of the request. Authorization Determinations for Covered Out Patient Drugs or Over-the-Counter Drugs: Consistent with Section 1927(d)(5) of the Social Security Act, all authorization determinations for prescriptions or over-the-counter drugs must be made no later than the following business day after receipt of the request for service unless additional information is required. Any additional information needed must be requested by the close of business on the first day following the initial request for authorization and determinations must be made no later than close of business on the first business day after receipt of the additional information. If the provider does not respond to the Contractor's request for additional information within three (3) business days of the request the Contractor must make a decision based on the information at hand.
- 11.3.3 Contractor shall have in place a mechanism to allow automated approval of prior authorization criteria based on situation specific codes or values submitted via point-of-sale by the dispensing pharmacy. Overrides of prior authorization criteria may be based on values submitted in either the prior authorization or diagnosis fields.
- 11.3.4 Contractor shall have a process for providing an emergency drug supply to Enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the Enrollee's health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.
- 11.3.5 Contractor shall have a process for authorization after the fact of an emergency fill as defined in this Contract when an emergency fill of a medication is dispensed according to the professional judgment of the dispensing pharmacist not to exceed thirty (30) calendar days' supply. The authorization for the prescription must match the drug quantity and days supplied as dispensed by the pharmacist.

#### 11.4 **Medical Necessity Determination**

The Contractor shall collect all information necessary to make medical necessity determinations. (42 C.F.R § 456.111 and 456.211). The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding appeals, hearings and independent review.

#### 11.5 **Authorization of Services**

- 11.5.1 The Contractor shall follow the authorization of services requirements described in this Section. The Contractor shall not have or implement authorization policies that inhibit Enrollees from obtaining medically necessary contracted services and supplies. For example, inpatient admissions for deliveries or home births should not require prior authorization because there is not a question of medical necessity associated with a delivery. It is reasonable to require notification of admissions for delivery or of a home delivery to support concurrent review activities or case management.

- 11.5.2 Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for chronic conditions.
- 11.5.3 The Contractor's policies and procedures related to authorization and post-service review of services shall include compliance with 42 C.F.R. § 438.210, WAC 284-43-2000(6)(b), chapters 182-538 and 182-550 WAC, WAC 182-501-0160 and -0169, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this Section, and shall include a definition of "service authorization" that includes an Enrollee's request for services.
- 11.5.4 The Contractor shall provide education and ongoing guidance to Enrollees and providers about its UM protocols and level of care guidelines, including admission, continued stay and discharge criteria.
- 11.5.5 The Contractor shall consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(2)(ii)).
- 11.5.6 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate expertise in addressing the Enrollee's medical or behavioral health condition or long-term services and supports (42 C.F.R. § 438.210(b)(3)).

- 11.5.6.1 In denying services, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the FFS program. For services that are excluded from this Contract, but are covered by HCA, the Contractor's denial will include directions to the Enrollee about how to obtain the services through HCA and will direct the Enrollee to those services and coordinate receipt of those services.

## 11.6 Timeframes for Authorization Decisions

- 11.6.1 The Contractor shall provide for the following timeframes for authorization decisions and notices:
  - 11.6.1.1 Denial of Payment that may result in Payment Liability: The authorization decision and notice is provided for the Enrollee, at the time of any Adverse Benefit Determination affecting the claim.
  - 11.6.1.2 Termination, Suspension, or Reduction of Previously Authorized Services: The authorization decision and notice is provided ten (10) calendar days prior to such termination, suspension, or reduction, except in the following circumstances:
    - 11.6.1.2.1 The Enrollee dies;
    - 11.6.1.2.2 The Contractor has a signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that termination, reduction or

- suspension of services is the result of supplying this information);
- 11.6.1.2.3 The Enrollee is admitted to an institution where he or she is ineligible for services;
  - 11.6.1.2.4 The Enrollee's address is unknown and mail directed to him or her has no forwarding address;
  - 11.6.1.2.5 The Enrollee has moved out of the Contractor's service area past the end of the month for which a premium was paid;
  - 11.6.1.2.6 The Enrollee's PCP prescribes the change in the level of medical care;
  - 11.6.1.2.7 An adverse determination regarding the preadmission screening for nursing facility was made; or
  - 11.6.1.2.8 The safety or health of individuals in the nursing facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to Adverse Benefit Determinations for nursing facility transfers).
- 11.6.1.3 Standard authorizations for Health Care Services determinations: The authorization decisions are to be made and notices are to be provided as expeditiously as the Enrollee's health condition requires (42 C.F.R. § 438.210(d)(1)). The Contractor must make a decision to approve, deny, or request additional information from the provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information.
- 11.6.1.3.1 A possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances (42 C.F.R. § 438.210(d)(1)):
    - 11.6.1.3.1.1 The Enrollee or the provider requests an extension; or
    - 11.6.1.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the Enrollee's interest.
  - 11.6.1.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:



- 11.6.1.3.2.1 The Contractor shall provide the Enrollee written notice within three business days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision.
    - 11.6.1.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires (42 C.F.R. § 438.404(c)(4)).
  - 11.6.1.3.3 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).
- 11.6.1.4 Expedited Authorization Decisions: For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires.
  - 11.6.1.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day, if the information provided is not sufficient to approve or deny the request. The Contractor must give the provider two (2) calendar days to submit the requested information and then approve or deny the request within two (2) calendar days of the receipt of the additional information.
  - 11.6.1.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances (42 C.F.R. § 438.210(d)(2)(ii):
    - 11.6.1.4.2.1 The Enrollee requests the extension; or
    - 11.6.1.4.2.2 The Contractor justifies and documents a need for additional information and how the extension is in the Enrollee's interest.
- 11.6.1.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) business day of receipt of the request for

authorization.

- 11.6.1.5.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) business days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) business day after the request for authorization of additional days or services.
- 11.6.1.5.2 Notification of the concurrent review determination shall be made within one (1) business day of the Contractor's decision.
- 11.6.1.5.3 Expedited appeal timeframes apply to Concurrent Review requests.
- 11.6.1.6 Post-service Authorizations: For post-service authorizations, including pharmacy post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.
  - 11.6.1.6.1 The Contractor shall notify the Enrollee in writing and the requesting provider either orally or in writing within three (3) business days of the Contractor's determination.
  - 11.6.1.6.2 Standard appeal timeframes apply to post-service denials.
  - 11.6.1.6.3 When post-service authorizations are approved, they become effective the date the service was first administered.
- 11.6.1.7 Verified Enrollee Fraud: The Contractor shall give notice at least five (5) calendar days before the effective date when the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Medicaid-Covered Services when Enrollee Fraud has been verified.
- 11.6.1.8 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).
- 11.6.1.9 Extenuating Circumstances: When extenuating circumstances are identified, consistent with *Best Practice Recommendation for Extenuating Circumstances around Pre-Authorization and Admission Notification*, and the provider is not able to request a pre-authorization prior to treating the Enrollee or provide timely notification to the Contractor of the Enrollee's admission, the Contractor shall allow claims and related appeals to process as if a pre-authorization had been requested or admission notification had been submitted within the time

period (WAC 284-43-2060).

## 11.7 Notification of Coverage and Authorization Determinations

- 11.7.1 For all Adverse Benefit Determinations, the Contractor must notify the Enrollee in writing and the ordering provider or facility orally or in writing. The Contractor must notify the parties, other than the Enrollee, in advance whether it will provide notification by phone, mail, fax, or other means. The Contractor must use an HCA-developed template for Skilled Nursing-related Adverse Benefit Determinations.
  - 11.7.1.1 Adverse Benefit Determinations Involving an Expedited Authorization: The Contractor must notify the Enrollee in writing of the decision. The Contractor may initially provide notice orally to the Enrollee or the requesting provider within seventy-two (72) hours of the request. The Contractor shall send the written notice no later than seventy-two (72) hours after receipt of the request for service.
  - 11.7.1.2 The Contractor shall notify the requesting provider and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements (42 C.F.R. § 438.210(c) and 438.404):
    - 11.7.1.2.1 The notice to the Enrollee shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.
    - 11.7.1.2.2 For all authorization decisions, the notice shall be mailed as expeditiously as the Enrollee's health condition requires and within three (3) business days of the Contractor's decision.
    - 11.7.1.2.3 The notice to the Enrollee and provider shall explain the following (42 C.F.R. § 438.404(b)(1-3)(5-7)):
      - 11.7.1.2.3.1 The Adverse Benefit Determination the Contractor has taken or intends to take.
      - 11.7.1.2.3.2 The reasons for the Adverse Benefit Determination, in easily understood language, including citation to the Washington Administrative Code rules or any Contractor guidelines, protocols, or other criteria that were the basis of the decision.
      - 11.7.1.2.3.3 If applicable the notice must include information about alternative covered services/treatment which may be seen as a viable treatment option in lieu of denied services.

- 11.7.1.2.3.4 The Enrollee and providers right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision.
- 11.7.1.2.3.5 A statement whether or not an Enrollee has any liability for payment.
- 11.7.1.2.3.6 A toll free telephone number to call if the Enrollee is billed for services.
- 11.7.1.2.3.7 The Enrollee's or the provider's right to file an appeal and any deadlines applicable to the process.
- 11.7.1.2.3.8 If services are denied as non-covered, inform Enrollees how to access the Exception to Rule (ETR) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an ETR to obtain the services that are the subject of the appeal, and that requesting an ETR does not affect any deadlines applicable to the appeal process.
- 11.7.1.2.3.9 If services are denied or authorized in a more limited scope, amount or duration than requested because they would exceed the established limit on the scope, amount or duration of the requested service, inform Enrollees how to access the Limitation Extension (LE) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an LE to obtain the services that are the subject of the appeal, and that requesting an LE does not affect any deadlines applicable to the appeal process.
- 11.7.1.2.3.10 The procedures for exercising the Enrollee's rights.
- 11.7.1.2.3.11 The circumstances under which expedited resolution is available and how to request it.
- 11.7.1.2.3.12 The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued,

and the circumstances under which the Enrollee may be required to pay for these services.

11.7.1.2.3.13 The Enrollee's right to receive the Contractor's or regional Ombuds' assistance with filing the appeal.

11.7.1.2.3.14 The Enrollee's right to equal access to services for Enrollees and potential Enrollees with communications barriers and disabilities.

11.7.1.3 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations, it is considered a denial and, thus, an Adverse Benefit Determination. The Contractor shall issue a formal Notice of Adverse Benefit Determination to the Enrollee, including the Enrollee's right to an appeal. See 42 C.F.R. § 438.404(c)(5).

11.7.1.4 UM Authorization Turnaround Time Compliance Report: The Contractor will send a quarterly report to HCA by the last day of the month following the quarter that shall include:

11.7.1.4.1 Monthly UM authorization determination data that demonstrates timeliness compliance rates separated into Standard, Pharmacy, Expedited, Concurrent Review, and Post-service timelines, including:

11.7.1.4.1.1 Percentage compliance, including those in which the timeline is extended appropriately;

11.7.1.4.1.2 Specific numbers of authorization determinations meeting contractual timeframes and the numbers of those that did not; and

11.7.1.4.1.3 For those authorization determinations that did not meet contractual timeframes, the range of time to complete the authorization determinations.

11.7.1.4.2 If UM authorization turnaround time compliance is below 90 percent in any month during the quarter for any of the authorization categories specified in this Contract, the report shall also include a narrative description of the Contractor's efforts before and after notification to HCA to address the problem.

## 11.8 Experimental and Investigational Services for Managed Care Enrollees

11.8.1 In determining whether a service that the Contractor considers experimental or

investigational is medically necessary for an individual Enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its FFS program described in WAC 182-501-0165, including the option to approve an investigational or experimental service when there is:

- 11.8.1.1 A humanitarian device exemption for the requested service or device from the Food and Drug Administration (FDA); or
  - 11.8.1.2 A local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the HCA and the requesting provider.
- 11.8.2 Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual Enrollee based on that Enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.
- 11.8.3 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid Enrollees than that applied to any other members.
- 11.8.4 An Adverse Benefit Determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing, and independent review process in accordance with the Grievance and Appeal System Section of this Contract.

#### **11.9 Compliance with Office of the Insurance Commissioner Regulations**

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with Federal regulations. Where it is necessary to harmonize Federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

## 12 PROGRAM INTEGRITY

### 12.1 General Requirements

- 12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents and subcontractors to comply with the requirements of this Section. (42 C.F.R. § 438.608).
- 12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.
- 12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed below:
  - 12.1.3.1 Section 1902(a)(68) of the Social Security Act;
  - 12.1.3.2 42 C.F.R. § 438;
  - 12.1.3.3 42 C.F.R. § 455;
  - 12.1.3.4 42 C.F.R. § 1000 through 1008;
  - 12.1.3.5 Chapter 182-502A WAC; and
  - 12.1.3.6 Chapters 74.09 and 74.66 RCW.
- 12.1.4 The Contractor shall ensure compliance with the program integrity provisions of this Contract, including proper payments to providers or subcontractors and methods for detection and prevention of Fraud, Waste, and Abuse.
- 12.1.5 The Contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues, and with MFCD on fraud or abuse investigation issues. This will include the following:
  - 12.1.5.1 Participation in MCO-specific, quarterly program integrity meetings with HCA following the submission of the quarterly allegation log defined in Subsection 12.9, Reporting, of this Contract. Discussion at these meetings shall include but not be limited to case development and monitoring.
  - 12.1.5.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.
  - 12.1.5.3 Quality control and review of encounter data submitted to HCA.
  - 12.1.5.4 Participation in meetings with MFCD, as determined by MFCD and the Contractor.
- 12.1.6 The Contractor shall have adequate staffing and resources dedicated to Washington State to perform fraud, waste and abuse analysis of its authorization, utilization, claims, provider's billing patterns, encounter data to detect improper payments, and shall perform audits and investigations of subcontractors, providers, and provider entities that provide services to Washington State Medicaid Enrollees.

- 12.1.6.1 When the Contractor or the state identifies an overpayment, pursuant to Section 1128J(d), the funds must be recovered by and returned to the State or the Contractor. For the purposes of this subsection, “overpayment” means a payment from the Contractor to a provider or subcontractor to which the provider or subcontractor is not legally entitled.
- 12.1.6.2 To maintain compliance with Section 1128J(d) of the Social Security Act, Overpayments that are not recovered by or returned to the Contractor within sixty (60) calendar days from the date they were identified and known by the provider or subcontractor and the Contractor, may be recovered by HCA.

## 12.2 Disclosure by Managed Care Organization: Information on Ownership and Control

The Contractor must provide to HCA the following disclosures (42 C.F.R. § 455.103, 42 C.F.R § 455.104(b), SSA §§ 1903(m)(2)(A)(viii), 1124(a)(2)(A)):

- 12.2.1 The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5 percent or more of the Contractor’s equity (or, in the case of a subcontractor’s disclosure, 5 percent or more of the subcontractor’s equity);
- 12.2.2 The identification of any person or corporation with an ownership interest of 5 percent or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the Contractor’s assets (or, in the case of a subcontractor’s disclosure, a corresponding obligation secured by the subcontractor equal to 5 percent of the subcontractor’s assets);
- 12.2.3 The name, address, date of birth, and Social Security Number of any managing employee of the managed care organization. For the purposes of this Subsection “managing employee” means a general manager, business manager, administrator, corporate officer, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.
- 12.2.4 The disclosures must include the following:
  - 12.2.4.1 The name, address, and financial statement(s) of any person (individual or corporation) that has 5 percent or more ownership or control interest in the Contractor.
  - 12.2.4.2 The name and address of any person (individual or corporation) that has 5 percent or more ownership or control interest in any of the Contractor’s subcontractors.
  - 12.2.4.3 Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor’s employee such as a spouse, parent, child, or siblings; or is related to one of the Contractor’s officers, directors or other owners.
  - 12.2.4.4 Indicate whether the individual/entity with an ownership or control



interest owns 5 percent or greater in any other organizations.

- 12.2.4.5 The address for corporate entities must include as applicable primary business address, every business location, and PO Box address.
  - 12.2.4.6 Date of birth and Social Security Number (in the case of an individual).
  - 12.2.4.7 Other tax identification number (in the case of a corporation) with an ownership or control interest in the managed care organization or its subcontractor.
- 12.2.5 The Contractor must terminate or deny network participation if a provider, or any person with 5 percent or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by HCA, within thirty (30) calendar days when requested by HCA or any authorized federal agency.
- 12.2.6 Disclosures from the Contractor are due to HCA at any of the following times:
- 12.2.6.1 When the Contractor submits a proposal in accordance with an HCA procurement process.
  - 12.2.6.2 When the Contractor executes the Contract with HCA.
  - 12.2.6.3 Upon renewal or extension of the Contract.
  - 12.2.6.4 Within thirty-five (35) calendar days after any change in ownership of the Contractor. The Contractor shall report the change on the HCA Medicaid Provider Disclosure Statement Form HCA-09-048.
  - 12.2.6.5 Upon request by HCA.
- 12.3 Disclosure by Managed Care Organization: Information on Ownership and Control, Subcontractors and Providers**
- 12.3.1 The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:
- 12.3.1.1 Requiring the subcontractor or provider to disclose to the MCO upon contract execution [42 C.F.R. § 455.104(c)(1)(ii)], upon request during the re-validation of enrollment process under 42 C.F.R. § 455.414 [42 C.F.R. § 455.104(c)(1)(iii)], and within thirty-five (35) business days after any change in ownership of the subcontractor or provider 42 C.F.R. § 455.104(c)(1)(iv).
  - 12.3.1.2 The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(1)(i).
- 12.3.2 If the subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and PO Box address. 42 C.F.R. § 455.104(b)(1)(i).
- 12.3.2.1 If the subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s). 42 C.F.R. §

- 455.104(b)(1)(iii).
- 12.3.2.2 If the subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. § 455.104(b)(1)(ii).
  - 12.3.2.3 If the subcontractor or provider has a 5 percent ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s). 42 C.F.R. § 455.104(b)(1)(iii).
  - 12.3.2.4 Whether any person with an ownership or control interest in the subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor/provider. 42 C.F.R. § 455.104(b)(2).
  - 12.3.2.5 If the subcontractor or provider has a 5 percent ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(2).
  - 12.3.2.6 Whether any person with an ownership or control interest in the subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider or in any managed care entity. 42 C.F.R. § 455.104(b)(3).
- 12.3.3 Upon request, the Contractor and the Contractor's subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:
- 12.3.3.1 The ownership of any subcontractor with whom the Contractor or subcontractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request. (42 C.F.R. § 455.105(b)(1)).
  - 12.3.3.2 Any significant business transactions between the Contractor or subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b)(2)).
- 12.3.4 Upon request, the Contractor and the Contractor's subcontractors shall furnish to the Washington Secretary of State, the Secretary of the US Department of Health and Human Services, the Inspector General of the US Department of Health and Human Services, the Washington State Auditor, the Comptroller of the Currency, and HCA a description of the transaction identified under 42 C.F.R. § 455.105 between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions 42 C.F.R. § 438.50(c)(1):
- 12.3.4.1 A description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following:
    - 12.3.4.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.

- 12.3.4.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.
- 12.3.4.1.3 Any lending of money or other extension of credit between the Contractor and such a party. (1903(m)(4)(B); 42 C.F.R. § 438.50(c)(1)).

#### 12.4 Information on Persons Convicted of Crimes

The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

- 12.4.1 Requiring the subcontractor/provider to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is [42 C.F.R. § 455.106(a)]:
  - 12.4.1.1 A person who has an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.106(a)(1).
  - 12.4.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or provider. 42 C.F.R. § 455.101; 42 C.F.R. § 455.106(a)(1).
  - 12.4.1.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the subcontractor or provider. 42 C.F.R. § 455.101; 42 C.F.R. § 455.106(a)(2).

#### 12.5 Fraud, Waste and Abuse (FWA)

- 12.5.1 The Contractor, or the Contractor's subcontractor delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between HCA and the Contractor, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. (42 C.F.R. § 438.608(a)). The arrangements or procedures must include the following:
  - 12.5.1.1 A compliance program that includes, at a minimum, all of the following elements:
    - 12.5.1.1.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.
    - 12.5.1.1.2 Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the contract and who directly reports to

the Chief Executive Officer (CEO) and the Board of Directors.

- 12.5.1.1.3 Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.
  - 12.5.1.1.4 System for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under this Contract.
  - 12.5.1.1.5 Effective lines of communication between the Compliance Officer and the Contractor's staff and subcontractors.
  - 12.5.1.1.6 Enforcement of standards through well-publicized disciplinary guidelines.
  - 12.5.1.1.7 Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract.
- 12.5.1.2 Provision for prompt reporting of all overpayments identified and recovered, specifying the overpayments due to potential fraud, to HCA. (42 C.F.R § 438.608(a)(2)).
- 12.5.1.3 Provision for notification to HCA when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. (42 C.F.R § 438.608(a)(4)).
- 12.5.1.4 Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis. (42 C.F.R § 438.608(a)(5)).
- 12.5.1.4.1 The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20).

- 12.5.1.4.2 Results of the verification and any action(s) taken must be available upon HCA's request.
- 12.5.1.5 Written policies for all employees of the Contractor that provide detailed information about the False Claims Act, including protections for whistleblowers, as described in Section 1902(a)(68) of the Social Security Act, 42 C.F.R § 438.608(a)(6), and the Washington false claims statutes, chapters 74.66 RCW and RCW 74.09.210, including information about rights of employees to be protected as whistleblowers, and the criminal statutes found in chapter 74.09.230-.280 RCW.
- 12.5.1.6 Provision for prompt referral of any potential fraud, waste, or abuse the Contractor identifies to HCA Program Integrity and potential fraud to the MFCD pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(7)).
- 12.5.1.7 Provision for the Contractor's suspension of payments to a network provider for which HCA determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 and pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(8)).
- 12.5.1.8 Provision for prompt response to detected offenses, and for development of corrective action initiatives.
- 12.5.1.9 Provision for notification of the Contractor's program integrity activities when requested by HCA or MFCD to prevent duplication of activities.
- 12.5.2 The Contractor and its subcontractors shall:
  - 12.5.2.1 Provide written disclosure of any prohibited affiliation in accordance with 42 C.F.R. § 438.610; 42 C.F.R. § 455.106; and 42 C.F.R § 438.608(c)(1) to HCA;
  - 12.5.2.2 Provide written disclosures of information on ownership and control required under 42 C.F.R. § 455.104; 42 C.F.R. § 455.105; and 42 C.F.R § 438.608(c)(2); and
  - 12.5.2.3 Report to HCA within sixty (60) calendar days when it has identified capitation payments or other payment amounts received are in excess to the amounts specified in this Contract. (42 C.F.R. § 438.608(c)(3)).
- 12.5.3 Treatment of recoveries made by the Contractor of overpayments to the providers. (42 C.F.R. § 438.608(d)).
  - 12.5.3.1 The Contractor and its subcontractors shall:
    - 12.5.3.1.1 Have internal policies and procedures for the documentation, retention, and recovery of all overpayments, specifically for the recovery of overpayments due to fraud, waste, or abuse.
    - 12.5.3.1.2 Report the identification and recovery of all overpayments as required in 12.9.
  - 12.5.3.2 This subsection of the Contract does not apply to any amount of a recovery to be retained under False Claim Act cases or through other

investigations.

- 12.5.3.3 The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment within sixty (60) calendar days, and to notify the Contractor in writing of the reason for the overpayment.
- 12.5.3.4 The Contractor shall report at least annually to HCA, or as required in the Contract, on their recoveries of overpayments. See Subsection 12.9, Reporting.
- 12.5.4 In accordance with RCW 74.09.195, when the Contractor conducts an audit of a Contractor's provider or subcontractor, the Contractor must:
  - 12.5.4.1 Provide a thirty (30) day notice to a provider or subcontractor prior to an onsite audit, unless there is evidence of danger to public health and safety or fraudulent activities.
  - 12.5.4.2 Avoid auditing a provider or subcontractor claim that is or has already undergone an audit, review or investigation by the Contractor, HCA, MFCD, or another governmental or law enforcement entity.
  - 12.5.4.3 Allow a provider or subcontractor, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the Contractor, or by facsimile transmission.
  - 12.5.4.4 Extrapolate only when there is a sustained high level of payment error or when documented provider or subcontractor educational intervention has failed to correct the level of payment error.
  - 12.5.4.5 Issue draft or preliminary findings within one-hundred twenty (120) calendar days from receipt of all provider or subcontractor information required to conduct the audit.
  - 12.5.4.6 Provide a detailed explanation in writing to a provider or subcontractor for any adverse determination that would result in partial or full recoupment of a payment to the provider or subcontractor. The written notification shall, at a minimum, include the following:
    - 12.5.4.6.1 The reason for the adverse determination;
    - 12.5.4.6.2 The specific criteria on which the adverse determination was based;
    - 12.5.4.6.3 An explanation of the provider's appeal rights; and
    - 12.5.4.6.4 If applicable, the appropriate procedure to submit a claim adjustment.
  - 12.5.4.7 Ensure all informal and formal appeal processes are completed before recouping overpayments.
  - 12.5.4.8 Offer a provider or subcontractor with an adverse determination the option of repaying the amount owed according to a negotiated

repayment plan of up to twelve months.

- 12.5.4.9 In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board-certified, and experienced in the treatment, billing, and coding procedures used by the provider being audited to make findings and determinations.
- 12.5.4.10 Provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement.
- 12.5.4.11 In the event of an audit of a provider or subcontractor who is no longer in the Contractor's network, include a description of the claim with patient name, date of service and procedure.
- 12.5.4.12 Consistent with the requirements in 42 C.F.R. § 438.4, HCA will utilize the information and documentation collected in subsections 12.5.3 and 12.5.4 of this Contract for setting actuarially sound capitation rates for each Contractor.
- 12.5.5 The Contractor must provide HCA a detailed list of current and past program integrity activities initiated and completed by the Contractor upon HCA's or MFCD's request.
- 12.5.6 Notification and treatment of potential provider and subcontractor improper payments made by the Contractor and identified by HCA.
  - 12.5.6.1 HCA will notify the Contractor to conduct an audit or review when potential provider or subcontractor improper payment(s) are identified by HCA, see chapter 182-502A WAC. The Contractor shall:
    - 12.5.6.1.1 Initiate an audit or review of the potential improper payment(s) within thirty (30) calendar days of HCA's notification;
    - 12.5.6.1.2 Report to HCA when initiation of the audit or review occurs; and
    - 12.5.6.1.3 Report to HCA the outcome of the Contractor's audit or review.
  - 12.5.6.2 If the Contractor confirms an improper payment was made to the provider or subcontractor, the Contractor shall follow the requirements found in RCW 74.09.195, and:
    - 12.5.6.2.1 Following any applicable appeal process, recoup overpayments from the provider or subcontractor, as appropriate;
    - 12.5.6.2.2 Work with the provider or subcontractor to void or adjust improperly paid claim(s);
    - 12.5.6.2.3 Submit an adjustment to or void the encounter record submitted to HCA to reflect the recoupment of the

overpayment or provider/subcontractor adjusted or voided;  
and

- 12.5.6.2.4 Record all fraud, waste and abuse program integrity activities, in progress and completed in the monthly Program Integrity Report.

## 12.6 Referrals of Credible Allegations of Fraud and Provider Payment Suspensions

The Contractor shall establish policies and procedures for referring all identified allegations of potential fraud to HCA and MFCD, and for provider payment suspensions. When HCA notifies the Contractor that a credible allegation of fraud exists, the Contractor shall follow the provisions for payment suspension contained in this Section. (42 C.F.R § 455.23).

- 12.6.1 When the Contractor has concluded that an allegation of potential fraud exists, the Contractor shall make a Fraud referral to MFCD and HCA within five (5) business days of the determination. The referral must be submitted to HCA through MC-Track and emailed to [MFCUreferrals@atg.wa.gov](mailto:MFCUreferrals@atg.wa.gov). The Contractor shall report using the WA Fraud Referral Form.
- 12.6.2 When HCA determines the Contractor's referral of potential fraud is a credible allegation of fraud, HCA shall notify the Contractor's compliance officers.
  - 12.6.2.1 To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend. (42 C.F.R § 438.608(a)(8)).
    - 12.6.2.1.1 Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral.
  - 12.6.2.2 Whether MFCD, or other law enforcement agency, accepts or declines the referral.
    - 12.6.2.2.1 If HCA, MFCD, or other law enforcement agencies decline to investigate the fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in this Subsection 12.6.
- 12.6.3 Upon receipt of payment suspension notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless the MCFD or other law enforcement agency requests a temporary withhold of the notice.
- 12.6.4 The notice of payment suspension must include or address all of the following (42 C.F.R. § 455.23(2)):
  - 12.6.4.1 State that payments are being suspended in accordance with this provision;
  - 12.6.4.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;
  - 12.6.4.3 State that the suspension is for a temporary period and cite suspension



- will be lifted when notified by HCA that it is no longer in place;
- 12.6.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and
  - 12.6.4.5 Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.
- 12.6.5 All suspension of payment actions under this Section will be temporary and will not continue after either of the following:
- 12.6.5.1 The Contractor is notified by HCA, MFCD, or other law enforcement agency that there is insufficient evidence of Fraud by the provider; or
  - 12.6.5.2 The Contractor is notified by HCA, MFCD, or other law enforcement agency that the legal proceedings related to the provider's alleged fraud are completed.
- 12.6.6 The Contractor must document in writing the termination of a payment suspension and issue a notice of the termination to the provider and send a copy to HCA.
- 12.6.7 HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a Credible Allegation of Fraud if any of the following are applicable:
- 12.6.7.1 MFCD or other law enforcement agency have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
  - 12.6.7.2 Other available remedies are available to the Contractor, after HCA approves the remedies as more effective or timely to protect Medicaid funds.
  - 12.6.7.3 HCA determines, based upon the submission of written evidence by the Contractor, individual or entity that is the subject of the payment suspension, there is no longer a Credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by the Contractor or provider. The Contractor may include a recommendation to HCA. HCA shall direct the Contractor to continue, reduce, or remove the payment suspension within thirty (30) calendar days of having received the evidence.
  - 12.6.7.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:
    - 12.6.7.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
    - 12.6.7.4.2 The individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

- 12.6.7.5 MFCD or law enforcement agency declines to certify that a matter continues to be under investigation.
- 12.6.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.
- 12.6.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:
  - 12.6.8.1 Details of payment suspensions that were imposed in whole or in part; and
  - 12.6.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.
- 12.6.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a Credible Allegation of Fraud without good cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accord with the Sanctions Subsection of this Contract.
- 12.6.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor and any involved subcontractor have no claim to any portion of such recovery.
- 12.6.11 Furthermore, the Contractor is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.
- 12.6.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.
- 12.6.13 For the purposes of this Section, "subrogation" means the right of any state of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party.

## 12.7 Investigations

- 12.7.1 The Contractor shall cooperate with all state and federal agencies that investigate fraud, waste and abuse.
- 12.7.2 The Contractor shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable state or federal agency.
- 12.7.3 The Contractor shall maintain all records, documents and claim or encounter data for Enrollees, providers and subcontractors who are under investigation by any

state or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating state or federal agency.

12.7.4 The Contractor shall comply with directives resulting from state or federal agency investigations.

12.7.5 The Contractor shall request a refund from a third-party payor, provider or subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to HCA as overpayments.

## 12.8 Excluded Individuals and Entities

The Contractor and its subcontractors are prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction, or on the prescription of an excluded person. The Contractor shall notify the suppliers of the excluded individual and allow the suppliers a fifteen (15) day grace period from the notification to stop all prescription fills. (Social Security Act (SSA) Section 1903(i)(2); 42 C.F.R. § 455.104, § 455.106, and § 1001.1901(b)).

12.8.1 The Contractor shall monitor for excluded individuals and entities by:

12.8.1.1 Screening Contractor and Subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes, and 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 and payable by a federal health care program.

12.8.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process, and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.

12.8.1.3 Screening the LEIE and SAM lists monthly by the 15th of each month for all Contractor and Subcontractor individuals and entities with an ownership or control interest, and individuals defined as affiliates in the Federal Acquisition Regulation, of an individual that is debarred, suspended, or otherwise excluded from participating in procurement activities, and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities. (42 C.F.R. § 438.610(a) and (b), SMD letter 2/20/98).

12.8.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

12.8.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within five (5) business days of discovery.

- 12.8.4 Civil monetary penalties may be imposed against the Contractor 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 C.F.R. § 1003.102(a)(2)).
- 12.8.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., 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), and 42 C.F.R. § 455.104(a).
- 12.8.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).
- 12.8.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

## 12.9 Reporting

- 12.9.1 All Program Integrity notification and reporting to HCA shall be in accordance with the provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.
- 12.9.2 All Program Integrity notification and reports shall be submitted through the MC-Track application unless otherwise instructed in this Section and/or within the notification form or report templates. See table below of listing of notification forms and reports and their respective due dates:

<u>DELIVERABLES</u>	<u>FREQUENCY</u>	<u>DUE DATE</u>
Annual Program Integrity Plan for WA State	Annual	March 1 of each calendar year
Records	On Request, or while On-site	By the date specified in HCA's record request or while onsite
Program Integrity Report	Monthly	Thirty (30) calendar days after the end of the reporting month
PIR001 – Annual Program Integrity Report for WA State	Annual	March 1 of each calendar year
HCA Medicaid Provider Disclosure Statement Form HCA-09-048	Ad Hoc	Within thirty-five (35) calendar days of an owner change
WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) business days from the date of discovery
WA Fraud Referral Form	Ad Hoc	Within five (5) business days from the date of determining a credible allegation of fraud exists

12.9.3 On a monthly basis, the Contractor shall use the Program Integrity Reporting Form to report the following:

12.9.3.1 Allegations of provider and subcontractor fraud received and reviewed by the Contractor.

12.9.3.2 Program Integrity Activities and all required notifications found in Section 12.5.

12.9.3.3 Provider Termination Report to include but not limited to:

12.9.3.3.1 Termination for convenience;

12.9.3.3.2 Provider self-termination;

12.9.3.3.3 Terminations due to:

12.9.3.3.3.1 Sanction;

12.9.3.3.3.2 Invalid Licenses;

12.9.3.3.3.3 Services or Billing Errors;

12.9.3.3.3.4 Re-credentialing Errors;

12.9.3.3.3.5 Data Mining;

12.9.3.3.3.6 Investigation; or

12.9.3.3.3.7 Any other related program integrity involuntary terminations.

- 12.9.4 A completed HCA PIR001 –Annual Program Integrity Report for WA State. See subsection 12.9.2 for the specific due date.
- 12.9.4.1 A completed Annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report shall include a report of all provider and service-specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations, authorization denials, payment edits and audits, provider credentialing outcomes and terminations, and COB/TPL identification outcomes.
- 12.9.5 The Contractor is responsible for investigating Enrollee fraud, waste and abuse. If the Contractor suspects Client/member/Enrollee fraud:
- 12.9.5.1 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of Enrollee fraud to the HCA Office of Medicaid Eligibility and Policy (OMEP) by:
- 12.9.5.1.1 Sending an email to WAEligibilityfraud@hca.wa.gov; or
- 12.9.5.1.2 Calling the Office of Medicaid Eligibility and Policy at 360-725-0934 and leave a detailed voice mail message; or
- 12.9.5.1.3 Mailing a written referral to:  
Health Care Authority  
Attention: OMEP  
PO Box 45534  
Olympia, WA 98504-5534
- Or
- 12.9.5.1.4 Faxing the written complaint to Attention Washington Apple Health Eligibility Fraud at 360-725-1158.
- 12.9.6 Any excluded individuals and entities discovered in the screening described in the Fraud, Waste and Abuse subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) business days of discovery. The identified excluded individual/entities shall be reported using the WA Excluded Individual Reporting Form.
- 12.9.7 The Contractor shall investigate and disclose to HCA, within five (5) calendar days of Contractor's discovery or upon request from HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) services program since the inception of those programs and:
- 12.9.7.1 Who is an agent or person who has been delegated the authority to

- obligate or act on behalf of the Contractor; or
- 12.9.7.2 Any person entering into a provider or subcontractor agreement with the Contractor, or
  - 12.9.7.3 Any person who has ownership or control interest in a provider or subcontractor, or
  - 12.9.7.4 Is an agent or managing employee of the provider or subcontractor.
- 12.9.8 The Contractor and any person entering into a provider or subcontractor agreement, or a person who has ownership or control interest in a provider or subcontractor, or is an agent or managing employee of the provider or subcontractor shall, on a monthly basis, check the LEIE and SAM database to identify any excluded individuals/entities. Documentation shall be kept validating the review of the databases and provided to HCA upon request.
- 12.9.9 The Contractor shall submit to HCA via MC-Track or ProviderOne help ticket all payment and enrollment inquiries to include but not limited to Newborn retro-enrollment, Service Base Enhancement (DCR, WISe, etc.), regular premium payments and other demographic changes that may impact eligibility (DOD, Address, etc.). Please refer to the Payment Assistant Request section of the Encounter Data Reporting Guide.
- 12.9.10 The Contractor shall submit an Annual Program Integrity Plan of activities the Contractor plans for the upcoming year. The Plan shall include all provider, service, and subcontractor specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations planned, services requiring authorization, prepayment services or providers, payment edits and audits, provider credentialing, and COB/TPL identification.

#### **12.10 Access to Records, On-site Inspections and Periodic Audits**

- 12.10.1 The Contractor and its providers and subcontractors shall permit the state of Washington, including HCA, MFCD and state auditor, and federal agencies, including but not limited to: CMS, Government Accountability Office, Office of Management and Budget, Office of the Inspector General, Comptroller General, and their designees, to access, inspect and audit any records or documents of the Contractor or its subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time.
- 12.10.2 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation identified in subsection 12.10.1. If the requesting agency requests copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other

timeframe authorized by law. (42 C.F.R. § 438.3(h)).

- 12.10.3 A record, in this Section, includes but is not limited to:
  - 12.10.3.1 Medical records;
  - 12.10.3.2 Billing records;
  - 12.10.3.3 Financial records;
  - 12.10.3.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;
  - 12.10.3.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and
  - 12.10.3.6 Any record of a Contractor-paid claim or encounter, or a Contractor-denied claim or encounter.
- 12.10.4 Upon request, the Contractor, its provider or subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate HCA, MFCD or other state or federal agency.
- 12.10.5 HCA will conduct, or contract for the conduct of, periodic audits of the Contractor no less frequently than once every three (3) years of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Contractor. (42 C.F.R. § 438.602(e)).

#### **12.11 Affiliations with Debarred or Suspended Persons**

Pursuant to Section 1932(d)(1)(A) of the SSA (42 U.S.C. § 1396u-2(d)(1)(A)):

- 12.11.1 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.
- 12.11.2 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.
- 12.11.3 The Contractor shall not have an employment, consulting, or any other contractual agreement with a debarred or suspended person or entity for the provision of items or services that are significant and material to this Contract.
- 12.11.4 The Contractor shall agree and certify it does not employ or contract, directly or indirectly, with:
  - 12.11.4.1 Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the



provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

- 12.11.4.2 Any individual or entity discharged or suspended from doing business with the HCA; or
- 12.11.4.3 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

## 12.12 Transparency

- 12.12.1 HCA shall post on its website, as required by 42 C.F.R. § 438.10(c)(3), the following documents and reports:
  - 12.12.1.1 The Contract;
  - 12.12.1.2 The data at 42 C.F.R. § 438.604(a)(5) which HCA certifies that the Contractor has complied with the contract requirements for availability and accessibility of services, including adequacy of the provider network, as set forth in 42 C.F.R. § 438.206;
  - 12.12.1.3 The name and title of individuals included in 42 C.F.R. § 438.604(a)(6) to confirm ownership and control of the Contractor, described in 42 C.F.R. § 455.104, and subcontractors as governed by 42 C.F.R. § 438.230; and
  - 12.12.1.4 The results of any audits, under 42 C.F.R. 438.602(e), of the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by the Contractor.
- 12.12.2 In accordance with RCW 74.09.195, HCA will post performance metrics and outcomes on its website.

## 13 GRIEVANCE AND APPEAL SYSTEM

### 13.1 General Requirements

The Contractor shall have a Grievance and Appeal System which complies with the requirements of 42 C.F.R. § 438 Subpart F and chapters 182-538, 182-526, and 284-43 WAC, insofar as those WACs are not in conflict with 42 C.F.R. § 438 Subpart F. The Grievance and Appeal System includes a grievance process, a single level of appeal, access to the state's administrative hearing process, and access to independent review through the Contractor. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

- 13.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to enrollees regarding the Grievance and Appeal System.
- 13.1.2 The Contractor is an independent party and is responsible for its own representation in any administrative hearing, independent review, review by the Board of Appeals, and subsequent judicial proceedings.
- 13.1.3 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-4020(2)(h)).
- 13.1.4 The Contractor shall give Enrollees any reasonable assistance necessary in completing forms and other procedural steps for grievances and appeals (42 C.F.R. § 438.406(a)(1) and WAC 284-43-4020(2)(d)).
- 13.1.5 The Contractor shall cooperate with any representative authorized in writing by the Enrollee (WAC 284-43-4020(2)(e)).
- 13.1.6 The Contractor shall consider all information submitted by the Enrollee or representative (WAC 284-43-4020(2)(f)).
- 13.1.7 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within two (2) business days.
- 13.1.8 The Contractor shall acknowledge in writing the receipt of each appeal. The Contractor shall provide the written notice to both the Enrollee and requesting provider within five (5) calendar days of receipt of the appeal. (42 C.F.R. § 438.406(a)(2)).
- 13.1.9 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making, nor were they a subordinate or direct report of any such individual (42 C.F.R. § 438.406(a)(3)(i)).
- 13.1.10 A physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral health appeal of care based on medical necessity.
- 13.1.11 Decisions regarding grievances and appeals shall be made by individuals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply (42 C.F.R. § 438.406(a)(3)(ii)):
  - 13.1.11.1 If the Enrollee is appealing an Adverse Benefit Determination concerning medical necessity, including any decision to not authorize

the service in an amount, duration or scope less than requested.

13.1.11.2 If an Enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.11.3 If the grievance or appeal involves any clinical issues.

## 13.2 Grievance Process

The following requirements are specific to the grievance process:

- 13.2.1 An Enrollee or the Enrollee's authorized representative may file a grievance with the Contractor at any time. Only an Enrollee or the Enrollee's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of an Enrollee (42 C.F.R. § 438.402(b)(3)) unless the provider is acting on behalf of the Enrollee and with the Enrollee's written consent.
- 13.2.2 Enrollee grievances must be filed with the Contractor, not with HCA. HCA will forward any grievance received by HCA to the Contractor for resolution.
- 13.2.3 The Contractor shall accept, document, record, and process grievances forwarded by HCA. The Contractor shall provide a written response to HCA within three (3) business days to any constituent grievance, unless HCA requests an expedited response. For the purpose of this subsection, "constituent grievance" means a complaint or request for information from any state or federal elected official or any state or federal agency director or designee.
- 13.2.4 The Contractor shall investigate and resolve all grievances whether received orally or in writing (WAC 284-43-4020(g)). The Contractor shall not require an Enrollee or his/her authorized representative to provide written follow-up for a grievance the Contractor received orally.
- 13.2.5 The Contractor shall complete the resolution of a grievance and notice to the affected parties as expeditiously as the Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance. The Contractor may extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the Enrollee requests the extension. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee's best interest and give the Enrollee prompt oral notice of the delay.
- 13.2.5.1 If the Contractor extends the timeline for a grievance not at the request of the Enrollee, it must give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision. 42 C.F.R. § 438.408(c)(2)(ii); and 42 C.F.R. § 438.408(b)(1).
- 13.2.6 The Contractor must notify Enrollees of the resolution of grievances within five (5) business days of determination. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing, must be easily understood and meet all Enrollee communications requirements in Subsection 3.2.
- 13.2.7 Enrollees do not have the right to a hearing in regard to the resolution of a

grievance.

### 13.3 Appeal Process

The following requirements are specific to the appeal process:

- 13.3.1 An Enrollee, the Enrollee's authorized representative, or a provider acting on behalf of the Enrollee and with the Enrollee's written consent, may appeal a Contractor Adverse Benefit Determination (42 C.F.R. § 438.402(b)(1)(ii)).
  - 13.3.1.1 If a provider has requested an Appeal on behalf of an Enrollee, but without the Enrollee's written consent, the Contractor shall not dismiss the Appeal without first contacting the Enrollee, informing the Enrollee within five (5) calendar days of receipt of the provider's request, that an Appeal has been made on the Enrollee's behalf, and then asking if the Enrollee would like to continue the Appeal. The Contractor shall have made at least three (3) attempts to contact the Enrollee on three (3) different business days, at three (3) different times during the day, without success, prior to dismissing the provider-initiated appeal request.
  - 13.3.1.2 If the Enrollee wants to continue the Appeal, the MCO shall obtain from the Enrollee a written consent for the Appeal. If the Enrollee does not wish to continue the Appeal, the MCO shall formally dismiss the Appeal, in writing, with appropriate Enrollee Appeal rights and by delivering a copy of the dismissal to the provider as well as the Enrollee.
  - 13.3.1.3 For expedited Appeals, the Contractor may bypass the requirement for Enrollee written consent and obtain Enrollee oral consent. The Enrollee's oral consent shall be documented in the Contractor's UMP records.
- 13.3.2 If HCA receives a request to Appeal an Adverse Benefit Determination of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Enrollee.
- 13.3.3 For Appeals of standard service authorization decisions, an Enrollee, or a provider acting on behalf of the Enrollee, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Adverse Benefit Determination. This also applies to an Enrollee's request for an expedited Appeal (42 C.F.R. § 438.402(b)(2) and WAC 182-538-110).
- 13.3.4 For Appeals for termination, suspension, or reduction of previously authorized services when the Enrollee requests continuation of such services, an Enrollee must file an Appeal within ten (10) calendar days of the date of the Contractor's mailing of the Notice of Adverse Benefit Determination. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for Appeals of standard resolution apply (42 C.F.R. § 438.420 and WAC 182-538-110).
- 13.3.5 The Enrollee may request an Appeal either orally or in writing. An oral Appeal must be followed by a written, signed, Appeal unless the Enrollee requests an expedited resolution or the Contractor determines the timeframe for standard Appeal decisions could seriously jeopardize the Enrollee's life or health or ability to attain,

maintain, or regain maximum function (42 C.F.R. § 438.402(c)(3)(ii)). The Contractor shall outreach and coordinate as needed to assist the Enrollee in submitting a written, signed Appeal.

- 13.3.5.1 If the Enrollee does not provide a written, signed Appeal within ten (10) calendar days of a standard oral Appeal request, the Contractor shall notify the Enrollee, in writing, of the need for the written Appeal, unless the Enrollee's sixty (60) calendar day timeline to file an Appeal has expired. The notification shall include an HCA-produced template for written Appeals; a pre-stamped and addressed return envelope; and the Enrollee's Appeal rights, which allow the Enrollee to Appeal until sixty (60) calendar days from the date on the Contractor's Notice of Adverse Benefit Determination.
- 13.3.5.2 During the Appeal process, the Contractor shall proactively engage the Enrollee offering alternative treatment or pathway of care steps, care coordination, or explaining the continuation of benefits to support meeting medically necessary care.
- 13.3.6 The Appeal process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals in the case of expedited resolution (42 C.F.R. § 438.406(b)(4)).
- 13.3.7 The Appeal process shall provide the Enrollee and the Enrollee's representative copies of the Enrollee's case file, including medical records, other documents and records relied on, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. This information must be provided upon request by either the Enrollee or the Enrollee's representative and free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.406(b)(5) and § 438.408(b) and (c).
- 13.3.8 The Appeal process shall include as parties to the Appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate (42 C.F.R. § 438.406(b)(4)).
- 13.3.9 In any Appeal of an Adverse Benefit Determination by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.
- 13.3.10 The Contractor shall resolve each Appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):
  - 13.3.10.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Enrollee that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for

Appeal. For any extension not requested by an Enrollee, the Contractor shall resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

13.3.10.2 The Enrollee may request an extension in the timeframe for processing an Appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay.

13.3.10.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

13.3.11 The Contractor shall provide notice of resolution of the Appeal in a language and format which may be understood by the Enrollee. The notice of the resolution of the Appeal shall:

13.3.11.1 Be in writing and sent to the Enrollee and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice (42 C.F.R. § 438.408(d)).

13.3.11.2 Include the date completed and reasons for the determination in easily understood language (42 C.F.R. § 438.408(e)).

13.3.11.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or Enrollee may obtain the UMP clinical review or decision-making criteria.

13.3.11.4 For Appeals not resolved wholly in favor of the Enrollee (42 C.F.R. § 438.408(e)(2)):

13.3.11.4.1 Include information on the Enrollee's right to request a hearing and an independent review and how to do so.

13.3.11.4.2 Include information on the Enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.11.4.3 Inform the Enrollee that the Enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's Adverse Benefit Determination.

#### 13.4 Expedited Appeal Process

13.4.1 The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).

13.4.2 The Enrollee may file an expedited appeal either orally or in writing. No additional

Enrollee follow-up is required.

- 13.4.3 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):
  - 13.4.3.1 For expedited resolution of appeals or appeals of mental health drug authorization decisions, including notice to the affected parties, the Contractor shall make a decision within seventy-two (72) hours after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice of the decision.
  - 13.4.3.2 The Enrollee may request an extension in the timeframe for processing an appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay. If the Contractor extends the timeline for processing an expedited appeal not at the request of the enrollee, it must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.
    - 13.4.3.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision
- 13.4.4 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's appeal (42 C.F.R. § 438.410(b)).
- 13.4.5 If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard resolution of appeals timeframe in this Contract; and make reasonable efforts to give the Enrollee prompt oral notice of the denial; and follow up within two (2) calendar days with a written notice of denial (42 C.F.R. § 438.410(c)).
  - 13.4.5.1 The Enrollee has a right to file a grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor must inform the Enrollee of their right to file a grievance in the notice of denial.

### 13.5 Administrative Hearing

- 13.5.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an Enrollee.
- 13.5.2 If an Enrollee does not agree with the Contractor's resolution of the appeal, the Enrollee may file a request for a hearing within the following time frames (See WAC 182-526-0200):
  - 13.5.2.1 For hearings regarding a standard service, within one hundred twenty (120) calendar days of the date of the notice of the resolution of the appeal (42 C.F.R. § 438.402(b)(2)).
  - 13.5.2.2 For hearings regarding termination, suspension, or reduction of a

previously authorized service, if the Enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

- 13.5.3 If the Enrollee requests a hearing, the Contractor shall provide to HCA and the Enrollee, upon request, and within three (3) business days, and for expedited appeals, within one (1) business day, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.
- 13.5.4 When medical necessity is an issue, the Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals and the outcome of any independent review.
- 13.5.5 The Enrollee must exhaust appeal rights prior to filing a request for a hearing with HCA. If the Contractor fails to adhere to the appeal notice and timing requirements, the Enrollee is deemed to have exhausted the appeal process and may initiate a hearing (42 C.F.R § 438.408(c)(3))
- 13.5.6 HCA will notify the Contractor of hearing determinations. The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination of enrollment by the Contractor.
- 13.5.7 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.
- 13.5.8 The hearings process shall include as parties to the hearing, the Contractor, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate and HCA.

### **13.6 Independent Review**

After exhausting both the Contractor's Appeal process and the Administrative Hearing, the Enrollee has the right to request an independent review in accordance with RCW 48.43.535 and chapter 182-538 WAC.

The MCO will advise the HCA Appeals Administrator at P.O. Box 45504, Olympia, WA 98504-5504 when an Enrollee requests an independent review as soon as the MCO becomes aware of the request. The MCO will forward a copy of the decision made by the Independent Review Organization to the Appeals Administrator as soon as the MCO receives the decision.

### **13.7 Petition for Review**

Any party may appeal the initial order from the administrative hearing to HCA Board of Appeals in accord with chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the administrative hearing.

### **13.8 Continuation of Services**

- 13.8.1 The Contractor shall continue the Enrollee's services if all of the following apply (42



C.F.R. § 438.420):

- 13.8.1.1 An appeal, hearing, or independent review, is requested on or before the later of the following:
  - 13.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of Adverse Benefit Determination, which for Adverse Benefit Determinations involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.
  - 13.8.1.1.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.
- 13.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- 13.8.1.3 The original period covered by the original authorization has not expired.
- 13.8.1.4 The Enrollee requests an extension of services.
- 13.8.2 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's services while the appeal, hearing, or independent review, is pending, the services shall be continued until one of the following occurs (42 C.F.R. § 438.420 and WAC 182-526-0200 and WAC 182-538-110):
  - 13.8.2.1 The Enrollee withdraws the appeal, hearing, or independent review request.
  - 13.8.2.2 The Enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days after the Contractor mailed the notice of resolution of the appeal.
  - 13.8.2.3 When the Office of Administrative Hearings issues a decision adverse to the Enrollee.
- 13.8.3 If the final resolution of the appeal upholds the Contractor's Adverse Benefit Determination, the Contractor may recover from the Enrollee the amount paid for the services provided to the Enrollee for the first sixty (60) calendar days during which the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

### **13.9 Effect of Reversed Resolutions of Appeals and Hearings**

- 13.9.1 If the Contractor, or an independent review (IR) decision by an independent review organization (IRO), or a final order from the Office of Administrative Hearings (OAH) or Board of Appeals (BOA), reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination (42 C.F.R. § 438.424(a)).
- 13.9.2 If the Contractor reverses a decision to deny authorization of services, or the denial is reversed through an IR decision or a final order of OAH or the Board of Appeals,

and the Enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services. (42 C.F.R. § 438.424(b)).

### **13.10 Recording and Reporting Adverse Benefit Determinations, Grievances, Appeals and Independent Reviews**

The Contractor shall maintain records of all Adverse Benefit Determinations, grievances, appeals and independent reviews.

- 13.10.1 The records shall include Adverse Benefit Determinations, grievances and appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Adverse Benefit Determinations, grievances, appeals, and independent reviews.
- 13.10.2 The Contractor shall provide a report of all Adverse Benefit Determinations, grievances, appeals and independent reviews to HCA in accord with the Grievance and Appeal System Reporting Requirements published by HCA.
- 13.10.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, Adverse Benefit Determinations, and appeals handled by delegated entities.
- 13.10.4 Delegated Adverse Benefit Determinations, grievances, and appeals are to be integrated into the Contractor's report.
- 13.10.5 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance and Appeal System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.
- 13.10.6 The report medium shall be specified by HCA and shall be in accord with the Grievance and Appeal System Reporting Requirements published by HCA.
- 13.10.7 Reporting of Adverse Benefit Determinations shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the Enrollee is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.
- 13.10.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.
- 13.10.9 Reporting of grievances shall include all expressions of Enrollee dissatisfaction not related to an Adverse Benefit Determination. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

## 14 CARE COORDINATION

The Contractor shall provide the services described in this Section for all Enrollees who need care coordination, regardless of acuity level. The Contractor shall either provide the additional services described in Exhibit H, Health Homes to those Enrollees who are determined eligible for Health Home or shall contract with a Qualified Health Home to provide such services.

### 14.1 Continuity of Care

The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition. The Contractor shall ensure that medically necessary care for Enrollees is not interrupted and that transitions from one setting or level of care to another are promoted (42 C.F.R. § 438.208).

- 14.1.1 When changes occur in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions found in the Access to Care and Provider Network section of this Contract.
- 14.1.2 The Contractor shall make a good faith effort to preserve Enrollee provider relationships through transitions.
- 14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's medical condition requires.
- 14.1.4 The Contractor shall allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has a documented established relationship. The Contractor shall take the following steps:
  - 14.1.4.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.
  - 14.1.4.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.
  - 14.1.4.3 If the non-participating provider or the Enrollee will not cooperate with a necessary transition, the Contractor may transfer the Enrollee's care to a participating provider within ninety (90) calendar days of the Enrollee's enrollment effective date.
  - 14.1.4.4 Pay the non-participating provider indefinitely if it chooses when the non-participating provider accepts payment rates the Contractor has established.
  - 14.1.4.5 Apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.
- 14.1.5 Unless otherwise required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new Enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

- 14.1.5.1 The Enrollee's prescription expires. If the Enrollee's prescription expires before he or she is able to be evaluated by a participating provider, the Contractor shall facilitate the receipt of a primary care visit and shall not deny the prescription. For the purposes of this subsection, a prescription expires when the date by which a prescribed refill for the prescription passes or when the last fill on the prescription has been made by a pharmacy and the Enrollee has used the medications for that fill.
- 14.1.5.2 A participating provider examines the Enrollee to evaluate the continued need for the prescription, and if necessary, oversees medically appropriate changes that do not threaten the health of the Enrollee.
  - 14.1.5.2.1 If the Enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the Enrollee's safety and the safety of others is considered in the decision. The Contractor shall document in writing the information and factors it considered in refusing the fill the prescription.
- 14.1.5.3 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.
- 14.1.6 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the BHO in other RSAs to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.

## 14.2 Population Health Management: Plan

The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas:

- 14.2.1 Keeping Enrollees healthy;
- 14.2.2 Managing Enrollees with emerging risk;
- 14.2.3 Enrollee safety and outcomes across settings; and
- 14.2.4 Managing multiple chronic conditions.

The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and Section 14.

## 14.3 Population Health Management: Identification and Triage

- 14.3.1 Initial Health Screen.
- 14.3.2 The Contractor shall conduct a brief IHS containing behavioral, developmental, physical and oral health questions within sixty (60) calendar days of enrollment for

all new Enrollees, including Family Connects and reconnects, beginning the first (1<sup>st</sup>) of the month after the month of enrollment (42 C.F.R. § 438.208(b)(3)).

- 14.3.2.1 The Contractor shall use evidence-based screening tools appropriate to the age of the Enrollee, which shall include but is not limited to:
  - 14.3.2.1.1 Tobacco use assessment; and
  - 14.3.2.1.2 Housing and housing instability assessment.
- 14.3.3 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an Enrollee to complete the IHS and document these attempts, for Enrollees who are not referred for Health Home services. The requirements described in Exhibit H apply to Enrollees who are referred for Health Home services.
- 14.3.4 Initial Health Assessment (IHA): To assess identified Individuals who need Long Term Supports and Services (LTSS) or those with Special Health Care Needs who are not eligible for Health Home services, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or LTSS needs or IHS that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.
  - 14.3.4.1 The assessment shall include, at minimum, an evaluation of the Enrollee's physical, behavioral, and oral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.
  - 14.3.4.2 The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community-based social services and LTSS.
  - 14.3.4.3 The IHA shall be maintained in the Enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.
- 14.3.5 The Contractor will use other data sources to identify enrollees who need care coordination and care management services, including but not limited to:

- 14.3.5.1 Review of administrative data sets, such as PRISM;
- 14.3.5.2 Children with elevated blood lead screen levels;
- 14.3.5.3 Indicators of potential for high risk pregnancy;
- 14.3.5.4 Enrollees with unmet care needs or evidence of being underserved;
- 14.3.5.5 Claims or encounter data;
- 14.3.5.6 Pharmacy data;
- 14.3.5.7 Laboratory data;
- 14.3.5.8 Electronic health records; or
- 14.3.5.9 Results of Contractor-specific algorithms.

14.3.6 The Contractor will risk stratify the population to determine the level of intervention enrollees require.

#### 14.4 Population Health Management: Interventions

14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care.

14.4.1.1 The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence based guidelines for:

- 14.4.1.1.1 Behavioral health conditions.
- 14.4.1.1.2 Chronic medical conditions.
- 14.4.1.1.3 Acute conditions.
- 14.4.1.1.4 Unhealthy behaviors.
- 14.4.1.1.5 Wellness.
- 14.4.1.1.6 Overuse/appropriateness issues.

#### 14.5 Care Coordination Services (CCS) General Requirements

The Contractor shall implement the following activities:

14.5.1 The Contractor shall offer Wellness and Prevention services to all Enrollees according to the benefits outlined in this Contract.

14.5.1.1 Refer individuals identified in the IHS as having a need for Care Coordination services to the Enrollee's PCP, Mental Health Professional or SUD provider or to DSHS/Home and Community Services (HCS) for follow-up care and needed services within thirty (30) calendar days of screening and identification.

14.5.1.2 Ensure the PCP has assessed and/or examined the Enrollee according to wellness assessment requirements and appointment scheduling standards (42 C.F.R. § 438.208(c)(2)).

14.5.1.3 Ensure the Enrollee has received appropriate follow-up health care

services, including preventive care, care for Chronic Conditions, and referrals to LTSS, social services and community-based organizations.

- 14.5.2 Care Coordination services are provided by the Contractor, clinic-based Care Coordinator staff, or community based organizations, and delivered to Enrollees who have short-term, or intermittent needs for coordination of care, such as those identified as Enrollees with Emerging Risk. Care Coordination services may be provided by non-licensed staff and include but are not limited to:
  - 14.5.2.1 Coordinating authorization of services such as Contractor timely approval of durable medical equipment, pharmacy, and medical supplies;
  - 14.5.2.2 Ensuring access to medically necessary mental health, or physical health services and coordination with entities that provide mental health, SUD services, and oral health services; or
  - 14.5.2.3 Ensuring access to community-based services, such as home care or long-term services and supports.
- 14.5.3 The Care Coordinator and affiliated staff shall work with Enrollees to promote the following:
  - 14.5.3.1 Improved clinical outcomes;
  - 14.5.3.2 Enrollee participation in care;
  - 14.5.3.3 Continuity of Care;
  - 14.5.3.4 Increased self-management skills;
  - 14.5.3.5 Improved adherence to prescribed treatment; and
  - 14.5.3.6 Improved access to care or to services that address social needs.
- 14.5.4 The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices.
- 14.5.5 The Care Coordinator shall deliver services in a culturally competent manner that addresses health disparities by interacting directly and in-person with the Enrollee and his or her family in the Enrollee's primary language; with appropriate consideration of literacy and cultural preference.
- 14.5.6 The Care Coordinator is responsible for:
  - 14.5.6.1 Conducting IHS or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs;
  - 14.5.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action;
  - 14.5.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs;
  - 14.5.6.4 Ensuring referrals are made and services are delivered, including any

- follow-up action;
    - 14.5.6.5 Ensuring the deployment of standardized screening tools outlined in this Contract; and
    - 14.5.6.6 Ensuring collaboration with the regional Behavioral Health - Administrative Services Organization (BH-ASO).
  - 14.5.7 The Contractor shall develop policies and procedures for Care Coordination services that include:
    - 14.5.7.1 Identification of gaps in care through IHS or analysis of claims and encounter data for Enrollee patterns of under- or overutilization.
    - 14.5.7.2 Referral of Enrollees identified through self-referral or the IHS as having a gap in behavioral, developmental, physical or oral health services to the Enrollee's PCP and as appropriate, to a Mental Health Professional or SUD provider for services and follow-up care within thirty (30) calendar days of screening and identification.
    - 14.5.7.3 Communication with the PCP and other providers regarding:
      - 14.5.7.3.1 The Contractor's medical necessity decisions to authorize care and services.
      - 14.5.7.3.2 Shared care plans and transitional services between the Care Coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service providers, and the PCP.
      - 14.5.7.3.3 Enrollee over-use of emergency department, preventable hospitalizations and re-hospitalizations, crisis service, and opioid use.
  - 14.5.8 If an Enrollee changes enrollment to another AH MCO, the Contractor shall coordinate transition of the Enrollee to the new MCO's Care Coordination system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208 (b)(6)).
  - 14.5.9 Care Coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.
  - 14.5.10 The Contractor shall provide a toll-free line for PCPs and specialists who seek technical and referral assistance when any condition, including behavioral health conditions, requires treatment or developmental delays are suspected or identified.
    - 14.5.10.1 Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals and referrals to LTSS when appropriate. Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to providers.
  - 14.5.11 The Contractor shall implement policies and procedures to ensure the completion of



Advance Directives (physical health and mental health).

- 14.5.12 Use and promotion of recovery and resiliency principles to mitigate future risk of the development of physical or behavioral health care conditions.
- 14.5.13 The Contractor shall support practice change activities including the deployment of evidence-based and Promising Practices, preventive screening of Enrollees and models of service delivery that optimize health care service delivery, Enrollee social support and coordinated health care and social services.

#### 14.6 Care Management Services

The Contractor shall implement activities for Enrollees identified as requiring Complex Case Management (CCM), or those with multiple chronic conditions.

- 14.6.1 Support of a person-centered approach to care in which Enrollee's needs, strengths, and preferences play a central role in the development and implementation of the care plan by:
  - 14.6.1.1 Ensuring the clinical appropriateness of care;
  - 14.6.1.2 Addressing gaps in care, including appropriate use of culturally appropriate, evidence- or research-based practices;
  - 14.6.1.3 Promoting recovery using Certified Peer Counselors, Community Health Workers and community and natural supports;
  - 14.6.1.4 Requesting modifications to treatment plans to address unmet service needs that limit progress;
  - 14.6.1.5 Assisting Enrollees in relapse/crisis prevention planning that goes beyond crisis intervention and includes development and incorporation of recovery action plans and Advance Directives for individuals with a history of frequent mental health readmissions or crisis system utilization; and
  - 14.6.1.6 Assuring coordination of assessments and evaluations with mental health, SUD and other providers.
- 14.6.2 Individuals identified by HCA as Health Home eligible shall receive Health Home Services as described in Exhibit H if the Enrollee consents to participate.
- 14.6.3 Individuals identified by the Contractor as requiring CCM shall receive services in accordance with NCQA Standards and interventions as described elsewhere in Section 14.
- 14.6.4 Complete or verify the PCP completion of an Enrollee care plan. The care plan shall be developed in partnership with the Enrollee and in consultation with specialists and social service providers serving the Enrollee, updated at minimum annually and maintained in the Enrollee's health record (42 C.F.R. § 438.208(c)(3)); 42 C.F.R. § (438.208(c)(3)(i)). The care plan shall include all of the following:
  - 14.6.4.1 Presenting diagnosis(es) and health problems;
  - 14.6.4.2 An action plan, including agreed-upon health goals;
  - 14.6.4.3 Documentation of behavioral health, social service, and community

resource interventions that promote child development, healthy behaviors, and early referral and treatment for mental health and SUD conditions, including recovery-based programs; and

- 14.6.4.4 Documentation of Advance Directives (physical health and mental health).
- 14.6.5 The Contractor shall respond to EPSDT referrals from primary medical care providers with a written notice that must at a minimum include date of intake and diagnosis.
- 14.6.6 The Contractor shall provide information on how to obtain a provider for children/Youth who do not have a PCP.
- 14.6.7 For Enrollees with Special Health Care Needs, the Contractor will develop the Enrollee's care plan in accordance with the requirements described throughout Section 14 and will ensure the plan is reviewed and revised upon reassessment, at least every twelve (12) months or when the Enrollee's circumstances or needs change, or when the Enrollee requests an update.
  - 14.6.7.1 For Enrollees determined to have LTSS needs, the Contractor shall coordinate with staff of Home and Community Services (HCS) to ensure the Enrollee has access to and appropriate evaluation and LTSS services.

#### **14.7 Data Exchange Protocols**

- 14.7.1 The Contractor shall develop data exchange protocols, including consent to release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including sharing of claims and pharmacy data, treatment plans or care plans and Advance Directives necessary to coordinate service delivery, and care management for each Enrollee in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

#### **14.8 HIT Tools for Integrated Care**

- 14.8.1 The Contractor shall support the use by contracted providers, of Health Information Technology (HIT)/Health Information exchange (HIE) tools and services such as:
  - 14.8.1.1 Certified EHR Technology (CEHRT);
  - 14.8.1.2 Emergency Department Information Exchange (EDIE);
  - 14.8.1.3 PreManage tools (including use by behavioral health providers);
  - 14.8.1.4 Services offered by OneHealthPort (OHP), (such as the Clinical Data Repository); and
  - 14.8.1.5 Other HIT/HIE tools and services to support the integration, coordination and continuity of care.
- 14.8.2 The Contractor shall consider how HIT/HIE can be used to support data exchange protocols and tools to support provider integration of behavioral health and medical services, transitional services, care coordination oversight and transitional planning for incarcerated individuals, and coordinate with the state to advance the use of statewide HIT/HIE tools/services and engage in the implementation of the HIT

Operational Plan.

- 14.8.3 The Contractor shall develop policies and procedures for Care Coordination and Care Management Services that encourage and support the use of HIT and HIE technologies (Certified EHRs, existing statewide HIE and HIT, and other technology solutions) to coordinate care across the care continuum, including physical health, behavioral health, social service, and other community-based organizations.

#### 14.9 Coordination Between the Contractor and External Entities

- 14.9.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to:
  - 14.9.1.1 The Department of Social and Health Services:
    - 14.9.1.1.1 Aging and Long-Term Support Administration (AL TSA) Home and Community Services including contracted Area Agencies on Aging;
    - 14.9.1.1.2 Skilled nursing facilities and community-based residential programs;
    - 14.9.1.1.3 Behavioral Health Administration, including contracted Behavioral Health Organizations;
    - 14.9.1.1.4 Developmental Disabilities Administration;
    - 14.9.1.1.5 Division of Vocational Rehabilitation; and
    - 14.9.1.1.6 Juvenile Justice and Rehabilitation Administration (JJ&RA).
  - 14.9.1.2 Oral Health services, including the promotion of oral health screening and prevention;
    - 14.9.1.2.1 Contractors operating in counties served by the Oral Health Connections Pilot Project shall identify and refer Enrollees eligible for the pilot project services, in coordination with the Arcora Foundation (Arcora) through Arcora's referral portal.
  - 14.9.1.3 Department of Health (DOH) and Local Health Jurisdiction (LHJ) services, including Title V services for Children with Special Health Care Needs;
  - 14.9.1.4 Department of Children, Youth and Families: Early childhood and family support services including home visiting, ESIT, ECLIPSE, ECEAP/Head Start;
  - 14.9.1.5 Department of Corrections;
  - 14.9.1.6 Criminal Justice Systems (courts, jails, law enforcement, public defenders);
  - 14.9.1.7 State Hospitals and other facilities that provide care for individuals with

- 90 and 180-day civil commitments;
- 14.9.1.8 Children's Long-term Inpatient facilities;
- 14.9.1.9 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Apple Health Managed Care Organizations;
- 14.9.1.10 Educational Service Districts (ESDs);
- 14.9.1.11 Support Services for families and family/kinship caregivers;
- 14.9.1.12 HCA First Steps Program - Maternity Support Services (MSS);
- 14.9.1.13 HCA Apple Health Integrated Foster Care program;
- 14.9.1.14 Qualified Health Homes contracted with HCA;
- 14.9.1.15 Supported Housing and Employment programs;
- 14.9.1.16 State and/or federal agencies and local partners that manage access to housing;
- 14.9.1.17 Tribal entities;
- 14.9.1.18 Non-Emergency Medicaid Transportation services;
- 14.9.1.19 Interpreter Services;
- 14.9.1.20 Women, Infants, and Children (WIC) providers and programs;
- 14.9.1.21 HCA's contracted Third Party Administrator for supportive housing and supported employment;
- 14.9.1.22 BHOs and BH-ASOs outside of the RSA regarding state only, federal block grant, Ombuds, crisis services, and any other areas where information sharing would improve the services of either system; and
- 14.9.1.23 Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.
- 14.9.2 The Contractor shall participate with, cooperate with, and coordinate with regional health alliances, such as the Southwest Washington Regional Health Alliance, Eastern Washington Regional Health Alliance, and CHOICE Regional Health Network.
- 14.9.3 The Contractor shall participate in the management or discussions held at the Bree Collaborative, or with the Foundation for Health Care Quality in their work on COAP, OB COAP, and SCOAP programs as well as coordinate with other organizations engaged in quality improvement in Washington State.
- 14.9.4 The Contractor shall join and pay a fee to be a member of the Washington Health Alliance (WHA) no later than February 15 of each calendar year.
  - 14.9.4.1 The Contractor shall actively cooperate and participate with the WHA in efforts to improve the quality and efficiency of health care services.
  - 14.9.4.2 The Contractor shall submit data to the WHA for the purpose of

producing results for the Community Checkup, the Washington State Common Measure Set on Health Care Quality and Cost, and all other health care measurement and reporting completed by WHA, according to the terms and schedule defined by the WHA.

14.9.4.2.1 As part of routine data submissions provided to the WHA as required under this subsection, the Contractor must include claim-line level financial information (e.g. Billed, Allowed, and Paid dollar amounts) as defined by the WHA.

- 14.9.5 The Contractor shall coordinate Enrollee information, including initial assessments, relevant SON reviews, and care plans, with other managed care entities as needed when an Enrollee changes from one MCO to another, changes from one Health Home lead to another, or receives services through a BHO, to reduce duplication of services and unnecessary delays in service provision for Enrollees.
- 14.9.6 For Enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC Enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the Enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.
- 14.9.7 The Contractor shall participate in the local Accountable Communities of Health (ACH) in each Regional Service Areas in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies, but must participate as follows:
- 14.9.7.1 Serve in a leadership or other supportive capacity;
  - 14.9.7.2 Participate in the design and implementation of transformation projects;
  - 14.9.7.3 Collaborate with provider networks to implement Value Based Purchasing Models; and
  - 14.9.7.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

#### **14.10 Children Eligible for Apple Health Integrated Foster Care**

- 14.10.1 When the Contractor is notified an Enrollee has been placed in foster care and enrolled with the Apple Health Integrated Foster Care (AHIFC) program, the Contractor shall coordinate with the AHIFC Contractor to ensure the Enrollee is transitioned to AHIFC with minimal disruption in services.
- 14.10.2 Within the limits of available information, the Contractor shall ensure continuity of services if an Enrollee has been re-enrolled with the Contractor at the end of a foster care placement.

#### **14.11 Children's Health Care Coordination**

- 14.11.1 The Contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to

treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under age 21 from receiving any other care coordination activity described in this Contract.

- 14.11.2 In accordance with chapter 74.09.337 RCW, when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary:
  - 14.11.2.1 Coordinate mental health treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider;
  - 14.11.2.2 Follow-up to ensure an appointment has been secured; and
  - 14.11.2.3 Coordinate with the PCP regarding development of a treatment plan, including medication management.
- 14.11.3 The Contractor will submit a report to HCA of children who have been identified as needing mental health care and appointment status. The quarterly Children's Mental Health report is due on the last business day of October, January, April, and July.
- 14.11.4 The Contractor will collaborate with Seattle Children's to receive Washington's Mental Health Referral Service for Children and Teens consultation letters. When Enrollee consultation letters are received, the Contractor will contact the Enrollee to ensure the Enrollee's needs are met and follow the provisions in this subsection as indicated.

#### **14.12 Behavioral Health Organizations (BHOs)**

- 14.12.1 The Contractor shall have an operational agreement with all BHO operating outside the Contractor's awarded RSAs that, in addition to transitional care, addresses comprehensively the day-to-day operational requirements to coordinate physical and Behavioral Health care services and fully recognizes the shared responsibility for their mutual Enrollees' health care.
- 14.12.2 The operational agreement shall address the following:
  - 14.12.2.1 Exchange of Enrollee health information with Enrollee consent to include:
    - 14.12.2.1.1 Diagnosis;
    - 14.12.2.1.2 Treatment, including treatment plan;
    - 14.12.2.1.3 Medications;
    - 14.12.2.1.4 Labs/Testing; and
    - 14.12.2.1.5 Treating providers, with contact information.
  - 14.12.2.2 Transitions in care between the Contractor and BHOs, and BHOs and the Contractor.
- 14.12.3 The Contractor shall require providers to coordinate with BHO providers and provide all required information to facilitate such coordination, with Enrollee

consent, and shall provide written instructions to its primary care and Mental Health Professionals on how to access mental health services for Enrollees. Instructions shall include information on when an Enrollee should be referred to the BHO for an evaluation and when the Enrollee should receive services from a provider contracted with the Contractor for mental health services.

#### **14.13 American Indian/Alaska Natives**

- 14.13.1 The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs).
- 14.13.2 The Contractor must provide for training of its tribal liaison, conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs.
- 14.13.3 The Contractor must ensure its employees and agents receive training in cultural humility, including training on how to communicate with AI/AN Enrollees and IHCP staff, and in the history, culture, and services of IHCPs within the RSAs under the Contract. Training shall be obtained in collaboration with the tribes and IHCPs in such RSAs.
- 14.13.4 The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such notification. To meet this requirement, the Contractor must develop and maintain a process for asking whether an Enrollee is a member of a federally recognized tribe or is receiving care from an IHCP and, if applicable, whether the Enrollee consents to the Contractor notifying such IHCP or federally recognized tribe.
- 14.13.5 The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services.

#### **14.14 Transitional Services**

The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another.

The Contractor shall provide Transitional Care services to Enrollees who participate in Health Home services in accordance with Exhibit H, Health Homes. When a Health Home Enrollee moves from one coverage area to another, the Contractor in the new coverage area shall provide Care Management Coordination services or other services to ensure the care plan established by the Health Home Care Coordinator in the previous county of residence continues for the Enrollee. If Health Home services were not available in the previous county of residence, the Contractor shall ensure a Health Home-eligible Enrollee receives Health Home services in the new coverage area consistent with Exhibit H of this Contract.

The Contractor shall work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which will support the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Contractor's contracted state and community physical and Behavioral Health hospitals, residential treatment facilities and long-term care facilities, and with BHOs, to ensure Enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

- 14.14.1 Completion of a standardized discharge screening tool. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or SUD treatment recidivism.
- 14.14.2 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:
  - 14.14.2.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee;
  - 14.14.2.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers;
  - 14.14.2.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care;
  - 14.14.2.4 Organized post-discharge services, such as home care services, after-treatment services and occupational physical therapy services;
  - 14.14.2.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge;
  - 14.14.2.6 Information on what to do if a problem arises following discharge;
  - 14.14.2.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition;
  - 14.14.2.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals;
  - 14.14.2.9 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of



discharge;

14.14.2.10 Follow-up to ensure the Enrollee saw his/her provider; and

14.14.2.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.

14.14.3 When appropriate, the Contractor will obtain the Enrollee's permission to share information with clinical and non-clinical providers to facilitate care transitions.

14.14.4 The Contractor, in collaboration with all hospitals including state hospitals, shall develop discharge planning policies and procedures.

14.14.4.1 The Contractor shall process hospital prior authorization requests for all clinic services required by the Enrollee within two (2) business days. Such services shall include authorizations for any therapies, home care services, equipment or pharmaceuticals.

14.14.4.2 The Contractor shall educate state hospital discharge planning staff on clinical services requiring pre-authorization to facilitate timely discharge from the state hospital.

14.14.4.3 The Contractor shall not delay discharge from a hospital because of Contractor authorization procedures that unnecessarily delay such discharges.

#### **14.15 Skilled Nursing Facility Coordination**

14.15.1 Skilled Nursing Care is care provided by trained individuals (RN, PT, OT, ST, or RT) that typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (for example, rehab) or due to chronic medical conditions or disabilities. Skilled care is:

14.15.1.1 Rehabilitative: Care provided for or post an acute illness or injury with the intent of restoring or improving skills and/or function that was lost or impaired; or

14.15.1.2 Skilled Medical: Care provided daily and including, but not limited to, IV therapy, IM injections, indwelling and subrapubic catheters, tube feeding, TPN, respiratory therapy, or wound care.

14.15.2 The Contractor is responsible for medically necessary Skilled Nursing care in a SNF or NF when the Contractor determines Nursing Facility care is more appropriate than acute hospital care. The Contractor shall coordinate with the hospital or other acute care facility discharge planners and nursing facility Care Managers or social workers, as described in the Coordination between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the Enrollee to or from a SNF or NF.

14.15.3 The Contractor shall coordinate with the SNF or NF to provide Care Coordination and transitional care services and shall ensure coverage of all Medically Necessary Services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary

service or product.

14.15.3.1 If the Contractor, in coordination with the NF or SNF, anticipates the Enrollee will be in the Facility for additional days after an Enrollee no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Contractor shall coordinate with the DSHS/ALTSA/HCS to:

14.15.3.1.1 Determine functional, financial, and institutional eligibility, if necessary; and

14.15.3.1.2 Assist the Enrollee to explore all options available for care, including whether the Enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for Long-Term Services and Supports (LTSS).

14.15.3.2 If the Enrollee is discharged home or a community residential setting, the Contractor shall coordinate with SNF/NF and HCS staff to ensure the Enrollee is discharged to a safe location and shall ensure Medically Necessary Services are available to the Enrollee including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the Enrollee's recovery. The Contractor shall also ensure follow-up care is provided consistent with the Transitional Care Coordination requirements of this Contract.

14.15.4 If the Enrollee remains in the SNF/NF, the Enrollee remains enrolled in FIMC and ALTSA is responsible for payment of SNF/NF room and board beginning on the date it is determined the Enrollee does not meet or no longer meets criteria for the rehabilitative or skilled benefit. The Contractor continues to be responsible for all Medically Necessary Services, prescriptions, and equipment not included in the ALTSA NF rate. The Contractor shall continue to monitor the Enrollee's status and assist in coordination of transitions back to the community.

14.15.5 Issuance of an award letter by ALTSA does not constitute a guarantee or promise of payment for nursing home care.

14.15.6 The Contractor must provide written notice to the Facility, including dates of service and the date coverage will end, if the Enrollee:

14.15.6.1 Is admitted under the rehabilitative or skilled benefit;

14.15.6.2 Does not meet rehabilitative or skilled nursing criteria; or

14.15.6.3 If a previously authorized stay is being reduced.

14.15.7 For purposes of this Section, "nursing facility level of care" means ongoing support services provided in a SNF/NF for Enrollees who do not meet the criteria for rehabilitative or skilled nursing services.

#### **14.16 Care Coordination Oversight**

14.16.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Care Coordination and ICM requirements and the quality and appropriateness of care furnished to individuals with special health care needs (42

C.F.R. § 438.208).

- 14.16.2 Quality assurance reviews of documented Care Coordination and ICM activities shall include:
  - 14.16.2.1 Case identification and assessment according to established risk stratification system;
  - 14.16.2.2 Documented treatment plans and care plans with evidence of periodic revision as appropriate to the Enrollee emerging needs;
  - 14.16.2.3 Effective Enrollee monitoring, including management of barriers;
  - 14.16.2.4 Referral management;
  - 14.16.2.5 Effective coordination of care, including coordination of services that the Enrollee receives through the FFS system; and
  - 14.16.2.6 Identification of appropriate actions for the Care Coordinator to take in support of the Enrollee, and the Care Coordinator's follow-through in performing the identified tasks.
- 14.16.3 The Contractor shall conduct quality assurance reviews, at a minimum, on a quarterly basis.

#### **14.17 Direct Access to Specialists for Individuals with Special Health Care Needs**

- 14.17.1 When the required treatment plan of Individuals with Special Health Care Needs, Children with Special Health Care Needs or Enrollees meeting Level 2 eligibility indicates the need for frequent utilization of a course of treatment with or regular monitoring by a specialist, the Contractor shall allow these Individuals to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care (42 C.F.R. § 438.208(c)(4) and 438.6(m)).

#### **14.18 Transitional Planning for Incarcerated Enrollees**

For the purposes of this subsection, "correctional facility" includes city and county jails, Department of Corrections (DOC) facilities, and Juvenile Rehabilitation facilities.

- 14.18.1 In accordance with SSB 6430 (Laws of 2016, chapter 154), the Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee's release. When correctional facilities opt out of this activity the Contractor is not required to pursue these facilities.
- 14.18.2 The Contractor shall:
  - 14.18.2.1 Provide transitional Care Coordination services to Enrollees when they enter a correctional facility, including:
    - 14.18.2.1.1 Working with the facility to define the responsible party at the facility who will provide Care Coordination activities in the facility;

- 14.18.2.1.2 Ensuring the facility is aware of the Enrollee's special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions, and is aware of medications and supplies the enrollee needs; and
  - 14.18.2.1.3 Providing information to enable the facility to maintain the Enrollee's medication regimen while the Enrollee is incarcerated.
- 14.18.2.2 Provide services and Care Coordination for Enrollees upon release from a correctional facility, state hospital, or other facility that provides care for individuals with 90 and 180-day civil commitments, including:
- 14.18.2.2.1 Coordinating with the facility to get copies of the Enrollee's medical records at the time of discharge;
  - 14.18.2.2.2 Requesting the Enrollee sign a Release of Information to allow exchange of health care information between systems;
  - 14.18.2.2.3 Using an evidence based approach to care coordination as the Enrollee transitions from incarceration to the community;
  - 14.18.2.2.4 Ensuring expedited prior authorization for medications or supplies prescribed while the Enrollee was incarcerated;
  - 14.18.2.2.5 Prioritize Care Coordination for Enrollees with special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions;
  - 14.18.2.2.6 Providing the Enrollee with an overview of benefits for which the Enrollee is eligible through the Contractor;
  - 14.18.2.2.7 Discuss with the Enrollee how to access a PCP, notify the Enrollee who their PCP is or help the Enrollee to find a PCP; and
  - 14.18.2.2.8 Assist the Enrollee to access the following services:
    - 14.18.2.2.8.1 Transportation to Medicaid appointments;
    - 14.18.2.2.8.2 Follow-up appointments for Behavioral Health or medical services;
    - 14.18.2.2.8.3 Housing and employment assistance; and
    - 14.18.2.2.8.4 Other support services the Enrollee may need.
- 14.18.3 HCA shall provide:
- 14.18.3.1 Information to the Contractor about the Enrollee's incarceration status when the information is available to HCA.
- 14.18.4 When possible, HCA shall coordinate with the Contractor to re-enroll the Enrollee

with the MCO he or she was enrolled in prior to incarceration, even when the incarceration was longer than six months, unless the Enrollee chooses to enroll with another MCO.

#### **14.19 Mental Health Parity**

- 14.19.1 The Contractor shall not impose Non-Quantitative Treatment Limits (NQTL) for mental health or substance use disorder benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the Contractor's policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 C.F.R. § 438.910(d)).
- 14.19.2 The Contractor shall monitor the Non-Quantitative Treatment Limits (NQTL) used or applied by the BHOs providing mental health or substance use disorder benefits to Enrollees, to assure they are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors the Contractor uses to apply limitations for medical/surgical benefits in the appropriate classifications. (42 C.F.R. § 438.910(d)). The Contractor shall report disparate applications and BHO/Contractor parity concerns to HCA.
- 14.19.3 The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.
- 14.19.4 The Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. part 438, subpart K, and the contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the state or the Contractor. (42 C.F.R. § 438.3(e)(1)(ii)).
- 14.19.5 If Enrollees are provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided. (42 C.F.R. § 438.910(b)(2)).
- 14.19.6 The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in (42 C.F.R. § 438.910(d)).
- 14.19.7 The Contractor must provide all necessary documentation and reporting to HCA to establish and demonstrate compliance with 42 C.F.R. part 438, subpart K regarding parity in mental health and substance use disorder benefits.
- 14.19.8 The Contractor shall make the criteria for medical necessity determinations made

by the Contractor for mental health or substance abuse disorder benefits available to any enrollee, potential enrollee, or contracting provider upon request.

- 14.19.9 The Contractor shall not impose aggregate lifetime, annual dollar limits or any other financial limitations on Enrollees for mental health, substance use disorder benefits regardless of whether the services are covered by the Contractor or a Behavioral Health Organization.

## **15 SPECIAL PROVISIONS FOR IHCPs AND AMERICAN INDIAN/ALASKA NATIVE ENROLLEES**

### **15.1 Special Provisions for Subcontracts with Indian Health Care Providers (IHCPs)**

- 15.1.1 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP.
  - 15.1.1.1 Any such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail.
  - 15.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the IHCP and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such Additional Special Terms and Conditions, in the format specified by the HCA, and a written statement that both parties have agreed to such Additional Special Terms and Conditions.
- 15.1.2 Any subcontracts with IHCPs must be consistent with the laws and regulations that are applicable to the IHCP. The Contractor must work with each IHCP to prevent the Contractor's business operations from placing requirements on the IHCP that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the IHCP.
- 15.1.3 The Contractor may seek technical assistance from the HCA Tribal Affairs Office to understand the legal protections applicable to IHCPs and American Indian/Alaska Native Medicaid recipients.
- 15.1.4 In the event that (a) the Contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request (as described in subsection 15.1.1) and (b) the IHCP submits a written request to HCA for a meeting to discuss the subcontract, the Contractor and the IHCP shall meet in person with HCA in Olympia, Washington or at an alternate location agreed upon by the parties involved within thirty (30) calendar days from the date of the IHCP's written consultation request in an effort to resolve differences and come to an agreement. Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

### **15.2 IHCP Engagement**

- 15.2.1 No later than April 30 of each year, the Contractor shall submit to the HCA Tribal Affairs Office a report that includes:
  - 15.2.1.1 A plan that describes the outreach activities the Contractor will undertake during the upcoming year to work with IHCPs in developing and implementing various services, financing models, and other

activities for the Contractor to:

- 15.2.1.1.1 Support and enhance the care coordination services provided by IHCPs for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-IHCP;
  - 15.2.1.1.2 Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed care; and
  - 15.2.1.1.3 A summary of the progress made during the previous year in building relationships, contractual and otherwise, with IHCPs.
- 15.2.2 No later than the 15th calendar day after the end of each calendar quarter, the Contractor shall submit to the HCA Tribal Affairs Office a report that briefly describes:
- 15.2.2.1 IHCPs the Contractor has worked with during the previous quarter;
  - 15.2.2.2 IHCPs with whom the Contractor successfully negotiated collaborative or contractual arrangements during the previous quarter; and
  - 15.2.2.3 IHCPs to whom the Contractor will reach out during the coming quarter.

### 15.3 **Special Provisions for American Indians and Alaska Natives**

- 15.3.1 If an American Indian/Alaska Native Enrollee indicates to the Contractor that he or she wishes to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an in-network PCP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor.
- 15.3.2 The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).
- 15.3.3 In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.
- 15.3.4 Facilities of the Indian Health Service and facilities operated by a tribe or tribal organization and funded by Title I or III of the Indian Self Determination and Education Assistance Act, whether designated with the Medicaid program as a Tribal 638 Clinic or a Federally Qualified Health Center (a Tribal FQHC), must be reimbursed the specific full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Federal Guidance.
- 15.3.5 The encounter rates for each contracted Indian Health Service facility, Tribal 638 Clinic, and Tribal FQHC will be provided by HCA to the Contractor with each accepted qualified claim. The rate files will be consistent with federal guidance



found at <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules> under Tribal Health Program or Tribal FQHC, and updated annually.

- 15.3.5.1 Tribal 638 Clinic and Tribal FQHC designation with the Medicaid program may be verified by contacting [tribalaffairs@hca.wa.gov](mailto:tribalaffairs@hca.wa.gov).
- 15.3.5.2 Claims paid to Indian Health Service facilities, Tribal 638 Clinics, and Tribal FQHCs and included in the encounter submission by the Contractor to HCA will include:
  - 15.3.5.2.1 An encounter service as outlined in the Tribal Health Program Billing Guide or Tribal FQHC Billing Guide;
  - 15.3.5.2.2 A T1015 procedure code; and
  - 15.3.5.2.3 An NPI of an Indian Health Service facility, Tribal 638 Clinic, or Tribal FQHC (participating NPIs will be shared by HCA with Contractors on the HCA Tribal affairs website found at <https://www.hca.wa.gov/assets/program/tribal-managed-care-plan-resources-npi-classifications.pdf> or by contacting [tribalaffairs@hca.wa.gov](mailto:tribalaffairs@hca.wa.gov)).
- 15.3.5.3 HCA will reimburse the Contractor for paid clean claims through ProviderOne for qualifying encounters as outlined in the ProviderOne Billing Guides and the Encounter Data Reporting Guide.
- 15.3.6 The Contractor shall ensure it has sufficiently trained staff to handle calls or inquiries from providers regarding the reimbursement process and how to ensure that services to AI/AN Enrollees are correctly processed.
- 15.3.7 The Contractor will submit the Indian Health Service Facility report quarterly to HCA of services provided to Tribal facilities. The report shall be submitted through MC-Track. The reports are due to HCA no later than the fifteenth of the month following the end of the quarter in January, April, July and October.
  - 15.3.7.1 The report shall include:
    - 15.3.7.1.1 A list of all facilities by name and NPI contracted by:
      - 15.3.7.1.1.1 IHS Facility;
      - 15.3.7.1.1.2 Tribal 638 Facility; and
      - 15.3.7.1.1.3 Tribal FQHC.
    - 15.3.7.1.2 Total number of unique clients by facility and by AI/AN or non-AI/AN status, and
    - 15.3.7.1.3 Total number of claims paid for each facility.

## 16 BENEFITS

### 16.1 Scope of Services

- 16.1.1 Medically Necessary Services. The Contractor is responsible for covering medically necessary services to Enrollees sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished (42 C.F.R. § 438.210(a)(3)(ii). The Contractor shall cover services that address the following (42 C.F.R. § 438.210(a)(4); and WAC 182-501-0060):
- 16.1.1.1 The prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability 42 C.F.R. § 438.210(a)(5)(ii)(A).
  - 16.1.1.2 The ability for an Enrollee to achieve age-appropriate growth and development.
  - 16.1.1.3 The ability for an Enrollee to attain, maintain, or regain functional capacity.
- 16.1.2 Integrated behavioral health services that support a bi-directional delivery of care model. The Contractor shall implement coverage of designated services collaboratively with HCA to support an integrated model of care that has no barriers by provider type or place of service, except as driven by scope of licensure, CPT or correct coding initiatives. This will include coverage of selected codes, including those classified as collaborative care codes, behavioral health integration codes and primary care codes.
- 16.1.3 Except as otherwise specifically provided in this Contract, the Contractor must provide the same amount, duration and scope of services as described in the Medicaid State Plan (42 C.F.R. § 438.210(a)(1 and 2) unless a service is specifically excluded from the Contract. Covered services that are not excluded are Contracted Services. For specific Contracted Services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the HCA under its FFS program, but shall rather be construed to require the Contractor to provide the same scope of services. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional without being limited by such guidelines.
- 16.1.4 The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a health care professional with expertise appropriate to the Enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision.
- 16.1.4.1 The amount and duration of contracted services that are medically necessary depends on the Enrollee's condition (42 C.F.R. § 438.210(a)(3)(i)).
  - 16.1.4.2 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the Enrollee's diagnosis,

type of illness or condition (42 C.F.R. § 438.210(a)(3)(ii)).

- 16.1.5 Except as specifically provided in the provisions of the Authorization of Services section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to Enrollees nor unduly burden providers or Enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid FFS program (42 C.F.R. § 438.210(a)(4)(ii)).
- 16.1.6 If the Contractor objects on moral or religious grounds to providing a counseling or referral service that it would otherwise be required to provide, reimburse for, or provide coverage for, the Contractor is not required to do so. The Contractor must document the grounds on which it objects to providing this service.
- 16.1.7 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the enrollee's right to choose the method of family planning to be used is protected.
- 16.1.8 For services that the HCA determines are non-covered that are not specifically excluded by this Contract, excluded from coverage under federal regulation or excluded from coverage by HCA, the Contractor shall have policies and procedures consistent with WAC 182-501-0160, Exception to Rule (ETR). The Contractor shall cover a service when the criteria in this WAC are met.
- 16.1.9 For services that are covered, but with limits in scope, amount or duration the Contractor will have policies and procedures consistent with WAC 182-501-0169 Limitation Extension (LE) to determine medical necessity of services outside or more than the limit. The Contractor is responsible for covering a service when the criteria in this WAC are met and results in an approval of services outside or more than the limitation.
- 16.1.10 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 C.F.R. § 438.3). Services provided outside the scope of Contracted Services shall be reported separately to HCA and shall not be included in the rates development process.
- 16.1.11 The Contractor may limit the provision of contracted services to participating providers except for the following:
  - 16.1.11.1 Emergency services;
  - 16.1.11.2 Services provided outside the Service Areas as necessary to provide medically necessary services; and
  - 16.1.11.3 Coordination of Benefits, when an Enrollee has other primary comparable medical coverage as necessary to coordinate benefits.
- 16.1.12 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment section of this Contract, the Contractor shall cover Enrollees for all medically necessary services.
- 16.1.13 Outside the Service Areas:

- 16.1.13.1 For Enrollees who are temporarily outside the service area or who have moved to a service area not served by the Contractor and have not been enrolled with another MCO, the Contractor shall cover the following services:
- 16.1.13.1.1 Emergency and post-stabilization services.
  - 16.1.13.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the, Appointment Standards provisions of the Access to Care and Provider Network section of this Contract are not exceeded.
  - 16.1.13.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access to Care and Provider Network section of this Contract are not exceeded.

## 16.2 Second Opinions

- 16.2.1 The Contractor must authorize a second opinion regarding the Enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the Enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for an independent and impartial qualified health care professional. The appointment for a second opinion must occur within thirty (30) calendar days of the request unless the Enrollee requests a delay for the second opinion to a date later than thirty (30) calendar days.
- 16.2.2 If the Contractor refuses to authorize a second opinion, or a second opinion from a provider of the Enrollee's choice, the refusal is an Adverse Benefit Determination, which shall be subject to appeal under the provisions of the Grievance and Appeal System section of this Contract.
- 16.2.3 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

## 16.3 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 C.F.R. § 441 Subpart F, and that a Consent for Sterilization form (HHS-687) is used. A hysterectomy requires the Hysterectomy Consent and Patient Information form (HCA 13-365). These forms can be accessed using the link provided in the HCA Sterilization Supplemental Billing Guide.

## 16.4 Enrollee in Facility at Enrollment

- 16.4.1 If an Enrollee was admitted to a hospital the same month that enrollment occurs, the Contractor is responsible for the admission and all related services unless:
  - 16.4.1.1 The Enrollee is SSI Blind/Disabled and admitted to a CPE hospital. In this case, HCA is responsible for the inpatient claim and the Contractor is responsible for professional services and management of the authorization requirements.
- 16.4.2 HCA is responsible for payment of all hospital and professional services provided from the date of admission until the date the Enrollee is discharged from the acute hospital inpatient stay when:
  - 16.4.2.1 The client was admitted to the hospital in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or
  - 16.4.2.2 The client was on FFS before the admission and is enrolled in AHMC during the admission; or
  - 16.4.2.3 The client's eligibility is retroactive to a month prior to the current month, the client is hospitalized, and enrollment is completed during the admission.
- 16.4.3 If an Enrollee was admitted to a skilled nursing or nursing facility the same month that enrollment occurs, the Contractor is responsible for the admission and all related services, until the Enrollee no longer meets rehabilitation or skilled level of care criteria.
- 16.4.4 DSHS is responsible for payment of any nursing facility admissions including when the Enrollee meets rehabilitation or skilled level of care criteria, provided from the date of admission until the date the Enrollee is discharged from the nursing facility when:
  - 16.4.4.1 The client was admitted to the nursing facility in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or
  - 16.4.4.2 The client was on FFS before the admission and is enrolled in AHMC during the admission; or
  - 16.4.4.3 The client's eligibility is retroactive to a month prior to the current month, the client is admitted, and enrollment is completed during the admission.
- 16.4.5 If the Enrollee's admission to a nursing facility is the responsibility of DSHS, under the provisions of subsection 16.4.4, the Contractor is responsible for all other services as described in this Contract, except for the room and board for the nursing facility, that are medically necessary and required to meet the client's needs, including professional services, specialty beds, specialty wheelchairs, etc. The Contractor is responsible for management of the authorization requirements for these services.
- 16.4.6 The Contractor is responsible for actively planning from either a hospital or a nursing facility when that admission is the responsibility of HCA or DSHS,

respectively. The Contractor is also responsible for coordinating the delivery of care pursuant to this Contract once discharge has occurred, including any subsequent care: hospital inpatient, rehabilitation, outpatient, outpatient observation, any professional services, and any subsequent nursing facility placements that meet rehabilitative or skilled stay nursing level of care criteria.

16.4.6.1 If the Enrollee is admitted to a hospital or a nursing facility after the first of the month in which enrollment occurred, the Contractor may conduct retrospective review to establish medical necessity of the admission.

16.4.7 If an Enrollee changes AH MCOs and the change becomes effective during an inpatient admission, the AH MCO that the Enrollee was enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for the rehabilitative or skilled benefit, or is discharged from a facility to home or a community residential setting or readmitted to an inpatient or observation hospital stay, consistent with the Skilled Nursing Facility Coordination subsection of this Contract. The AH MCO that is receiving the Enrollee is responsible for completing the responsibilities described in 16.4.6 above.

16.4.7.1 The party responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

#### **16.5 Enrollee in Hospice at Enrollment**

16.5.1 If an Enrollee changes AH MCOs and the change becomes effective while the Enrollee is receiving hospice services, the AH MCO that the Enrollee was enrolled with on the date of hospice admission is responsible for payment of all covered hospice services regardless of place of service. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for hospice or is discharged from hospice. The AH MCO that is receiving the Enrollee is responsible for coordinating discharge and ensuring continuity of services for the Enrollee.

#### **16.6 Enrollee in facility at Termination of Enrollment**

If an Enrollee is in a facility at the time of termination of enrollment and the Enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

16.6.1 The Enrollee is discharged from a facility to home or a community residential setting.

16.6.2 The Enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the Enrollee's Medicaid eligibility ends.

16.6.3 The Enrollee no longer meets the Contractor's rehabilitative or skilled criteria.

#### **16.7 Services Provided in Lieu of**

16.7.1 The Contractor may not provide services or settings that are in lieu of services or

settings covered by the State Plan without prior written approval from HCA as follows:

- 16.7.1.1 At the request of the Contractor, HCA shall determine whether the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan and provide the Contractor with written approval or denial of the request within no more than thirty (30) calendar days or as expeditiously as the Enrollees health condition requires the response;
- 16.7.1.2 The Enrollee is not required to use the alternative service or setting;
- 16.7.1.3 The approved in lieu of services are authorized and identified in this Contract and may be offered to the enrollee at the Contractor's discretion; and
- 16.7.1.4 The utilization of the lieu of services is reported in the Contractor's encounter data submission.

## **16.8 Deliveries and Newborn Coverage**

- 16.8.1 For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the enrolled newborn is discharged from the acute care hospital.
- 16.8.2 If the mother is not covered during the birth, the Contractor will be responsible for all covered inpatient Facility and professional services provided to the enrolled newborn starting from the date of birth or admission.
- 16.8.3 If the HCA is responsible for payment of labor and delivery services provided to a mother, the HCA shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions section of this Contract.
- 16.8.4 For covered deliveries in a birthing center, the Contractor shall pay for all covered services, including facility costs and professional services provided to the mother and the newborn until the date the enrolled mother and newborn are discharged from the birthing center.
- 16.8.5 For home deliveries, the Contractor shall pay for all costs associated with the home delivery, including professional services provided to the mother and newborn.

## 17 General Description of Contracted Services

### 17.1 Contracted Services

The Contractor shall provide the following services, as medically necessary, to Enrollees:

- 17.1.1 The Contractor shall provide a wellness exam to each Enrollee that documents the Enrollee's baseline health status and allows the Enrollee's PCP to monitor health improvements and outcome measures.
- 17.1.2 When an Enrollee has substance use disorder (SUD) and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the Enrollee is also receiving SUD and/or mental health treatment.
- 17.1.3 Inpatient Services:
  - 17.1.3.1 Provided by acute care hospitals including CPE hospitals (see subsection 5.18.4 of this Contract). Authorization and payment for services provided at CPE hospitals shall be made in accord with the Payments to Hospitals section of this Contract.
  - 17.1.3.2 Provided by a Nursing Facility, Skilled Nursing Facility or other acute care setting, when services are determined medically necessary and nursing facility services are not covered by DSHS' Aging and Long Term Supports Administration.
  - 17.1.3.3 Consultations with specialty providers, including psychiatric or psychology consultations, are covered during medical hospital stays or those admissions described in subsection 17.1.3.4.
  - 17.1.3.4 The Contractor shall pay for any and all covered services provided during an inpatient admission even if part of that admission is for mental health services, when the admission did not occur in a psychiatric facility or designated psychiatric bed or the admission was not approved by a BHO.
  - 17.1.3.5 Covered services provided during an inpatient admission for medical detoxification services.
- 17.1.4 Outpatient Hospital Services: Provided by acute care hospitals, including surgeries, labs, diagnostics and emergency room.
- 17.1.5 Emergency Services:
  - 17.1.5.1 The Contractor will provide all inpatient and outpatient Emergency Services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider is a participating provider, in accordance with the requirements of 42 C.F.R. § 438.114 as follows:
    - 17.1.5.1.1 An Enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 C.F.R. § 438.114(c)(1)(ii)(A)).



- 17.1.5.1.2 A participating provider or other Contractor representative instructs the Enrollee to seek emergency services (42 C.F.R. § 438.114(c)(1)(ii)(B)).
- 17.1.5.1.3 When the Enrollee presents at the emergency room with a psychiatric diagnosis:
  - 17.1.5.1.3.1 but is not admitted for inpatient treatment; or
  - 17.1.5.1.3.2 if the Enrollee was transferred for a BHO approved mental health admission to a different facility. The Contractor is responsible for all covered psychotropic medications prescribed as a part of the emergency room visit.
- 17.1.5.2 The Contractor shall ensure that an Enrollee who has an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (42 C.F.R. § 438.114(d)(2)).
- 17.1.5.3 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services (42 C.F.R. § 438.114 (d)(1)(ii)).
  - 17.1.5.3.1 The only exclusions to the Contractor's coverage of Emergency Services are:
    - 17.1.5.3.1.1 Emergency services for Enrollees with a mental health diagnosis, when the emergency room visit results in a BHO approved inpatient admission to the psychiatric facility/unit at the same hospital; and
    - 17.1.5.3.1.2 Dental services if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under HCA's FFS program.
- 17.1.5.4 Emergency services shall be provided without requiring prior authorization.
- 17.1.5.5 What constitutes an Emergency Medical Condition may not be limited on the basis of lists of diagnoses or symptoms (42 C.F.R. § 438.114 (d)(1)(i)).
- 17.1.5.6 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating Facility prevails and is binding on

the Contractor (42 C.F.R. § 438.114(d)(3)).

17.1.6 Post-stabilization Services:

17.1.6.1 The Contractor will provide all inpatient and outpatient post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating provider, in accord with the requirements of 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

17.1.6.2 The Contractor shall cover post-stabilization services under the following circumstances (42 C.F.R. § 438.114(e) and 42 C.F.R. § 438.113(c)(2)(iii)):

17.1.6.2.1 The services are pre-approved by a participating provider or other Contractor representative.

17.1.6.2.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

17.1.6.2.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the Enrollee's stabilized condition and the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(1)(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the Enrollee until a Contractor physician is reached or one of the criteria identified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3) is met.

17.1.6.2.3.1 The Contractor's responsibility for post-stabilization services it has not pre-approved ends when (42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3)):

17.1.6.2.3.1.1 A participating provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

17.1.6.2.3.1.2 A participating provider assumes responsibility for



Provider or practitioner.

- 17.1.9.7 Performing and/or reading diagnostic tests.
- 17.1.9.8 Medically intensive children's private duty nursing services for children age seventeen (17) and younger, in home and group home settings. The Contractor shall conduct a mortality review for any Enrollee who expires while authorized for these services. The mortality review shall include identification and analysis of trends or patterns and result in implementation of needed training, policy change, or other related action.
- 17.1.9.9 Surgical services.
- 17.1.9.10 Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction.
- 17.1.9.11 Telemedicine services, provided in accordance with Substitute Senate Bill 6519 (Chapter 68, Laws of 2016).
- 17.1.9.12 Anesthesia.
- 17.1.9.13 Administering pharmaceutical products.
- 17.1.9.14 Fitting prosthetic and orthotic devices.
- 17.1.9.15 Physical Medicine Rehabilitation services.
- 17.1.9.16 Enrollee health education.
- 17.1.9.17 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia.
- 17.1.9.18 Bio-feedback training when determined medically necessary.
- 17.1.9.19 Genetic testing for all Enrollees. Genetic counseling for children and non-pregnant adults.
- 17.1.9.20 Palliative care for adults and children.
- 17.1.9.21 Hormone therapy for any transgender Enrollees and puberty-blocking treatment for transgender adolescents consistent with HCA's gender dysphoria treatment benefit.
- 17.1.9.22 Medication Assisted Treatment, including buprenorphine/suboxone treatment provided by an SUD clinic.
- 17.1.10 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell. The MCO shall use the same standards respecting coverage and delivery of the services as the State uses.
- 17.1.11 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.
- 17.1.12 Vision Care: Eye examinations once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). (WAC 182-

531-1000. These limitations do not apply to additional services needed for medical conditions.

#### 17.1.13 Outpatient Mental Health

- 17.1.13.1 The Contractor shall evaluate an Enrollee requesting outpatient mental health services to determine whether the Enrollee is likely to meet medical necessity criteria to receive services through the BHO. See Exhibit B, Access to Care Standards (ACS).
- 17.1.13.2 If the Contractor determines the Enrollee is not likely to meet the ACS, it shall provide all medically necessary outpatient mental health services, including psychiatric and psychological testing, evaluation and diagnosis, treatment and counseling, and medication management as described in this Section.
- 17.1.13.3 If the Contractor determines the Enrollee is likely to meet the ACS, it shall refer the Enrollee to the BHO in the Enrollee's service area.
- 17.1.13.4 If the Enrollee is referred to the BHO for intake and evaluation, the Contractor shall continue to provide medically necessary outpatient mental health services until the BHO determines whether the Enrollee meets the ACS.
- 17.1.13.5 If the BHO determines the Enrollee meets the ACS, the Contractor shall coordinate with the BHO to transition the Enrollee to the BHO to ensure continuity of care.
- 17.1.13.6 If the BHO determines the Enrollee does not meet the ACS, the Contractor shall provide all medically necessary outpatient mental health services, including, but not limited to psychiatric and psychological testing, evaluation and diagnosis and medication management as described in this Section.
- 17.1.13.7 The Contractor shall ensure medication management:
  - 17.1.13.7.1 Provided by the PCP; or
  - 17.1.13.7.2 Provided in conjunction with a mental health professional contracted with the Contractor; or
  - 17.1.13.7.3 Provided by a BHO prescriber; and
  - 17.1.13.7.4 In accord with the requirements of pharmacists under RCW 69.41.190(3).
- 17.1.13.8 The Contractor may subcontract with BHOs to provide the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.
- 17.1.13.9 The Contractor shall utilize the full range of behavioral health professionals as described in Subsection 6.12 and Exhibit C, Designation of Behavioral Health Providers of this Contract to ensure mental health services are provided by the most appropriate provider to

meet the Enrollee's needs.

- 17.1.14 Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a developmental disability.
  - 17.1.14.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.
- 17.1.15 Non-pharmaceutical birth control products, including:
  - 17.1.15.1 ParaGard® (T 380A);
  - 17.1.15.2 Fertility awareness-based methods, such as cycle beads, basal body temperature thermometers, and charts; and
  - 17.1.15.3 Essure© sterilization method.
- 17.1.16 Enteral nutrition products, including the following:
  - 17.1.16.1 Parenteral nutritional supplements and supplies for all clients.
  - 17.1.16.2 Enteral nutrition products and supplies for tube-feeding are covered for all clients.
  - 17.1.16.3 Medically necessary oral enteral nutrition products, including prescribed infant formulas not covered by WIC or additional quantities beyond amounts allowed by WIC, for clients 20 years of age and under.
- 17.1.17 Home Health Services: Home health services, including palliative care, through state-licensed agencies.
- 17.1.18 Durable Medical Equipment (DME) and Supplies and any applicable sales tax including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for Enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the Enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax.
- 17.1.19 Respiratory Care: Equipment, services and supplies.
- 17.1.20 Palliative Care and Care Coordination: Provision of skilled care services and care coordination to Enrollees with a life-limiting medical condition under a palliative care model. Services can be provided in the following settings, but not limited to, hospice care centers, hospitals, clinics, and the Enrollee's home.

- 17.1.21 Hospice Services: Includes services for adults and children and provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the Enrollee's home. Hospice services include:
- 17.1.21.1 Pediatric Concurrent Care – Treatment, including diagnostics, that is related to an Enrollee's terminal condition for an Enrollee aged twenty and younger who voluntarily elects hospice care. Pediatric concurrent care preserves the Enrollee's rights to hospice care without waiving any rights to services that the Enrollee is entitled to under Title XIX Medicaid and Title XXI CHIP. (WAC 182-551-1860).
- 17.1.22 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.
- 17.1.23 Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.
- 17.1.24 Smoking Cessation Services with or without primary care provider referral or Contractor prior authorization. The Contractor shall submit a quarterly report to HCA. The report shall include the number of Enrollees that have accessed the Contractor's Quit Line in the previous quarter. The quarterly reports are due to HCA no later than the fifteenth of the month of January, April, July, and October.
- 17.1.25 Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health and shall contract with the DOH lab and cover all newborn screening by midwives for home births and other birthing scenarios in which the screening is not billed as part of the inpatient claim. These screenings shall be billed separately by the DOH lab.
- 17.1.26 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):
- 17.1.26.1 The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and HCA EPSDT WAC 182-534-0100.
    - 17.1.26.1.1 Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health, developmental and substance use disorder conditions, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory guidance for both the child and caregiver, and screenings for: vision, dental, substance use conditions, mental health and hearing.
    - 17.1.26.1.2 The Contractor shall conduct outreach efforts with Enrollees to promote completion of EPSDT services and coordinate EPSDT screening services both at established times and as requested (<https://www.hca.wa.gov/assets/billers-and->

[providers/EPSTD-bi-20180101.pdf](#)). The Contractor may implement Enrollee and primary care provider incentives to ensure that Enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at other times, when medically necessary (42 U.S.C. § 1396(r)(1)).

17.1.26.1.3 Diagnostic and treatment services include vision, dental and hearing services and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)).

17.1.26.1.4 When the Contractor becomes aware of a need for an EPSTD diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

17.1.26.1.5 The Contractor shall be responsible for all EPSTD screening, diagnostic, and treatment services found to be medically necessary. HCA has determined that EPSTD is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to diagnostic and treatment services identified by the child's primary care provider or another provider with authority to write orders for services for the child.

17.1.26.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, including evaluating the safety and effectiveness of the requested service and to establish it is not experimental. If a healthcare service is determined to be medically necessary under the EPSTD benefit, the Contractor will provide the service, whether or not it is a contracted service, unless it is specifically excluded by this Contract or prohibited by Federal rules.

17.1.26.2.1 If any EPSTD service exceeds the "soft" limit placed on the scope, amount or duration of a service, the Contractor shall use LE procedures in accordance with WAC 182-501-0169 to determine medical necessity of the requested



services and authorize the additional services as indicated.

- 17.1.26.3 If a child with special health care needs is assigned to a specialist for primary care, the assigned specialist is responsible for ensuring the child receives EPSDT services.
- 17.1.26.4 The Contractor may enter into contractual agreements with school-based health centers and family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. Such contracts shall:
  - 17.1.26.4.1 Require providers to follow EPSDT requirements;
  - 17.1.26.4.2 Coordinate identified needs for specialty care, such as referrals for vision or mental health evaluation and treatment services with the primary care provider;
  - 17.1.26.4.3 Not deny payment for EPSDT services delivered by more than one provider (primary care provider, school-based provider or family planning clinic) within a calendar year;
  - 17.1.26.4.4 Ensure the policies and procedures for accessing such services by contracting school-based health centers and family planning clinics are compliant with applicable federal and state statutes; and
  - 17.1.26.4.5 The Contractor shall coordinate with school-based health centers and other appropriate entities to assure activities performed by the Contractor are not duplicated.
- 17.1.26.5 The Contractor shall follow the guidelines found at the following website: <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>.
- 17.1.27 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair.
- 17.1.28 Bilateral Cochlear Implants, including implants, including parts, accessories, batteries, chargers, and repairs: For Enrollees age 20 and younger.
- 17.1.29 Bone-Anchored Hearing Aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries: For Enrollees age 20 and younger.
- 17.1.30 Services to Inmates of City and County Jail Facilities: The Contractor shall provide inpatient hospital services to Enrollees who are inmates of a city or county jail facility when an inpatient admission occurs during the first month of the incarceration period and HCA has paid a premium for that month to the Contractor. The Contractor's existing policies about establishing medical necessity for the inpatient admission and procedure(s) may be applied, even retrospectively, to determine payment. The Contractor shall provide transitional care coordination services to inmates upon release from jail in accordance with Subsection 14.18 of this Contract.
- 17.1.31 Habilitative Services: Limited to Enrollees in the Medicaid expansion population

that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME benefit.

17.1.31.1 For Children: No limitation.

17.1.31.2 For Adults: Twenty-four (24) units each for physical and occupational therapy and six (6) units of speech therapy, subject to limitation extensions as determined medically necessary.

17.1.31.3 Habilitative services do not include:

17.1.31.3.1 Day habilitation services designed to provide training, structured activities and specialized services to adults;

17.1.31.3.2 Chore services to assist with basic needs;

17.1.31.3.3 Vocational services;

17.1.31.3.4 Custodial services;

17.1.31.3.5 Respite care;

17.1.31.3.6 Recreational care;

17.1.31.3.7 Residential treatment;

17.1.31.3.8 Social services; and

17.1.31.3.9 Educational services.

17.1.32 Screening, Brief Intervention and Referral to Treatment (SBIRT) services for adolescents and adults who are at high risk for substance use disorder, to include alcohol and drugs with or without anxiety or depression. Screening conducted without brief intervention and referral to treatment is not reimbursable. SBIRT activities for identifying and reducing risk in individuals with drug or alcohol use concerns shall be one of the screening tools/interventions selected. Included as part of this effort are screens for depression and anxiety.

17.1.33 Comprehensive Medication Therapy Management Services.

17.1.34 Bariatric surgery for weight loss or reduction consistent with WAC 182-531-1600 and WAC 182-550-2301.

17.1.35 Early, elective inductions (before 39 weeks) that meet medically necessary indicators set by the Joint Commission. Because the Joint Commission's criteria do not capture all situations in which an early delivery is medically indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet that criteria, but which the hospital and delivering provider believe were medically necessary.

17.1.36 Services identified in the Section that are medically necessary to treat complications resulting from a non-covered or an excluded service (e.g. antibiotics to treat infection that occurs post operatively of a non-covered surgery or an excluded voluntary termination of pregnancy procedure).

## 17.2 Enrollee Self-Referral

17.2.1 Enrollees have the right to self-refer for certain services to participating or

nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington.

- 17.2.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.
- 17.2.3 The Enrollees also may choose to receive such services from the Contractor.
- 17.2.4 The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to Enrollees up to the limits described herein.
- 17.2.5 The Contractor shall make a reasonable effort to subcontract with all local health departments, school-based health centers, family planning agencies contracted with HCA, and Indian Health Service, Indian Tribe, Tribal Organization, UIHP, and IHCP providers.
- 17.2.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or Indian Health Service, Indian Tribe, Tribal Organization, UIHP, and IHCP providers as participating providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.
- 17.2.7 The services to which an Enrollee may self-refer are:
  - 17.2.7.1 Family planning services and supplies and sexually transmitted disease screening and treatment services provided at participating or nonparticipating providers, including but not limited to family planning agencies, such as Planned Parenthood.
  - 17.2.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department.
  - 17.2.7.3 Immunizations, sexually transmitted disease screening, family planning and mental health services through and if provided by a school-based health center.
  - 17.2.7.4 All services received by American Indian or Alaska Native Enrollees under the Special Provisions for American Indians and Alaska Natives Subsection of this Contract.

### **17.3 Pharmacy Benefits and Services**

- 17.3.1 Contractors with a subcontracted pharmacy benefit manager (PBM)
  - 17.3.1.1 On or before January 1, 2020, Contractors using a PBM shall require in their contract with the PBM that the PBM only seek reimbursement from the Contractor for the reimbursement amount paid to the participating

pharmacy for an individual prescription claim dispensed to an Enrollee.

- 17.3.1.2 On or before January 1, 2020, Contractor's PBM may not retroactively deny or reduce a payment made to a participating pharmacy for services after adjudication of the claim including direct and indirect remuneration, unless the original claim payment is adjusted by the MCO or the original claim was determined to be an improper payment described in Subsection 12.5 of this Contract.
- 17.3.1.3 On or before January 1, 2020, Contractor's contract with a PBM must require that they pass all retroactive adjustments in payments made to participating pharmacies for services after adjudication of the claim back to the Contractor within thirty (30) calendar days, including all forms of direct and indirect remuneration.
- 17.3.1.4 HCA will audit this requirement through ad hoc Network Pharmacy Reimbursement Reconciliation reports. HCA may impose sanctions if the Contractor is out of compliance with this section.

17.3.2 General Requirements:

- 17.3.2.1 The Contractor shall ensure that the amount, duration, and scope of covered outpatient drugs provided under this Contract is consistent with coverage under the FFS program. The Contractor shall cover all covered outpatient drugs when determined to be Medically Necessary, unless otherwise excluded from coverage. This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.
- 17.3.2.2 The Contractor shall provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature, unless otherwise directed by HCA.
- 17.3.2.3 The Contractor must cover all prescription drugs produced by rebate eligible manufacturers, with the exception of those excluded under this Contract or those eligible for exclusion under 42 U.S.C. §1396r-8(d)(2) which HCA has not specifically instructed the Contractor to cover.
- 17.3.2.4 The Contractor shall ensure that prescription drugs produced by non-rebate eligible manufacturers are not covered, regardless of the general status of the drug on the HCA defined formulary.
- 17.3.2.5 The Contractor shall have in place a mechanism to deny prescriptions:
  - 17.3.2.5.1 Written by excluded providers; and
  - 17.3.2.5.2 Prescribed for non-medically accepted indications.
- 17.3.2.6 The Contractor shall allow up to a ninety (90) day supply as an early prescription refill for prescriptions that are lost, stolen, or destroyed once

per prescription per 6-month period. Exceptions to the 6-month period may be granted for extreme circumstances (e.g. fire, flood, natural disaster, etc.) at the MCOs discretion.

17.3.2.7 The Contractor shall allow, once every 6 months, up to a ninety (90) day supply as an early prescription refill for a vacation for each prescription due during the vacation period.

### 17.3.3 Apple Health Preferred Drug List and Plan Formularies

#### 17.3.3.1 Apple Health Preferred Drug List (AH PDL)

17.3.3.1.1 The Contractor must use the AH-PDL as its primary preferred drug list. HCA has final authority on the status of products included on the AH-PDL. HCA will provide the Contractor with opportunities to offer feedback on the preferred status of products on the AH-PDL. Contractor's representatives may attend the Drug Utilization Review (DUR) Board and provide feedback directly to the DUR Board at the meeting.

17.3.3.1.2 The Contractor will follow the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions recommended by the DUR Board or approved by HCA, unless otherwise directed by HCA. The HCA will provide Contractor with final authorization criteria and step therapy protocols in the HCA clinical policy template ninety (90) calendar days prior to implementation.

17.3.3.1.3 HCA will notify the Contractor of major changes to the preferred status, authorization criteria, quantity limits, step therapy protocol, or other restrictions for products on the AH-PDL at least ninety (90) calendar days prior to implementation of the changes. The Contractor has ten (10) business days to review the file and submit questions or requests for changes to the HCA. The HCA will respond and provide final determination no later than sixty (60) calendar days prior to implementation.

17.3.3.1.4 HCA shall provide the Contractor with comprehensive files detailing the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions for products included in the AH-PDL. The file will also contain product specific information such as product identification number, active pharmaceutical ingredient, dosage form, route of administration, strength, and specific National Drug Code (NDC).

17.3.3.1.4.1 HCA will provide the AH-PDL file through secure file transfer protocol posted on the HCA website. The file will be submitted in a format and at a frequency mutually agreed

upon by all participating Apple Health Managed Care Contractors and HCA.

- 17.3.3.1.4.2 For new products to market the Contractor will adjudicate claims using the AH-PDL file within five (5) business days of notification the file is available.
  - 17.3.3.1.4.3 For changes to criteria for existing products on the AH-PDL which are not the result of DUR Board recommendations, the Contractor will adjudicate claims using the AH-PDL file within ten (10) business days of notification the file is available. If the Contractor determines any change is too complex to implement within the required timeframe, the Contractor must request an extension by close of business on the second business day after receiving the file. HCA will review the request and notify Contractor whether an extension is granted on the next business day.
  - 17.3.3.1.5 The Contractor shall place new drugs to market within a class included on AH-PDL in a non-preferred status until otherwise directed by HCA.
  - 17.3.3.1.6 The Contractor must achieve a threshold of at least 90 percent of the number of prescriptions written for preferred versus non-preferred products on the AH-PDL per calendar quarter, excluding drugs that were given permanent grandfathering status. For drugs that were grandfathered for three or six months, this provision applies to the first quarter after grandfathering expired. The Contractor shall provide data to HCA forty-five (45) calendar days after the end of each calendar quarter in a format determined by HCA. The first quarter AH-PDL Compliance report is due May 15.
  - 17.3.3.1.7 The HCA may require a corrective action for any AH-PDL non-compliance. HCA may impose sanctions if corrective actions fail to improve AH-PDL compliance.
  - 17.3.3.1.8 The Contractor shall maintain individual product coverage and exceptions to coverage according to this Section.
- 17.3.4 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL
- 17.3.4.1 The Contractor must develop and maintain a wrap-around formulary for drugs not included within a class on the AH-PDL.
  - 17.3.4.2 The Contractor's wrap-around formulary shall cover the following

products and supplies unless specifically detailed in the AH-PDL:

- 17.3.4.2.1 Antigens and allergens;
- 17.3.4.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;
- 17.3.4.2.3 Psychotropic medications according to the contractor's approved formulary when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice.
- 17.3.4.2.4 Hemophiliac Blood Product – Blood factors VII, VIII, and IX and the anti-inhibitor provided to Enrollees with a diagnosis of hemophilia or von Willebrand disease when the Enrollee is receiving services in an inpatient setting.
- 17.3.4.2.5 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:
  - 17.3.4.2.5.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over the counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.
  - 17.3.4.2.5.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.
  - 17.3.4.2.5.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months.
  - 17.3.4.2.5.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise

prescribed by the clinician or the Enrollee requests a smaller supply.

- 17.3.4.2.5.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs.
- 17.3.4.2.6 All drugs FDA labeled or prescribed as Medication Assisted Treatment (MAT) or maintenance therapy for substance use disorders, with the exception of methadone dispensed directly by opiate substitution treatment programs. The Contractor will cover all MAT according to detailed guidelines and requirements determined by HCA.
- 17.3.4.2.7 The term "Formulary" as used in this subsection includes lists of products and their formulary status, preferred status, authorization requirements and coverage limitations available through retail, specialty, and mail order pharmacies, and drugs paid by the Contractor under the medical benefits.
- 17.3.4.2.8 HCA may require changes to the formulary at any time, upon sixty (60) calendar days' written notice of the change. Required formulary changes may include any aspect of drug coverage, including, but not limited to: formulary status, limitations, prior authorization requirements, approval criteria, use of automated overrides, or determination of the benefit under which a product will be available. Failure to make requested changes by the date specified in HCA's notice may result in sanctions as described in the Sanctions subsection of this Contract.
- 17.3.4.2.9 If HCA determines the Contractor's online formulary does not accurately reflect coverage requirements, or the Contractor is not providing coverage as previously required by HCA, the Contractor shall make the necessary changes in coverage and update its online formulary and related materials as required by HCA within five (5) business days of the request.
- 17.3.4.2.10 The Contractor shall have a process in place to allow access to all non-formulary drugs, other than those excluded from coverage by the HCA, when determined to be Medically Necessary.
- 17.3.4.2.11 The Contractor shall submit its drug formulary and related material to HCA for review and approval no later than September 1 of each contract year. The submission shall



be in an electronic format according to HCA specifications for the following benefit year.

17.3.4.2.11.1 HCA shall notify the Contractor of either the approval of or required changes to the formulary and related materials, no later than October 1, of each contract year.

17.3.4.2.11.2 If HCA notifies the Contractor of required changes, all such changes shall be completed and resubmitted to HCA no later than December 1, of each contract year.

17.3.4.2.11.3 Once approved, any change to the formulary must be approved in writing by HCA before publication. Any proposed changes to the formulary and utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. after January 1, must be submitted to the HCA for review and approval prior to implementation, at least ninety (90) calendar days prior to implementing any changes.

17.3.4.2.12 The Contractor shall provide prominent public online access to the AH-PDL, the plan formulary and coverage criteria shall include information on how to request authorization for covered drugs, non-preferred drugs, and non-formulary drugs. The online formulary shall be easy to access and the website in which it is situated will be designed to use easily understandable language.

#### 17.3.5 Second Opinion for Children Prescribed Mental Health Medications.

17.3.5.1 The Contractor shall require a medication consultation by an HCA-approved Second Opinion Network (SON) provider before authorizing coverage of any psychotropic medication or medication regimens for children under eighteen (18) years of age that exceed the medication review thresholds established by HCA unless otherwise specified below.

17.3.5.1.1 For Enrollees who have previously filled prescriptions for the same drug at the same daily dosage, the Contractor shall authorize continuation of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON.

17.3.5.1.2 For Enrollees who have NOT previously filled prescriptions at the same daily dosage, the Contractor shall deny authorization of psychotropic medications exceeding these review thresholds until receipt of written report containing

treatment recommendations from the SON or otherwise directed by HCA.

- 17.3.5.2 HCA will provide the Contractor with a list of products and definitions of review thresholds for certain psychotropic medications which require a second opinion. Changes to the medication review thresholds established by HCA will be communicated to the Contractor no less than ninety (90) calendar days before any required implementation date.
- 17.3.5.3 The Contractor must identify all psychotropic medication prescriptions that require a second opinion. HCA may require corrective action or apply sanctions if the Contractor incorrectly authorizes or fails to identify psychotropic medications requiring consultation.
- 17.3.5.4 For the defined list of psychotropic medications, the Contractor is prohibited from applying any clinically or therapeutically based claim rejections or authorization requirements which have not been reviewed and approved by HCA.
  - 17.3.5.4.1 No later than two (2) business days after an Enrollee is determined to exceed review thresholds, the Contractor shall contact the prescriber to request relevant clinical information and chart notes detailing the need for the requested medication(s). In the event that multiple prescribers are prescribing mental health medications for the same Enrollee, the Contractor shall request relevant documentation from each prescriber.
  - 17.3.5.4.2 If a prescriber fails to provide documentation to support a prescription which exceeds HCA defined review thresholds within ten (10) business days, the Contractor shall deny all medications exceeding thresholds within two (2) business days.
  - 17.3.5.4.3 No later than close of business on the first business day after obtaining all relevant documentation, the Contractor shall send notification of required authorization to [applehealthpharmacypolicy@hca.wa.gov](mailto:applehealthpharmacypolicy@hca.wa.gov). Documentation received after close of business is considered received on the next business day. Notification shall include Enrollee's name, date of birth, ProviderOne client ID, National Drug Code of the drug denied, prescribed quantity and days' supply, National Provider Identifier of prescriber, name of prescriber, fax or phone number for prescriber, National Provider Identifier of dispensing pharmacy, name of dispensing pharmacy, fax or phone number of dispensing pharmacy, date of denial by plan, and reason for denial.
  - 17.3.5.4.4 Upon receipt of a written report from HCA, the Contractor shall approve or deny medications according to the recommendations of the SON within five (5) business days.

- 17.3.5.4.5 The Contractor shall have processes in place to accurately follow up with SON recommendations for future care, such as gradual tapering of medications, or required re-review based on other medication trials.
- 17.3.5.4.6 The Contractor shall provide case management to assist and facilitate the provision of any psychosocial recommendations made by SON.
  - 17.3.5.4.6.1 If the Contractor is unable to contact the Enrollee to provide case management, the Contractor shall inform the prescriber that participated in the SON review.
- 17.3.5.4.7 Upon notification by HCA that a prescriber has failed to participate in an SON consultation, the Contractor shall deny all medications exceeding thresholds within five (5) business days.
- 17.3.5.4.8 Changes to medications or medication regimens which exceed HCA review thresholds and which are not addressed in an existing SON report require the initiation of a new SON review by the Contractor. Reduction of medication doses or discontinuation of medications in a psychotropic polypharmacy regimen do not require a new SON.
- 17.3.5.4.9 If the provider submits a SON report or Partnership Access Line (PAL) consultation letter that addresses the requested medication regimen, the Contractor shall approve or deny medications according to the recommendations in the SON report or PAL consultation letter.
- 17.3.5.4.10 Payment to the SON provider for required reviews are the responsibility of HCA according to the provisions of HCA's contract with the SON provider.
- 17.3.5.4.11 The Contractor is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.
- 17.3.5.4.12 To assist prescribers in meeting the needs of Enrollees who are children with a mental health diagnosis, and in order to minimize the need for required medication reviews, the Contractor shall inform network prescribers that HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL). The Contractor is not required to provide payment to prescribers for voluntarily accessing the PAL.

### 17.3.6 Provider and Enrollee Notification

- 17.3.6.1 The Contractor shall have policies and procedures for notifying

Providers and Enrollees of changes to the Contractor's Formulary or AH-PDL, and any changes to Prior Authorization requirements.

17.3.6.1.1 The Contractor shall provide:

17.3.6.1.1.1 Written notification for changes to the Formulary or AH-PDL and Prior Authorization requirements to all affected Providers and Enrollees at least thirty (30) days prior to the effective date of the change.

17.3.6.1.1.2 Written information about changes to the Formulary or AH-PDL and Prior Authorization requirements upon request by Providers or Enrollees.

17.3.6.1.1.3 Provide information about Formulary, AH-PDL, and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

#### 17.3.7 Medication Therapy Management

17.3.7.1 The Contractor shall ensure its provider contracts include provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington State to provide chronic care management including comprehensive medication management services to individuals, consistent with the goals established in RCW 74.09.522.

#### 17.3.8 Rebates

17.3.8.1 The Contractor or the Contractor's pharmacy benefit manager (PBM) is prohibited from negotiating and collecting rebates for utilization by Apple Health enrollees with drug companies for preferred or non-preferred pharmaceutical products included on the AH-PDL. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer for a product on the AH-PDL, all Medicaid outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements.

17.3.8.2 The Contractor or the Contractor's PBM, is authorized to negotiate and collect rebates with drug manufacturers for any product that is not included in a class on the AH-PDL.

17.3.8.3 Section 2501(c) of the Patient Protection and Affordable Care Act (ACA) expanded the drug rebate requirement to include drugs dispensed to Enrollees. Covered outpatient drugs dispensed by the Contractor to Enrollees, including those administered by physicians in their offices, are subject to the same manufacturer rebate requirements as HCA's

FFS outpatient drugs.

- 17.3.8.4 The Contractor is subject to requirements for rebate agreements as defined in Section 1927 of the Social Security Act found at: [http://www.ssa.gov/OP\\_Home/ssact/title19/1927.htm](http://www.ssa.gov/OP_Home/ssact/title19/1927.htm)
- 17.3.8.5 The Contractor shall ensure that:
  - 17.3.8.5.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer as defined in this Contract. A list of eligible manufacturers can be found at: [https://www.hca.wa.gov/assets/billers-and-providers/rebate\\_customer\\_list.xls](https://www.hca.wa.gov/assets/billers-and-providers/rebate_customer_list.xls);
  - 17.3.8.5.2 Bulk chemicals used in the compounding of medications are exempt from the federal rebate requirements.
  - 17.3.8.5.3 Drug rebate records are kept in accordance with the Records section of this Contract and are made available to HCA upon request.
- 17.3.8.6 The Contractor will have processes in place to ensure the validity of medical claim data for rebate collection purposes, including but not limited to:
  - 17.3.8.6.1 Validating the association between submitted HCPC codes and their corresponding National Drug Code (NDC) using sources other than the CMS NDC - HCPCS Crosswalk for Medicare Part B Drugs. Validation must include processes for correctly paying claims with previously unknown NDC-HCPC associations as well as denying claims for invalid associations.
  - 17.3.8.6.2 Denying claims for products that come in unbreakable package sizes such as single-dose vials when the number of units billed is not a multiple of the number of units included in the unbreakable package.
- 17.3.8.7 HCA retains all funds collected from pharmaceutical manufacturers from rebates under the federal Medicaid Drug Rebate Program based on drug utilization by the Contractor's Enrollees.
- 17.3.8.8 HCA retains all funds collected from pharmaceutical manufacturers from rebates negotiated by the HCA under its supplemental rebate program for utilization of drugs by the Contractor's Enrollees that are listed on the AH-PDL.
- 17.3.8.9 Contractor retains all funds from rebates or discounts negotiated by the Contractor with pharmaceutical manufacturers for drugs not included in the AH-PDL, and must report those to HCA as an offset to the costs of providing healthcare.

#### 17.3.9 Reports

- 17.3.9.1 Prior Authorization
  - 17.3.9.1.1 The Contractor shall submit a report of all prescription drug authorizations forty-five (45) calendar days after the end of the calendar quarter in a format determined by HCA. Detail must be provided by drug label name, number of requests, number denied, and number approved. The first quarter Prescription Drug Authorization report is due May 15.
- 17.3.9.2 Drug Utilization Review (DUR)
  - 17.3.9.2.1 The Contractor shall submit an Annual Drug Utilization Review report on the CMS-approved template by the specific due dates stated in subsection 11.2.1.2. The report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.
- 17.3.9.3 Rebates and Pharmacy Reimbursement
  - 17.3.9.3.1 The Contractor shall provide a Network Pharmacy Reimbursement Reconciliation report detailing the actual ingredient cost and dispensing fee paid to network pharmacies by the Contractor or by the Contractor's PBM for all paid claims as well as total amount paid to the PBM for the same claims that Contractor reported to HCA through submission of encounter data. The Network Pharmacy Reimbursement Reconciliation report is due on an ad hoc basis.
  - 17.3.9.3.2 The Contractor shall provide a quarterly Drug Rebate report no later than forty-five (45) calendar days following the end of the calendar quarter estimating the amounts of rebates or discounts negotiated with drug manufacturers that will be invoiced to manufacturers for drug utilization by managed care Enrollees in the preceding calendar quarter. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected. The first quarter Drug Rebate report is due May 15.
  - 17.3.9.3.3 The Contractor shall provide an annual Drug Rebate report, no later than June 30, of any actual savings collected from manufacturers for rebates or discounts negotiated by the Contractor with drug manufacturers for utilization in the previous calendar year. The reports shall be in a format determined by HCA and will include, at a

minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected.

#### 17.3.9.4 Historical Reports

17.3.9.4.1 The Contractor shall provide a report by April 30 of all rebates or discounts received from drug manufacturers for drug utilization by Enrollees for each calendar quarter January 1, 2015 through December 31, 2017. The report shall be in a format determined by HCA and will include, at a minimum, manufacturer, drug name, rebate amounts invoiced and collected per drug, and total rebate projected or collected. The Historical Drug Rebate report shall be submitted as one document but broken down by calendar quarters that span 2015, 2016 and 2017. For example: January through March 2015, April through June 2015, etc.

#### 17.3.9.5 Confidentiality of Proprietary Rebate Information

17.3.9.5.1 The Contractor shall identify any confidential or proprietary information contained within reports. Failure to label such materials or failure to respond timely after notice of request for public disclosure has been given shall be deemed a waiver by the Contractor of any claim that information contained in the submitted reports is confidential, proprietary or trade secrets.

### 17.4 Exclusions

The following services and supplies are excluded from coverage under this Contract.

- 17.4.1 Unless otherwise required by this Contract, Ancillary Services resulting solely from or ordered in the course of receiving non-contracted or excluded services are also non-covered or an excluded service (e.g. dressing supplies as a non-durable medical supply to care for an incision related to a cosmetic abdominoplasty).
- 17.4.2 The Contractor shall not provide or pay for services that violate the Assisted Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).
- 17.4.3 The Contractor is not responsible for coverage of any services when an Enrollee is outside the United States of America and its territories and possessions.
- 17.4.4 Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by the Joint Commission.
- 17.4.5 The following Covered Services are provided by the state and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication, or Contractor publications.
  - 17.4.5.1 Inpatient Hospital charges at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by

HCA;

- 17.4.5.2 School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan who have a disability, developmental delay or are diagnosed with a physical or mental condition;
- 17.4.5.3 Eyeglass frames, lenses, and fabrication services covered under HCA's selective contract for these services for children under age twenty-one (21), and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult Enrollees age twenty-one (21) and over if not offered by the Contractor as a value added benefit;
- 17.4.5.4 Voluntary Termination of Pregnancy;
- 17.4.5.5 Court-ordered transportation services, including ambulance services;
- 17.4.5.6 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation, and common carriers;
- 17.4.5.7 Ambulance services, including air and ground ambulance transportation services with dates of service after December 31, 2017;
- 17.4.5.8 Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a dental condition, including anesthesia;
- 17.4.5.9 Orthodontics;
- 17.4.5.10 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;
- 17.4.5.11 Sterilizations for Enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);
- 17.4.5.12 Services provided by a health department when an Enrollee self-refers for care if the health department is not contracted with the Contractor;
- 17.4.5.13 HIV Case Management;
- 17.4.5.14 Prenatal Genetic Counseling;
- 17.4.5.15 Hemophiliac Products – Blood factors VII, VIII, and IX, anti-inhibitor, and all FDA approved products labeled with an indication for use in treatment of hemophilia and von Willebrand disease when distributed for administration in the Enrollee's home or other outpatient setting;
- 17.4.5.16 Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C;
- 17.4.5.17 The exclusion of the following drugs does not apply to any other



services related to the treatment or diagnosis of conditions for which the drug may be prescribed. No services will be considered ancillary to this exclusion under subsection 17.4.1, including the treatment of complications from or adverse reactions to treatment with the drugs. The Contractor shall cover all new drugs regardless of cost, unless HCA notifies Contractor that the drug will be excluded.

- 17.4.5.17.1 AVXS-101 as marketed under the brand name Zolgensma®;
- 17.4.5.17.2 axicabtagene ciloleucel, as marketed under the brand name Yescarta®;
- 17.4.5.17.3 burosumab-twza, as marketed under the brand name Crysvita®;
- 17.4.5.17.4 cerliponase alfa, as marketed under the brand name Brineura™;
- 17.4.5.17.5 edaravone, as marketed under the brand name Radicava™;
- 17.4.5.17.6 elapegademase-lvlr as marketed under the brand name Revcovi™;
- 17.4.5.17.7 emapalumab as marketed under the brand name Gamifant™;
- 17.4.5.17.8 eteplirsen, as marketed under the brand name Exondys 51™;
- 17.4.5.17.9 lutetium Lu 177 dotatate as marketed under the brand name Lutathera®;
- 17.4.5.17.10 nusinersen, as marketed under the brand name Spinraza®;
- 17.4.5.17.11 pegvaliase-pqpz, as marketed under the brand name Palynziq™;
- 17.4.5.17.12 tisagenlecleucel-t, as marketed under the brand name Kymriah™; and
- 17.4.5.17.13 voretigene neparvovec-rzyl, as marketed under the brand name Luxturna™.
- 17.4.5.18 Sexual reassignment surgery as described in WAC 182-531-1675(6)(d) and (e) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures;
- 17.4.5.19 Chemical-Using Pregnant (CUP) Women program as described in WAC 182-533-0730 when provided by an HCA-approved CUP provider; and
- 17.4.5.20 “Treat and Refer”, or treatment with no transport when provided by eligible providers defined as fire departments pursuant to a community assistance referral and education services program (CARES) as

described in RCW 35.21.930.

- 17.4.6 The following services are covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or Contractor publications.
- 17.4.6.1 Inpatient psychiatric services, including psychiatric consultations when the inpatient admission is approved by a BHO;
  - 17.4.6.2 Long-term private duty nursing for Enrollees ages 18 and over. These services are covered by DSHS, Aging and Long-Term Support Administration;
  - 17.4.6.3 Substance use treatment services covered through the DSHS, Behavioral Health and Service Integration Administration (BHSIA). Drugs prescribed as Medication Assisted Treatment or maintenance therapy for substance use disorders are a separate course of treatment, not ancillary to other treatment services and are a contracted service under the Pharmaceutical Products provisions of this Contract;
  - 17.4.6.4 Community-based services (e.g., COPES, CFC and Personal Care Services) covered through the Aging and Long-Term Support Administration (ALTSA);
  - 17.4.6.5 Nursing facility stays that do not meet rehabilitative or skilled criteria are covered through the Aging and Long-Term Support Administration (ALTSA);
  - 17.4.6.6 Mental health services separately purchased for all Medicaid clients by the DSHS, BHSIA;
  - 17.4.6.7 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;
  - 17.4.6.8 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health;
  - 17.4.6.9 Any service provided to an Enrollee while incarcerated with the Washington State Department of Corrections (DOC); and
  - 17.4.6.10 Early Childhood services (e.g., home visiting, ESIT, ECLIPSE, ECEAP/Head Start) covered by DCYF.

#### 17.5 Patient Review and Coordination (PRC)

- 17.5.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135. PRC is authorized by 42 U.S.C. § 1396n (a)(2) and 42 C.F.R. § 431.54.
- 17.5.2 Clinical oversight of the PRC review process must be provided by a qualified professional who is legally licensed and authorized by law or rule to determine if Enrollees have used health care services at a frequency or amount that is not medically necessary. Licensed professionals that may provide this clinical oversight include Physician, ARNP, Physician's Assistant, and Registered Nurse.

- 17.5.3 If either the Contractor or the HCA places an Enrollee into the PRC program, both parties will honor that placement.
- 17.5.4 The Contractor's placement of an Enrollee into the PRC program shall be considered an Adverse Benefit Determination, which shall be subject to appeal under the provisions of the Grievance and Appeal System section of this Contract. If the Enrollee appeals the PRC placement the Contractor will notify the HCA of the appeal and the outcome.
- 17.5.5 When an Enrollee is placed in the Contractor's PRC program, the Contractor shall send the Enrollee a written notice of the Enrollee's PRC placement, or any change of status, in accord with the requirements of WAC 182-501-0135.
- 17.5.6 The Contractor shall send the HCA a written notice of the Enrollee's PRC placement, or any change of status, in accord with the required format provided in the Patient Review and Coordination Program Guide published by the HCA.
- 17.5.7 The Contractor shall ensure PRC Enrollees and providers have direct access to the Contractor's PRC-trained program staff during the Business Day, including access to make needed changes to assigned providers. The Contractor may also subcontract to provide this service.
- 17.5.8 The Contractor shall have policies to ensure PRC Enrollees do not experience a lapse in access to program staff that can assist with the Enrollee's ability to obtain needed prescriptions from the narcotics prescriber or Primary Care Provider.
- 17.5.9 For an Enrollee admitted to a residential treatment center, the Contractor shall allow a representative of the center to make changes to assigned providers, including pharmacies, on the Enrollee's behalf without the Enrollee's written or oral consent.
- 17.5.10 In accord with WAC 182-501-0135, the HCA will limit the ability of an Enrollee placed in the PRC program to change their enrolled contractor for twelve months after the Enrollee is placed in the PRC program by the HCA or the Contractor unless the PRC Enrollee moves to a residence outside the Contractor's service areas, the Enrollee's assigned PCP no longer participates with the Contractor and is available in another MCO, or if the Enrollee is admitted to a subacute mental health facility. The Contractor shall allow for a temporary change in PCP or pharmacy for the Enrollee. The Contractor shall accept notification from the facility of the change in Enrollee status and the need for a newly assigned PCP and pharmacy. The temporary change in providers is effective until the date of discharge from the facility.
- 17.5.11 Family members of an Enrollee whose ability to change their enrolled MCO is limited because of placement in the PRC program may still change enrollment as provided in this Contract.

## 18 Third Party Liability

### 18.1 Definitions. For the purposes of this Section:

- 18.1.1 “Cost Avoidance” means a method used by HCA to avoid payment when other primary insurance resources are available to the Enrollee. When claims are submitted on behalf of Enrollees who have other primary insurance on file, payment will be denied and claims returned to the providers, who are then required to bill and collect payment from any liable third parties. (42 C.F.R. § 433.139(b)).
- 18.1.2 “Cost Recovery” (also known as “pay and chase”) means that the payer pays providers for submitted claims and then attempts to recover payments from liable third parties. Payers pay and chase claims for two primary reasons: post- payment identification of primary third party resources and Social Security Act exceptions to cost avoidance that require States to pay and chase claims instead of using cost avoidance. This is required when (1) the service is preventive pediatric care, (2) the service is covered under EPSDT, including Applied Behavior Analysis (ABA) treatment services, or (3) coverage is through a parent whose obligation to pay support is enforced by the states’ child enforcement agency. (Social Security Act §§ 1902(a)(25)(E) and (F), 42 U.S.C. §§ 1396a(a)(25)(E) and (F). See also 42 C.F.R. § 433.139(b)(3)).
- 18.1.3 “Post Payment Recovery” means seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). “Cost Recovery”, “Post Payment Recovery” may be referred to as “pay and chase”.
- 18.1.4 “Third Party Liability” means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a State Plan.

### 18.2 General Provisions

- 18.2.1 HCA authorizes the Contractor to obtain TPL reimbursement by any lawful means in accord with 42 C.F.R. § 433.139, and to coordinate benefits for Enrollees. The Contractor shall take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the Medicaid state plan.
- 18.2.2 The Contractor shall assume full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services provided to Enrollees under this Contract. The Contractor also shall be responsible for identifying existing TPL resources, undertaking cost avoidance, and recovering any liability from the third party. The Contractor shall develop and implement policies and procedures to meet its obligations regarding TPL.
- 18.2.3 For Enrollees who have primary health insurance, the Contractor shall coordinate benefits in accordance with the 42 U.S.C. § 1396a(a)(25) and other applicable law. RCW 41.05A.005. Coordination of Benefits includes paying any applicable cost-sharing on behalf of an Enrollee, up to the Medicaid allowed amount.
- 18.2.4 Nothing in this Section negates any of the Contractor’s responsibilities under this Contract, including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections section of this Contract. The Contractor shall:

- 18.2.4.1 Identify third party resources consistent with the Contractor's policies and procedures;
  - 18.2.4.2 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts;
  - 18.2.4.3 Attempt to recover any third-party resources available to Enrollees (42 C.F.R. § 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under Subsection 12.10 of this Contract;
  - 18.2.4.4 Pay preventive pediatric care, and services covered under EPSDT, including Applied Behavior Analysis treatment services and medically intensive children's program services, and then seek reimbursement from third parties (42 C.F.R. § 433.139(b)(3));
  - 18.2.4.5 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 C.F.R. § 433.139(c));
  - 18.2.4.6 Coordinate with out-of-network providers with respect to payment to ensure the cost to Enrollees is no greater than it would be if the services were furnished within the network;
  - 18.2.4.7 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them;
  - 18.2.4.8 Deny claims the primary payer denied because the provider or the Enrollee did not follow the payer's payment or adjudication rules; (e.g., claims submission without required prior authorization or untimely claims filing); and
  - 18.2.4.9 Make its own independent decisions about approving claims for payment that have been denied by the primary payer if either (a) the primary payer does not cover the service and the Contractor does, or (b) the service was denied as not medically necessary and the provider followed the dispute resolution and/or appeal process of the primary carrier and the denial was upheld.
- 18.2.5 If the Contractor's allowed amount for a service exceeds the primary insurer's paid amount, the Contractor shall pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount paid by the primary insurer.
  - 18.2.6 The Contractor shall have policies and procedures in place to investigate potential TPL resources related to trauma or accident and pursue recoveries.

### 18.3 Provider Agreements

- 18.3.1 All provider agreements executed by the Contractor and all provider agreements executed by subcontracting entities or organizations shall define the provider's responsibilities regarding TPL, including the provider's obligation to identify TPL coverage and, except as otherwise provided in this Contract, to seek such third

party payment before submitting claims to the Contractor.

#### 18.4 Cost Avoidance

- 18.4.1 The Contractor shall ensure coverage by all potential third-party payers is exhausted before the Contractor makes a payment for covered services, by directing subcontracted providers to submit a claim and receive final determination from the identified Third Party payer before billing the Contractor for services.
- 18.4.2 The Contractor shall use a Cost Avoidance procedure for all claims or services subject to third-party payment to the extent permitted by state and federal law. If the Contractor has established the probable existence of TPL at the time the provider submits a claim, the Contractor shall deny the claim and provide information about the Third Party payer to the billing provider.

#### 18.5 Post-Payment Recoveries

- 18.5.1 The Contractor shall recover funds post payment in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or the Contractor was not able to use a Cost Avoidance procedure. The Contractor shall identify and pursue all potential TPL payments. Potentially liable third party coverage sources include, but are not limited to:
  - 18.5.1.1 Third party liability insurance (for example, group health plans including medical, pharmacy);
  - 18.5.1.2 Self-insured plans;
  - 18.5.1.3 Managed care organizations;
  - 18.5.1.4 Pharmacy benefit managers;
  - 18.5.1.5 Union and other fraternal organizations; and
  - 18.5.1.6 Certain other state or federal programs.
- 18.5.2 Cost Benefit. (1) The Contractor's Post Payment Recovery processes shall not require the Contractor to spend more on an individual claim basis than the threshold limits established by the State Plan. (2) The Contractor shall use Cost Avoidance procedures to avoid payment on any claim where TPL is on file, other than those in Subsection 18.10 below.
- 18.5.3 Contractor must attempt to recover any third party resources available to Enrollees (42 C.F.R. § 433 Subpart D) and will make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under subsection 12.10 of this Contract.
  - 18.5.3.1 Contractor must pay and chase if the claim is for a service provided to an Enrollee on whose behalf child support enforcement is being carried out if, 1) the third party coverage is through an absent parent; and 2) the Provider certifies that, if the Provider has billed a third party the provider has waited thirty (30) calendar days from the date of billing without receiving payment before billing Medicaid (42 C.F.R. § 433.139(b)(3)(ii).
- 18.5.4 Retention of Recoveries. The Contractor is entitled to retain any amounts recovered through its efforts. Distributions of recoveries will be made to the Contractor, in an

amount equal to the Contractor's expenditures for the individual on whose behalf the collection was based, and to the beneficiary, any remaining amount.

- 18.5.5 Unsuccessful Effort. If the Contractor is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after a period of sixty (60) calendar days of such efforts, pursuant to 42 C.F.R. §§ 433.145 and 433.147, the Contractor must inform HCA in a format to be determined by HCA that its efforts have been unsuccessful.

## 18.6 Data

- 18.6.1 HCA shall include information about known TPL resources on the daily 834 enrollment files. Any new TPL resources learned of by HCA through its contractor(s) are added to the next available enrollment file.
- 18.6.2 The Contractor shall:
- 18.6.2.1 Proactively identify those Enrollees with other primary health insurance including their enrollment and disenrollment dates, and provide this information to HCA on the Enrollees with Other Health Insurance (OHI) report;
  - 18.6.2.2 Cooperate with HCA in any manner necessary to ensure collection of this information;
  - 18.6.2.3 Include all third party payments by Enrollee in its regular encounter data submissions; and
  - 18.6.2.4 Provide TPL data to any contracted provider having a claim denied by the Contractor based on the third party coverage.

## 18.7 Reports

- 18.7.1 The Contractor shall submit a quarterly Recovery and Cost Avoidance Report that includes any recoveries for third party resources as well as claims that the Contractor denies due to TPL coverage. The report shall include recoveries or denied claim payments for any covered service. The Contractor shall calculate cost savings in categories described by HCA. The Contractor shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data submitted to HCA. The report is due by the sixtieth (60th) calendar day following the end of the quarter.
- 18.7.2 The Contractor shall submit to HCA on the 15<sup>th</sup> 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 Contractor.
- 18.7.3 The Contractor shall submit to HCA on the 20<sup>th</sup> of the following month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the Contractor newly becomes aware of a cause of action to recover health care costs for which the Contractor has paid under this Contract.
- 18.7.4 HCA will continue to terminate enrollment for clients who become eligible for Medicare.

## 18.8 Compliance

- 18.8.1 HCA may determine whether the Contractor is in compliance with the requirements in this Section by inspecting source documents for:
  - 18.8.1.1 Appropriateness of recovery attempt;
  - 18.8.1.2 Timeliness of billing;
  - 18.8.1.3 Accounting for third party payments;
  - 18.8.1.4 Settlement of claims; and
  - 18.8.1.5 Other monitoring deemed necessary by HCA.
- 18.8.2 The Contractor shall demonstrate, upon request, to HCA that reasonable efforts have been made to seek, collect and/or report third party recoveries. HCA shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. In making its determination, HCA shall (a) take into account reasonable industry standards and practices and (b) have the right to inspect the Contractor's books and records in accordance with Subsection 12.10.

## 18.9 Subrogation of Rights and Third Party Liability

- 18.9.1 For the purposes of this subsection:
  - 18.9.1.1 "Injured person" means an Enrollee who sustains bodily injury.
  - 18.9.1.2 "Contractor's -health care expense" means the expense incurred by the Contractor for the care or treatment of the injury sustained, computed in accord with the Contractor's FFS schedule.
- 18.9.2 If an Enrollee requires health care services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.
- 18.9.3 HCA specifically assigns to the Contractor HCA's rights to such third party payments for health care provided to an Enrollee on behalf of HCA, which the Enrollee assigned to HCA as provided in WAC 182-503-0540.
- 18.9.4 HCA also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor shall be subrogated to HCA's rights and remedies under RCW 74.09.180(2) and RCW 41.05A.050-.080 with respect to covered services provided to Enrollees on behalf of HCA under chapter 74.09 RCW.
- 18.9.5 The Contractor may obtain a signed agreement from the Enrollee in which the Enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.
- 18.9.6 The Contractor shall notify HCA of the name, address, and other identifying information of any Enrollee and the Enrollee's attorney:
  - 18.9.6.1 Who settles a claim without protecting the Contractor's interest in



contravention of RCW 41.05A.060; or

18.9.6.2 When a claim has been identified as having potential TPL.

#### **18.10 Good Cause Exemption from Billing Third Party Insurance**

- 18.10.1 The Contractor must have a policy to allow Enrollees the right to be exempt from billing third party insurance due to good cause. This includes a procedure that allows for the good cause process to apply on an individual claim basis and a means to flag the Enrollee's account so that the need for additional privacy and precaution can be easily seen. "Good cause" means that the use of the third-party coverage would violate an Enrollee's confidentiality because the third party:
- 18.10.1.1 Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;
  - 18.10.1.2 Requires the Enrollee to use a primary care provider who is likely to report the Enrollee's request for family planning services to the subscriber;
  - 18.10.1.3 The Enrollee has a reasonable belief that cooperating with the Contractor in identifying TPL coverage would result in serious physical or emotional harm to the Enrollee, a child in his or her care, or a child related to him or her; or
  - 18.10.1.4 The Enrollee is incapacitated without the ability to cooperate with the Contractor.
- 18.10.2 A description of this process, including any steps the Enrollee must take to seek exemption based on good cause, must be included in every notice the Contractor provides to Enrollees regarding Third Party billing or seeking cooperation with such billing. The notices must include that reasons such as fear of domestic violence or other harm are included in good cause. The Contractor's policy must include a procedure that allows for the good cause process to apply on an individual claim basis. Any denial of good cause is an Adverse Benefit Determination. Any communications or billing must be suspended pending a good cause request or appeal of a request denial.

## EXHIBIT A – RATES

### Apple Health Managed Care

The rate exhibits are not included in this online version of the contract.

## Exhibit B

### Access to Care Standards

### Apple Health Managed Care Contract

Effective October 1, 2017

# STATE OF WASHINGTON ACCESS TO CARE STANDARDS

FOR BEHAVIORAL HEALTH ORGANIZATIONS

Effective: 01 October 2017

## INTRODUCTION AND SCOPE

The statewide Access to Care Standards describes the minimum standards and criteria for clinical eligibility for behavioral health services for the Behavioral Health Organization (BHO) care delivery system. This includes mental health and substance use disorder (SUD) services. Medicaid enrollees are eligible for all outpatient and residential levels of care and clinical services in the Medicaid State Plan based on medical necessity and the Access to Care Standards that now include qualifying substance use diagnoses and the American Society of Addiction Medicine (ASAM) Criteria.

## BACKGROUND

The State of Washington (SOW) Access to Care Standards provide Behavioral Health Organizations (BHOs) and their contracted Agencies with guidelines to determine eligibility for authorization of services for individuals served through the Washington state public behavioral health system.

The guidelines are the result of an emphasis that began 30 years ago to establish medical treatment policy for those dealing with a major mental illness. During the 1980's, the Federal government began monitoring the care provided to individuals diagnosed with a major mental illness including the type and duration of services that were provided to them. Diagnosis (as listed in the DSM-III edition), functional impairment and duration of illness were the criteria used to define the target population as individuals with "chronic mental illness." Stakeholders were invested in the development of medically necessary community-based mental health services with the intent of decreasing disability and mortality in the "chronically mentally ill" populations.

By 1992, Congress directed Health and Human Services to develop a Federal definition of Serious Mental Illness (SMI) to assist in monitoring incidence and prevalence rates among states, particularly for those states applying for grant funds to support mental health services. An additional definition was created to include children, and is referred to as Seriously Emotionally Disturbed (SED). This includes children with mental health disorders that result in behavioral or conduct problems, and cause functional impairment.

The guidelines for SMI and SED have become essential elements in the "managed care" model of providing services with Medicaid funds. In 2002 the President's New Freedom Commission was formed to study the mental health service delivery system within communities. Their research led to recommendations for systems that would "enable adults with serious mental illnesses and children with serious emotional disturbance to live, work, learn, and participate fully in their communities", thus moving toward recovery, resilience and prevention. The order inspired many states to create managed care organizations to oversee services for Medicaid recipients who met the criteria for SMI and SED. Washington State Division of Behavioral Health and Recovery (DBHR), formerly the Mental Health Division, formed a workgroup to create Access to Care Standards eligibility and authorization criteria for services for this population. The standards were established and made available to each Regional Support Network (RSN) on 01 January 2003. These standards guide providers in determining who is eligible for services, as well as what types of services are best suited to meet the enrollees' needs.

More recently, several changes occurring within a close time frame have necessitated the revision of SOW Access to Care Standards. The major changes are the deployment of the DSM-5 in 2014 which eliminates the Global Assessment of Functioning Scale (GAF), and the CMS mandate to implement ICD-10-CM coding by 01 October 2015. Without the use of the GAF score, a way to assess level of functioning was still necessary to determine eligibility of services for RSN enrollees. A workgroup to accomplish this was formed, comprised of clinicians from RSNs, DBHR staff, other state affiliated organizations, and consumer advocates. The workgroup desired a standardized way to help providers identify eligible diagnoses, determine functional impairment, and determine the most appropriate service/s that can be provided within the individual's community setting.

In March 2014 Senate Bill 6312 and House Bill 2572 were enacted. This legislation mandated that the State's publicly-funded mental health system (operated by the Regional Support Networks) and the county-operated substance use disorder program be integrated. The result of this integration was to create a system of Behavioral Health Organizations – to be fully operational by April 2016. As part of this full behavioral health integration, the Access to Care Standards have been revised to include substance use disorder services.

## CODING AND SYSTEM CHANGES

Periodically, new diagnosis codes may be added/changed/removed by CMS to the ICD-10-CM listing or its successor. As necessary, updates to the Access to Care Standards may be updated to incorporate published coding changes.

## ELIGIBILITY REQUIREMENTS FOR AUTHORIZATION OF BHO SERVICES

The following are intended to present minimum standards for authorization for BHO services. The application of these standards is expected to be used consistently across the state. An individual is authorized for their services under one or more authorizations, with one or more MH and/or SUD service agencies.

The Access to Care Standards are not intended solely to serve as continuing stay criteria, however referenced ASAM Criteria for SUD services does serve as continuing stay criteria.

An individual must meet medical necessity before being considered for routine BHO services. Authorizing entities must demonstrate medical necessity on all behavioral health assessments/intakes, as well as continuing stay authorization documents.

**For mental health authorizations only** the five (5) medical necessity criteria are presented below:

1. The individual has a mental illness as determined by a Mental Health Professional (MHP) in a face-to-face intake/assessment. The diagnosis must be included in the list of Mental Health Covered Diagnoses;
2. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The individual must meet the Functional Criteria for Serious Mental Illness (SMI) or Seriously Emotionally Disturbed (SED);
3. The intervention is deemed to be reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental illness;
4. The individual is expected to benefit from the intervention; and,
5. The individual's unmet need(s) cannot be more appropriately met by any other formal or informal system or support.

**For substance use disorder (SUD) services only** the two (2) medical necessity criteria are presented below:

1. The individual has a SUD as determined by a Chemical Dependency Professional (CDP), or a Chemical Dependency Professional Trainee (CDPT) under the supervision of a CDP, in a face-to-face assessment in accordance with WAC 388-877 and 388-877B. The diagnosis must be included in the list of SUD Covered Diagnoses;
2. Using the American Society of Addiction Medicine (ASAM) Criteria a multidimensional assessment of the individual's risk(s), impairment(s) and corresponding need(s) are documented. Additional medical necessity criteria are included in ASAM criteria.

## ACCESS TO CARE – DESCRIPTORS

### COVERED DIAGNOSES

A mental health intake is provided by a mental health professional and determines the presence of a covered mental health diagnosis. Special population consultation should be considered. For children, the mental health intake must be completed by, or under the supervision of a child mental health specialist.

### PERSONS AGED 18, 19, OR 20 YEARS OLD MAY QUALIFY FOR SERVICES UNDER SED OR SMI DETERMINATIONS

If a covered substance use disorder is determined to be present, an individual is eligible for placement into a clinically appropriate level of care using ASAM criteria.

## FUNCTIONAL CRITERIA FOR SMI DETERMINATION (MENTAL HEALTH SERVICES ONLY)

To meet the functional criteria for SMI, a person must have, as a result of a covered diagnosis, current dysfunction in at least one of the following four (4) domains, as described below. This dysfunction has been present for most of the past twelve months or for most of the past six months with an expected continued duration of at least six months. Six-month minimum timeframe does not apply to all diagnoses per DSM. Examples are acute stress disorder, adjustment disorder, and certain psychotic disorders.

**1. Inability to live in an independent or family setting without support**

Neglect or disruption of ability to attend to basic needs. Needs assistance in caring for self. Unable to care for self in safe or sanitary manner. Housing, food, and clothing must be provided or arranged for by others. Unable to attend one or more basic needs of hygiene, grooming, nutrition, medical, and/or dental care. Unwilling to seek necessary medical/dental care for serious medical or dental conditions due to mental health symptoms. Refuses treatment for life threatening illnesses because of behavioral health disorder.

**2. A risk of serious harm to self or others**

Seriously disruptive to family and/or community. Pervasively or imminently dangerous to self or others' bodily safety. Regularly engages in assaultive behavior. Has been arrested, incarcerated, hospitalized, or at risk of confinement because of dangerous behavior. Persistently neglectful or abusive towards others. Severe disruption of daily life due to frequent thoughts of death, suicide, or self-harm, often with behavioral intent and/or plan.

**3. Dysfunction in role performance**

Frequently disruptive or in trouble at work or at school. Frequently terminated from work or suspended/expelled from school. Major disruption of role functioning. Requires structured or supervised work or school setting. Performance significantly below expectation for cognitive/developmental level. Unable to work, attend school, or meet other developmentally appropriate responsibilities.

**4. Risk of deterioration**

Persistent or chronic factors such as social isolation, poverty, extreme chronic stressors. Care is complicated and requires multiple providers. Also, individuals with past psychiatric history, with gains in functioning that have not solidified or cannot be maintained without treatment and/or supports.

## FUNCTIONAL CRITERIA FOR SED DETERMINATION (MENTAL HEALTH SERVICES ONLY)

Must be a person under the age of 21.

To meet the functional criteria for SED, a person must have, as a result of a covered diagnosis, dysfunction in at least one (1) of the following Capacities or one (1) of the Symptoms. Duration of the dysfunction must be present, or expected to persist, for six (6) months.

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### CAPACITIES

**1. Functioning in self-care**

Impairment in age-appropriate/developmental age self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and/or nutritional needs.

**2. Functioning in community**

Inability to maintain safety without assistance; a consistent lack of age-appropriate/developmental age behavioral controls, decision making, and/or judgment any of which may increase the risk for potential out-of-home placement.

**3. Functioning in social relationships**

Impairment of social relationships is manifested by the consistent inability to develop and maintain normal relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

#### 4. **Functioning in the family**

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well-being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness, or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

#### 5. **Functioning at school/work**

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self-sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

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## SYMPTOMS

### 1. **Psychotic symptoms**

Symptoms that are characterized by defective or loss of contact with reality, often with hallucinations or delusions.

### 2. **Danger to self, others, or property as a result of emotional disturbance**

The individual is self-destructive (e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.)

### 3. **Trauma symptoms**

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience a disruption in their age-expected/developmental age range of emotional and social developmental capacities.

## FUNCTIONAL CRITERIA FOR SUD ONLY

Demonstrated by meeting ASAM criteria.

## LEVEL OF CARE (LOC) AND INTENSITY OF SERVICE DETERMINATION

- Authorizing entities (i.e., BHOs) must develop a method of determining appropriate Levels of Care (LOC) to assist Service Providers with assigning authorized individuals appropriate service levels, with the appropriate service intensity.
- Assignment into an appropriate Level of Care (LOC) is based on the specific SMI (adult), SED (children), or ASAM criteria.
- The individual's Level of Care and specific SMI/SED or ASAM criteria must be reflected on the individualized and mutually-developed individualized treatment plan/individualized service plan.
- The Individualized Treatment/Service Plan (ITP/ISP) must demonstrate that the selected intervention(s) are medically necessary, and reasonably necessary to improve, stabilize, or prevent deterioration of functioning resulting from the presence of a mental health or substance use disorder.

## PERIOD OF AUTHORIZATION

The period of authorization may be up to twelve (12) months of care as determined by medical necessity and treatment goal(s).



## TRANSITION PLANNING

- Individuals who require services beyond the initial authorization period must continue to meet medical necessity criteria. Authorizing entities must establish continuing stay criteria, to include a Level of Care (LOC) system that allows for movement along a continuum of care inclusive of discontinuing or reducing treatment services in lieu of alternative services and supports.
- For SUD, authorized services for continuing stay, transfer, and discharge criteria are established using ASAM Criteria.
- Authorizing entities must ensure that Network Providers have a system in place for establishing continued stay criteria at the time of initial assessment. Progress must be reviewed with the individual at regular intervals throughout the episode of care.

## MODALITY SET

The full scope of available treatment modalities may be provided based on clinical assessment, medical necessity, and individual need. Access to State Plan Modalities is based on clinical assessment, medical necessity, and individual need.

## MULTIPLE DIAGNOSIS

Individuals who have both a covered and non-covered diagnosis may be eligible for service based on the covered diagnosis. BHOs provide services that address the covered diagnosis and coordination of care for non-covered diagnosis.

## COVERED DIAGNOSTIC CLASSIFICATIONS

The diagnoses listed in the following tables are the only covered diagnoses for the BHO system. Descriptions in the tables below that are italicized are the ICD-10-CM description for the ICD-10-CM code. Non-italicized descriptions are from DSM-5.

**Please note: To make a diagnosis, the process should start with DSM-5 and shall be limited to the scope of the clinician's license.**

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

The diagnoses listed in the following tables are the only covered diagnoses for the BHO system. Descriptions in the tables below that are italicized are the ICD-10-CM description for the ICD-10-CM code. Non-italicized descriptions are from DSM-5.

### [F01-F09] MENTAL DISORDERS DUE TO KNOWN PHYSIOLOGICAL CONDITIONS

ICD-10-CM Code	Description
F01.50	<i>Vascular dementia without behavioral disturbance</i> Probable Major Vascular Neurocognitive Disorder, Without behavioral disturbance
F01.51	<i>Vascular dementia with behavioral disturbance</i> Probable Major Vascular Neurocognitive Disorder, With behavioral disturbance
F02.80	<i>Dementia in other diseases classified elsewhere without behavioral disturbance</i> Major Neurocognitive Disorder Due to Prion Disease, Without behavioral disturbance Major Neurocognitive Disorder Due to HIV Infection, Without behavioral disturbance Major Neurocognitive Disorder Due to Huntington’s Disease, Without behavioral disturbance Major Neurocognitive Disorder Due to Parkinson’s Disease, Without behavioral disturbance Major Neurocognitive Disorder Due to Alzheimer’s Disease, Without behavioral disturbance Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration, Without behavioral disturbance Major Neurocognitive Disorder With Lewy Bodies, Without behavioral disturbance Major Neurocognitive Disorder Due to Multiple Etiologies, Without behavioral disturbance
F02.81	<i>Dementia in other diseases classified elsewhere with behavioral disturbance</i> Major Neurocognitive Disorder Due to Prion Disease, With behavioral disturbance Major Neurocognitive Disorder Due to HIV Infection, With behavioral disturbance Major Neurocognitive Disorder Due to Huntington’s Disease, With behavioral disturbance Major Neurocognitive Disorder Due to Parkinson’s Disease, With behavioral disturbance Major Neurocognitive Disorder Due to Alzheimer’s Disease, With behavioral disturbance Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration, With behavioral disturbance Major Neurocognitive Disorder With Lewy Bodies, With behavioral disturbance Major Neurocognitive Disorder Due to Multiple Etiologies, With behavioral disturbance

### [F20-F29] SCHIZOPHRENIA, SCHIZOTYPAL, DELUSIONAL, AND OTHER NON-MOOD PSYCHOTIC DISORDERS

ICD-10-CM Code	Description
F20.81	<i>Schizophreniform disorder</i> Schizophreniform Disorder
F20.9	<i>Schizophrenia, unspecified</i> Schizophrenia

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F21	<i>Schizotypal disorder</i> Schizotypal (Personality) Disorder
F22	<i>Delusional disorders</i> Delusional Disorder
F23	<i>Brief psychotic disorder</i> Brief Psychotic Disorder
F25.0	<i>Schizoaffective disorder, bipolar type</i> Schizoaffective Disorder, Bipolar Type
F25.1	<i>Schizoaffective disorder, depressive type</i> Schizoaffective Disorder, Depressive Type
F28	<i>Other psychotic disorder not due to a substance or known physiological condition</i> Other specified schizophrenia spectrum and other psychotic disorder

## [F30-F39] MOOD (AFFECTIVE) DISORDERS

ICD-10-CM Code	Description
F31.0	<i>Bipolar disorder, current episode hypomanic</i> Bipolar I Disorder, Current or most recent episode hypomanic
F31.11	<i>Bipolar disorder, current episode manic without psychotic features, mild</i> Bipolar I Disorder, Current or most recent episode manic, Mild
F31.12	<i>Bipolar disorder, current episode manic without psychotic features, moderate</i> Bipolar I Disorder, Current or most recent episode manic, Moderate
F31.13	<i>Bipolar disorder, current episode manic without psychotic features, severe</i> Bipolar I Disorder, Current or most recent episode manic, Severe
F31.2	<i>Bipolar disorder, current episode manic severe with psychotic features</i> Bipolar I Disorder, Current or most recent episode manic, With psychotic features
F31.31	<i>Bipolar disorder, current episode depressed, mild</i> Bipolar I Disorder, Current or most recent episode depressed, Mild
F31.32	<i>Bipolar disorder, current episode depressed, moderate</i> Bipolar I Disorder, Current or most recent episode depressed, Moderate
F31.4	<i>Bipolar disorder, current episode depressed, severe, without psychotic features</i> Bipolar I Disorder, Current or most recent episode depressed, Severe
F31.5	<i>Bipolar disorder, current episode depressed, severe, with psychotic features</i> Bipolar I Disorder, Current or most recent episode depressed, With psychotic features

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F31.71	<i>Bipolar disorder, in partial remission, most recent episode hypomanic</i> Bipolar I Disorder, Current or most recent episode hypomanic, In partial remission
F31.72	<i>Bipolar disorder, in full remission, most recent episode hypomanic</i> Bipolar I Disorder, Current or most recent episode hypomanic, In full remission
F31.73	<i>Bipolar disorder, in partial remission, most recent episode manic</i> Bipolar I disorder, Current or most recent episode manic, In partial remission
F31.74	<i>Bipolar disorder, in full remission, most recent episode manic</i> Bipolar I disorder, Current or most recent episode manic, In full remission
F31.75	<i>Bipolar disorder, in partial remission, most recent episode depressed</i> Bipolar I Disorder, Current or most recent episode depressed, In partial remission
F31.76	<i>Bipolar disorder, in full remission, most recent episode depressed</i> Bipolar I Disorder, Current or most recent episode depressed, In full remission
F31.81	<i>Bipolar II disorder</i> Bipolar II Disorder
F31.89	<i>Other bipolar disorder</i> Other Specified Bipolar and Related Disorder
F31.9	<i>Bipolar disorder, unspecified</i> Bipolar I Disorder, Current or most recent episode manic, unspecified Bipolar I Disorder, Current or most recent episode hypomanic, unspecified Bipolar I Disorder, Current or most recent episode depressed, unspecified Bipolar I Disorder, Current or most recent episode unspecified
F32.0	<i>Major depressive disorder, single episode, mild</i> Major Depressive Disorder, Single episode, Mild
F32.1	<i>Major depressive disorder, single episode, moderate</i> Major Depressive Disorder, Single episode, Moderate
F32.2	<i>Major depressive disorder, single episode, severe without psychotic features</i> Major Depressive Disorder, Single episode, Severe
F32.3	<i>Major depressive disorder, single episode, severe with psychotic features</i> Major Depressive Disorder, Single episode, With psychotic features
F32.4	<i>Major depressive disorder, single episode, in partial remission</i> Major Depressive Disorder, Single episode, In partial remission
F32.5	<i>Major depressive disorder, single episode, in full remission</i> Major Depressive Disorder, Single episode, In full remission

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F32.89	<i>Other specified depressive episodes</i> Other Specified Depressive Disorder
F32.9	<i>Major depressive disorder, single episode, unspecified</i> Major Depressive Disorder, Single episode, Unspecified Unspecified Depressive Disorder
F33.0	<i>Major depressive disorder, recurrent, mild</i> Major Depressive Disorder, Recurrent episode, Mild
F33.1	<i>Major depressive disorder, recurrent, moderate</i> Major Depressive Disorder, Recurrent episode, Moderate
F33.2	<i>Major depressive disorder, recurrent severe without psychotic features</i> Major Depressive Disorder, Recurrent episode, Severe
F33.3	<i>Major depressive disorder, recurrent, severe with psychotic symptoms</i> Major Depressive Disorder, Recurrent episode, With psychotic features
F33.41	<i>Major depressive disorder, recurrent, in partial remission</i> Major Depressive Disorder, Recurrent episode, In partial remission
F33.42	<i>Major depressive disorder, recurrent, in full remission</i> Major Depressive Disorder, Recurrent episode, In full remission
F33.9	<i>Major depressive disorder, recurrent, unspecified</i> Major Depressive Disorder, Recurrent episode, Unspecified
F34.0	<i>Cyclothymic disorder</i> Cyclothymic Disorder
F34.1	<i>Dysthymic disorder</i> Persistent Depressive Disorder (Dysthymia)
F34.81	<i>Disruptive mood dysregulation disorder</i> Disruptive Mood Dysregulation Disorder

## [F40-F49] ANXIETY, DISSOCIATIVE, STRESS-RELATED, SOMATOFORM AND OTHER NONPSYCHOTIC MENTAL DISORDERS

ICD-10-CM Code	Description
F40.00	<i>Agoraphobia, unspecified</i> Agoraphobia
F40.10	<i>Social phobia, unspecified</i> Social Anxiety Disorder (Social Phobia)

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F40.218	Other animal type phobia Specific Phobia, Animal
F40.228	Other natural environment type phobia Specific Phobia, Natural environment
F40.230	Fear of blood Specific Phobia, Blood-injection-injury, Fear of blood
F40.231	Fear of injections and transfusions Specific Phobia, Blood-injection-injury, Fear of injections or transfusions
F40.232	Fear of other medical care Specific Phobia, Blood-injection-injury, Fear of other medical care
F40.233	Fear of injury Specific Phobia, Blood-injection-injury, Fear of injury
F40.248	Other situational type phobia Specific Phobia, Situational
F40.298	Other specified phobia Specific Phobia, Other
F41.0	Panic disorder [episodic paroxysmal anxiety] Panic Disorder
F41.1	Generalized anxiety disorder Generalized Anxiety Disorder
F41.8	Other specified anxiety disorders Other Specified Anxiety Disorder
F41.9	Anxiety disorder, unspecified Unspecified Anxiety Disorder
F42.2	Mixed obsessional thoughts and acts Obsessive-Compulsive Disorder
F42.3	Hoarding disorder Hoarding Disorder
F42.4	Excoriation (skin-picking) disorder Excoriation (Skin-Picking) Disorder
F42.8	Other obsessive-compulsive disorder Other Specified Obsessive-Compulsive and Related Disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F42.9	<i>Obsessive-compulsive disorder, unspecified</i> Unspecified Obsessive-Compulsive and Related Disorder
F43.0	<i>Acute stress reaction</i> Acute Stress Disorder
F43.10	<i>Post-traumatic stress disorder, unspecified</i> Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger)
F43.20	<i>Adjustment disorder, unspecified</i> Adjustment Disorders, Unspecified
F43.21	<i>Adjustment disorder with depressed mood</i> Adjustment Disorders, With depressed mood
F43.22	<i>Adjustment disorder with anxiety</i> Adjustment Disorders, With anxiety
F43.23	<i>Adjustment disorder with mixed anxiety and depressed mood</i> Adjustment Disorders, With mixed anxiety and depressed mood
F43.24	<i>Adjustment disorder with disturbance of conduct</i> Adjustment Disorders, With disturbance of conduct
F43.25	<i>Adjustment disorder with mixed disturbance of emotions and conduct</i> Adjustment Disorders, With mixed disturbance of emotions and conduct
F43.8	<i>Other reactions to severe stress</i> Other specified trauma- and stressor-related disorder
F44.0	<i>Dissociative amnesia</i> Dissociative Amnesia
F44.1	<i>Dissociative fugue</i> Dissociative Amnesia, With dissociative fugue
F44.4	<i>Conversion disorder with motor symptom or deficit</i> Conversion Disorder (Functional Neurological Symptom Disorder), With weakness or paralysis Conversion Disorder (Functional Neurological Symptom Disorder), With abnormal movement Conversion Disorder (Functional Neurological Symptom Disorder), With swallowing symptoms Conversion Disorder (Functional Neurological Symptom Disorder), With speech symptoms
F44.5	<i>Conversion disorder with seizures or convulsions</i> Conversion Disorder (Functional Neurological Symptom Disorder), With attacks or seizures

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F44.6	<i>Conversion disorder with sensory symptom or deficit</i> Conversion Disorder (Functional Neurological Symptom Disorder), With anesthesia or sensory loss Conversion Disorder (Functional Neurological Symptom Disorder), With special sensory symptom
F44.7	<i>Conversion disorder with mixed symptom presentation</i> Conversion Disorder (Functional Neurological Symptom Disorder), With mixed symptoms
F44.81	<i>Dissociative identity disorder</i> Dissociative Identity Disorder
F44.89	<i>Other dissociative and conversion disorders</i> Other Specified Dissociative Disorder
F44.9	<i>Dissociative and conversion disorder, unspecified</i> Unspecified Dissociative Disorder
F45.1	<i>Undifferentiated somatoform disorder</i> Somatic Symptom Disorder
F45.21	<i>Hypochondriasis</i> Illness Anxiety Disorder
F45.22	<i>Body dysmorphic disorder</i> Body Dysmorphic Disorder
F45.8	<i>Other somatoform disorders</i> Other Specified Somatic Symptom and Related Disorder
F45.9	<i>Somatoform disorder, unspecified</i> Unspecified Somatic Symptom and Related Disorder
F48.1	<i>Depersonalization-derealization syndrome</i> Depersonalization/Derealization Disorder

## [F50-F59] BEHAVIORAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS

ICD-10-CM Code	Description
F50.01	<i>Anorexia nervosa, restricting type</i> Anorexia Nervosa, Restricting type
F50.02	<i>Anorexia nervosa, binge eating/purging type</i> Anorexia Nervosa, Binge-eating/purging type
F50.2	<i>Bulimia nervosa</i> Bulimia Nervosa



# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F50.81	<i>Binge eating disorder</i> Binge-Eating Disorder
F50.82	<i>Avoidant/Restrictive Food Intake Disorder</i>
F50.89	<i>Other specified eating disorder</i> Pica, in adults Avoidant/Restrictive Food Intake disorder Other Specified Feeding or Eating Disorder

## [F60-F69] DISORDERS OF ADULT PERSONALITY AND BEHAVIOR

ICD-10-CM Code	Description
F60.0	<i>Paranoid personality disorder</i> Paranoid Personality Disorder
F60.1	<i>Schizoid personality disorder</i> Schizoid Personality Disorder
F60.2	<i>Antisocial personality disorder</i> Antisocial Personality Disorder
F60.3	<i>Borderline personality disorder</i> Borderline Personality Disorder
F60.4	<i>Histrionic personality disorder</i> Histrionic Personality Disorder
F60.5	<i>Obsessive-compulsive personality disorder</i> Obsessive-Compulsive Personality Disorder
F60.6	<i>Avoidant personality disorder</i> Avoidant Personality Disorder
F60.7	<i>Dependent personality disorder</i> Dependent Personality Disorder
F60.81	<i>Narcissistic personality disorder</i> Narcissistic Personality Disorder
F60.89	<i>Other specific personality disorders</i> Other Specified Personality Disorder
F60.9	<i>Personality disorder, unspecified</i> Unspecified Personality Disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F63.81	<i>Intermittent explosive disorder</i> Intermittent explosive disorder
F68.10	<i>Factitious disorder, unspecified</i> Factitious Disorder (includes Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another)

## [F90-F98] BEHAVIORAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILDHOOD AND ADOLESCENCE

ICD-10-CM Code	Description
F90.0	<i>Attention-deficit hyperactivity disorder, predominantly inattentive type</i> Attention-Deficit/Hyperactivity Disorder, Predominantly inattentive presentation
F90.1	<i>Attention-deficit hyperactivity disorder, predominantly hyperactive type</i> Attention-Deficit/Hyperactivity Disorder, Predominantly hyperactive/impulsive presentation
F90.2	<i>Attention-deficit hyperactivity disorder, combined type</i> Attention-Deficit/Hyperactivity Disorder, Combined Presentation
F90.8	<i>Attention-deficit hyperactivity disorder, other type</i> Other Specified Attention-Deficit/Hyperactivity Disorder
F90.9	<i>Attention-deficit hyperactivity disorder, unspecified type</i> Unspecified Attention-Deficit/Hyperactivity Disorder
F91.1	<i>Conduct disorder, childhood-onset type</i> Conduct Disorder, Childhood-onset type
F91.2	<i>Conduct disorder, adolescent-onset type</i> Conduct Disorder, Adolescent-onset type
F91.3	<i>Oppositional defiant disorder</i> Oppositional Defiant Disorder
F91.8	<i>Other conduct disorders</i> Other Specified Disruptive, Impulse-Control, and Conduct Disorder
F91.9	<i>Conduct disorder, unspecified</i> Conduct Disorder, Unspecified onset Unspecified Disruptive, Impulse-Control, and Conduct Disorder
F93.0	<i>Separation anxiety disorder of childhood</i> Separation Anxiety Disorder
F94.0	<i>Selective mutism</i> Selective Mutism

# COVERED DIAGNOSTIC CLASSIFICATIONS

## MENTAL HEALTH SERVICES

ICD-10-CM Code	Description
F94.1	<i>Reactive attachment disorder of childhood</i> Reactive Attachment Disorder
F94.2	<i>Disinhibited attachment disorder of childhood</i> Disinhibited Social Engagement Disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

The diagnoses listed in the following tables are the only covered diagnosis for the BHO system. Descriptions in the tables below that are italicized are the ICD-10-CM description for the ICD-10-CM code. Non-italicized descriptions are from DSM-5.

ICD-10-CM Code	Description
F10.10	<i>Alcohol abuse, uncomplicated</i> Alcohol use disorder, Mild
F10.11	<i>Alcohol abuse, in remission</i> Alcohol use disorder, Mild, in early or sustained remission
F10.121	<i>Alcohol abuse with intoxication, delirium</i> Alcohol intoxication delirium, With mild use disorder
F10.129	<i>Alcohol abuse with intoxication, unspecified</i> Alcohol intoxication, With mild use disorder
F10.14	<i>Alcohol abuse with alcohol-induced mood disorder</i> Alcohol-induced bipolar and related disorder, With mild use disorder Alcohol-induced depressive disorder, With mild use disorder
F10.159	<i>Alcohol abuse with alcohol-induced psychotic disorder, unspecified</i> Alcohol-induced psychotic disorder, With mild use disorder
F10.180	<i>Alcohol abuse with alcohol-induced anxiety disorder</i> Alcohol-induced anxiety disorder, With mild use disorder
F10.181	<i>Alcohol abuse with alcohol-induced sexual dysfunction</i> Alcohol-induced sexual dysfunction, With mild use disorder
F10.182	<i>Alcohol abuse with alcohol-induced sleep disorder</i> Alcohol-induced sleep disorder, With mild use disorder
F10.20	<i>Alcohol dependence, uncomplicated</i> Alcohol use disorder, Moderate Alcohol use disorder, Severe
F10.21	<i>Alcohol dependence, in remission</i> Alcohol use disorder, Moderate, in early or sustained remission Alcohol use disorder, Severe, in early or sustained remission

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F10.221	<i>Alcohol dependence with intoxication delirium</i> Alcohol intoxication delirium, With moderate or severe use disorder
F10.229	<i>Alcohol dependence with intoxication, unspecified</i> Alcohol intoxication, With moderate or severe use disorder
F10.231	<i>Alcohol dependence with withdrawal delirium</i> Alcohol withdrawal delirium
F10.232	<i>Alcohol dependence with withdrawal with perceptual disturbance</i> Alcohol withdrawal, With perceptual disturbances
F10.239	<i>Alcohol dependence with withdrawal, unspecified</i> Alcohol withdrawal, Without perceptual disturbances
F10.24	<i>Alcohol dependence with alcohol-induced mood disorder</i> Alcohol-induced bipolar and related disorder, With moderate or severe use disorder Alcohol-induced depressive disorder, With moderate or severe use disorder
F10.259	<i>Alcohol dependence with alcohol-induced psychotic disorder, unspecified</i> Alcohol-induced psychotic disorder, With moderate or severe use disorder
F10.26	<i>Alcohol dependence with alcohol-induced persisting amnestic disorder</i> Alcohol-induced major neurocognitive disorder, Amnestic confabulatory type, With moderate or severe use disorder
F10.27	<i>Alcohol dependence with alcohol-induced persisting dementia</i> Alcohol-induced major neurocognitive disorder, Nonamnestic confabulatory type, With moderate or severe use disorder
F10.280	<i>Alcohol dependence with alcohol-induced anxiety disorder</i> Alcohol-induced anxiety disorder, With moderate or severe use disorder
F10.281	<i>Alcohol dependence with alcohol-induced sexual dysfunction</i> Alcohol-induced sexual dysfunction, With moderate or severe use disorder
F10.282	<i>Alcohol dependence with alcohol-induced sleep disorder</i> Alcohol-induced sleep disorder, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F10.288	<i>Alcohol dependence with other alcohol-induced disorder</i> Alcohol-induced mild neurocognitive disorder, With moderate or severe use disorder
F10.921	<i>Alcohol use, unspecified with intoxication delirium</i> Alcohol intoxication delirium, Without use disorder
F10.929	<i>Alcohol use, unspecified with intoxication, unspecified</i> Alcohol intoxication, Without use disorder
F10.94	<i>Alcohol use, unspecified with alcohol-induced mood disorder</i> Alcohol-induced bipolar and related disorder, Without use disorder Alcohol-induced depressive disorder, Without use disorder
F10.959	<i>Alcohol use, unspecified with alcohol-induced psychotic disorder, unspecified</i> Alcohol-induced psychotic disorder, Without use disorder
F10.96	<i>Alcohol use, unspecified with alcohol-induced persisting amnestic disorder</i> Alcohol-induced major neurocognitive disorder, Amnestic confabulatory type, Without use disorder
F10.97	<i>Alcohol use, unspecified with alcohol-induced persisting dementia</i> Alcohol-induced major neurocognitive disorder, Nonamnestic confabulatory type, Without use disorder
F10.980	<i>Alcohol use, unspecified with alcohol-induced anxiety disorder</i> Alcohol-induced anxiety disorder, Without use disorder
F10.981	<i>Alcohol use, unspecified with alcohol-induced sexual dysfunction</i> Alcohol-induced sexual dysfunction, Without use disorder
F10.982	<i>Alcohol use, unspecified with alcohol-induced sleep disorder</i> Alcohol-induced sleep disorder, Without use disorder
F10.988	<i>Alcohol use, unspecified with other alcohol-induced disorder</i> Alcohol-induced mild neurocognitive disorder, Without use disorder
F10.99	<i>Alcohol use, unspecified with unspecified alcohol-induced disorder</i> Unspecified alcohol-related disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F11.10	<i>Opioid abuse, uncomplicated</i> Opioid use disorder, Mild
F11.11	<i>Opioid abuse, in remission</i> Opioid use disorder, Mild, in early or sustained remission
F11.121	<i>Opioid abuse with intoxication delirium</i> Opioid intoxication delirium, With mild use disorder
F11.122	<i>Opioid abuse with intoxication with perceptual disturbance</i> Opioid intoxication, With perceptual disturbances, With mild use disorder
F11.129	<i>Opioid abuse with intoxication, unspecified</i> Opioid intoxication, With perceptual disturbances, With mild use disorder
F11.14	<i>Opioid abuse with opioid-induced mood disorder</i> Opioid-induced depressive disorder, With mild use disorder
F11.181	<i>Opioid abuse with opioid-induced sexual dysfunction</i> Opioid-induced sexual dysfunction, With mild use disorder
F11.182	<i>Opioid abuse with opioid-induced sleep disorder</i> Opioid-induced sleep disorder, With mild use disorder
F11.188	<i>Opioid abuse with other opioid-induced disorder</i> Opioid-induced anxiety disorder, With mild use disorder
F11.20	<i>Opioid dependence, uncomplicated</i> Opioid use disorder, Moderate Opioid use disorder, Severe
F11.21	<i>Opioid dependence, in remission</i> Opioid use disorder, Moderate, in early or sustained remission Opioid use disorder, Severe, in early or sustained remission
F11.221	<i>Opioid dependence with intoxication delirium</i> Opioid intoxication delirium, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F11.222	<i>Opioid dependence with intoxication with perceptual disturbance</i> Opioid intoxication, with perceptual disturbances, With moderate or severe use disorder
F11.229	<i>Opioid dependence with intoxication, unspecified</i> Opioid intoxication, Without perceptual disturbances, With moderate or severe use disorder
F11.23	<i>Opioid dependence with withdrawal</i> Opioid withdrawal Opioid withdrawal delirium
F11.24	<i>Opioid dependence with opioid-induced mood disorder</i> Opioid-induced depressive disorder, With moderate or severe use disorder
F11.281	<i>Opioid dependence with opioid-induced sexual dysfunction</i> Opioid-induced sexual dysfunction, With moderate or severe use disorder
F11.282	<i>Opioid dependence with opioid-induced sleep disorder</i> Opioid-induced sleep disorder, With moderate or severe use disorder
F11.288	<i>Opioid dependence with other opioid-induced disorder</i> Opioid-induced anxiety disorder, With moderate or severe use disorder
F11.921	<i>Opioid use, unspecified with intoxication delirium</i> Opioid-induced delirium Opioid intoxication delirium, Without use disorder
F11.922	<i>Opioid use, unspecified with intoxication with perceptual disturbance</i> Opioid intoxication, With perceptual disturbances, Without use disorder
F11.929	<i>Opioid use, unspecified with intoxication, unspecified</i> Opioid intoxication, Without perceptual disturbances Without use disorder
F11.94	<i>Opioid use, unspecified with opioid-induced mood disorder</i> Opioid-induced depressive disorder, Without use disorder
F11.981	<i>Opioid use, unspecified with opioid-induced sexual dysfunction</i> Opioid-induced sexual dysfunction, Without use disorder



# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F11.982	<i>Opioid use, unspecified with opioid-induced sleep disorder</i> Opioid-induced sleep disorder, Without use disorder
F11.988	<i>Opioid use, unspecified with other opioid-induced disorder</i> Opioid-induced anxiety disorder, Without use disorder
F11.99	<i>Opioid use, unspecified with unspecified opioid-induced disorder</i> Unspecified opioid-related disorder
F12.10	<i>Cannabis abuse, uncomplicated</i> Cannabis use disorder, Mild
F12.11	<i>Cannabis abuse, in remission</i> Cannabis use disorder, Mild, in early or sustained remission
F12.121	<i>Cannabis abuse with intoxication delirium</i> Cannabis intoxication delirium, With mild use disorder
F12.122	<i>Cannabis abuse with intoxication with perceptual disturbance</i> Cannabis intoxication, With perceptual disturbances, With mild use disorder
F12.129	<i>Cannabis abuse with intoxication, unspecified</i> Cannabis intoxication, Without perceptual disturbances, With mild use disorder
F12.159	<i>Cannabis abuse with psychotic disorder, unspecified</i> Cannabis-induced psychotic disorder, With mild use disorder
F12.180	<i>Cannabis abuse with cannabis-induced anxiety disorder</i> Cannabis-induced anxiety disorder, With mild use disorder
F12.188	<i>Cannabis abuse with other cannabis-induced disorder</i> Cannabis-induced sleep disorder, With mild use disorder
F12.20	<i>Cannabis dependence, uncomplicated</i> Cannabis use disorder, Moderate Cannabis use disorder, Severe

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F12.21	<i>Cannabis dependence, in remission</i> Cannabis use disorder, Moderate, in early or sustained remission Cannabis use disorder, Severe, in early or sustained remission
F12.221	<i>Cannabis dependence with intoxication delirium</i> Cannabis intoxication delirium, With moderate or severe use disorder
F12.222	<i>Cannabis dependence with intoxication with perceptual disturbance</i> Cannabis intoxication, With perceptual disturbances, With moderate or severe use disorder
F12.229	<i>Cannabis dependence with intoxication, unspecified</i> Cannabis intoxication, With perceptual disturbances, With moderate or severe use disorder
F12.259	<i>Cannabis dependence with psychotic disorder, unspecified</i> Cannabis-induced psychotic disorder, With moderate or severe use disorder
F12.280	<i>Cannabis dependence with cannabis-induced anxiety disorder</i> Cannabis-induced anxiety disorder, With moderate or severe use disorder
F12.288	<i>Cannabis dependence with other cannabis-induced disorder</i> Cannabis-induced sleep disorder, With moderate or severe use disorder Cannabis withdrawal
F12.921	<i>Cannabis use, unspecified with intoxication delirium</i> Cannabis intoxication delirium, Without use disorder
F12.922	<i>Cannabis use, unspecified with intoxication with perceptual disturbance</i> Cannabis intoxication, With perceptual disturbances, Without use disorder
F12.929	<i>Cannabis use, unspecified with intoxication, unspecified</i> Cannabis intoxication, Without perceptual disturbances, Without use disorder
F12.959	<i>Cannabis use, unspecified with psychotic disorder, unspecified</i> Cannabis-induced psychotic disorder, Without use disorder
F12.980	<i>Cannabis use, unspecified with anxiety disorder</i> Cannabis-induced anxiety disorder, Without use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F12.988	<i>Cannabis use, unspecified with other cannabis-induced disorder</i> Cannabis-induced sleep disorder, Without use disorder
F12.99	<i>Cannabis use, unspecified with unspecified cannabis-induced disorder</i> Unspecified cannabis-related disorder
F13.10	<i>Sedative, hypnotic or anxiolytic abuse, uncomplicated</i> Sedative, hypnotic, or anxiolytic use disorder, Mild
F13.11	<i>Sedative, hypnotic or anxiolytic abuse, in remission</i> Sedative, hypnotic, or anxiolytic use disorder, Mild, in early or sustained remission
F13.121	<i>Sedative, hypnotic or anxiolytic abuse with intoxication delirium</i> Sedative, hypnotic, or anxiolytic intoxication delirium, With mild use disorder
F13.129	<i>Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified</i> Sedative, hypnotic, or anxiolytic intoxication, With mild use disorder
F13.14	<i>Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder</i> Sedative-, hypnotic-, or anxiolytic-induced bipolar and related disorder, With mild use disorder Sedative-, hypnotic-, or anxiolytic-induced depressive disorder, With mild use disorder
F13.159	<i>Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified</i> Sedative-, hypnotic-, or anxiolytic-induced psychotic disorder, With mild use disorder
F13.180	<i>Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced anxiety disorder</i> Sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, With mild use disorder
F13.181	<i>Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sexual dysfunction</i> Sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction, With mild use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F13.182	<i>Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced sleep disorder</i> Sedative-, hypnotic-, or anxiolytic-induced sleep disorder, With mild use disorder
F13.20	<i>Sedative, hypnotic or anxiolytic dependence, uncomplicated</i> Sedative, hypnotic, or anxiolytic use disorder, Moderate Sedative, hypnotic, or anxiolytic use disorder, Severe
F13.21	<i>Sedative, hypnotic or anxiolytic dependence, in remission</i> Sedative, hypnotic or anxiolytic use disorder, Moderate, in early or sustained remission Sedative, hypnotic or anxiolytic use disorder, Severe, in early or sustained remission
F13.221	<i>Sedative, hypnotic or anxiolytic dependence with intoxication delirium</i> Sedative, hypnotic, or anxiolytic intoxication delirium, With moderate or severe use disorder
F13.229	<i>Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified</i> Sedative, hypnotic, or anxiolytic intoxication, With moderate or severe use disorder
F13.231	<i>Sedative, hypnotic or anxiolytic dependence with withdrawal delirium</i> Sedative, hypnotic, or anxiolytic withdrawal delirium
F13.232	<i>Sedative, hypnotic or anxiolytic dependence with withdrawal with perceptual disturbance</i> Sedative, hypnotic, or anxiolytic withdrawal, With perceptual disturbances
F13.239	<i>Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified</i> Sedative, hypnotic, or anxiolytic withdrawal, Without perceptual disturbances
F13.24	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced mood disorder</i> Sedative-, hypnotic, or anxiolytic-induced bipolar and related disorder, With moderate or severe use disorder Sedative-, hypnotic, or anxiolytic-induced depressive disorder, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F13.259	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified</i> Sedative-, hypnotic-, or anxiolytic-induced psychotic disorder, With moderate or severe use disorder
F13.27	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced persisting dementia</i> Sedative-, hypnotic-, or anxiolytic-induced major neurocognitive disorder, With moderate or severe use disorder
F13.280	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced anxiety disorder</i> Sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, With moderate or severe use disorder
F13.281	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sexual dysfunction</i> Sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction, With moderate or severe use disorder
F13.282	<i>Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder</i> Sedative-, hypnotic-, or anxiolytic-induced sleep disorder, With moderate or severe use disorder
F13.288	<i>Sedative, hypnotic or anxiolytic dependence with other sedative, hypnotic or anxiolytic-induced disorder</i> Sedative-, hypnotic-, or anxiolytic-induced mild neurocognitive disorder, With moderate or severe use disorder
F13.921	<i>Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium</i> Sedative-, hypnotic-, or anxiolytic-induced delirium Sedative-, hypnotic-, or anxiolytic intoxication delirium, Without use disorder
F13.929	<i>Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified</i> Sedative, hypnotic, or anxiolytic intoxication, Without use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F13.94	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced mood disorder</i> Sedative-, hypnotic-, or anxiolytic-induced bipolar and related disorder, Without use disorder Sedative-, hypnotic-, or anxiolytic-induced depressive disorder, Without use disorder
F13.959	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced psychotic disorder, unspecified</i> Sedative-, hypnotic-, or anxiolytic-induced psychotic disorder, Without use disorder
F13.97	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced persisting dementia</i> Sedative-, hypnotic-, or anxiolytic-induced major neurocognitive disorder, Without use disorder
F13.980	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced anxiety disorder</i> Sedative-, hypnotic-, or anxiolytic-induced anxiety disorder, Without use disorder
F13.981	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sexual dysfunction</i> Sedative-, hypnotic-, or anxiolytic-induced sexual dysfunction, Without use disorder
F13.982	<i>Sedative, hypnotic or anxiolytic use, unspecified with sedative, hypnotic or anxiolytic-induced sleep disorder</i> Sedative-, hypnotic-, or anxiolytic-induced sleep disorder, Without use disorder
F13.988	<i>Sedative, hypnotic or anxiolytic use, unspecified with other sedative, hypnotic or anxiolytic-induced disorder</i> Sedative-, hypnotic-, or anxiolytic-induced mild neurocognitive disorder, Without use disorder
F13.99	<i>Sedative, hypnotic or anxiolytic use, unspecified with unspecified sedative, hypnotic or anxiolytic-induced disorder</i> Unspecified sedative-, hypnotic-, or anxiolytic-related disorder
F14.10	<i>Cocaine abuse, uncomplicated</i> Cocaine use disorder, Mild

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F14.11	<i>Cocaine abuse, in remission</i> Cocaine use disorder, Mild, in early or sustained remission
F14.121	<i>Cocaine abuse with intoxication with delirium</i> Cocaine intoxication delirium, With mild use disorder
F14.122	<i>Cocaine abuse with intoxication with perceptual disturbance</i> Cocaine intoxication, With perceptual disturbances, With mild use disorder
F14.129	<i>Cocaine abuse with intoxication, unspecified</i> Cocaine intoxication, Without perceptual disturbances, With mild use disorder
F14.14	<i>Cocaine abuse with cocaine-induced mood disorder</i> Cocaine-induced bipolar and related disorder, With mild use disorder Cocaine-induced depressive disorder, With mild use disorder
F14.159	<i>Cocaine abuse with cocaine-induced psychotic disorder, unspecified</i> Cocaine-induced psychotic disorder, With mild use disorder
F14.180	<i>Cocaine abuse with cocaine-induced anxiety disorder</i> Cocaine-induced anxiety disorder, With mild use disorder
F14.181	<i>Cocaine abuse with cocaine-induced sexual dysfunction</i> Cocaine-induced sexual dysfunction, With mild use disorder
F14.182	<i>Cocaine abuse with cocaine-induced sleep disorder</i> Cocaine-induced sleep disorder, With mild use disorder
F14.188	<i>Cocaine abuse with other cocaine-induced disorder</i> Cocaine-induced obsessive-compulsive and related disorder, With mild use disorder
F14.20	<i>Cocaine dependence, uncomplicated</i> Cocaine use disorder, Moderate Cocaine use disorder, Severe
F14.21	<i>Cocaine dependence, in remission</i> Cocaine use disorder, Moderate, in early or sustained remission Cocaine use disorder, Severe, in early or sustained remission

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F14.221	<i>Cocaine dependence with intoxication delirium</i> Cocaine intoxication delirium, With moderate or severe use disorder
F14.222	<i>Cocaine dependence with intoxication with perceptual disturbance</i> Cocaine intoxication, With perceptual disturbances, With moderate or severe use disorder
F14.229	<i>Cocaine dependence with intoxication, unspecified</i> Cocaine intoxication, Without perceptual disturbances, With moderate or severe use disorder
F14.23	<i>Cocaine dependence with withdrawal</i> Cocaine withdrawal
F14.24	<i>Cocaine dependence with cocaine-induced mood disorder</i> Cocaine-induced bipolar and related disorder, With moderate or severe use disorder Cocaine-induced depressive disorder, With moderate or severe use disorder
F14.259	<i>Cocaine dependence with cocaine-induced psychotic disorder, unspecified</i> Cocaine-induced psychotic disorder, With moderate or severe use disorder
F14.280	<i>Cocaine dependence with cocaine-induced anxiety disorder</i> Cocaine-induced anxiety disorder, With moderate or severe use disorder
F14.281	<i>Cocaine dependence with cocaine-induced sexual dysfunction</i> Cocaine-induced sexual dysfunction, With moderate or severe use disorder
F14.282	<i>Cocaine dependence with cocaine-induced sleep disorder</i> Cocaine-induced sleep disorder, With moderate or severe use disorder
F14.288	<i>Cocaine dependence with other cocaine-induced disorder</i> Cocaine-induced obsessive-compulsive and related disorder, With moderate or severe use disorder
F14.921	<i>Cocaine use, unspecified with intoxication delirium</i> Cocaine intoxication delirium, Without use disorder
F14.922	<i>Cocaine use, unspecified with intoxication with perceptual disturbance</i> Cocaine intoxication, With perceptual disturbances, Without use disorder



# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F14.929	<i>Cocaine use, unspecified with intoxication, unspecified</i> Cocaine intoxication, Without perceptual disturbances, Without use disorder
F14.94	<i>Cocaine use, unspecified with cocaine-induced mood disorder</i> Cocaine-induced bipolar and related disorder, Without use disorder Cocaine-induced depressive disorder, Without use disorder
F14.959	<i>Cocaine use, unspecified with cocaine-induced psychotic disorder, unspecified</i> Cocaine-induced psychotic disorder, Without use disorder
F14.980	<i>Cocaine use, unspecified with cocaine-induced anxiety disorder</i> Cocaine-induced anxiety disorder, Without use disorder
F14.981	<i>Cocaine use, unspecified with cocaine-induced sexual dysfunction</i> Cocaine-induced sexual dysfunction, Without use disorder
F14.982	<i>Cocaine use, unspecified with cocaine-induced sleep disorder</i> Cocaine-induced sleep disorder, Without use disorder
F14.988	<i>Cocaine use, unspecified with other cocaine-induced disorder</i> Cocaine-induced obsessive-compulsive and related disorder, Without use disorder
F14.99	<i>Cocaine use, unspecified with unspecified cocaine-induced disorder</i> Unspecified stimulant-related disorder, Unspecified Cocaine-related disorder
F15.10	<i>Other stimulant abuse, uncomplicated</i> Amphetamine-type substance use disorder, Mild Other or unspecified stimulant use disorder, Mild
F15.11	<i>Other stimulant abuse, in remission</i> Amphetamine-type substance use disorder, Mild, in early or sustained remission
F15.121	<i>Other stimulant abuse with intoxication delirium</i> Amphetamine (or other stimulant) intoxication delirium, With mild use disorder
F15.122	<i>Other stimulant abuse with intoxication with perceptual disturbance</i> Amphetamine or other stimulant intoxication, With perceptual disturbances, With mild use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F15.129	<i>Other stimulant abuse with intoxication, unspecified</i> Amphetamine or other stimulant intoxication, Without perceptual disturbances, With mild use disorder
F15.14	<i>Other stimulant abuse with stimulant-induced mood disorder</i> Amphetamine (or other stimulant)-induced bipolar and related disorder, With mild use disorder Amphetamine (or other stimulant)-induced depressive disorder, With mild use disorder
F15.159	<i>Other stimulant abuse with stimulant-induced psychotic disorder, unspecified</i> Amphetamine (or other stimulant)-induced psychotic disorder, With mild use disorder
F15.180	<i>Other stimulant abuse with stimulant-induced anxiety disorder</i> Amphetamine (or other stimulant)-induced anxiety disorder, With mild use disorder Caffeine-induced anxiety disorder, With mild use disorder
F15.181	<i>Other stimulant abuse with stimulant-induced sexual dysfunction</i> Amphetamine (or other stimulant)-induced sexual dysfunction, With mild use disorder
F15.182	<i>Other stimulant abuse with stimulant-induced sleep disorder</i> Amphetamine (or other stimulant)-induced sleep disorder, With mild use disorder Caffeine-induced sleep disorder, With mild use disorder
F15.188	<i>Other stimulant abuse with other stimulant-induced disorder</i> Amphetamine (or other stimulant)-induced obsessive-compulsive and related disorder, With mild use disorder
F15.20	<i>Other stimulant dependence, uncomplicated</i> Amphetamine-type substance use disorder, Moderate Amphetamine-type substance use disorder, Severe Other or unspecified stimulant use disorder, Moderate Other or unspecified stimulant use disorder, Severe

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F15.21	<i>Other stimulant dependence, in remission</i> Amphetamine-type substance use disorder, Moderate, in early or sustained remission Amphetamine-type substance use disorder, Severe, in early or sustained remission
F15.221	<i>Other stimulant dependence with intoxication delirium</i> Amphetamine (or other stimulant) intoxication delirium, With moderate or severe use disorder
F15.222	<i>Other stimulant dependence with intoxication with perceptual disturbance</i> Amphetamine or other stimulant intoxication, With perceptual disturbances, With moderate or severe use disorder
F15.229	<i>Other stimulant dependence with intoxication, unspecified</i> Amphetamine or other stimulant intoxication, Without perceptual disturbances, With moderate or severe use disorder
F15.23	<i>Other stimulant dependence with withdrawal</i> Amphetamine or other stimulant withdrawal
F15.24	<i>Other stimulant dependence with stimulant-induced mood disorder</i> Amphetamine (or other stimulant)-induced bipolar and related disorder, With moderate or severe use disorder Amphetamine (or other stimulant)-induced depressive disorder, With moderate or severe use disorder
F15.259	<i>Other stimulant dependence with stimulant-induced psychotic disorder, unspecified</i> Amphetamine (or other stimulant)-induced psychotic disorder, With moderate or severe use disorder
F15.280	<i>Other stimulant dependence with stimulant-induced anxiety disorder</i> Amphetamine (or other stimulant)-induced anxiety disorder, With moderate or severe use disorder Caffeine-induced anxiety disorder, With moderate or severe use disorder
F15.281	<i>Other stimulant dependence with stimulant-induced sexual dysfunction</i> Amphetamine (or other stimulant)-induced sexual dysfunction, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F15.282	<i>Other stimulant dependence with stimulant-induced sleep disorder</i> Amphetamine (or other stimulant)-induced sleep disorder, With moderate or severe use disorder Caffeine-induced sleep disorder, With moderate or severe use disorder
F15.288	<i>Other stimulant dependence with other stimulant-induced disorder</i> Amphetamine (or other stimulant)-induced obsessive-compulsive and related disorder, With moderate or severe use disorder
F15.921	<i>Other stimulant use, unspecified with intoxication delirium</i> Amphetamine (or other stimulant)-induced delirium Amphetamine (or other stimulant) intoxication delirium, Without use disorder
F15.922	<i>Other stimulant use, unspecified with intoxication with perceptual disturbance</i> Amphetamine or other stimulant intoxication, With perceptual disturbances, Without use disorder
F15.929	<i>Other stimulant use, unspecified with intoxication, unspecified</i> Amphetamine or other stimulant intoxication, Without perceptual disturbances, Without use disorder Caffeine intoxication
F15.93	<i>Other stimulant use, unspecified with withdrawal</i> Caffeine withdrawal
F15.94	<i>Other stimulant use, unspecified with stimulant-induced mood disorder</i> Amphetamine (or other stimulant)-induced bipolar and related disorder, Without use disorder Amphetamine (or other stimulant)-induced depressive disorder, Without use disorder
F15.959	<i>Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified</i> Amphetamine (or other stimulant)-induced psychotic disorder, Without use disorder
F15.980	<i>Other stimulant use, unspecified with stimulant-induced anxiety disorder</i> Amphetamine (or other stimulant)-induced anxiety disorder, Without use disorder Caffeine-induced anxiety disorder, Without use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F15.981	<i>Other stimulant use, unspecified with stimulant-induced sexual dysfunction</i> Amphetamine (or other stimulant)-induced sexual dysfunction, Without use disorder
F15.982	<i>Other stimulant use, unspecified with stimulant-induced sleep disorder</i> Amphetamine (or other stimulant)-induced sleep disorder, Without use disorder Caffeine-induced sleep disorder, Without use disorder
F15.988	<i>Other stimulant use, unspecified with other stimulant-induced disorder</i> Amphetamine (or other stimulant)-induced obsessive-compulsive and related disorder, Without use disorder
F15.99	<i>Other stimulant use, unspecified with unspecified stimulant-induced disorder</i> Unspecified amphetamine or other stimulant-related disorder Unspecified caffeine-related disorder
F16.10	<i>Hallucinogen abuse, uncomplicated</i> Other hallucinogen use disorder, Mild Phencyclidine use disorder, Mild
F16.11	<i>Hallucinogen abuse, in remission</i> Other hallucinogen use disorder, Mild, in early or sustained remission Phencyclidine use disorder, Mild, in early or sustained remission
F16.121	<i>Hallucinogen abuse with intoxication with delirium</i> Other hallucinogen intoxication delirium, With mild use disorder Phencyclidine intoxication delirium, With mild use disorder
F16.129	<i>Hallucinogen abuse with intoxication, unspecified</i> Other hallucinogen intoxication, With mild use disorder Phencyclidine intoxication, With mild use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F16.14	<p><i>Hallucinogen abuse with hallucinogen-induced mood disorder</i></p> <p>Other hallucinogen-induced bipolar and related disorder, With mild use disorder</p> <p>Other hallucinogen-induced depressive disorder, With mild use disorder</p> <p>Phencyclidine-induced bipolar and related disorder, With mild use disorder</p> <p>Phencyclidine-induced depressive disorder, With mild use disorder</p>
F16.159	<p><i>Hallucinogen abuse with hallucinogen-induced psychotic disorder, unspecified</i></p> <p>Other hallucinogen-induced psychotic disorder, With mild use disorder</p> <p>Phencyclidine-induced psychotic disorder, With mild use disorder</p>
F16.180	<p><i>Hallucinogen abuse with hallucinogen-induced anxiety disorder</i></p> <p>Other hallucinogen-induced anxiety disorder, With mild use disorder</p> <p>Phencyclidine-induced anxiety disorder, With mild use disorder</p>
F16.20	<p><i>Hallucinogen dependence, uncomplicated</i></p> <p>Other hallucinogen use disorder, Moderate</p> <p>Other hallucinogen use disorder, Severe</p> <p>Phencyclidine use disorder, Moderate</p> <p>Phencyclidine use disorder, Severe</p>
F16.21	<p><i>Hallucinogen dependence, in remission</i></p> <p>Other hallucinogen use disorder, Moderate, in early or sustained remission</p> <p>Other hallucinogen use disorder, Severe, in early or sustained remission</p> <p>Phencyclidine use disorder, Moderate, in early or sustained remission</p> <p>Phencyclidine use disorder, Severe, in early or sustained remission</p>
F16.221	<p><i>Hallucinogen dependence with intoxication with delirium</i></p> <p>Other hallucinogen intoxication delirium, With moderate or severe use disorder</p> <p>Phencyclidine intoxication delirium, With moderate or severe use disorder</p>
F16.229	<p><i>Hallucinogen dependence with intoxication, unspecified</i></p> <p>Other hallucinogen intoxication, With moderate or severe use disorder</p> <p>Phencyclidine intoxication, With moderate or severe use disorder</p>

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F16.24	<p><i>Hallucinogen dependence with hallucinogen-induced mood disorder</i></p> <p>Other hallucinogen-induced bipolar and related disorder, With moderate or severe use disorder</p> <p>Other hallucinogen-induced depressive disorder, With moderate or severe use disorder</p> <p>Phencyclidine-induced depressive bipolar and related disorder, With moderate or severe use disorder</p> <p>Phencyclidine-induced depressive disorder, With moderate or severe use disorder</p>
F16.259	<p><i>Hallucinogen dependence with hallucinogen-induced psychotic disorder, unspecified</i></p> <p>Other hallucinogen-induced psychotic disorder, With moderate or severe use disorder</p> <p>Phencyclidine-induced psychotic disorder, With moderate or severe use disorder</p>
F16.280	<p><i>Hallucinogen dependence with hallucinogen-induced anxiety disorder</i></p> <p>Other hallucinogen-induced anxiety disorder, With moderate or severe use disorder</p> <p>Phencyclidine-induced anxiety disorder, With moderate or severe use disorder</p>
F16.921	<p><i>Hallucinogen use, unspecified with intoxication with delirium</i></p> <p>Other hallucinogen intoxication delirium, Without use disorder</p> <p>Phencyclidine intoxication delirium, Without use disorder</p>
F16.929	<p><i>Hallucinogen use, unspecified with intoxication, unspecified</i></p> <p>Other hallucinogen intoxication, Without use disorder</p> <p>Phencyclidine intoxication, Without use disorder</p>
F16.94	<p><i>Hallucinogen use, unspecified with hallucinogen-induced mood disorder</i></p> <p>Other hallucinogen-induced bipolar and related disorder, Without use disorder</p> <p>Other hallucinogen-induced depressive disorder, Without use disorder</p> <p>Phencyclidine-induced bipolar and related disorder, Without use disorder</p> <p>Phencyclidine-induced depressive disorder, Without use disorder</p>
F16.959	<p><i>Hallucinogen use, unspecified with hallucinogen-induced psychotic disorder, unspecified</i></p> <p>Other hallucinogen-induced psychotic disorder, Without use disorder</p> <p>Phencyclidine-induced psychotic disorder, Without use disorder</p>

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F16.980	<i>Hallucinogen use, unspecified with hallucinogen-induced anxiety disorder</i> Other hallucinogen-induced anxiety disorder, Without use disorder Phencyclidine-induced anxiety disorder, Without use disorder
F16.983	<i>Hallucinogen use, unspecified with hallucinogen persisting perception disorder (flashbacks)</i> Hallucinogen persisting perception disorder
F16.99	<i>Hallucinogen use, unspecified with unspecified hallucinogen-induced disorder</i> Unspecified hallucinogen-related disorder Unspecified phencyclidine-related disorder
F17.200	<i>Nicotine dependence, unspecified, uncomplicated</i> Tobacco use disorder, Moderate Tobacco use disorder, Severe
F17.201	<i>Nicotine dependence, unspecified, in remission</i> Tobacco use disorder, Moderate, in early or sustained remission Tobacco use disorder, Severe, in early or sustained remission
F17.203	<i>Nicotine dependence, unspecified, with withdrawal</i> Tobacco withdrawal
F17.208	<i>Nicotine dependence, unspecified, with other nicotine-induced disorders</i> Tobacco-induced sleep disorder, With moderate or severe use disorder
F17.209	<i>Nicotine dependence, unspecified, with unspecified nicotine-induced disorders</i> Unspecified tobacco-related disorder
F18.10	<i>Inhalant abuse, uncomplicated</i> Inhalant use disorder, Mild
F18.11	<i>Inhalant abuse, in remission</i> Inhalant use disorder, Mild, in early or sustained remission
F18.121	<i>Inhalant abuse with intoxication delirium</i> Inhalant intoxication delirium, With mild use disorder



# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F18.129	<i>Inhalant abuse with intoxication, unspecified</i> Inhalant intoxication, With mild use disorder
F18.14	<i>Inhalant abuse with inhalant-induced mood disorder</i> Inhalant-induced depressive disorder, With mild use disorder
F18.159	<i>Inhalant abuse with inhalant-induced psychotic disorder, unspecified</i> Inhalant-induced psychotic disorder, With mild use disorder
F18.17	<i>Inhalant abuse with inhalant-induced dementia</i> Inhalant-induced major neurocognitive disorder, With mild use disorder
F18.180	<i>Inhalant abuse with inhalant-induced anxiety disorder</i> Inhalant-induced anxiety disorder, With mild use disorder
F18.188	<i>Inhalant abuse with other inhalant-induced disorder</i> Inhalant-induced mild neurocognitive disorder, With mild use disorder
F18.20	<i>Inhalant dependence, uncomplicated</i> Inhalant use disorder, Moderate Inhalant use disorder, Severe
F18.21	<i>Inhalant dependence, in remission</i> Inhalant use disorder, Moderate, in early or sustained remission Inhalant use disorder, Severe, in early or sustained remission
F18.221	<i>Inhalant dependence with intoxication delirium</i> Inhalant intoxication delirium, With moderate or severe use disorder
F18.229	<i>Inhalant dependence with intoxication, unspecified</i> Inhalant intoxication, With moderate or severe use disorder
F18.24	<i>Inhalant dependence with inhalant-induced mood disorder</i> Inhalant-induced depressive disorder, With moderate or severe use disorder
F18.259	<i>Inhalant dependence with inhalant-induced psychotic disorder, unspecified</i> Inhalant-induced psychotic disorder, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F18.27	<i>Inhalant dependence with inhalant-induced dementia</i> Inhalant-induced major neurocognitive disorder, With moderate or severe use disorder
F18.280	<i>Inhalant dependence with inhalant-induced anxiety disorder</i> Inhalant-induced anxiety disorder, With moderate or severe use disorder
F18.288	<i>Inhalant dependence with other inhalant-induced disorder</i> Inhalant-induced mild neurocognitive disorder, With moderate or severe use disorder
F18.921	<i>Inhalant use, unspecified with intoxication with delirium</i> Inhalant intoxication delirium, Without use disorder
F18.929	<i>Inhalant use, unspecified with intoxication, unspecified</i> Inhalant intoxication, Without use disorder
F18.94	<i>Inhalant use, unspecified with inhalant-induced mood disorder</i> Inhalant-induced depressive disorder, Without use disorder
F18.959	<i>Inhalant use, unspecified with inhalant-induced psychotic disorder, unspecified</i> Inhalant-induced psychotic disorder, Without use disorder
F18.97	<i>Inhalant use, unspecified with inhalant-induced persisting dementia</i> Inhalant-induced major neurocognitive disorder, Without use disorder
F18.980	<i>Inhalant use, unspecified with inhalant-induced anxiety disorder</i> Inhalant-induced anxiety disorder, Without use disorder
F18.988	<i>Inhalant use, unspecified with other inhalant-induced disorder</i> Inhalant-induced mild neurocognitive disorder, Without use disorder
F18.99	<i>Inhalant use, unspecified with unspecified inhalant-induced disorder</i> Unspecified inhalant-related disorder
F19.10	<i>Other psychoactive substance abuse, uncomplicated</i> Other (or unknown) substance use disorder, Mild
F19.11	<i>Other psychoactive substance abuse, in remission</i> Other (or unknown) substance use disorder, Mild, in early or sustained remission

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F19.121	<i>Other psychoactive substance abuse with intoxication delirium</i> Other (or unknown) substance intoxication delirium, With mild use disorder
F19.129	<i>Other psychoactive substance abuse with intoxication, unspecified</i> Other (or unknown) substance intoxication, With mild use disorder
F19.14	<i>Other psychoactive substance abuse with psychoactive substance-induced mood disorder</i> Other (or unknown) substance-induced bipolar and related disorder, With mild use disorder Other (or unknown) substance-induced depressive disorder, With mild use disorder
F19.159	<i>Other psychoactive substance abuse with psychoactive substance-induced psychotic disorder, unspecified</i> Other (or unknown) substance-induced psychotic disorder, With mild use disorder
F19.17	<i>Other psychoactive substance abuse with psychoactive substance-induced persisting dementia</i> Other (or unknown) substance-induced major neurocognitive disorder, With mild use disorder
F19.180	<i>Other psychoactive substance abuse with psychoactive substance-induced anxiety disorder</i> Other (or unknown) substance-induced anxiety disorder, With mild use disorder
F19.181	<i>Other psychoactive substance abuse with psychoactive substance-induced sexual dysfunction</i> Other (or unknown) substance-induced sexual dysfunction, With mild use disorder
F19.182	<i>Other psychoactive substance abuse with psychoactive substance-induced sleep disorder</i> Other (or unknown) substance-induced sleep disorder, With mild use disorder
F19.188	<i>Other psychoactive substance abuse with other psychoactive substance-induced disorder</i> Other (or unknown) substance-induced mild neurocognitive disorder, With mild use disorder Other (or unknown) substance-induced obsessive-compulsive and related disorder, With mild use disorder
F19.20	<i>Other psychoactive substance dependence, uncomplicated</i> Other (or unknown) substance use disorder, Moderate Other (or unknown) substance use disorder, Severe

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F19.21	<i>Other psychoactive substance dependence, in remission</i> Other (or unknown) substance use disorder, Moderate, in early or sustained remission Other (or unknown) substance use disorder, Severe, in early or sustained remission
F19.221	<i>Other psychoactive substance dependence with intoxication delirium</i> Other (or unknown) substance intoxication delirium, With moderate or severe use disorder
F19.229	<i>Other psychoactive substance dependence with intoxication, unspecified</i> Other (or unknown) substance intoxication, With moderate or severe use disorder
F19.231	<i>Other psychoactive substance dependence with intoxication with withdrawal delirium</i> Other (or unknown) substance withdrawal delirium
F19.239	<i>Other psychoactive substance dependence with withdrawal, unspecified</i> Other (or unknown) substance withdrawal
F19.24	<i>Other psychoactive substance dependence with psychoactive substance-induced mood disorder</i> Other (or unknown) substance-induced bipolar and related disorder, With moderate or severe use disorder Other (or unknown) substance-induced depressive disorder, With moderate or severe use disorder
F19.259	<i>Other psychoactive substance dependence with psychoactive substance-induced psychotic disorder, unspecified</i> Other (or unknown) substance-induced psychotic disorder, With moderate or severe use disorder
F19.27	<i>Other psychoactive substance dependence with psychoactive substance-induced persistent dementia</i> Other (or unknown) substance-induced major neurocognitive disorder, With moderate or severe use disorder
F19.280	<i>Other psychoactive substance dependence with psychoactive substance-induced anxiety disorder</i> Other (or unknown) substance-induced anxiety disorder, With moderate or severe use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F19.281	<i>Other psychoactive substance dependence with psychoactive substance-induced sexual dysfunction</i> Other (or unknown) substance-induced sexual dysfunction, With moderate or severe use disorder
F19.282	<i>Other psychoactive substance dependence with psychoactive substance-induced disorder</i> Other (or unknown) substance-induced sleep disorder, With moderate or severe use disorder
F19.288	<i>Other psychoactive substance dependence with other psychoactive substance-induced disorder</i> Other (or unknown) substance-induced mild neurocognitive disorder, With moderate or severe use disorder Other (or unknown) substance-induced obsessive-compulsive and related disorder, With moderate or severe use disorder
F19.921	<i>Other psychoactive substance use, unspecified with intoxication with delirium</i> Other (or unknown) substance-induced delirium Other (or unknown) substance intoxication delirium, Without use disorder
F19.929	<i>Other psychoactive substance use, unspecified with intoxication, unspecified</i> Other (or unknown) substance intoxication, Without use disorder
F19.94	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced mood disorder</i> Other (or unknown) substance-induced bipolar and related disorder, Without use disorder Other (or unknown) substance-induced depressive disorder, Without use disorder
F19.959	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced psychotic disorder, unspecified</i> Other (or unknown) substance-induced psychotic disorder, Without use disorder
F19.97	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced persisting dementia</i> Other (or unknown) substance-induced major neurocognitive disorder, Without use disorder

# COVERED DIAGNOSTIC CLASSIFICATIONS

## SUBSTANCE USE DISORDER SERVICES

ICD-10-CM Code	Description
F19.980	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced anxiety disorder</i> Other (or unknown) substance-induced anxiety disorder, Without use disorder
F19.981	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced sexual dysfunction</i> Other (or unknown) substance-induced sexual dysfunction, Without use disorder
F19.982	<i>Other psychoactive substance use, unspecified with psychoactive substance-induced sleep disorder</i> Other (or unknown) substance-induced sleep disorder, Without use disorder
F19.988	<i>Other psychoactive substance use, unspecified with other psychoactive substance-induced disorder</i> Other (or unknown) substance-induced mild neurocognitive disorder, Without use disorder Other (or unknown) substance-induced obsessive-compulsive and related disorder, Without use disorder
F19.99	<i>Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder</i> Unspecified other (or unknown) substance-related disorder

## DIAGNOSTIC CLASSIFICATIONS NOT COVERED

- [F70-F79] Intellectual Disabilities
- [F80-F89] Pervasive and Specific Developmental Disorders
- [F99] Unspecified Mental Disorder

## SOURCES

- ICD-10-CM Codes and Descriptions – FY2018 code descriptions  
[ftp://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Publications/ICD10CM/2018/](ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2018/)
- Requirements for use of DSM-5 in determining diagnosis:
  - Mental Health – [WAC 388-877A-0130](#)
  - Substance Use Disorder – [WAC 388-877B](#)

## SUMMARY OF CHANGES IN THIS REVISION

- Added/Modified the new/revised ICD-10-CM codes that went into effect 01 October 2017.

**Exhibit C**

**Designation of Behavioral Health Providers**

State Licensure and Certification and Providers Restricted to Working under Supervision and/or in Affiliation with an Approved Agency:

All Behavioral Health Providers listed below may provide behavioral health services. They are licensed or certified by the Washington Department of Health. Providers licensed or certified by the Department of Health, Independent Contractors and those working under supervision, consultation, or in an employee status are designated below.

#	Behavioral Health Providers	Licensed or Certified by the Washington Department of Health	Independent versus Supervised Clinical Practice		Practice in a DSHS-DBHR Licensed Behavioral Health Agency <b>Only</b>
			Independent Practitioner	Under Supervision, Consultation or Employee Status	
1	Advanced registered nurse practitioner including psychiatric advanced registered nurse practitioner and psychiatric mental health and board-certified nurse practitioners	X	X		
2	Agency affiliated counselor	X		X	X
3	Certified adviser	X		X	
4	Certified counselor	X		X	
5	Chemical dependency professional	X		X	X *A CDP that also holds a DOH license may practice in settings outside of a DBHR licensed agency [RCW 18.205.040(2)]
6	Chemical dependency professional - trainee (CDPT)	X		X	X
7	Hypnotherapist	X		X	
8	Licensed marriage and family therapist	X	X		
9	Licensed marriage and family therapist – associate (LMFTA)	X		X	



**Exhibit C**

**Designation of Behavioral Health Providers**

#	Behavioral Health Providers	Licensed or Certified by the Washington Department of Health	Independent versus Supervised Clinical Practice		Practice in a DSHS-DBHR Licensed Behavioral Health Agency <b>Only</b>
			Independent Practitioner	Under Supervision, Consultation or Employee Status	
10	Licensed mental health counselor	X	X		
11	Licensed mental health counselor – associate (LMHCA)	X		X	
12	Licensed practical nurse (LPN)	X		X	
13	Physician (MD)	X	X		
14	Physician Assistant (PA)	X		X	
15	Registered Nurse (RN)	X		X	
16	Psychiatrist (MD)	X	X		
17	Psychologist (PhD)	X	X		
18	Licensed social worker associate, advanced (LSWAA)	X		X	
19	Licensed social worker associate, independent clinical (LSWAIC)	X		X	
20	Licensed social worker, advanced (LASW)	X		X	
21	Licensed, Independent Clinical Social worker (LICSW)	X	X		
22	Sex offender Treatment Provider	X	X		
23	Affiliate sex offender treatment provider	X		X	
24	DBHR-Certified Peer Counselor	X		X	X

**Notes:**

1. Agency-affiliated counselors, chemical dependency professional trainees and DBHR-certified peer counselors are restricted to working in a recognized DOH agency also licensed as a behavioral health agency by DSHS-DBHR.
2. Agency affiliated counselors must notify DSHS within thirty calendar days if they are no longer employed by the agency identified on their application, are now employed with another agency, or both. Agency affiliated counselors may not practice counseling unless they are employed by an agency.

**Exhibit D-2  
Value-Based Purchasing**

**1. Quality Improvement – Withhold**

- 1.1. HCA will withhold a percentage portion of monthly Capitation Payments, as defined under subsection 1.6 of this Exhibit, paid by HCA under this Contract. The Contractor will be eligible to earn back part or all of the withhold (“Withhold”) as set out in this Exhibit.
- 1.2. The time periods covered by the Withhold and the applicable percentage amount of the Withhold for each time period are set out in Table 1. Each Performance Year, Improvement Baseline Year and Evaluation Period identified in Table 1 shall encompass services provided in the defined time period and payments for those services.

**Table 1  
Performance Years, Time Periods and Thresholds**

Year	Performance Year Time Period	Withhold Percent	Evaluation Period*	Provider Incentives Threshold*	VBP Payments Threshold*	Improvement Baseline Year Time Period**
1	Jan. 1, 2017 – Dec. 31, 2017	1.0%	Oct. 1, 2017 – Dec. 31, 2017	.75%	30%	Jan. 1, 2016 – Dec. 31, 2016
2	Jan. 1, 2018 – Dec. 31, 2018	1.5%	N/A	1%	50%	Jan. 1, 2017 – Dec. 31, 2017
3	Jan. 1, 2019 – Dec. 31, 2019	1.5%	N/A	1%	75%	Jan. 1, 2018 – Dec. 31, 2018
4	Jan. 1, 2020 – Dec. 31, 2020	TBD	N/A	TBD	TBD	Jan. 1, 2019 – Dec. 31, 2019

\*The limited Evaluation Period, Provider Incentives Threshold, and VBP Payments Threshold applies only as set out in sections 2 and 3 of this Exhibit.

\*\*The Improvement Baseline Year applies only as set out in section 4 of this Exhibit.

- 1.3. Following each Performance Year, HCA will determine the total amount of the Withhold for the Performance Year and the amount of such Withhold that the Contractor is eligible to earn back. The Contractor will be eligible to earn back part or all of the Withhold (“Withhold”) based on performance measures in the following three areas:
- 1.3.1. Up to 12.5 percent of the Withhold may be earned back by implementing qualifying Provider Incentives tied to quality and financial attainment as described in section 2 of this Exhibit (the “Provider Incentives Portion” of the Withhold);

- 1.3.2. Up to 12.5 percent of the Withhold may be earned through Value-Based Purchasing arrangements as described in section 3 of this Exhibit (the “VBP Payments Portion” of the Withhold); and
    - 1.3.3. Up to 75 percent of the Withhold may be earned by achieving quality improvement and attainment targets as described in section 4 of this Exhibit (the “QIS Portion” of the Withhold).
  - 1.4. No later than November 30th following each Performance Year, HCA will notify the Contractor of the amount of the Withhold that the Contractor has earned back for the Performance Year. HCA will schedule payment to the Contractor based on the calculated method defined above and as described in section 5 of this Exhibit. HCA will also provide the Contractor with a copy of Value-Based Purchasing Withhold Calculation Summary Form, Attachment C to this Exhibit, signed by the HCA Chief Financial Officer, outlining the percent withhold recovered through provider incentive payments, Value Based Purchasing arrangements, and the Quality Improvement Score Achieved.
  - 1.5. For Performance Year 1, Capitation Payments subject to the Withhold are defined in Section 5 of this Contract and include all Capitation Payments excluding any SNAF, PAP, IMD or FQHC/RHC enhancement funding. For Performance Years 2 and subsequently, Capitation Payments subject to the Withhold are the same, except that they additionally exclude administrative and WSHIP funding.
  - 1.6. For sections 2 and 3, of this Exhibit, “Assessed Payments” shall refer to all contractor payments made to providers using funds that were subject to the Withhold as defined under subsection 1.5 of this Exhibit, with the exception of any case payments for delivery and low birth weight, administrative dollars, or other payments funded through Washington State Health Insurance Pool (WSHIP), premium tax, or Institutions for Mental Disease (IMD) funding.
  - 1.7. For purposes of this Exhibit, a “Value-Based Payment Arrangement” means a payment arrangement that meets the definition of Category 2C or higher of the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated 1/12/2016, attached as Attachment A (“Whitepaper”). For Performance Year 1, for the Contractor to be eligible for reimbursement of all or a portion of the Withhold under this Exhibit, contracts that include Value-Based Payment Arrangements must be signed no later than September 30, 2017, with an effective date of October 1, 2017, or earlier.

- 1.8. For purposes of reporting regional data, each regional service area is defined as follows:
  - 1.8.1. Better Health Together (BHT) includes Ferry, Stevens, Pend Oreille, Spokane, Lincoln, and Adams Counties.
  - 1.8.2. Cascade Pacific Action Alliance (Cascade) includes Grays Harbor, Mason, Thurston, Pacific, Lewis, Cowlitz, and Wahkiakum Counties.
  - 1.8.3. Greater Columbia (GC) includes Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Whitman, and Asotin Counties.
  - 1.8.4. King includes King County.
  - 1.8.5. North Central (NC) includes Chelan, Douglas, Grant, and Okanogan Counties.
  - 1.8.6. North Sound (NS) includes Whatcom, Skagit, San Juan, Island, and Snohomish Counties.
  - 1.8.7. Olympic includes Clallam, Jefferson, and Kitsap Counties.
  - 1.8.8. Pierce includes Pierce County.
  - 1.8.9. South West Washington Regional Health Alliance (SW WA) includes Clark, Skamania, and Klickitat Counties.

## **2. Qualifying Provider Incentives**

- 2.1. For purposes of this section, the term “Provider Incentive” means Payment Incentives and Payment Disincentives that apply to base payments that are Assessed Payments in a Value-Based Payment Arrangement.
- 2.2. For purposes of this section, the term “Payment Incentives” means the portion of contractor rates that are paid to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include retrospective bonus payments made on top of a provider's existing reimbursement structure (i.e. upside only), savings achieved by a provider under a shared-savings arrangement whereby the provider's portion of the savings is tied to quality reporting and/or performance, or prospective care management incentive or payment, on top of a provider's existing reimbursement structure, that is tied to quality reporting and/or performance.

- 2.3. For purposes of this section, the term “Payment Disincentives” means the portion of Contractor rates that are charged to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include downside risk arrangements whereby providers make payments to contracted payer(s) from their existing reimbursement structure based on quality reporting and/or performance, deficit payments made by a provider to contracted payer(s) based on quality reporting and/or performance, or withheld payments from existing provider reimbursement structures based on quality reporting and/or performance.
- 2.4. The Provider Incentives Portion of the Withhold shall be 12.5 percent of the total Withhold. The Provider Incentives Portion may be earned back in whole or in part by establishing Payment Incentives and Payment Disincentives tied to quality and financial attainment, and by satisfying the additional requirements set out in this section. The formula under which all or part of the Provider Incentives Portion of the Withhold may be earned back is set out in this section.
- 2.5. During the Performance Year, the Contractor at its discretion can seek feedback from HCA on whether provider payment arrangements qualify as Provider Incentives.
- 2.6. On or before August 1<sup>st</sup> following each Performance Year, the Contractor shall report to HCA the total statewide and regional Assessed Payments that the Contractor made to providers for the Performance Year, and the amount of statewide and regional Payment Incentives and Payment Disincentives for the Performance Year. Failure to provide the report by the deadline may result in loss of the amount withheld under subsection 1.1 of this Exhibit.
  - 2.6.1. Provider Incentives will be assigned to each region based on the location of the Provider.
  - 2.6.2. Assessed Payments will be considered to have been made when the services have been provided.
- 2.7. The Contractor shall report the data outlined in subsection 2.6 of this Exhibit, and provide examples of the types of Payment Incentives and Payment Disincentives implemented in each region, in the format set out in Table 2. For Performance Year 1, the Contractor shall provide the data identified in this subsection for the Performance Year and Evaluation Period using a separate table for the Performance Year and Evaluation Period.

**Table 2  
Statewide and Regional Qualifying Incentives**

Region	Assessed Payments	Payment Incentives		Payment Disincentives	
		Total Amount	Describe*	Total Amount	Describe*
BHT					
Cascade					
GC					
King					
NC					
NS					
Olympic					
Pierce					
SW WA					
Statewide total					

*\*For example: "Downside risk arrangement whereby providers make payments to contracted payers from an existing reimbursement structure based on quality reporting and performance."*

- 2.8. A third-party contractor to HCA will validate the Contractor's reported actual Payment Incentives and Payment Disincentives to network providers.
- 2.9. Provider Incentives should be reported in the period in which they are paid or accrue in the Contractor's financial statements. The method of reporting should be consistent to ensure that amounts are not double-counted from year to year.
- 2.10. HCA will use the data supplied by the contractor to calculate the total Provider Incentives for the Performance Year as a percent of total Assessed Payments for the contractor for the Performance Year, except that in Performance Year 1, HCA will calculate the total Provider Incentives for the Evaluation Period as a percent of total Assessed Payments for the contractor for the Evaluation Period.
- 2.11. For the Contractor to earn back the Provider Incentives Portion of the Withhold in full, the total Provider Incentives for the Performance Year must equal at least the Provider Incentives Threshold percent of Assessed Payments made during the Performance Year, except that for Performance Year 1, the total Provider Incentives for the Evaluation Period must equal at least the Provider Incentives Threshold percent of Assessed Payments made during the Evaluation Period. The Provider Incentives Threshold for each Performance Year is set out in Table 1.

- 2.12. If for the Performance Year the percentage calculated under subsection 2.10 of this Exhibit is equal to or less than the Provider Incentives Threshold for the Performance Year, then the percentage calculated under subsection 2.10 of this Exhibit will be recalculated as a percentage of the Provider Incentives Threshold for the Performance Year. The resulting Provider Incentives “Partial Earn-Back Percentage” will then be the percentage of the Provider Incentives Portion of the Withhold that the contractor is eligible to earn back.
- 2.13. The results of the calculations made in subsections 2.10 and 2.12 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

### **3. Qualifying Value-Based Payments**

- 3.1. For the purposes of this section, “Payments in a Value-Based Payment Arrangement” means Assessed Payments in a Value-Based Payment Arrangement.
- 3.2. For purposes of this section, "Hybrid Payment Models" means payment arrangements that incorporate multiple APMs. Payments in Hybrid Payment Model shall assign Total Payments to the most dominant APM Category. The dominant APM Category is defined as the APM Category under which a plurality of payments are made.
- 3.3. For purposes of this section, “Integrated Primary Care Payment and Delivery Systems” are systems whereby a primary care provider is held accountable for the total cost of care for their patient population. Assessed Payments that are Integrated Primary Care Payment and Delivery Systems shall be included in APM Category 3A (for an upside only, shared savings arrangement) or Category 3B (for a two-sided, shared savings and downside risk arrangement).
- 3.4. The VBP Payments Portion of the Withhold shall be 12.5 percent of the total Withhold. The VBP Payments Portion of the Withhold may be earned back in whole or in part by ensuring that Assessed Payments are tied to Value-Based Payment Arrangements. The formula under which all or part of the VBP Payments Portion of the Withhold may be earned back is set out in this section.
- 3.5. On or before August 1st following each Performance Year, the Contractor shall report to HCA the total regional and statewide Assessed Payments in

each HCP-LAN Category as defined under subsection 1.7 of this Exhibit. In addition, the Contractor shall report to HCA the total regional and statewide Assessed Payments made by the Contractor in MACRA A-APM payment models certified through the Centers for Medicare and Medicaid Services (CMS). Failure to provide the report by the deadline may result in loss of the amount withheld. Payments will be assigned to each region based on the location of the Provider.

- 3.6. The Contractor shall report the data outlined in subsection 3.5 of this Exhibit in the format laid out in Table 3. For Performance Year 1, the Contractor shall provide the data identified in this subsection for the Performance Year and Evaluation Period using a separate table for the Performance Year and Evaluation Period.

**Table 3  
Statewide and Regional Payments by HCP-LAN Category**

Medicaid Total Assessed Payments by APM Category													
Category			Region: Accountable Communities of Health										
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WA	Out-of-State	All
1 FFS - No Link to Quality	1	Fee-for-Service											
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
	2D	Rewards and Penalties for Performance											
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment											
	4B	Comprehensive Population-Based Payment											
<b>Total Annual Payments</b>													
Payments in MACRA A-APMS (all payments entered here should ALSO be entered under categories 1-4 above)													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

- 3.7. The Contractor shall report the total annual covered lives by HCP-LAN category at a statewide and regional level as described in Table 4. Covered lives shall be reported for Enrollee member months as defined in this



Contract. For Performance Year 1, the Contractor shall provide the data identified in this subsection for the Performance Year and Evaluation Period using a separate table for the Performance Year and Evaluation Period.

- 3.8. Where an Enrollee receives services that are funded under multiple payment models, the Enrollee shall be reported under the dominant category of payment model either by month or over the total reporting period so long as a consistent method is used. The dominant category for this purpose shall be the payment category with the greatest assessed payments for the Enrollee.

**Table 4  
Statewide and Regional Covered Lives by HCP-LAN Category**

Medicaid Total Statewide Covered Lives by APM Category													
Category			Region: Accountable Communities of Health										
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WA	Out-of-State	All
1 FFS – No Link to Quality	1	Fee-for-Service											
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
	2D	Rewards and Penalties for Performance											
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment											
	4B	Comprehensive Population-Based Payment											
<b>Total Covered Lives</b>													
<b>Covered Lives in MACRA A-APMs (all covered lives entered here should ALSO be entered under categories 1-4 above)</b>													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

- 3.9. A third party contractor to HCA shall validate the Contractor's reporting of the total amounts and categorization of the reported Payments in a Value-Based Payment Arrangement.
- 3.10. HCA will use the data supplied by the contractor to calculate the total Payments in a Value-Based Payment Arrangement as a percent of total Assessed Payments for the contractor for the Performance Year, except that in Performance Year 1, HCA will calculate the total Payments in a Value-Based Payment Arrangement for the Evaluation Period as a percent of total Assessed Payments for the contractor for the Evaluation Period.
- 3.11. For the Contractor to earn back the VBP Payments Portion of the Withhold in full, the total Payments in a Value-Based Payment Arrangement for the Performance Year must equal at least the VBP Payments Threshold percent of Assessed Payments made during the Performance Year, except that for Performance Year 1, the total Payments in a Value-Based Payment Arrangement for the Evaluation Period must equal at least the VBP Payments Threshold percent of Assessed Payments made during the Evaluation Period. The Provider Incentives Threshold for each Performance Year is set out in Table 1.
- 3.12. If for the Performance Year the percentage calculated under subsection 3.9 of this Exhibit is less than the VBP Payments Threshold for the Performance Year, then the percentage calculated under subsection 3.9 of this Exhibit will be recalculated as a percentage of the VBP Payments Threshold for the Performance Year. The resulting VBP Payments "Partial Earn-Back Percentage" will then be the percentage of the VBP Payments Portion of the Withhold that the contractor is eligible to earn back.
- 3.13. The results of the calculation made in subsections 3.9 and 3.11 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

#### **4. Overall Quality Improvement Score Calculation**

- 4.1. The QIS Portion of the Withhold shall be 75 percent of the total Withhold. The QIS Portion may be earned back in whole or in part by achieving quality improvement and attainment targets on the basis of Healthcare Effectiveness Data and Information Set HEDIS® scores that the Contractor will report to HCA, and by satisfying the additional requirements set out in this section.

- 4.2. In accordance with Section 7 of this Contract, the Contractor shall report HEDIS® measures electronically to the HCA contracted External Quality Review Organization no later than the date in June of each year as specified by the audit team. Specific measures will be evaluated to determine the share of the QIS Portion of the Withhold that the Contractor is eligible to earn back and are identified in Tables 5 and 6. Failure to provide the report by the deadline may result in loss of the amount withheld.
- 4.3. If the value for one or more measures in the Improvement Baseline Year is missing or not available, the HCA Chief Medical Officer (CMO), in his or her sole discretion, will determine the values to be used in place of the missing values using publicly available sources. If the value using publicly available sources is missing or not available, the HCA CMO will either determine an alternative measure or exclude the measure from the calculation.
- 4.4. HCA will use the data supplied by the Contractor to calculate a single Quality Improvement Score for the Contractor for the Performance Year. The total Quality Improvement Score will reflect a weighted average of individual composite scores (the “Measure Composite Score”) that assess annual improvement (the “Measure Improvement Score”) and objective attainment (the “Measure Quality Score”) on each Quality Measure.
- 4.5. The Measure Improvement Score and Measure Quality Score for each Quality Measure will measure the HEDIS® scores provided by the Contractor against Target Measure Score and Mean Measure Score values shown in Tables 5 and 6. The values in Table 5 shall apply for Performance Year 2019 and after, and the values in Table 6 shall apply for Performance Year 2018.
  - 4.5.1. The Target Measure Score values referenced in Table 5 are NCQA Quality Compass Medicaid HMO 90th percentile values for the year immediately preceding the Performance Year.
  - 4.5.2. The Mean Measure Score values referenced in Table 5 are NCQA Quality Compass Medicaid HMO average values for the year immediately preceding the Performance Year.
  - 4.5.3. The Target Measure Scores values and Mean Measure Score values in Table 6 are NCQA Quality Compass Medicaid HMO values for 2016.

4.5.4. The poor Hb A1c control CDC measure referenced in Tables 5 and 6 is a measure where a lower value indicates better performance. The Target Measure Score and Mean Measure Score values used in calculating the QIS for this measure are referenced in Tables 5 and 6 as one minus the target and mean values based on NCQA Quality Compass values.

**Table 5**  
**Measure Weights, Target Measure Scores and Mean Measure Scores for PY 2019 and Forward**

	Quality Measure	Quality Measures Description	Measure Weight	Target Measure Score	Mean Measure Score
Adult Measures	CDC	Comprehensive Diabetes Care - Poor Hb A1c Control (>9%)	Full	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	Full	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	CBP	Controlling High Blood Pressure (<140/90)	No weight	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	AMM	Antidepressant Medication Management –Effective Acute Phase Treatment	Half	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	Half	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
Pediatric Measures	CIS	Childhood Immunization Status - Combo 10	Full	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	W34	Well-child visits in the 3rd, 4th, 5th and 6th years of life	Full	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	Half	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	Half	Quality Compass 90 <sup>th</sup> Percentile	Quality Compass Mean

**Table 6**  
**Measure Weights, Target Measure Scores and Mean Measure Scores for PY 2018**

	Quality Measure	Quality Measures Description	Measure Weight w(i)	Target Measure	Mean Measure
Adult Measures	CDC	Comprehensive Diabetes Care - Poor HbA1c Control (>9%)	Full	70.77%	54.65%
	CDC	Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	Full	75.73%	59.04%
	CBP	Controlling High Blood Pressure (<140/90)	Full	70.69%	54.74%
	AMM	Antidepressant Medication Management –Effective Acute Phase Treatment	Half	67.57%	54.45%
	AMM	Antidepressant Medication Management - Effective Continuation Phase Treatment (6 Months)	Half	54.3%	39.44%
Pediatric Measures	CIS	Childhood Immunization Status - Combo 10	Full	46.47%	33.24%
	W34	Well-child visits in the 3rd, 4th, 5th and 6th years of life	Full	82.97%	71.27%
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	Half	41.18%	28.33%
	MMA	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	Half	37.63%	26.33%

4.6. The Measure Quality Score QS(i) for a given measure will reflect the Contractor’s attainment beyond the Mean Measure Score in terms of the total distance between the Mean Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure QS Ratio where Measure QS Ratio = (Performance Year Measure Score - Mean Measure Score) / (Target Measure Score - Mean Measure Score).

4.6.1. The Measure QS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

- 4.6.2. The Measure QS Ratio will be transformed into a curved distribution using a lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be a QS Table Lookup Value.
- 4.6.3. For a given measure, the QS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Performance Year Measure Score - Mean Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score - Mean Measure Score). However, if the Performance Year Measure Score is less than the Mean Measure Score, then the QS Table Lookup Value shall be considered to be zero.
- 4.7. The Measure Improvement Score for a given measure will reflect the Contractor's improvement from the Improvement Baseline Year Measure Score in terms of the total distance between the Improvement Baseline Year Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure IS Ratio where  $\text{Measure IS Ratio} = (\text{Performance Year Measure Score} - \text{Improvement Baseline Year Measure Score}) / (\text{Target Measure Score} - \text{Improvement Baseline Year Measure Score})$ .
- 4.7.1. The Measure IS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.
- 4.7.2. The Measure IS Ratio will be transformed into a curved distribution using the lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be an IS Table Lookup Value.
- 4.7.3. For a given measure, the IS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Performance Year Measure Score - Improvement Baseline Year Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score - Improvement Baseline Year Measure Score). However, if the Performance Year Measure Score is less than the Improvement Baseline Year Measure Score, then the IS Table Lookup Value shall be considered to be zero.
- 4.8. The Measure Q-I Weighting Factor for a given measure will determine the respective weight given to the Measure Quality Score and the Measure Improvement Score in calculating the Measure Composite Score. The

Measure Q-I Weighting Factor shall range from .25 to 1, dependent on the Measure QS Ratio (not the QS Table Lookup Value) as follows:

- 4.8.1. If the Measure QS Ratio is equal to or less than .25, then the Measure Q-I Weighting Factor shall equal .25.
- 4.8.2. If the Measure QS Ratio is more than .25 and less than 1 then the Measure Q-I Weighting Factor shall equal the Measure QS Ratio.
- 4.8.3. If the Measure QS Ratio is equal to or greater than 1, then the Measure Q-I Weighting Factor shall equal 1.
- 4.9. The Measure Quality Score QS(i) for a given measure shall equal the QS Table Lookup Value multiplied by the Measure Q-I Weighting Factor.
- 4.10. The Measure Improvement Score IS(i) for a given measure shall equal the IS Table Lookup Value multiplied by a value equal to one minus the Measure Q-I Weighting Factor.
- 4.11. The Measure Composite Score QIS(i) for a given measure shall equal the sum of the Measure Improvement Score IS(i) and the Measure Quality Score QS(i).
- 4.12. The overall Quality Improvement Score, QIS, is the weighted average of all the individual Measure Composite Scores, QIS(i), where the Measure Weight for each measure is specified in Table 4. The resulting number (e.g. 0.14) is converted to a percentage (e.g. 14 percent).
- 4.13. For the Contractor to earn back the QIS Portion of the Withhold in full, the overall Quality Improvement Score, QIS, for the Performance Year must equal at least 20 percent.
- 4.14. If for the Performance Year the Quality Improvement Score for the Performance Year is equal to less than 20 percent, then the Quality Improvement Score will be recalculated as a percentage of 20 percent. The resulting QIS "Partial Earn-Back Percentage" will then be the percentage of the QIS Portion of the Withhold that the contractor is eligible to earn back.
- 4.15. The results of the calculation made in subsections 4.12 and 4.14 of this Exhibit is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

## 5. Payment

- 5.1. On or before October 31 following each Performance Year, HCA will provide the Contractor with a completed Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C to this Exhibit to notify the Contractor in writing of its percentage of Withhold earned back based on the calculations described in this Exhibit.
- 5.2. The Contractor will have twenty (20) calendar days from the date the Contractor is notified of its percentage Withhold earned back to review and sign the Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C to this Exhibit and return to HCA, in writing, of any alleged discrepancies with the calculations.
- 5.3. If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.
- 5.4. HCA will schedule payment for the percentage of the Withhold earned back no later than November 30 of the year following the Performance Year.



Exhibit D-2, Attachment C  
Value-Based Purchasing Withhold Calculation Summary Form

Contractor/Vendor Name: \_\_\_\_\_

Contract No: \_\_\_\_\_

Performance Period: \_\_\_\_\_ to \_\_\_\_\_

Percent of qualifying Provider incentive payments tied to quality: \_\_\_\_\_

Percent of payments in a qualifying Value Based Purchasing Arrangements: \_\_\_\_\_

Quality Improvement Score: \_\_\_\_\_

The Contractor earned back \_\_\_\_\_% of the Value-Based Purchasing Withhold described in Exhibit D.

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Washington State Health Care Authority Chief Financial Officer Signature:

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name & Title

Email Address: \_\_\_\_\_

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Contractor hereby agrees to the accuracy of this Value-Based Purchasing Withhold Calculation Summary and the underlying calculations.

Contractor Authorized Agent Signature

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Print Name & Title

Email  
Address: \_\_\_\_\_



# ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

Written by:

Alternative Payment Model Framework  
and Progress Tracking (APM FPT) Work Group

For Public Release  
Version Date: 1/12/2016

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## Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

To advance this goal, the Alternative Payment Models Framework and Progress Tracking Work Group (“the Work Group”) was charged with creating an alternative payment model (APM) Framework (“the APM Framework”) that could be used to track progress towards payment reform. Composed of diverse health care stakeholders, the Work Group has deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care.

Although the Work Group was not charged with developing a working definition of person centered care, it thought that it was important to do so because it views payment reform as one means for accomplishing the larger goal of person centered care. The Work Group believes that person centered care rests on three pillars: quality, cost effectiveness, and patient engagement. For the purposes of the White Paper, the term is nominally defined as follows: *high quality care that is both evidence based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs, and values are paramount.* In addition, it should be noted that the opinions expressed within the White Paper are those of the Work Group Members and not of the organizations of which they are affiliated.

The Work Group is committed to the notion that transitioning the U.S. health care system away from fee for service (FFS) and towards shared risk and population based payment is necessary, though not sufficient in its own right, to a value based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person centered care because it does not reward high quality, cost effective care. By contrast, population based payments (including bundled payments for clinical episodes of care) offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the Work Group and the LAN as a whole believe that the health care system should transition towards shared risk and population based payments. The Work Group hopes the Framework will be useful in this context to establish a common nomenclature upon which progress can be discussed and measured.

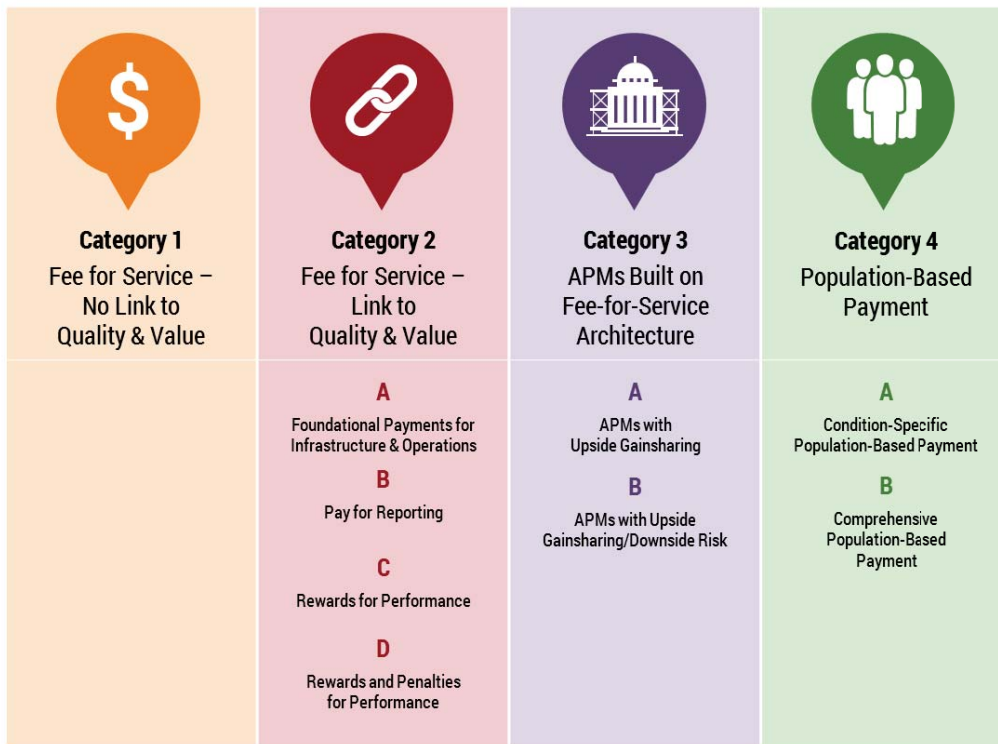
The APM Framework rests on seven principles, which can be summarized as follows:

1. Changing providers’ financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by the Centers for Medicare & Medicaid Services (CMS), and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated below:

**Figure 1. APM Framework (At-A-Glance)**



## Overview

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the “Work Group”) and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the “APM Framework”). The Work Group brought together public and private stakeholders to assess APMs in use across the nation and to define terms and concepts essential for understanding, categorizing, and measuring APMs. (A roster of Work Group members, representing the diverse constituencies convened by the LAN, is provided in [Appendix A](#). Please note that opinions expressed within the White Paper are those of the Work Group Members not of the organizations of which they are affiliated.) The aim of the Work Group is to create a clear and understandable APM Framework, to provide a deeper understanding of payment models and how those models can enhance health and health care, and to provide examples of how public and private payment models are organized within the APM Framework.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Work Group is hopeful that this White Paper will help CMS consider some of the issues involved in implementing MACRA, but stresses that providing formal recommendations on how to do so is explicitly not part of the Work Group’s charge. Although the Work Group is no longer soliciting comments on the White Paper, formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS.

## *Health Care Payment Learning & Action Network (LAN)*

To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. To enable these reforms, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

### U.S. Health Care Payments in APMs



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## *The Case for Reforming the Health Care Payment System*

The LAN and the Work Group are unanimous in their desire to drive payment approaches that improve the quality and safety of care and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides person centered care. Recognizing that the Work Group was not charged with developing a comprehensive definition of the term or its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands person centered care to mean *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. The Work Group believes that person centered care, so defined, rests upon three pillars:

- **Quality:** This term indicates that patients receive appropriate and timely care that not only is consistent with evidence based guidelines and patient goals, but also results in optimal patient outcomes and patient experience. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process, outcome, patient reported outcome, and patient experience measures that both provide an accurate and comprehensive assessment of clinical and behavioral health, and that report results that can be meaningfully accessed, understood, and used by patients and consumers.
- **Cost Effectiveness:** This term indicates a level of severity adjusted total costs (and, when relevant, unit prices) that reflect benchmarked best achievable results, and that are consistent with robust and competitive health insurance marketplaces as characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial, and government programs sectors. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Conversely, care that is costly but that results in dramatic improvements in patient outcomes could be considered cost effective. Affordable health care services are vital to ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health.
- **Patient Engagement:** This term encompasses the important aspects of care that improve patient experience, enhance shared decision making, and ensure that patients and consumers achieve their health goals. Patient engagement should occur at all levels of care delivery, with patients and caregivers serving as partners when setting treatment plans and goals at the point of care; when designing and redesigning delivery and payment models; on governance boards and decision making bodies; and when identifying and establishing connections to social support services. Engaged patients and consumers are informed of their health status and share in their own care; they are easily able to access appointments and clinical opinions; they seek care at the appropriate site; they possess the information they need to identify high value providers and to tailor treatment plans to individual health goals; they provide ongoing feedback that providers can use to improve patient experience; they are able to obtain transparent price information about services and their value for patients and consumers; and they can move seamlessly among providers that are engaged in different aspects of their care. Routine communication with family caregivers and other support members is also a critical part of comprehensive, person centered care.

As evidenced by the creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders in the health care system that efforts to deliver person centered care have been stymied, in large part, by a payment system that is oriented largely towards volume, as opposed to value for patients and caregivers. These stakeholders and the

Work Group believe that by reconfiguring payments to incentivize value, and by ensuring that valuable activities (e.g., care coordination) are compensated appropriately, providers will be able to invest in care delivery systems that are optimized for the provision of care that is more focused on patient needs. In other words, changes in payment are necessary (though insufficient on their own) to change provider behavior and drive delivery system transformations, thereby ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group believes that shifting from traditional fee for service (FFS) payments to person focused payments (in which all or much of a person's overall care or care for related conditions is encompassed within a single payment) is a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Such payments should thus include accountability for the quality of care at the population level, rather than for the volume of particular services. Although it is not yet possible to reach a definitive, evidence based conclusion about the impact of population based payments on patient care, there is a belief that these types of payment models are designed in a way that holds substantial promise. This is because person focused, population based payments give providers more flexibility to coordinate and manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and increased incentives to provide services that are currently undervalued in FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

At present, FFS payments are ill suited for initiating investments and sustaining population health management innovations, such as information technology, clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., payments for telehealth, home visits, and additional office hours). This is because FFS incentivizes providers to optimize volume. As a result, FFS may at times discourage the perspective that patients require individualized and highly coordinated care. Population based payments may enable providers to develop more innovative approaches to person centered health care delivery because they reward providers that successfully manage all or much of an individual's care. Provided that safeguards are put in place to ensure that quality and patient engagement are not sacrificed to reduce costs, and that the care delivered is state of the art and takes advantage of valuable advances in science and technology, these innovative approaches to health care delivery stand to benefit patients and society alike. Patients may come to expect a more coordinated, more accessible, and more effective health care system, and the nation would benefit from reductions in national health care expenditures, and a healthier, more productive workforce.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care, and that the transition away from FFS may be costly and administratively difficult. The Work Group also recognizes that participation in shared risk and population based payment models involves financial risk for providers, that not all provider organizations possess the capacity to successfully operate in these payment models, and that providers will need assistance to develop additional capabilities. In order to smooth and accelerate this transition, the Work Group believes that a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a population based health system that delivers the best health care possible. If providers were able to participate in APMs that were consistently deployed across multiple payer networks, this would reduce the administrative burden of making the transition and allow investments to be applied to all patient populations, independent of payer. Aligned payments from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long term. The Work Group



expects that the adoption and diffusion of these innovative delivery systems should ultimately improve the quality, efficiency, safety, and experience of patient care, while becoming sustainable business models for providers that are eager to take a more comprehensive and coordinated approach to medical practice.

The Work Group believes that a shift to person focused, population based payments will, in concert with other reforms, result in an expansion of high value care in the United States. The Work Group recognizes the possibility that shifts in payment can result in unintended and unanticipated consequences, such as cost increases owing to provider consolidation, reduced provider willingness to exchange data, and a potential reduction in costly but effective medical services. The Work Group believes that it is therefore absolutely essential to monitor the impact of population based payment systems on patient outcomes, health care costs, and other indicators of significance to patients and other stakeholders in the health care system. The Work Group envisions the shift to person focused, population based payment as a course correcting feedback loop between innovation, implementation, and evaluation; it also anticipates that its forthcoming effort to measure progress will help accelerate this process. The Work Group is hopeful this, the first in a series of LAN publications, will help align stakeholders in the public and private sectors and support the implementation of payment systems that promote person centered care.

### *Purpose of the White Paper*

In order to accelerate the transformations described above, the Guiding Committee charged the Work Group with creating an APM Framework through which progress towards payment reform can be described and measured. In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a shared set of conventions that can facilitate discussions among stakeholders and expedite the generation of evidence based knowledge about the capabilities and results of APMs.

The White Paper begins by describing the approach that the Work Group used to develop the APM Framework, and then describes the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates the Categories within the APM Framework by explaining how the Categories are defined and where their boundaries lie. The White Paper concludes with a summary of the Work Group's key findings and recommendations, as well as recommendations for how various stakeholders can use the Framework to accelerate payment reform. To further clarify the classification of individual APMs, the Work Group has separately released a collection of APMs that are currently in use.

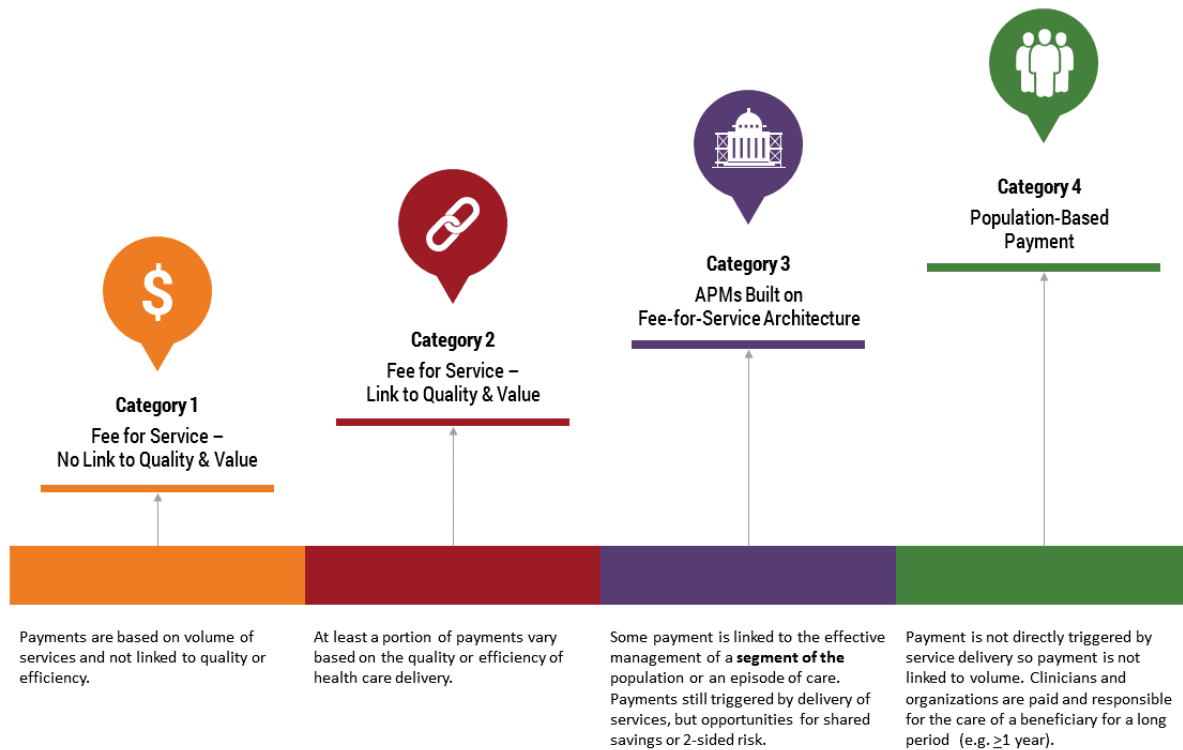
### *Approach*

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,<sup>1</sup> and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from plans to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).

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<sup>1</sup> Rajkumar R, Conway PH, Tavenner M. [CMS: Engaging multiple payers in payment reform](#). JAMA. 2014 May 21: 311(19):1967-8.

**Figure 2. CMS Payment Framework**



The Work Group added to and refined the CMS model by: 1) articulating key principles to explain what the APM Framework does and does not mean to convey; 2) introducing four new Categories to account for payment models that are not considered progress towards payment reform; 3) introducing eight subcategories to account for nuanced but important distinctions between APMs within a single Category; 4) delineating explicit decision rules that can be used to place a specific APM within a specific subcategory; and 5) compiling, with the help of the LAN, examples of APMs that illustrate key characteristics of each of the subcategories.

## Key Principles for the APM Framework

The Work Group’s Framework is predicated on several key principles. To provide context for understanding the APM Framework and the Work Group’s recommendations, these principles are delineated and explained below.

**Principle 1:** *Changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of person centered care. In the future, it will be important to monitor progress in initiatives that empower patients to have a voice in model design, to seek care from high value providers (via performance metrics, financial incentives, and other means), and to become active participants in shared decision making.*

Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a high value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, the Work Group expects all stakeholders to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. Such approaches may include strategies to clearly and meaningfully communicate, to patients and consumers, information about provider and health plan performance on clinical and patient experience measures; financial rewards for patients and consumers to select high value providers and to successfully manage chronic diseases; and efforts to enlist patients and caregivers as partners in the setting of health goals and the development of treatment plans. In order to avoid unintended consequences associated with APMs, the Work Group also believes it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or a greater need for social support, and that patients and consumers will be informed of providers' financial incentives in APMs. Additional activities and monitoring will also be needed to ensure that the expansion of population based payments does not lead to disparities in health outcomes or to a decline in access to care.

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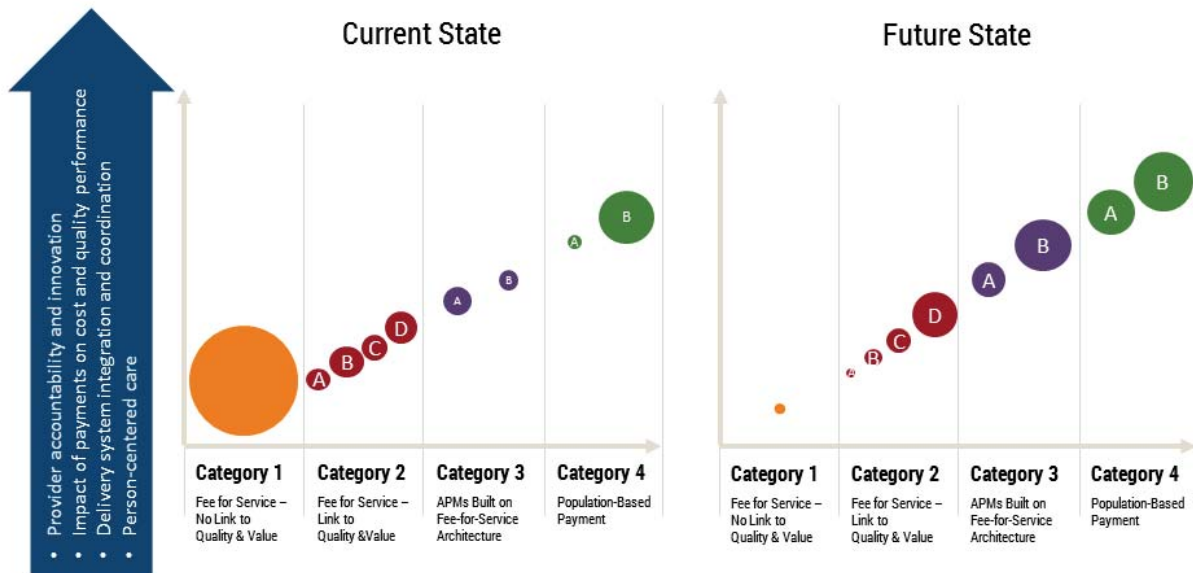
***Principle 2:** As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.*

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The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional FFS payment. Consistent with this objective, the Work Group recommends that over time, the U.S. health care system should move concertedly towards APMs in Categories 3 and 4. Nevertheless, the Work Group strongly believes that providers should clearly understand the requirements for financial and clinical participation in APMs, as well as that participation in APMs should be voluntary and that providers should not take on risk that they are not prepared to accept. The Work Group also recognizes that market forces have led to different levels of delivery system organization and integration, and investment in infrastructure and management will be required to build the capabilities that will ensure greater success of more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market, for every clinical domain (e.g., dental care), or for every patient population. Furthermore, the Work Group anticipates that some regional markets may be slower to make the transition to these Categories. In particular, the Work Group expects participation in Category 3 and 4 APMs to be more limited for rural providers and for certain small or solo practices. Additionally, the transition may be more challenging for safety net providers, given the broad array of other services needed by their patient populations that are not integrated into health care, unless such services can be better integrated into payment reform.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 3.

**Figure 3. The Work Group's Goals for Health Care Reform**



*\* Note: The values presented in the above “current state” graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent the Work Group’s belief of how the health care system should change, and it takes into account the likely impact of Medicare’s Merit Based Incentive Payment System. The Work Group cautions that values displayed in the graphic are not precise, nor are they intended to lay out specific targets for health care reform.*

In Figure 3, the size of the various circles represents spending across various types of payment models. As Figure 3 illustrates, payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally, the Work Group expects that, over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value based care.

**Principle 3:** *To the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care.*

Based on the experience of members of the Work Group, payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for providers that are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop mechanisms that drive person centered, well-coordinated, and high value care that ultimately lead to better outcomes. For example, an accountable care organization (ACO) that is at risk for cost and quality would ideally design financial incentives for individual physicians and hospitals in a way that aligns with the ACO’s incentives as an organization. The Work Group recognizes that it may not always be possible to measure accurately the degree to which incentive payments reach individual practitioners. Nevertheless, the Work Group considers this a best practice and affirms that all delivery systems participating in Category 3 and 4 APMs should commit to

this principle. The Work Group believes that making population based payments to provider organizations that, in turn, pay individual providers on an FFS basis will not harness the full potential of the incentives in the APM.

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*Principle 4: Payment models that do not take quality and value into account will be classified within the appropriate category with a designation that distinguishes them as a payment model that is not value based. They will not be considered APMs for the purposes of tracking progress towards payment reform.*

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As illustrated in Figure 4, the APM Framework represents a continuum of payment approaches across four Categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 are organized according to the degree to which they advance beyond traditional FFS payment. The Work Group believes strongly that there is limited merit in moving toward population based payments if the resulting payment models do not include incentives to deliver quality health care based on current clinical knowledge. Although the Work Group was not charged with making specific recommendations about what constitutes meaningful quality measurement, it believes that APMs should use harmonized measure sets that include process, clinical outcome, patient reported outcome, and patient experience of care measures. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Payment models that represent some movement away from traditional FFS, but that do not take quality (and therefore value) into account, will be placed under the appropriate payment category and marked with an "N" to indicate "No Quality" considerations (e.g., population based payments not linked to value will fall into Category 4N). Accordingly, such models will not be considered to represent progress toward true payment reform, and the Work Group will not track them as part of measuring the achievement of the LAN's goals.

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*Principle 5: In order to reach the LAN's goals for health care reform, value based incentives should be intense enough for providers to invest in and implement delivery reforms, and they should increase over time. However, the strength of incentives does not affect the classification of APMs in the APM Framework.*

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The Work Group believes that APMs can be effective stimuli for delivery system change if providers are given meaningful incentives to develop and sustain innovative approaches to care delivery, and it acknowledges that shifting to person focused, population based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value based incentives be large enough to motivate providers to invest in and adopt new approaches to care delivery, and—over time—to outweigh profits that could be generated by increasing FFS billing. For example, the Work Group believes that a two sided incentive of plus or minus 10% is likely to promote change to a greater extent than a plus or minus 2% incentive. To accelerate and sustain progress throughout the entire health care system, the Work Group also believes that the size of this incentive should grow over time, as providers obtain greater experience in advancing quality while managing costs. A similar principle

applies to the setting of cost and quality benchmarks, in the sense that higher expectations for quality improvements and cost reductions are more effective at stimulating innovative approaches to care delivery.

At this time the Work Group classifies APMs without considering the intensity of the associated incentive payments because it believes that doing so would unnecessarily complicate the APM Framework. Using the example above, an episode based payment with a 10% financial risk/reward is classified the same as an episode based payment with a 2% financial risk/reward. The Work Group believes that more experience and analysis will be needed to determine what the “right” risk/reward level is to promote progress, while also recognizing that it may be different for hospitals and health systems than for physician organizations and health professionals. Nevertheless, the Work Group believes that a minimal threshold of risk and reward should be 5%, but likely greater.

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***Principle 6:** For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count towards the category of the most dominant APM. This will avoid double counting payments through APMs.*

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The Work Group recognizes that a particular payment model may utilize several APMs concurrently, especially as the model is evolving. For example, an ACO may utilize a shared savings model in years one and two along with nominal pay for performance incentives, and then transition to a shared risk model in year three. For the purpose of tracking progress in such hybrid cases, the entire payment model will be placed in the category that best captures the “dominant” APM (in this case, shared savings for years one and two, and shared risk in year three). It is also possible that bundled payments may be used within gainsharing, shared risk, and population health models, and that a patient centered medical home may be supported by FFS based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count towards the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed.

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***Principle 7:** Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them.*

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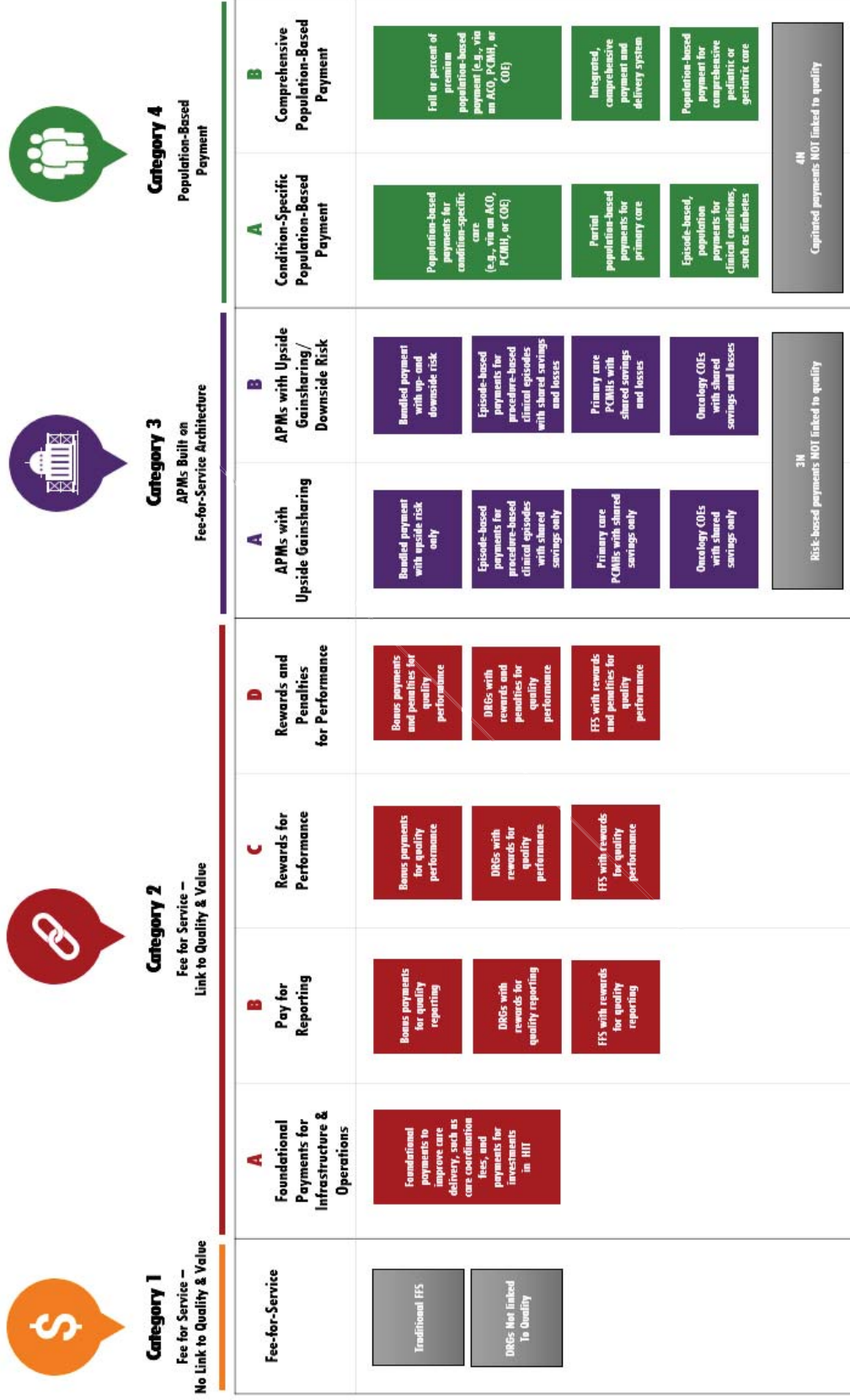
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they will be listed according to their underlying payment arrangement when they appear in the APM Framework. For example, a PCMH that participates in a shared savings/risk model will be classified in Category 3, but a PCMH that receives population based payments linked to value will be classified in Category 4. The Work Group recognizes that PCMHs and ACOs are commonly understood to be associated with risk sharing payment models. Nevertheless, the Work Group strongly

recommends maintaining a clear distinction between concepts that describe payment models and those that describe delivery models. At the same time, the Work Group believes these delivery models have been developed with the goal of driving care coordination and delivery improvements, and will enable more advanced payment models while at the same time requiring more advanced payment models to succeed. In recognition of their dramatic potential to improve the delivery of high quality and efficient health care, the Work Group elected to represent ACOs, PCMHs, and COEs in multiple categories, where corresponding APMs exist today and, likely, in the future.

## **The APM Framework**

The Work Group's APM Framework is depicted in Figure 4. The Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The following discussion identifies the organizing principles that serve as the foundation for each Category, explains how the Categories are differentiated, and highlights examples of APMs in each Category. Please note that the examples in Figure 4 are not meant to be exhaustive, but are rather intended to give a sense of possible arrangements in each of the subcategories.

Figure 4. APM Framework



■ = example payment models will not count toward APM goal. N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.



### ① *Fee for Service with No Link to Quality & Value (Category 1):*

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments are made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor for provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1. This is because the Work Group has determined that DRGs are used to reimburse a group of services delivered within a hospitalization, and while DRGs drive efficiencies in inpatient care, hospitals typically bill DRGs in much the same way that physicians bill services that are paid on a fee schedule. In both instances, the provider's incentive may be to bill for additional services because they are paid more for more volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter incentivizes infrastructure investments and/or involves some method of reporting or assessing the quality of the care delivered. Unlike payments made in Category 1, payments made in Category 2 are influenced by whether a provider invests in infrastructure, reports quality data, or achieves quality targets.

### ② *Fee for Service Linked to Quality & Value (Category 2):*

Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments that are made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.

The Work Group has split Category 2 into subcategories A, B, C, and D as outlined below:

- Payments placed into **Category 2A** involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, the Work Group considers these types of FFS or per member per month (PMPM) payments an important—though preliminary—step toward payment reform.
- Payments placed into **Category 2B** provide positive or negative incentives to report quality data to the health plan and—preferably—to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay for reporting program therefore gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan's reporting system. Because pay for reporting does not link payment to quality performance, the Work Group maintains that participation in Category 2B payment models should be time limited and that participation in Category 2B payment models will often evolve into subsequent categories.
- Payments are placed into **Category 2C** if they provide rewards for high performance on clinical quality measures. Much like pay for reporting programs, pay for performance programs that only reward high performance on quality metrics give providers an opportunity to acclimate themselves to the applicable reporting systems and measures before they are subject to penalties for low performance. In some instances, these programs have an extensive set of performance measures

that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in a hospital acquired infections.

- Payments placed into **Category 2D** reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive lower updates to their FFS baseline or may receive a percent reduction on all claims paid if they do not meet quality goals. (Please note that payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may take into account performance on a more limited set of cost measures.)

In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT). Although the Work Group was not tasked with developing specific recommendations on HIT and data sharing, it believes that providers should invest in interoperable systems; that administrative reporting requirements should be minimized as much as possible; that patients and caregivers should have free and ready access to patient records; and that HIT should be used to maintain patient registries and contribute to the development of clinical measures and guidelines.

As indicated in the discussion above, the Work Group expects that providers receiving Category 2A and 2B payments are investing in the HIT and other infrastructure needed to assess and improve quality performance, and that payments in these categories will be an “on ramp” to participation in subsequent categories. In other words, the Work Group expects that under most circumstances, providers and provider groups will transition quickly into Categories 2C and 2D, though they may do so in different ways. In the private sector, few payment plans support pay for reporting arrangements, and providers often move directly into pay for performance models. By contrast, Medicare pay for reporting programs typically precede and serve as the foundation for pay for performance programs in the same facility setting. Because data from the former determine payment adjustments in the latter, providers paid under that Medicare arrangement are typically eligible to receive both Category 2B and Category 2D payment adjustments. The Work Group stresses that the payment models in Categories 2A through 2C will prepare providers to take on the additional accountability and financial risk associated with APMs in Categories 3 and 4. This concept of Categories 2A and 2B as an “on ramp” for subsequent categories will be assessed as the Work Group measures and tracks progress towards adoption of APMs.

Payments that fall under Category 2 are distinguished from those that fall under Category 3 in two respects. First, Category 2 payments do not involve arrangements in which providers assume either shared savings or shared losses based on established cost targets. Second, FFS based payments in Category 3 reflect, to a greater degree, care that is provided longitudinally, such that multiple providers are responsible for the cost and quality associated with a particular set of procedures or services. By contrast, Category 2 payments are limited to specific providers.

### **3** *APMs Built on Fee for Service Architecture (Category 3):*

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account (as in Category 2), Category 3 payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. For APMs in Category 3, providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures, such as hip replacement or back surgery.

The Work Group has split Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. If a provider participating in a Category 3A APM meets quality targets but does not meet cost targets, then the provider is not held financially responsible for excess spending.
- Payments in **Category 3B** involve both upside gainsharing (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments) based on performance on cost measures.

Most ACO arrangements today can be placed into either Category 3A (most often) or Category 3B, depending on whether the underlying risk arrangement includes only upside gainsharing or both upside gainsharing and downside risk for providers. The Work Group believes payments in Category 3 will advance clinical integration and affordability to a greater extent than payments in Category 2 because risk sharing arrangements provide stronger incentives to manage health care costs and reward care coordination across the span of care.

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single payment that encompasses a broad array of services, whereas providers participating in Category 3 models are eligible for only a portion of the losses and/or savings they generate. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population. By contrast, even if they are fully capitated, payments that cover a more limited set of specialty services (including primary care) would be classified in Category 3. For example, a Category 4 model for pediatric care would have to cover a wide range of medical, preventive, and developmental services, whereas a population based payment model for primary care would fall under Category 3 if it did not hold primary care providers accountable for care coordination and the appropriate utilization of specialty services. Similarly, clinical episode payments tied to conditions (e.g., diabetes or cancer) fall under Category 4, whereas clinical episode payments tied to procedures (e.g., hip replacement or back surgery) fall under Category 3, even if they are made on a per member per month basis. As such, Category 4 payments are more person focused, insofar as they include stronger incentives to promote health and wellness throughout the care continuum.

#### ④ *Population Based Payment (Category 4):*

Payment models classified as Category 4 involve population based payments, structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined (4A) or overall (4B) budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventive health, health maintenance, and health improvement services, and these payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4A and 4B APMs are held accountable for delivering high quality, clinically necessary, and appropriate care.

The Work Group has split Category 4 into subcategories A and B as outlined below:

- **Category 4A** payments are limited to certain sets of condition specific services (e.g., asthma, diabetes, or cancer), but they remain person focused in the sense that they hold providers accountable for the total cost and quality of care related to that condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. The Work Group recognizes that in certain instances patient care will predominantly revolve around the management of particular types of conditions, such as cancer or heart disease. In such cases, we recognize that Category 4A may become a suitable and justifiable endpoint, especially for smaller provider organizations which may never be able to deliver certain types of care (such as transplants). Nevertheless, the Work Group maintains that providers should ideally be paid to maintain health and manage illness for an entire population, rather than compartmentalizing payments according to particular conditions. We also believe that condition specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population. For highly integrated delivery systems, the Work Group envisions that Category 4A payments will evolve into Category 4B.
- Payments in **Category 4B** are capitated or population based for all of the individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements with varying degrees of integration between plans and provider groups. On one end of the spectrum, plans and providers in Category 4B models may be virtually integrated. On the other end of the spectrum are highly integrated arrangements that are characterized by vertical integration of financing and care delivery, common ownership, and strong linkage across strategy, clinical performance, quality, and resource use. These groups may also have a higher percentage of salaried physicians. After reviewing the literature and discussing these highly integrated arrangements with people who operate within them, the Work Group has reached the conclusion that they can be ideally suited for delivering person centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. Although the underlying payment approaches were not sufficiently distinct to warrant the creation of a separate subcategory for highly integrated payment and delivery systems, the Work Group believes that these arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to quality and value incentives.

Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care. Nevertheless, the Work Group recognizes that not every market currently is suited to support APMs in Category 4, and that the journey to Category 4 will occur along different trajectories in different markets, based in significant part on the organization of care delivery systems.

## Conclusion

As set forth in this document, the Work Group is committed to the concept that transitioning from FFS to population based payments is critical for health care transformation. Keeping in mind the underlying principles, the APM Framework provides a high level mapping of payment approaches, as well as a pathway for payment reform and a foundation for measuring progress. The Work Group envisions that these mappings will be useful for all stakeholders and prove enduring as they navigate the health care ecosystem.

While the Work Group believes that this Framework identifies and encompasses all models of payment reform and will be enduring, Work Group members hope to return to the White Paper at a later date to take into account new developments in the health care sector. Nevertheless, the Work Group intends the APM Framework to be robust enough to accommodate foreseeable changes, and it strongly believes that this should become the overarching framework for discussing and evaluating payments in the U.S. health care system. The LAN intends to continue compiling and periodically releasing case studies of payment models. (See APM Framework White Paper Addendum.) The Work Group believes this is important because it will disseminate lessons learned and provide the nation with models to consider as public and private plans align around common payment approaches.

### *Stakeholders and the APM Framework*

*Patient Advocacy Groups* can use the APM Framework to understand the context behind plan and benefit design so that they can identify and communicate desirable elements and become empowered to participate in decisions about how to design payment plans and delivery systems.

*Providers* can use the APM Framework to make sense of the types of payment reforms underway, to achieve a better understanding of where they are situated, to begin to conceive of where they might like to end up, and—most importantly—to plan for the future.

*Plans* can use the APM Framework to drive payment and contracting models and as an accounting tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important, because adopting a common classification scheme would represent a first step towards the alignment of payment approaches.

*Purchasers* can use the APM Framework to engage and educate their employees about the health insurance landscape and to share information for population based plans, along with the safeguards and benefits that would tip them towards enrolling in such plans.

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## Appendix A: Work Group Members and Staff

### *Work Group Chair*

**Samuel R. Nussbaum, MD**

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### *Work Group Members*

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Executive Vice President, Health Care Services and Chief Medical Officer, Cambia Health Solutions and Regence Health Insurance Company

**Rahul Rajkumar, MD, JD**

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**Jeffrey Rideout, MD, MA, FACP**

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**Dick Salmon, MD, PhD**

National Medical Director, Performance Measurement and Improvement, CIGNA

**Julie Sonier**

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**Lisa Woods**

Senior Director Health Care Benefits, Wal-Mart Stores, Inc.

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CAMH, sponsored by CMS, is an FFRDC operated by The MITRE Corporation. MITRE is chartered to work in the public interest.

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CPR is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S.

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**Andréa Caballero**

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Table 1  
Positive QS(i) and IS(i) - Score Values for Lookup

Table with 100 columns (0.01 to 1.00) and 100 rows (0.01 to 1.00). Each cell contains a numerical value representing a score. The values are generally small, ranging from approximately 0.01 to 1.00, and are arranged in a grid pattern. The table is titled 'Exhibit D, VBP, Attachment B - QIS Lookup Table'.

## Exhibit E-2

### Challenge Pool Value-Based Purchasing Incentives

#### 1. Value-Based Purchasing Incentives

- 1.1. As outlined in HCA's Value-Based Roadmap and Apple Health Appendix, which can be found on HCA's website and is incorporated by reference, funding will be available under the terms of this Exhibit to encourage the transition among MCOs to Alternative Payment Models (APMs). This Exhibit describes the funds that are available and the conditions under which these funds may be earned, including reporting requirements and the performance measures that will be used.
- 1.2. The Challenge Pool described in this Exhibit, and from which all funds earned under this Exhibit will be drawn, is a pool of funding that will be distributed annually based on reporting and performance metrics that are defined under HCA's Apple Health Contracts, including Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care contracts. Where more than one of these contracts is effective between HCA and the Contractor, the amount earned under this Exhibit will not be calculated separately for each contract, but will be calculated as a single payment to the Contractor based on data aggregated from each of the Contractor's Apple Health Contract(s). Each Apple Health Contract includes the same Challenge Pool Exhibit, describing the same pool of funding and set of conditions under which these funds may be earned.
- 1.3. The funding that the Contractor is eligible to receive under this Exhibit draws from annual Delivery System Reform Incentive Payment System (DSRIP) funds via the Healthier Washington Medicaid Transformation (Medicaid Transformation) may be earned under Sections 2, 3 and 4 of this Exhibit. The Total Available Funds per year is set out in Table 1 of this Exhibit. The amounts in Table 1 are subject to amendment by HCA without prior notice to the Contractor and subject to the availability of state and federal funding.
- 1.4. The Base Earnable Funds (BEF) is the amount that the Contractor can earn under Sections 2 and 3 of this Exhibit. The BEF will be a share of the annual DSRIP Funds based on the Contractor's share of the total attributed member months under signed Apple Health Contracts for the year. The Contractor's BEF shall be calculated as the Contractor's attributed state-wide managed care member months for the Performance Year divided by the state wide managed care member months for the Performance Year, multiplied by total state-wide DSRIP Funds available for that Performance Year. The Contractor's Base Earnable Funds for the Performance Year may be earned on two bases, referred to as Pay for Reporting (P4R) and Pay for Performance (P4P).
- 1.5. In the event that the Contractor or any other HCA-contracted Apple Health MCO does not earn the full BEF that have been allocated to it for a Performance Year under the P4R and P4P terms set out in the Apple Health Contracts, the unearned Challenge Pool Remaining Funds will be distributed to the MCOs using a formula that accounts for the MCO's achievement related to high level APMs (HCP LAN

Categories 3A-4B) as well as the MCO's Quality Improvement Score (QIS) as calculated under the Contractor's Apple Health Contract(s). The conditions under which the Contractor may earn these Challenge Pool Remaining Funds are set out in Section 4 of this Exhibit.

- 1.6. For purposes of this Exhibit, reporting and measurement relating to the adoption of APMs will be based on the APM categorization set out in the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated January 12, 2016, attached as Attachment A (Whitepaper) of the VBP Exhibit. The performance measures will assess the percentage of Contractor payments to providers that fits into each APM category under the Whitepaper.
- 1.7. The Challenge Pool will operate over the five-year period as set out in Table 1. Table 1 shows the relevant time periods, and the division of funding in each year between P4R and P4P.

**Table 1**  
**Performance Years, Time Periods and Thresholds**

Time Periods			Funding			
Year	Performance Year	Improvement Baseline Year	Total Available (millions)	Base Earnable Funds (BEF)	P4R Portion of BEF	P4P Portion of BEF
PY1	1/1/17 – 12/31/17	1/1/16 – 12/31/16	\$0	\$0	75%	25%
PY2	1/1/18 – 12/31/18	1/1/17 – 12/31/17	\$8	TBD	50%	50%
PY3	1/1/19 – 12/31/19	1/1/18 – 12/31/18	\$8	TBD	25%	75%
PY4	1/1/20 – 12/31/20	1/1/19 – 12/31/19	\$8	TBD	0%	100%
PY5	1/1/21 – 12/31/21	1/1/20 – 12/31/20	\$8	TBD	0%	100%

- 1.8. The conditions for earning full or partial payment of the funds identified in Table 1 are set out below.
- 1.9. During the Performance Year, the Contractor may, at its discretion, seek feedback from HCA on whether provider payment arrangements qualify as APMs that will result in earned Challenge Pool funds.

**2. Pay for Reporting (P4R)**

- 2.1. The Pay for Reporting (P4R) portion of the Base Earnable Funds will be available to the Contractor for the complete and timely reporting of data required to assess the Contractor’s progress toward meeting performance targets. The amount of the P4R portion of Base Earnable Funds will be determined by HCA as set out in Table 1.
- 2.2. The required data to be submitted under this Section is set out in the VBP Exhibit to the Contractor’s Apple Health Contract(s) with HCA. All terms for the submission of data in the VBP Exhibit identified in this subsection are applicable here and must be met for HCA to deem that the Contractor has met the terms of this Section.
- 2.3. If all requirements are met under this Section, then the full amount of the P4R portion will be due to the Contractor. If all requirements under this Section are not met, then no funds will be paid to the Contractor under this Section.

**3. Pay for Performance (P4P)**

- 3.1. The Pay for Performance (P4P) portion of Base Earnable Funds will be available to the Contractor based on its performance in adopting Alternative Payment Models as set out in this Section. The amount of the P4P portion of Base Earnable Funds will be determined by HCA as set out in Table 1.
- 3.2. The amount of the P4P Portion of the Base Earnable Funds that the Contractor earns will be determined by a model that incorporates attainment of thresholds and targets, and improvement over the Contractor’s APM adoption levels in the Baseline Year. Each of these elements is set out in Table 2.

**Table 2  
P4P Weights, Targets and Thresholds**

Year	Performance Targets & Thresholds			Calculation Weight		
	HCP LAN 2C-4B Target	HCP LAN 3A-4B Threshold Score*	MACRA A-APMs Target	Achievement Score	Achievement Subset Score	Improvement Score
PY1	30%	N/A	N/A	40%	0%	60%
PY2	50%	10%	N/A	35%	5%	60%
PY3	75%	20%	10%**	45%	5%	50%
PY4	85%	30%	TBD	50%	5%	45%
PY5	90%	50%	TBD	55%	5%	40%

\* In all years the HCP LAN 3A-4B Threshold Score applies under Section 4 of this Exhibit. In PY4 and PY5 the HCP LAN 3A-4B Threshold Score is additionally applicable under subsection 3.3.5 of this Exhibit.

\*\*This percentage is subject to approval by the Centers for Medicare and Medicaid Services (CMS).

- 3.3. By meeting each of the Performance Targets and Thresholds set out in Table 2, the Contractor can earn all or part of the P4P portion of the Total Earnable Funds available to the Contractor. HCA will determine the amount of Base Earnable Funds that the Contractor can earn as follows.
- 3.3.1. The Contractor's Achievement Percentages for the Performance Year will be established using the data submitted by the Contractor and validated as set out in the Contractor's Apple Health Contract(s), the definition of "Assessed Payments," and other terms included in Contractor's Apple Health Contract(s). VBP adoption Achievement Percentages are measured as the share of MCO Assessed Payments to providers via one or more specified APMs out of total MCO Assessed Payments to providers. For purposes of these measures, MCO Assessed Payments by category of APM and total MCO Assessed Payments to providers will be aggregated across Contracts identified in this subsection. Failure to provide data by the deadlines set out in any of the Contracts referenced in this subsection may result in loss of eligibility to earn any funds under this Exhibit.
- 3.3.2. Achievement Score: In each Performance Year HCA will calculate an Achievement Score for the Contractor. The Contractor will have reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1) if the Contractor's Achievement Percentage for HCP LAN categories 2C-4B is equal to or greater than the HCP LAN 2C-4B Target for the Performance Year. The Contractor will have reached or exceeded the HCP LAN 3A-4B Threshold Score for the Performance year (AS Item 2) if the Contractor's Achievement Percentage for HCP LAN categories 3A-4B is equal to or greater than the HCP LAN 3A-4B Target for the Performance Year. The Contractor will have reached or exceeded the MACRA A-APMs Target for the Performance Year (AS Item 3) if the Contractor's Achievement Percentage for MACRA A-APMs is equal to or greater than the MACRA A-APMs Target for the Performance Year.
- 3.3.2.1. For PY2: If the Contractor has reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1), then the Achievement Score will be 100 percent. If not, the Achievement Score shall be zero percent.
- 3.3.2.2. For PY3, PY4 and PY5: The Achievement Score will consist of three additive parts. If the Contractor has reached or exceeded AS Item 1 under subsection 3.3.2 for the Performance Year, the Contractor earns 50 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 2 under subsection 3.3.2 for the Performance Year, the Contractor earns 40 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 3 for the Performance Year, the Contractor earns 10 percent toward the Achievement Score. For instance, if the Contractor has reached or exceeded AS Item 1 and AS Item 3, but not AS Item 2, then the Achievement Score

shall be 60 percent for the Performance Year (50 percent + 10 percent). If the Contractor has not reached or exceeded any of the three AS Items for the Performance Year, then the Achievement Score shall be zero percent.

- 3.3.3. Achievement Subset Score: In PY2, PY3, PY4, and PY5 HCA will assess whether the Contractor has met an annual Subset Attainment Target. In PY2, the Subset Attainment Target requires that the Contractor have at least one VBP contract in HCP-LAN category 3B or above. In PY3, the Subset Attainment Target additionally requires that the Contractor achieve certification from CMS for at least one VBP arrangement as an Other Payer Advanced Alternative Payment Model under the MACRA Quality Payment Program. A single contract may satisfy the PY2 and PY3 requirements in this subsection. If the Contractor has met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be 100 percent, and if the Contractor has not met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be zero percent.
- 3.3.4. Improvement Score: In each Performance Year HCA will calculate an Improvement Score for the Contractor. If the Contractor has met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be 100 percent. If the Contractor has not met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be calculated as the percent change from the Improvement Baseline Year achievement percentage for HCP LAN 2C-4B to the Performance Year achievement percentage for HCP LAN 2C-4B such that  $\text{Improvement Score} = (\text{Performance Year Achievement Percentage} - \text{Improvement Baseline Year Achievement Percentage}) / \text{Improvement Baseline Year Achievement Percentage}$ . Where the prior calculation produces a negative percentage, the Improvement Score shall be zero percent. The Improvement Score is capped at 100 percent.
- 3.3.5. HCP LAN 3A-4B Threshold Score: An achievement threshold applies in years four and five for HCP LAN 3A – 4B such that no funds under the P4P portion of Base Earnable Funds may be earned by the Contractor unless the threshold is met.
- 3.3.6. In each year, the Contractor's total P4P Score will be calculated as follows. First, the Achievement Score, Achievement Subset Score, and Improvement Score will each be multiplied by their respective weights as set out in Table 2. The resulting products will be summed to produce the provisional P4P score. In PY2 and PY3 the provisional P4P score will be the final P4P score for the Contractor. In PY4 and PY5 the provisional P4P score will be the final P4P score for the Contractor if the Contractor has met the HCP LAN 3A-4B Threshold Score, but if the Contractor has not met the HCP LAN 3A-4B Threshold Score then the final P4P score will be zero percent. In all years the final P4P score will range from zero percent to 100 percent.

- 3.3.7. The Contractor's final P4P Score will represent the percent of the P4P Portion of the Contractor's Base Earnable Funds that the Contractor is eligible to receive.

#### 4. Remaining Challenge Pool Funds Share

- 4.1. If funds remain in the Challenge Pool for a given Performance Year as described in subsection 1.5 of this Exhibit, the Challenge Pool Remaining Funds will be distributed as set out in this Section.
- 4.2. Each MCO with Apple Health Contract(s), will be eligible to earn a Challenge Pool Remaining Funds Share that is determined by two factors as follows.
- 4.2.1. HCP LAN 3A-4B Threshold Score: First HCA will determine if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year set out in Table 2. To make this determination, HCA will use the data and methodology outlined in subsection 3.3.1 of this Exhibit to establish the HCP LAN 3A-4B achievement percentage for the MCO. If the MCO's annual HCP LAN 3A-4B achievement percentage is less than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share for the MCO will be zero percent of the Challenge Pool Remaining Funds. If the MCO's annual HCP LAN 3A-4B achievement percentage is equal to or greater than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share shall be calculated under subsection 4.2.2 below.
- 4.2.2. Relative QIS Adjusted for Relative Membership: Second, if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year then the MCO will receive a percentage of the Challenge Pool Remaining Funds that is determined by the relative magnitude of each MCO's all-contract QIS score established under the Contractor's Apple Health Contract(s), adjusted for attributed member months per MCO.
- 4.2.2.1. To calculate the Contractor's all-contract QIS score, HCA will calculate an average of the Contractor's QIS score calculated under the Contractor's Apple Health Contract(s), weighted by the share of Apple Health Managed Care Member Months attributable to each contract for the Performance Year. The same methodology will be used to calculate an all-contract QIS score for each of HCA's contracted Apple Health MCOs.
- 4.2.2.2. The all-contract QIS scores of all MCOs that meet the HCP LAN 3A-4B Threshold Score will be summed to find the Challenge Pool Remaining Funds Denominator. For each MCO that meets the HCP LAN 3A-4B Threshold Score, the preliminary Challenge Pool Remaining Funds Share for the MCO shall then be calculated as the all-contract QIS for the MCO divided by the Challenge Pool Remaining Funds Denominator times the total Challenge Pool Remaining Funds under subsection 1.5 of this Exhibit. Finally, the preliminary Challenge Pool Remaining Funds Share for the MCO will be adjusted for attributed member months to produce the final Challenge Pool Remaining Funds Share for the MCO. For this



adjustment, HCA will multiply the preliminary Challenge Pool Remaining Funds Share by a Member Months Index and readjust the resulting product for each qualifying MCO on a proportional basis so that the percentage share for all MCOs adds up to 100 percent of Challenge Pool Remaining Funds.

- 4.2.2.3. The Member Months Index referenced in subsection 4.2.2.2 will be calculated for each MCO by dividing attributed member months for the MCO over the Performance Year by the average MCO attributed member months over the Performance Year.

## **5. Payment**

- 5.1. The total amount that the Contractor is eligible to receive under this Exhibit will be the sum of the amounts earned under Sections 2 and 3 of this Exhibit for Reporting (P4R) and Performance (P4P), plus the Challenge Pool Remaining Funds Share for the Contractor under Section 4 of this Exhibit.
- 5.2. On or before October 30th following the end of each Performance Year, HCA will provide the Contractor with a completed Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit to notify the Contractor in writing of its Challenge Pool Value-Based Purchasing Incentives Earned based on the calculations described in this Exhibit.
- 5.3. The Contractor will have 20 calendar days from the date the Contractor is notified of its Challenge Pool Value-Based Purchasing Incentives Earned to review and sign the Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit and return to HCA, in writing, of any alleged discrepancies with the calculations.
- 5.4. If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.
- 5.5. HCA will schedule payment for the percentage of the Challenge Pool Value-Based Purchasing Incentives Earned no later than June 30th following the receipt of Challenge Pool Calculation Summary Form.

Exhibit E-2, Attachment 1  
Challenge Pool Calculation Summary Form

Contractor/Vendor Name: \_\_\_\_\_

Contract No: \_\_\_\_\_

Performance Period: \_\_\_\_\_ to \_\_\_\_\_

Base Earnable Funds

Base Earnable Funds for Performance year: \_\_\_\_\_

P4R Portion For Performance Year: \_\_\_\_\_

P4P Portion For Performance Year: \_\_\_\_\_

P4R

All Reporting requirements met: \_\_\_\_\_

Reporting elements not met: \_\_\_\_\_

Percent of P4R Portion of Base Earnable Funds Earned: \_\_\_\_\_

P4P

Assessed Payments

Total Assessed Payments: \_\_\_\_\_

Assessed Payments Categories 2C-4B: \_\_\_\_\_

Assessed Payments Categories 3A-4B: \_\_\_\_\_

Percent of all-contract payments in Categories 2C-4B

Performance Year: \_\_\_\_\_

Improvement Baseline Year: \_\_\_\_\_

All Subset Attainment Target Requirements Met: \_\_\_\_\_

Thresholds Met or Not Applicable for Performance Year: \_\_\_\_\_

Achievement Score: \_\_\_\_\_

Performance Weight: \_\_\_\_\_

Achievement Subset Score: \_\_\_\_\_

Achievement Subset Weight: \_\_\_\_\_

Improvement Score: \_\_\_\_\_

Improvement Weight: \_\_\_\_\_

Performance Threshold Score: \_\_\_\_\_

Percent of P4P Portion of Base Earnable Funds Earned: \_\_\_\_\_

Challenge Pool Remaining Funds and Share

Challenge Pool Remaining Funds Available to all HCA MCOs: \_\_\_\_\_

Contractor's all-contract QIS Score: \_\_\_\_\_

Challenge Pool Remaining Funds Denominator: \_\_\_\_\_

Member Months Index: \_\_\_\_\_

Percent of all-contract Assessed Payments in Categories 3A-4B: \_\_\_\_\_

HCP-LAN 3A-4B Threshold Score for Performance Year: \_\_\_\_\_

HCP-LAN 3A-4B Achievement Score for Performance Year: \_\_\_\_\_

Percent of Challenge Pool Remaining Funds Earned: \_\_\_\_\_

Totals

P4R Funds Earned: \_\_\_\_\_

P4P Funds Earned: \_\_\_\_\_

Challenge Pool Remaining Funds Share: \_\_\_\_\_

Total Challenge Pool Value-Based Purchasing Incentives Earned: \_\_\_\_\_

Washington State Health Care Authority Chief Financial Officer Signature:

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Signature

Date

---

Print Name & Title

---

Email Address

Contractor hereby agrees to the accuracy of this Challenge Pool Calculation Summary and the underlying calculations.

---

Contractor Authorized Agent Signature

---

Signature

Date

---

Print Name & Title

---

Email Address

**Exhibit F**  
**Washington State Health Care Authority**  
**Instructions for MLR Reporting**  
**Apple Health Managed Care**

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## **Introduction**

These instructions are for the Excel-based MLR Reporting Template. The Excel workbook is designed to collect all information needed for MLR reporting as required by CMS in 42 CFR §438.8. The federal rule regarding MLR requires that all Medicaid managed care contracts require the contracted managed care organizations to calculate and report a MLR.

The MLR Reporting Template is to be completed and submitted to the Health Care Authority (HCA) via MC-Track by May 31<sup>st</sup> of the year following the MLR reporting year. For example the first report is due May 31, 2019.

If the state were to make a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit new MLR reports to the state for all impacted reporting years.

Throughout these instructions there will be references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. All regulations are part of 42 CFR unless cited otherwise. The information requested by the report follow regulation [§ 438.8\(k\)](#).

## **General Requirements**

The Contractor will aggregate data for all Medicaid eligibility groups covered under this contract unless the state requires separate reporting and a separate MLR calculation for specific populations. If the data is aggregated, a description of the aggregation method used to calculate total incurred claims for each reporting year.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

## **Plan Information**

Please fill out the contact information of your MCO.

## **Numerator**

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

The expenditures reported by the Contractor shall include non-claims costs and expenditures related to activities compliant with program integrity requirements 438.608(a)(1) - (5); 438.608(a)(7) - (8); and 438.608(b).

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

## **NUMERATOR: INCURRED CLAIMS**

**Line 1.1** Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ [438.8\(e\)\(2\)\(i\)\(A\)](#) and [438.8\(e\)\(2\)\(i\)\(B\)](#):

(A) Direct claims that the MCO paid to providers for services or supplies covered under the contract and services meeting the requirements of § [438.3\(e\)](#) provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

**Line 1.2** Incurred but not reported (IBNR) for claims incurred in the period expected to be paid in months after the known runout. This requires the MCO to estimate the cost of claims owed but not yet received. See § [438.8\(e\)\(2\)\(i\)\(F\)](#)

**Line 1.3** Withholds from payments made to network providers: See § [438.8\(e\)\(2\)\(i\)\(C\)](#)

**Line 1.4** Amount of incentive and bonus payments made, or expected to be made, to network providers: See § [438.8\(e\)\(2\)\(iii\)\(A\)](#)

**Line 1.5** Changes in other claims-related reserves: See § [438.8\(e\)\(2\)\(i\)\(G\)](#)

**Line 1.6** Reserves for contingent benefits and the medical claim portion of lawsuits: See § [438.8\(e\)\(2\)\(i\)\(H\)](#)

**Line 1.7** Net payment or receipts related to state-mandated solvency funds: See § [438.8\(e\)\(2\)\(iv\)](#)

**Line 1.8a** Amount spent on fraud reduction: See § [438.8\(e\)\(2\)\(iii\)\(B\)](#)

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities specified in paragraph (e)(4) of this section. § [438.8\(e\)\(4\)](#): *Fraud prevention activities. MCO expenditures on activities related to fraud prevention as adopted for the private market at [45 CFR part 158](#). Expenditures under this paragraph must not include*

*expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.*

**Line 1.8b** Amount of claims payments recovered through fraud reduction: See also Line 1.8a.

### **Items Deducted from Incurred Claims**

**Line 1.9** Claims that are recoverable for anticipated coordination of benefits (payments from third party payors): See § [438.8\(e\)\(2\)\(i\)\(D\)](#)

**Line 1.10** Claims payments recoveries received as a result of subrogation: See § [438.8\(e\)\(2\)\(i\)\(E\)](#)

**Line 1.11** Overpayment recoveries received from network providers: The State expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system. See § [438.8\(e\)\(2\)\(ii\)\(A\)](#)

**Line 1.12** Prescription drug rebates received and accrued: See § [438.8\(e\)\(2\)\(ii\)\(B\)](#)

### **NUMERATOR: ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY**

**Line 2.1** MCO activity that meets [45 CFR § 158.150\(b\)](#) and is NOT EXCLUDED under [45 CFR § 158.150\(c\)](#): See § [438.8\(e\)\(3\)\(i\)](#)

**Line 2.2** MCO activity related to any EQR-related activity as described in §§ [438.358\(b\)](#) and [438.358\(c\)](#): See § [438.8\(e\)\(3\)\(ii\)](#)

**Line 2.3** MCO expenditure that is related to Health Information Technology and meaningful use: See § [438.8\(e\)\(3\)\(iii\)](#)

### **Excluded Non-Claim Costs**

This worksheet collects information for items excluded from the numerator, but is required to be reported. Note that incurred claims by one MCO that are later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

**Line 3.1** Amounts paid to third party vendors for secondary network savings: See § [438.8\(e\)\(2\)\(v\)\(A\)\(1\)](#)

Payments made by one managed care plan to another vendor to purchase their network

for use as a secondary network. In practice, the managed care plan purchases another managed care plan's network to serve as contracted, out-of-network providers so as to avoid single-case agreements with those providers, resulting in savings on out-of-network service costs.

**Line 3.2** Amounts paid to third party vendors for network development, admin fees, claims: processing, and utilization management: See § [438.8\(e\)\(2\)\(v\)\(A\)\(2\)](#)

**Line 3.3** Amounts paid to a provider for professional or administrative services outside of providing services to enrollees: See § [438.8\(e\)\(2\)\(v\)\(A\)\(3\)](#)

Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

§ 438.3(e): See Line 1.1

**Line 3.4** Fines and penalties assessed by regulatory authorities: See § [438.8\(e\)\(2\)\(v\)\(A\)\(4\)](#)

**Line 3.5** Amounts paid to the State as remittance for prior MLR experience: See § [438.8\(e\)\(2\)\(v\)\(B\)](#)

Remittance to the State if specific MLR is not met.

**Line 3.6** Amounts for pass-through payments under § [438.6\(d\)](#): See § [438.8\(e\)\(2\)\(v\)\(C\)](#)  
Amounts paid to network providers under to § [438.6\(d\)](#).

## **Denominator**

### **DENOMINATOR: PREMIUM REVENUE**

This worksheet collects information for the denominator. Note that the total amount of the denominator for a MCO, which is later assumed by another entity, must be reported by the assuming MCO for the entire MLR reporting year, and no amount for that year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

**Line 4.1** State capitation payments, including adjustments, excluding pass-through payments: See § [438.8\(f\)\(2\)\(i\)](#)

State capitation payments, developed in accordance with § [438.4](#), to the MCO for all enrollees under a risk contract approved under § [438.3\(a\)](#), excluding payments made under to § [438.6\(d\)](#).

**Line 4.2** State developed one time payments for specific life events of enrollees: See §



[438.8\(f\)\(2\)\(ii\)](#)

**Line 4.3** Earned premium withholds approved under § [438.6\(b\)\(3\)](#): See § [438.8\(f\)\(2\)\(iii\)](#)  
Other payments to the MCO approved under § [438.6\(b\)\(3\)](#)

**Line 4.4** Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract: See § [438.8\(f\)\(2\)\(iv\)](#)  
Unpaid cost-sharing amounts that the MCO could have collected from enrollees under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect.

**Does not apply.**

**Line 4.5** All changes to unearned premium reserves: See § [438.8\(f\)\(2\)\(v\)](#)  
**Does not apply.**

**Line 4.6** Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms referenced in § [438.5](#) and § [438.6](#) are risk adjustment, risk corridors, reinsurance, and stop loss limits: See § [438.8\(f\)\(2\)\(vi\)](#)

**DENOMINATOR: FEDERAL, STATE, AND LOCAL TAXES**

Taxes paid by the MCO if applicable.

**Line 5.1** Statutory assessments to defray the operating expense of any state or federal department: See § [438.8\(f\)\(3\)\(i\)](#)  
**Does not apply.**

**Line 5.2** Examination fees in lieu of premium taxes as specified by state law: See § [438.8\(f\)\(3\)\(ii\)](#)  
**Does not apply.**

**Line 5.3** Federal taxes and assessments allocated to MCOs: See § [438.8\(f\)\(3\)\(iii\)](#)  
Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

**Line 5.4** State and local taxes and assessments: See § [438.8\(f\)\(3\)\(iv\)](#)  
(iv) State and local taxes and assessments including:  
(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.  
(B) Guaranty fund assessments.  
(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.  
(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.  
(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

**Line 5.5** Amounts otherwise exempt from Federal income taxes for community benefit expenditures: See § [438.8\(f\)\(3\)\(v\)](#)

[45 CFR § 158.162\(c\)](#)

- (c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:
- (1) Are available broadly to the public and serve low-income consumers;
  - (2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
  - (3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
  - (4) Leverage or enhance public health department activities such as childhood immunization efforts; and
  - (5) Otherwise would become the responsibility of government or another tax-exempt organization.

### **MLR Calculation**

This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. There are also inputs for member months and credibility adjustments if applicable. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible but the Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

**The MCO should enter the number of member months in the appropriate cell.**

The State has elected a minimum MLR of 85%

### **Expense Allocation**

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document: See § [438.8\(g\)](#)

Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the

remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results and shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

### **Remittance Calculation**

Remittance of amounts owed to the State will be calculated as described in Gain Share Program section of the AHFC contract.

### **Financial Comparison**

Per § [438.8\(k\)\(1\)\(xi\)](#), a comparison of the financial amounts included in this report and what is reported in audited financials is required. Show the comparison in this worksheet or reference an attached document with the comparison.

### **MLR Report Summary**

This worksheet summarizes the information requested by CMS and meets § [438.8 \(k\)](#).

### **Attestation**

An attestation to the accuracy of this MLR report is required per § [438.8\(n\)](#), § 438.604(a)(3), and § 438.606.

**Exhibit G**  
**DATA USE, SECURITY AND CONFIDENTIALITY**

**1. Definitions**

The definitions below apply to this Exhibit:

- 1.1. **“Authorized User”** means an individual or individuals with an authorized business need to access HCA's Confidential Information under this Contract.
- 1.2. **“Breach”** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract 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 Contract. For purposes of this Exhibit, 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”** 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, webservices, 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 Exhibit 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, *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>. Section 4 is hereby incorporated by reference.)

The Data that is the subject of this Contract 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 Contract does not constitute a release of the Data for the Contractor’s discretionary use. Contractor must use the Data received or accessed under this Contract only to carry out the purpose of this Contract. Any ad hoc analyses or other use or reporting of the Data is not permitted without HCA’s prior written consent.
- 3.2. Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.
- 3.3. The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.
  - 3.3.1. Contractor must identify:
    - 3.3.1.1. Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and
    - 3.3.1.2. 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. Contractor 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 Contract.

## 4. Security of Data

- 4.1. Data Protection
  - 4.1.1. The Contractor must protect and maintain all Confidential Information gained by reason of this Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor 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. Contractor 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.](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 Contract.
  - 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 Contractor must use a Trusted System.
  - 4.2.3. Protection of Data. The Contractor 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 HCA 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. HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor 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. HCA Data received under this Contract must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the Contractor, all of HCA's Data can be identified for return or destruction. It also aids in determining whether HCA's Data has or may have been compromised in the event of a security breach.

HCA'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 HCA Data;

4.2.4.1.2. In a logical container on electronic media, such as a partition or folder dedicated to HCA's Data;

4.2.4.1.3. In a database that contains only HCA Data;

4.2.4.1.4. Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;

4.2.4.1.5. Physically segregated from non-HCA 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 HCA's Data from non-HCA data, both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Exhibit.

4.3. Data Disposition

4.3.1. Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA 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 Exhibit 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 Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:

5.1.1.1. (a) as provided by law; or

5.1.1.2. (b) 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 Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (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 Exhibit before gaining access to the Data identified herein. The Contractor will ensure that

any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.

5.2.2. The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and non-disclosure requirements of Data under this Contract. The Contractor 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 Contractor will make this documentation available to HCA upon request.

5.3. Penalties for Unauthorized Disclosure of Data

5.3.1. The Contractor 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 Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

**6. Data Shared with Subcontractors**

6.1. If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract 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 HCA Privacy Officer at [PrivacyOfficer@hca.wa.gov](mailto:PrivacyOfficer@hca.wa.gov) and to the Managed Care Contract Manager at [hcamcprograms@hca.wa.gov](mailto:hcamcprograms@hca.wa.gov) within five (5) business days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within 15 business days of discovery. To the extent possible, these reports must include the following:

7.1.1. The identification of each 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 Contractor 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 Enrollees whose PHI is believed to have been used or disclosed and the steps those Enrollees should take to protect themselves; and

7.1.6. Any other information HCA reasonably requests.

7.2. The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA 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 Contractor must notify HCA in writing, as described in the *General Terms and Conditions* section, *Notices*, within two (2) business days of determining notification must be sent to enrollees.

7.4. At HCA's request, the Contractor will provide draft Enrollee notification to HCA at least five (5) business days prior to notification, and allow HCA an opportunity to review and comment on the notifications.

7.5. At HCA's request, the Contractor 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 Contractor must perform all of its duties, activities, and tasks under this Contract 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 Contractor and Contractor's subcontracts must fully cooperate with HCA efforts to implement HIPAA requirements.
- 8.2. Within ten business days, Contractor must notify the HCA Privacy Officer at [PrivacyOfficer@hca.wa.gov](mailto:PrivacyOfficer@hca.wa.gov), with a copy to the Managed Care Contract Manager at [hcamcprograms@hca.wa.gov](mailto:hcamcprograms@hca.wa.gov), 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 HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines, or sanctions imposed against Contractor for violations of HIPAA or the HIPAA Rules and for any sanction imposed against its Subcontractors or agents for which it is found liable.

## **9. Inspection**

- 9.1. HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of Contractor 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 Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.

## **Exhibit H-2 Health Homes**

### **1. Health Homes Definitions**

- 1.1. “Aging and Long-Term Support Administration (AL TSA)” means the administration within the Department of Social and Health Services responsible for providing long-term services and supports to individuals who are functionally and financially eligible to receive such services.
- 1.2. “Allied or Affiliated Staff” means community health workers, peer counselors, wellness or health coaches or other non-clinical personnel who provide supportive services outreach and engagement to the enrollee under the direction and supervision of the Health Home Care Coordinator.
- 1.3. “Area Agency on Aging (AAA)” means a network of State and local programs that help older people to plan and care for their life long needs.
- 1.4. “Authorizing Entity” means an organization contracted by the State to approve or disapprove covered benefits for Medicaid beneficiaries following utilization guidelines. Examples include Managed Care Organizations, Behavioral Health Organizations, and Home and Community-based Services Providers.
- 1.5. “Behavioral Health Organization (BHO)” means a single or multiple-county authority or other entity operating as a prepaid inpatient health plan through which the agency or the agency’s designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area to enrollees who meet Access to Care Standards.
- 1.6. “Behavioral Health Services” means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.
- 1.7. “Care Coordination Organization (CCO)” means an organization within the Qualified Health Home network that is responsible for delivering Health Home services.
- 1.8. “Caregiver Activation Measure® (CAM®)” means an assessment that gauges the knowledge, skills and confidence essential to a caregiver providing care for a person with chronic conditions.
- 1.9. “Comprehensive Assessment Report and Evaluation (CARE)” means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC.
- 1.10. “Coverage Area(s)” means pre-determined geographical areas composed of specific counties.
- 1.11. “Department of Social and Health Services (DSHS)” means the Washington State Department of Social and Health Services.
- 1.12. “Designated Staff” means either the Contractor’s employee(s) or employee of any Subcontractor or employees of any Health Home Provider with whom the Contractor

has a MOA to provide Health Home Services to the Contractor's enrollees and whom have been authorized by their employer to access data.

- 1.13. "Developmental Disabilities Administration (DDA)" means the administration within the Department of Social and Health Services that provides services to individuals with disabilities who are functionally and financially determined to receive such services.
- 1.14. "Engagement" means the enrollee's agreement to participate in Health Homes as demonstrated by the completion of the enrollee's Health Action Plan.
- 1.15. "Fee-For-Service (FFS)" means the Medicaid delivery system that provides covered Medicaid benefits to eligible beneficiaries through any willing and contracted provider. Providers are paid on a per service basis.
- 1.16. "Full Dual Eligible" means a Medicare Beneficiary who is also eligible for the full scope of Medicaid covered benefits.
- 1.17. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the enrollee's health or health outcomes.
- 1.18. "Health Action Plan (HAP)" means an enrollee-prioritized plan identifying what the enrollee plans to do to improve his or her health.
- 1.19. "Health Home Care Coordinator" means an individual employed by the Contractor or a CCO who provides Health Home Services.
- 1.20. "Health Home Participation Authorization and Information Sharing Consent Form" means a release form signed by the enrollee to confirm the Enrollee's consent to participate in the health home program and to authorize the release of information to facilitate the sharing of the enrollee's health information.
- 1.21. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six (6) Health Home Services are:
  - 1.21.1. Comprehensive Care Management
  - 1.21.2. Care Coordination and Health Promotion
  - 1.21.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up
  - 1.21.4. Individual and Family Support
  - 1.21.5. Referral to Community and Social Support Services
  - 1.21.6. The use of Health Information Technology to link services, as appropriate
- 1.22. "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.
- 1.23. "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives.
- 1.24. "Memorandum of Agreement/Understanding (MOA or MOU)" means a business agreement for partnerships that do not involve a financial arrangement describing the roles and responsibilities of each party to the agreement.

- 1.25. "Multidisciplinary Team" means a group of clinical and non-clinical staff, such as primary care providers, mental health professionals, chemical dependency treatment providers, and social workers, community health workers, peer counselors or other non-clinical staff that facilitates the work of the Health Home Care Coordinator. Optional team members may include nutritionists/dieticians, direct care workers, pharmacists, peer specialists, DCYF-contracted early childhood and family support providers, family members or housing representatives.
- 1.26. "Parent Patient Activation Measure® (PPAM®)" means an assessment that gauges the knowledge, skills and confidence of the parent's management of their child's health.
- 1.27. "Patient Activation Measure® (PAM®)" means an assessment that gauges the knowledge, skills and confidence essential to managing one's own health and health care.
- 1.28. "Patient Protection and Affordable Care Act" or "ACA" means Public Laws 111-148 and 111-152 (both enacted in March 2010).
- 1.29. "PRISM User Coordinator" means the employee appointed by the Contractor to be the point of contact for the HCA and DSHS's PRISM Administration Team.
- 1.30. "Qualified Health Home" means an entity qualified by the state to administer the Health Home program to eligible beneficiaries.

## 2. Health Home Services for FIMC Enrollees

- 2.1. The Contractor shall provide Health Home services in addition to the Care Coordination Services described in Section 14 of the FIMC Contract, to high cost, high needs enrollees who have both medical and behavioral health benefits and meet Health Home eligibility criteria. Health Home Services shall be community-based, integrated and coordinated across medical, mental health, substance use disorder and long-term services and supports to enrollees based on the services described in Section 1945(h)(4) of the Social Security Act. The Contractor shall ensure that the following are operational:
  - 2.1.1. Submission of completed and updated HAP data through the *OneHealthPort* Health Information Exchange using the OneHealthPort Canonical Guide located at: [http://www.hca.wa.gov/medicaid/health\\_homes/Documents/HAP\\_CanonicalGuide.pdf](http://www.hca.wa.gov/medicaid/health_homes/Documents/HAP_CanonicalGuide.pdf). The HAP data will be stored in a Medicaid data base for evaluation purposes;
  - 2.1.2. A system to track and share enrollee information and care needs among providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the enrollee's preferences and identified needs;
  - 2.1.3. A system to track Health Home Services through claims paid or services rendered and report the encounter data in accordance with HCA Encounter Data Reporting Guide;
  - 2.1.4. The Contractor shall submit encounter data according to the three tier process listed below:

- 2.1.4.1. Tier One: Outreach, Engagement, and Health Action Plan Development includes:
  - 2.1.4.1.1. Outreach by mail; phone; or other methods, continues until the eligible enrollee agrees to participate or declines participation in the Health Home program. Contractor must document all attempts to contact Enrollee. In offering Health Home services, the Contractor shall follow the HCA documented due diligence process.
  - 2.1.4.1.2. Engagement occurs when the Enrollee agrees to a face-to-face visit between the Enrollee and the Health Home Care Coordinator in a location of the Enrollee's choosing, such as their home or provider's office.
  - 2.1.4.1.3. Health Action Plan Development includes face-to-face visits to complete the initial Health Action Plan, the Health Home Participation Authorization and Information Sharing Consent form, and coaching to assist the Enrollee in identifying short and long-term goals and associated action steps.
- 2.1.4.2. Tier Two: Intensive Health Home Care Coordination is the highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services and includes evidence that the Care Coordinator, the Enrollee, and the Enrollee's caregivers are:
  - 2.1.4.2.1. Actively engaged in achieving health action goals;
  - 2.1.4.2.2. Participating in activities that support improved health and well-being; and
  - 2.1.4.2.3. Have value for the Enrollee and caregivers, supporting an active level of care coordination through delivery of Health Home Services.
  - 2.1.4.2.4. At a minimum provide, Intensive Health Home Care Coordination which typically includes one face-to-face visit with the Enrollee every month in which a qualified Health Home Service is provided. Exceptions to the monthly face-to-face visit may be approved by the Contractor as long as the Health Home Services provided during the month achieve one or more of the following:
    - 2.1.4.2.4.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;
    - 2.1.4.2.4.2. Continuity and coordination of care through in-person visits, and the ability to accompany Beneficiaries to health care provider



- treatment in a hospital emergency department for Health Home enrollment;
- 2.1.8. The Contractor's PRISM Coordinator shall identify all Designated Staff who have a business need to access PRISM.
    - 2.1.8.1. The Contractor shall ensure that Designated Staff complete and submit to the DSHS PRISM Administration Team all the necessary forms required by CMS and DSHS for data authorization and PRISM access, including:
      - 2.1.8.1.1. The PRISM Registration form; and
      - 2.1.8.1.2. The DSHS provided spreadsheet.
    - 2.1.8.2. The Contractor shall promptly notify the DSHS PRISM Administration Team to remove established Designated Staff user accounts due to employment termination, job reassignment, or other changes in circumstances.
  - 2.1.9. Policies and Procedures: The Contractor shall abide by all HCA policies and procedures for Health Home services, and maintain regularly updated Contractor-specific policies and procedures that address the following:
    - 2.1.9.1. The requirement to maintain frequent, in-person contact between the Health Home enrollee and the Health Home Care Coordinator when delivering Health Home services;
    - 2.1.9.2. Ongoing availability of support staff to complement the work, collaborate, receive direction and report to the Health Home Care Coordinator;
    - 2.1.9.3. Support screening, referral and co-management of individuals with both behavioral health and physical health conditions;
    - 2.1.9.4. The Contractor's and subcontractor's roles and responsibilities for enrollee engagement;
    - 2.1.9.5. Ensuring an appointment reminder system is in place for enrollees.
    - 2.1.9.6. Tracking of enrollee assignment to Care Coordination Organizations;
    - 2.1.9.7. Referrals to HCA for eligibility review of any potential enrollee who seeks or needs Health Home services;
    - 2.1.9.8. Transitional care services for enrollees transferring to or from hospital or other inpatient setting or emergency departments;
    - 2.1.9.9. A policy and procedure to deal with the compromise or potential compromise of Data that complies with the HITECH Act of ARRA; and
    - 2.1.9.10. Due diligence for contacting the enrollee for affirmation of participation.
  - 2.1.10. Methods to identify and address enrollee gaps in care through:
    - 2.1.10.1. Assessment of existing data sources (e.g., PRISM, CARE, etc.) for evidence of the standard of care for and preventive care appropriate to the enrollee's age and underlying chronic conditions;

- 2.1.10.2. Evaluation of enrollee perception of gaps in care;
  - 2.1.10.3. Documentation of gaps in care in the enrollee case file;
  - 2.1.10.4. Documentation of interventions in HAP and progress notes;
  - 2.1.10.5. Findings from the enrollee's response to interventions; and
  - 2.1.10.6. Documentation of follow-up actions, and the person or organization responsible for follow-up.
- 2.2. The Health Home Care Coordinator shall provide or oversee interventions that address the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors affecting enrollee's health and health care choices available to Health Home enrollees.
- 2.3. The Health Home Care Coordinator shall provide or oversee Health Home Services in a culturally and linguistically appropriate manner and address health disparities by:
- 2.3.1. Interacting directly with the enrollee and his or her family in the enrollee's primary language and recognizing cultural differences when developing the HAP;
  - 2.3.2. Understanding the dynamics of substance use disorder without judgment; and
  - 2.3.3. Recognizing obstacles faced by persons with developmental disabilities and providing assistance to the enrollee and his or her caregivers in addressing the obstacles.
- 2.4. The Health Home Care Coordinator shall:
- 2.4.1. Discuss changes in enrollee circumstances or condition with the treating/authorizing entities who serve the enrollee;
  - 2.4.2. Document changes in the enrollee's circumstances or conditions in the HAP in a timely manner;
  - 2.4.3. With the enrollee's permission, include paid or unpaid caregivers who have a role in supporting the enrollee to achieve health action goals and access health care services;
  - 2.4.4. Collaborate with health care professionals such as primary care providers, mental health professionals, substance use disorder treatment providers, and social workers;
  - 2.4.5. Have access to providers from the local community who authorize Medicaid, state or federally funded mental health, long-term services and supports (including the direct care workforce), substance use disorder and medical services. This group may include BHOs, DSHS-Home and Community Services (HCS), Community Mental Health Agencies (CMHA's), Area Agencies on Aging (AAAs), substance use disorder providers, and community supports that assist with housing; and
  - 2.4.6. Coordinate or collaborate with nutritionist/dieticians, direct care workers, pharmacists, peer specialist, family members and housing representatives or others, to support the enrollee's HAP.



- 2.5. Lead Entities must have executed a Memorandum of Understanding or Agreement with organizations that authorize Medicaid services such as DSHS Home and Community Services (HCS), BHOs, DDA, and Area Agencies on Aging (AAAs) to ensure continuity of care. MOU/MOAs must contain information related to enrollee privacy and protections, data sharing, referral protocols, and sharing of prior authorizations for hospital stays when applicable.

### **3. Health Home Care Coordinator Qualification and Training Requirements**

The Contractor shall ensure that:

- 3.1. Health Home Coordinators must possess one of the following licenses or credentials:
  - 3.1.1. Current license as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists; or certified chemical dependency professionals; or
  - 3.1.2. Master's or Bachelor's in social work, psychology, social services, human services, or behavioral sciences; or
  - 3.1.3. Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR).
- 3.2. Health Home Care Coordinators and affiliated staff complete enrollee confidentiality, data security, and mandatory reporting training upon hire and annually thereafter.
- 3.3. Health Home Care Coordinators complete the State-approved Health Home Care Coordinator training prior to completing the HAP with the enrollee.
- 3.4. Health Home Care Coordinators complete the following special-topic modules through State-sponsored classroom training or using State-developed training materials published on the DSHS website within six (6) months of hire.
  - 3.4.1. Outreach and Engagement Strategies;
  - 3.4.2. Navigating the LTSS System;
  - 3.4.3. Cultural and Disability Considerations;
  - 3.4.4. Assessment Screening Tools; and
  - 3.4.5. Coaching and Engaging Clients with Mental Health Needs.
- 3.5. Health Home Care Coordinators and affiliated personnel comply with continued training requirements as necessary.
- 3.6. Evidence of satisfactory completion of training requirements is maintained in the appropriate personnel records.
- 3.7. The Contractor has a Health Home Care Coordinator trainer on staff, or shall subcontract for Health Home Care Coordinator training services.
  - 3.7.1. The trainer shall be qualified by DSHS prior to providing Health Home Care

Coordinator training.

3.7.2. Trainer Qualification includes:

3.7.2.1. Completion of the Health Home Care Coordinator training course;

3.7.2.2. Completion of a State-sponsored trainer's preparation course;

3.7.2.3. Satisfactory delivery of a Health Home Care Coordinator training observed by DSHS; and

3.7.2.4. Receipt of a State-issued letter authorizing the individual to provide training to Health Home Care Coordinators.

3.7.3. The Contractor shall ensure that the trainer uses and maintains fidelity to the State-developed Training Manual for Health Home Care Coordinators.

3.8. The Health Home Care Coordinator training is delivered using all of the DSHS materials including the small group activities using de-identified PRISM data, training agenda, training manual inserts, and handouts.

3.9. The trainer does not change, alter, or modify the State-approved Health Home Care Coordinator training, activities, curriculum or materials or include unauthorized topics, curriculum, or material in the Health Home Care Coordinator Training.

#### **4. Eligibility and Enrollment**

HCA shall determine eligibility and identify enrollees who are eligible for the Contractor's Health Home program.

4.1. Those determined eligible for Health Home services must have at least one chronic condition and be at risk of a second as determined by a minimum PRISM score of 1.5. The chronic conditions are:

4.1.1. Mental health conditions;

4.1.2. Substance use disorders;

4.1.3. Asthma;

4.1.4. Diabetes;

4.1.5. Heart disease;

4.1.6. Cancer;

4.1.7. Cerebrovascular disease;

4.1.8. Coronary artery disease;

4.1.9. Dementia or Alzheimer's disease;

4.1.10. Intellectual disability or disease;

4.1.11. HIV/AIDS;

4.1.12. Renal failure;

4.1.13. Chronic respiratory conditions;

- 4.1.14. Neurological disease;
  - 4.1.15. Gastrointestinal disease;
  - 4.1.16. Hematological conditions; and
  - 4.1.17. Musculoskeletal conditions.
- 4.2. HCA shall include a Health Home Clinical Indicator in the monthly enrollment listing of FIMC and BHSO enrollees that meet Health Home criteria.
- 4.2.1. The Contractor shall ensure eligible FIMC Health Home enrollees are offered Health Home services through a contracted Qualified Health Home or a CCO until they agree to participate or decline to participate in the Health Home program. The Contractor shall follow the HCA documented due diligence process in offering services to eligible enrollees.
  - 4.2.2. The Contractor must document in the client record why an eligible enrollee declines to participate, unless the enrollee does not want to explain his or her decision.
  - 4.2.3. When an enrollee's PRISM risk score falls below 1.0 for six (6) consecutive months and the enrollee has not been engaged in Health Home services, the enrollee's eligibility for the program will end.
- 4.3. The Contractor shall ensure Health Home eligible enrollees are assigned a Health Home Care Coordinator through a Qualified Health Home.
- 4.4. Enrollees who have agreed to participate may disenroll from the Health Home program at any time. The Contractor shall maintain a record of all enrollees who choose to disenroll from the Health Home program and the reason why.
- 4.5. Enrollees may be reenrolled in the Health Home program at any time if they meet the eligibility criteria at the time of the reenrollment request.
- 4.6. The Contractor shall use a standardized tool provided by the State to determine initial eligibility for Health Home services if the enrollee has less than fifteen (15) months of claims history or is referred by a provider. The Contractor shall notify HCA when the enrollee has been screened. When HCA determines the enrollee qualifies, the Contractor shall ensure the enrollee receives Health Home services unless the enrollee declines to participate in the program.
- 4.7. The Contractor shall accept referrals for Health Home services from any health care provider, whether or not the provider is contracted with the Contractor.

## 5. Assignment, Engagement and Participation

- 5.1. The Contractor shall use a smart assignment process that takes into account the enrollee's current health care provider(s) when assigning Health Home enrollees to community based subcontracted CCOs. This may be achieved by:
  - 5.1.1. Using PRISM or other data systems to match the enrollee to a CCO that provides most of the enrollee's services; or
  - 5.1.2. Allowing enrollee choice of CCOs.
- 5.2. Subcontracted community based CCOs will receive a priority in the assignment of the total Health Home eligible enrollees.
- 5.3. The Contractor shall achieve and maintain the managed care Health Home eligible enrollee engagement rate of at least 15 percent based on HCA's monthly Health Home Enrollment and Encounter Summary.
- 5.4. The Contractor shall ensure the Health Home Care Coordinator uses the following resources to develop enrollee HAPs:
  - 5.4.1. The enrollee's medical record, if available, and PRISM data;
  - 5.4.2. Treatment plans, CARE assessments, and results of previous screens and assessments, if available;
  - 5.4.3. Information from the Contractor's authorization and service utilization systems; and
  - 5.4.4. Input from the enrollee and his or her family and/or caregivers.
- 5.5. The Contractor shall ensure the Health Home eligible enrollee is assigned to a Health Home CCO or internal Health Home Care Coordinator within thirty (30) calendar days of initial date of Health Home identification and enrollment.
- 5.6. The Contractor shall ensure initial HAPs are completed within ninety (90) calendar days from the date of notification of the enrollee's Health Home eligibility. A complete HAP must include documentation of agreement by the enrollee to participate in the Health Home program.
  - 5.6.1. The Contractor must ensure that:
    - 5.6.1.1. The Health Home Care Coordinator meets in-person with each enrollee at the enrollee's choice of location to explain, develop, and complete the HAP with input from the enrollee and/or the enrollee's caregiver(s);
    - 5.6.1.2. The HAP documents the enrollee's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;
    - 5.6.1.3. The HAP includes the required BMI, Katz ADL, and PSC-17 or PHQ-9

- screening scores;
- 5.6.1.4. The HAP includes the required Patient Activation Measure (PAM®), or Patient Parent Activation Measure (PPAM®), or Caregiver Activation Measure (CAM®) activation level and screening score;
  - 5.6.1.5. The Health Home Care Coordinator also documents in the HAP all other screenings administered when medically indicated; and
  - 5.6.1.6. The HAP includes the reason the enrollee declined assessment or screening tools.
- 5.6.2. HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:
- 5.6.2.1. After every four (4) month activity period to update the PAM®, PPAM®, CAM®, BMI, Katz ADL, and PSC-17 or PHQ-9 screening scores and reassess the enrollee's progress towards meeting self-identified health action goals, add new goals or change in current goals; and
  - 5.6.2.2. Whenever there is a change in the enrollee's health status or a change in the enrollee's needs or preferences.
- 5.6.3. A completed and updated HAP with the enrollee's goals and action steps must be provided to the enrollee and with the enrollee's consent shared with the enrollee's caregiver and family in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.
- 5.6.4. Additional information not included in the State-developed HAP form must be included as an addendum. Written information in the HAP must use language that is understandable to the enrollee and/or the enrollee's caregiver(s).
- 5.6.5. Upon request, completed and updated HAPs must be shared with other individuals identified and authorized by the enrollee on the signed Health Home Participation Authorization and Information Sharing Consent form.
- 5.6.6. The Health Home Care Coordinator or affiliated staff shall:
- 5.6.6.1. Arrange an in-person visit in the enrollee's choice of location.
  - 5.6.6.2. Describe the program to the enrollee, including a description of Health Home Services and care coordination.
  - 5.6.6.3. Arrange an appointment with the Health Home Care Coordinator to complete the HAP.
- 5.6.7. The Health Home Care Coordinator shall meet with the enrollee in person to complete the HAP, including the following:
- 5.6.7.1. Explain the HAP and the development process to the enrollee;
  - 5.6.7.2. Complete a Health Home Participation Authorization and Information Sharing Consent form;
  - 5.6.7.3. Evaluate the enrollee's support system; and
  - 5.6.7.4. Administer and score either the PAM®, PPAM® or CAM®.

- 5.6.8. The Health Home Care Coordinator uses the PAM®; PPAM®; or CAM® to:
  - 5.6.8.1. Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent declines and access appropriate and high quality health care;
  - 5.6.8.2. Target tools and resources commensurate with the enrollee's level of activation;
  - 5.6.8.3. Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;
  - 5.6.8.4. Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the enrollee; and
  - 5.6.8.5. As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

## **5.7. Comprehensive Care Management Services**

- 5.7.1. The Contractor shall ensure the Health Home Care Coordinator:
  - 5.7.1.1. Documents interactions with the Health Home enrollee including periodic follow-up, both in-person and telephonically;
  - 5.7.1.2. Assesses enrollee's readiness for self-management and promotion of self-management skills;
  - 5.7.1.3. Reassesses the HAP and Health Home enrollee's progress in meeting goals;
  - 5.7.1.4. Manages barriers to achieving health action goals;
  - 5.7.1.5. Facilitates communication between the Health Home enrollee and service providers to address barriers and achieve health action goals;
  - 5.7.1.6. Supports the achievement of self-directed, health goals designed to attain recovery, improve functional or health status or prevent or slow declines in functioning;
  - 5.7.1.7. Reassesses patient activation at minimum every four (4) month activity period, or more frequently if changes warrant reassessment using the PAM®; PPAM® or CAM® and documents the results in the HAP; and
  - 5.7.1.8. Ensures communication, coordination, and care management functions are not duplicated between the Health Home Care Coordinator and Medicaid case managers involved in the enrollee's care, including DSHS and AAA case managers.

## **5.8. Care coordination and health promotion**

- 5.8.1. The Contractor shall ensure the Health Home Care Coordinator:
  - 5.8.1.1. Develops and executes cross-system care coordination to assist enrollees to access and navigate needed services;

- 5.8.1.2. Fosters communication between the care providers, including the treating primary care provider, medical specialists, behavioral health providers and entities authorizing behavioral health and long-term services and supports;
- 5.8.1.3. Maintains a caseload that ensures timely intervention;
- 5.8.1.4. Uses community health workers, peer counselors or other non-clinical staff to assist clinical staff in the delivery of Health Home Services;
- 5.8.1.5. Provides interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect an enrollee's health and health care choices; and
- 5.8.1.6. Provides educational materials that promote the following:
  - 5.8.1.6.1. Improved clinical outcomes;
  - 5.8.1.6.2. Enrollee participation in his or her care;
  - 5.8.1.6.3. Continuity of care;
  - 5.8.1.6.4. Increased self-management skills; and
  - 5.8.1.6.5. Use of peer supports to increase the enrollee's knowledge about his or her health conditions and improve adherence to prescribed treatment.
- 5.8.2. Shares the HAP with individuals identified by the enrollee, with the enrollee's written consent. These individuals may include, but are not limited to: family, caregivers, primary care providers, mental health treatment providers, and authorizers of long term services and supports and/or substance use disorder treatment providers.
  - 5.8.2.1. The HAP shall provide written evidence of:
    - 5.8.2.1.1. The enrollee's chronic conditions, severity factors and gaps in care, activation level, and opportunities to prevent avoidable emergency room, inpatient hospital and institutional use;
    - 5.8.2.1.2. Enrollee self-identified goals;
    - 5.8.2.1.3. Needed interventions and desired outcomes;
    - 5.8.2.1.4. Transitional care planning, including assessment and deployment of needed supports; and
    - 5.8.2.1.5. Use of self-management, recovery and resiliency principles that employ person-identified supports, including family members, and paid or unpaid caregivers.
  - 5.8.2.2. The Health Home Care Coordinator shall assess the enrollee's patient activation scores and level to determine the appropriate coaching methods and a teaching and support plan that includes:
    - 5.8.2.2.1. Introduction of customized educational materials based on

- the enrollee's readiness for change;
  - 5.8.2.2.2. Progression of customized educational materials in combination with the enrollee's level of confidence and self-management abilities;
  - 5.8.2.2.3. Documentation of opportunities for mentoring and modeling communication with health care providers provided through joint office visits and communications with health care providers by the enrollee and the Health Home Care Coordinator;
  - 5.8.2.2.4. Documentation of wellness and prevention education specific to the enrollee's chronic conditions, including assessment of need and facilitation of routine preventive care;
  - 5.8.2.2.5. Support for improved social connections to community networks, and links the enrollee with resources that support a health promoting lifestyle; and
  - 5.8.2.2.6. Links to resources for, but not limited to: smoking cessation, substance use disorder prevention, nutritional counseling, obesity reduction, increasing physical activity, disease-specific or chronic care management self-help resources, and other services, such as housing, based on individual needs and preferences.
- 5.8.3. Accompanies the enrollee to critical health care and social service appointments when necessary to assist the enrollee in achieving his or her health action goals.
- 5.8.4. Ensures treating providers and authorizing entities coordinate and mobilize to reinforce and support the enrollee's health action goals.

## **5.9. Transitional Care**

- 5.9.1. The Contractor shall provide and document the comprehensive transitional care for Health Home enrollees to prevent avoidable readmission after discharge from an inpatient facility and to ensure proper and timely follow-up care.
- 5.9.2. In addition to services described in Transitional Care provisions of this Contract, the Contractor's transitional care planning process must include:
- 5.9.2.1. Participation by the Health Home Care Coordinator in appropriate phases of care transitions, including discharge planning; visits during hospitalizations or nursing home stays; home visits; post hospital/institutional stays; and follow-up telephone calls;
  - 5.9.2.2. A notification system between the Contractor and facilities that provides prompt notification of an enrollee's admission or discharge from an emergency department or inpatient setting;
  - 5.9.2.3. Progress notes or a case file that documents the notification;



- 5.9.2.4. Transition planning details such as medication reconciliation, follow-up with providers and monitoring documented in the HAP;
- 5.9.2.5. The Contractor may employ staff that have been trained specifically to provide transitional services, as long as the Health Home Care Coordinator is an active participant in the transitional planning process; and
- 5.9.2.6. Established frequency of communicating hallmark events to the assigned Health Home Care Coordinator.

#### **5.10. Individual and family support**

- 5.10.1. The Contractor shall use peer supports, support groups, and self-management programs as needed, to increase the enrollee's and caregiver's knowledge of the enrollee's chronic conditions, promote the enrollee's capabilities and engagement in self-management, and help the enrollee improve adherence to prescribed treatment.
- 5.10.2. The Contractor shall ensure the Health Home Care Coordinator, with the enrollee's participation:
  - 5.10.2.1. Identifies the role that the enrollee's family, informal supports and paid caregivers provide to help the enrollee achieve self-management and optimal levels of physical and cognitive function;
  - 5.10.2.2. Educates and supports self-management; self-help recovery and other resources necessary for the enrollee, his or her family and caregivers to support the enrollee's individual health action goals;
  - 5.10.2.3. Documents discussion of advance care planning with the enrollee within the first year of the Enrollee's agreement to participate in the Health Home program; and
  - 5.10.2.4. Communicates and shares information with the enrollee's family and other caregivers, with appropriate consideration of language, activation level, literacy, and cultural preferences.

#### **5.11. Referral to community and social support services**

- 5.11.1. The Health Home Care Coordinator shall ensure that:
  - 5.11.1.1. Available community resources are identified and accessible to the Health Home enrollee.
  - 5.11.1.2. Referrals:
    - 5.11.1.2.1. Are overseen by the Health Home Care Coordinator;
    - 5.11.1.2.2. Support the enrollee's health action goals;
    - 5.11.1.2.3. Include long-term services and supports, mental health, substance use disorder and other community and social supports; and
    - 5.11.1.2.4. Are documented in the enrollee's progress notes and HAP.

- 5.11.1.3. Assistance is provided to the enrollee to obtain and maintain eligibility for health care services, disability benefits, housing, personal needs and legal services, when needed and not provided through other case management systems.
- 5.11.1.4. Services are coordinated with appropriate departments of local, state, and federal governments and community-based organizations.

## **5.12. Quarterly Quality Reports**

- 5.12.1. The Contractor shall submit quality reports to HCA in the format provided by HCA in accordance with the following reporting periods:
  - 5.12.1.1. January through March due May 1;
  - 5.12.1.2. April through June due August 1;
  - 5.12.1.3. July through September due November 1; and
  - 5.12.1.4. October through December due February 1.

**EXHIBIT I-2, Service Areas  
January 1, 2019  
Apple Health Managed Care**

<b>County</b>	<b>Amerigroup</b>	<b>Community Health Plan</b>	<b>Coordinated Care of WA</b>	<b>Molina Healthcare</b>	<b>United Healthcare</b>
<b>Clallam (V)</b>				<b>X</b>	
<b>Cowlitz</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Grays Harbor</b>	<b>X</b>	<b>X</b>		<b>X</b>	<b>X</b>
<b>Jefferson</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Kitsap</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Lewis</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Mason</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Pacific</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Thurston</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>
<b>Wahkiakum</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>	<b>X</b>

Note: Effective April 1, 2016 residents of Clark and Skamania Counties are served by the Fully Integrated Managed Care (FIMC) program. Effective January 1, 2018 residents of Chelan, Douglas and Grant Counties are served by the Fully Integrated Managed Care (FIMC) program. Effective January 1, 2019 residents of Adams, Asotin, Benton, Columbia, Ferry, Franklin, Garfield, King, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Pierce, Spokane, Stevens, Walla Walla, Whitman, and Yakima are served by the Fully Integrated Managed Care (FIMC) program. Effective July 1, 2019 residents of Island, San Juan, Skagit, Snohomish and Whatcom are served by the Fully Integrated Managed Care (FIMC) program.

## ATTACHMENT 1

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**Attachment 2**  
**2019 HEDIS® Performance Measures**

**Apple Health Managed Care (AHMC)**  
**Fully Integrated Managed Care (FIMC)**  
**Apple Health Integrated Foster Care (IFC)**

The Contractor shall report the following HEDIS® measures statewide for all eligible Enrollees enrolled through AHMC, FIMC, and AHFC contracts. All measures must be publically reported by plan name to the NCQA Quality Compass. If “Hybrid” is noted in the Notes column, the Contractor is contractually required to report using this methodology. This is for 2019 HEDIS® reporting year (performance year 2018).

NCQA Abbreviation	Measure	Notes
<b>Prevention and Screening</b>		
<b>ABA</b>	Adult BMI Assessment	<b>Hybrid</b>
<b>WCC</b>	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	<b>Hybrid</b>
<b>CIS</b>	Childhood Immunization Status	<b>Hybrid</b>
<b>IMA</b>	Immunizations for Adolescents	<b>Hybrid</b>
<b>LSC</b>	Lead Screening in Children	<b>Hybrid</b>
<b>BCS</b>	Breast Cancer Screening	
<b>CCS</b>	Cervical Cancer Screening	<b>Hybrid</b>
<b>CHL</b>	Chlamydia Screening in Women	
<b>Respiratory Conditions</b>		
<b>CWP</b>	Appropriate Testing for Children With Pharyngitis	
<b>SPR</b>	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
<b>PCE</b>	Pharmacotherapy Management of COPD Exacerbation	
<b>MMA</b>	Medication Management for People With Asthma	
<b>AMR</b>	Asthma Medication Ratio	
<b>Cardiovascular</b>		
<b>CBP</b>	Controlling High Blood Pressure	<b>Hybrid</b>
<b>PBH</b>	Persistence of Beta-Blocker Treatment After a Heart Attack	
<b>SPC</b>	Statin Therapy for Patients With Cardiovascular Disease	
<b>Diabetes</b>		
<b>CDC</b>	CDC: Hemoglobin A1c (HbA1c) Testing	<b>Hybrid</b>
<b>CDC</b>	CDC: HbA1c Poor Control (>9.0%)	<b>Hybrid</b>
<b>CDC</b>	CDC: HbA1c Control (<8.0%)	<b>Hybrid</b>
<b>CDC</b>	CDC: Eye Exam	<b>Hybrid</b>
<b>CDC</b>	CDC: Medical Attention for Nephropathy	<b>Hybrid</b>

<b>NCQA Abbreviation</b>	<b>Measure</b>	<b>Notes</b>
<b>CDC</b>	CDC: Blood Pressure Control (<140/90 mm Hg)	<b>Hybrid</b>
<b>SPD</b>	Statin Therapy for Patients With Diabetes	
<b>Musculoskeletal</b>		
<b>ART</b>	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	
<b>Behavioral Healthcare</b>		
<b>AMM</b>	Antidepressant Medication Management	
<b>ADD</b>	Follow-Up Care for Children Prescribed ADHD Medication	
<b>FUH</b>	Follow-Up After Hospitalization for Mental Illness	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
<b>FUM</b>	Follow-Up After Emergency Department Visit for Mental Illness	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
<b>FUA</b>	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
<b>SSD</b>	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
<b>SMD</b>	Diabetes Monitoring for People With Diabetes and Schizophrenia	
<b>SMC</b>	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
<b>SAA</b>	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
<b>APM</b>	Metabolic Monitoring for Children and Adolescents on Antipsychotics	
<b>Medication Management</b>		
<b>MPM</b>	Annual Monitoring for Patients on Persistent Medication	
<b>Overuse/Appropriateness</b>		
<b>NCS</b>	Non-Recommended Cervical Cancer Screening in Adolescent Females	
<b>URI</b>	Appropriate Treatment for Children With Upper Respiratory	

<b>NCQA Abbreviation</b>	<b>Measure</b>	<b>Notes</b>
	Infection	
<b>AAB</b>	Avoidance of Antibiotic Therapy for Adults With Acute Bronchitis	
<b>LBP</b>	Use of Imaging Studies for Low Back Pain	
<b>APC</b>	Use of Multiple Concurrent Antipsychotics in Children and Adolescents	
<b>UOD</b>	Use of Opioids at High Dosage	
<b>UOP</b>	Use of Opioids from Multiple Providers	
<b>Access/Availability of Care</b>		
<b>AAP</b>	Adults' Access to Preventive/Ambulatory Health Services	
<b>CAP</b>	Children and Adolescents' Access to Primary Care Practitioners	
<b>ADV</b>	Annual Dental Visit	NO BENEFIT for AHMC, FIMC, and IFC
<b>IET</b>	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
<b>PPC</b>	Prenatal and Postpartum Care	<b>Hybrid</b>
<b>APP</b>	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
<b>Use of Services</b>		
<b>W15</b>	Well-Child Visits in the First 15 Months of Life	<b>Hybrid</b>
<b>W34</b>	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	<b>Hybrid</b>
<b>AWC</b>	Adolescent Well-Care Visits	<b>Hybrid</b>
<b>FSP</b>	Frequency of Selected Procedures	
<b>AMB</b>	Ambulatory Care	
<b>IPU</b>	Inpatient Utilization–General Hospital/Acute Care	
<b>IAD</b>	Identification of Alcohol and Other Drug Services	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
<b>MPT</b>	Mental Health Utilization	AHMC and IFC: Report the Outpatient/ED category only. NO BENEFIT for the following categories:

<b>NCQA Abbreviation</b>	<b>Measure</b>	<b>Notes</b>
		Inpatient Intensive Outpatient/ Partial Hospitalization, or Telehealth. FIMC: Report all categories
<b>ABX</b>	Antibiotic Utilization	
<b>Risk Adjusted Utilization</b>		
<b>PCR</b>	Plan All-Cause Readmission	
<b>NCQA Abbreviation</b>	<b>Health Plan Descriptive Information</b>	<b>Notes</b>
<b>ENPA</b>	Enrollment by Product Line - Total	
<b>EBS</b>	Enrollment by State	
<b>LDM</b>	Language Diversity of Membership	
<b>RDM</b>	Race/Ethnicity Diversity of Membership	
<b>TLM</b>	Total Membership	
<b>NEW HEDIS® MEASURE 2019</b>		
<b>COU</b>	Risk of Chronic Opioid Use	<b>To be reported to HCA</b>

HCA reserves the right to issue changes to this attachment or measure requirements, such as due to changes in HEDIS® technical specifications.



## ATTACHMENT 3

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## Attachment 4

### Oral Health Connections Pilot Project

In Section 213(1)(nn) of the Substitute Senate Bill 5883 (2017) and Section 213(1)(oo) of SSB 6032 (2018), HCA was directed to implement the Oral Health Connections Pilot Project, modeled after the ABCD program. The directive to HCA and Arcora (previously known as Washington Dental Foundation) is to work jointly from inception to completion of the program. Implementation is set for January 1, 2019 and the pilot project will run for three (3) years.

The Oral Health Connections Pilot Project's purpose is to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not including Dual-Eligible Clients), located in Cowlitz, Thurston, or Spokane counties are the target populations of the Oral Health Connections Pilot Project.

Arcora is responsible for:

- Financing and developing, in partnership with the University of Washington (UW), a training module and exam for participating dental providers;
- Providing the exam, in partnership with UW;
- Notifying HCA, within 5 business days, of successful course completion by participating dental providers;
- Developing tools and systems to assist medical providers with oral assessments;
- Developing referral and patient care coordination tools;
- Developing systems and processes to facilitate shared care between medical and dental providers;
- Developing systems and processes to assist dental provider offices in scheduling and keeping appointments;
- Recruiting dental providers to participate in the program;
- Attending local and statewide dental provider association meetings;
- Educating providers about the pilot, including background, duration, enhanced fees, and indicators;
- Recruiting and educating of medical providers on demographics of Oral Health Connections Pilot Project target populations;
- Training medical providers about oral systemic link between oral health and diabetes and/or pregnancy, including how to address oral health in medical settings while reinforcing the importance of medical and dental collaboration; and
- Developing and implementing an Oral Health Connections Pilot Project evaluation tool.

Both medical and dental Oral Health Connections Pilot Project providers will use a referral tool developed by Arcora, called DentistLink, to connect Clients to dental providers in the following ways:

- Medical provider will refer Clients diagnosed with diabetes or pregnancy to a trained dental provider participating in the Oral Health Connections Pilot Project through DentistLink;
- Medical Managed Care Organizations (MCOs) will refer Enrollees, with flagged qualifying diagnosis(es), through care coordination and DentistLink;

Dental providers will coordinate with medical providers through DentistLink to receive referrals for patients who are in the two identified target populations. Dental providers will be educated in the specifics of intervention and training for the identified Client population. The Oral Health Connections Pilot Project will also test the effects an enhanced dental benefit has on access to dental care, health care outcomes, and related medical costs.

Trained, participating dental providers will be eligible for enhanced reimbursement rates for specific CDT codes per Oral Health Connections Pilot Project guidelines. Periodontal health, in specific, will be the target of the enhancements. Medicaid will pay enhanced fees for codes D0150 (Comprehensive Oral Exam), D0210 (Intraoral complete series of radiographic images), D0274 (Bitewings four radiographic images), D4341 (Periodontal Scaling and Root Planing-4 or more teeth), D4342 (Periodontal Scaling and Root Planing 3 or more teeth per quadrant), D4910 (Periodontal maintenance). The Client will be eligible to receive up to three (3) additional D4910 (periodontal maintenance) per twelve-month period.

The Oral Health Connections Pilot Project success will be determined through measures evaluating access, cost, and health outcomes.