

HEALTH CARE AUTHORITY

2012 – 2013 CONTRACT

FOR

**HEALTHY OPTIONS, BASIC HEALTH
AND DISABILITY LIFELINE**

APPROVED AS TO FORM BY THE ATTORNEY GENERAL'S OFFICE

If you would like to provide comment for this draft, please send it to hcabhcomm@hca.wa.gov by May 27, 2011.

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SPACE HOLDER

DRAFT FOR COMMENT

1. DEFINITIONS:

- 1.1. **Action** means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services or act in a timely manner as required herein (42 CFR 438.400(b)).
- 1.2. **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 CFR 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 CFR 438.6(c)).
- 1.3. **Administrator** means the Administrator of the Health Care Authority (HCA). The Administrator may designate a representative to act on the Administrator's behalf. Any designation may include the representative's authority to hear and determine any matter.
- 1.4. **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 388-501-0125, 42 CFR 438.6, 438.10, 422.128, and 489.100).
- 1.5. **Ancillary Services** means health care services which are auxiliary, accessory, or secondary to a primary health care service.
- 1.6. **Anniversary Date** means the first day of January.
- 1.7. **Appeal** means a request for review of an action (42 CFR 438.400(b)).
- 1.8. **Appeal Process** means the Contractor's procedures for reviewing an action.
- 1.9. **Basic Health Plus (BH Plus)** means the federal aid medical care program jointly administered by HCA and Washington State Department of Social and Health Services (DSHS) for children under age 19 who qualify for Medical Assistance as defined under Title XIX of the federal social security act.
- 1.10. **Centers for Medicare and Medicaid Services (CMS)** means the federal agency within the U.S. Department of Health and Human

Services with primary responsibility for the Medicaid and Medicare program.

- 1.11. **Certificate of Coverage (COC) or Member Handbook** means the Member Handbook, Exhibit B-1 of this Agreement, published by HCA, which describes requirements for eligibility and enrollment, Covered Services, and other terms and conditions that apply to Enrollee participation.
- 1.12. **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 74.09.450 and WAC 388-542.
- 1.13. **Children with Special Health Care Needs** means children identified by the Health Care Authority to the Contractor as children served under the provisions of Title V of the Social Security Act.
- 1.14. **Cold Call Marketing** means any unsolicited personal contact by the Contractor or its designee, with a potential enrollee or an enrollee with another contracted managed care organization for the purposes of marketing (42 CFR 438.104(a)).
- 1.15. **Comparable Coverage** means an enrollee has other insurance that the Health Care Authority has determined provides a full scope of health care benefits.
- 1.16. **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.
- 1.17. **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)** means a family of standardized survey instruments, including a Medicaid survey used to measure client experience of health care.
- 1.18. **Continuity of Care** means the provision of continuous care for chronic or acute medical conditions through enrollee transitions between: facility to home; facility to facility; providers or service areas; managed care contractors; and Medicaid fee-for-service and Medicaid 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; and from substance abuse care to primary and/or mental health care.

- 1.19. **Contract** means the entire written agreement between the Health Care Authority and the Contractor, including any Exhibits, documents, and materials incorporated by reference.
- 1.20. **Contractor** means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, members, 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, members, officers, directors, partners, employees, and/or agents. In this Contract "contractor" means any managed care organization contracting with the Health Care Authority for the same services as the Contractor.
- 1.21. **Contracted Services** means covered services that are to be provided by the Contractor under the terms of this Contract.
- 1.22. **Coordination of Care** means the Contractor's mechanisms to assure that the enrollee and providers have access to and take into consideration, all required information on the enrollee's conditions and treatments to ensure that the enrollee receives appropriate health care services (42 CFR 438.208).
- 1.23. **Covered Services** means health care services that the Health Care Authority determines are covered for enrollees.
- 1.24. **Chronic Care Management Services** means the health care management within a health home of persons identified with, or at high risk for, one or more chronic conditions. Effective chronic care management:
- 1.24.1. Actively assists patients to acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;
 - 1.24.2. Employs evidence-based clinical practices;
 - 1.24.3. Coordinates care across health care settings and providers, including tracking referrals;
 - 1.24.4. Provides ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

- 1.24.5. Uses appropriate community resources to support individual patients and families in managing chronic conditions.
- 1.25. **Chronic condition** means a prolonged condition and includes, but is not limited to:
- 1.25.1. A mental health condition;
 - 1.25.2. A substance use disorder;
 - 1.25.3. Asthma;
 - 1.25.4. Diabetes;
 - 1.25.5. Heart disease; and
 - 1.25.6. Being overweight, as evidenced by a body mass index over twenty-five.
- 1.26. **Debarment** means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds.
- 1.27. **Dependent** means family members defined as eligible for Basic Health Covered Services in the COC (Exhibit B).
- 1.28. **Duplicate Coverage** means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under HO.
- 1.29. **EPSDT** (Early, Periodic Screening, Diagnosis and Treatment) means a package of services in a preventive (well child) exam covered by Medicaid as defined in the Social Security Act (SSA) Section 1905(r) and the Health Care Authority EPSDT program policy and billing instructions. Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found to be necessary during the EPSDT exam. the Health Care Authority has determined that EPSDT is available to all children eligible for any of its medical programs. EPSDT contracted services are described in the Benefits Section of this Contract.

- 1.30. **Eligible Clients** means individuals certified eligible by the Health Care Authority, living in the service area, and eligible to enroll for health care services under the terms of this Contract, as described in the Enrollment Section of this Contract.
- 1.31. **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 CFR 438.114(a)).
- 1.32. **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 CFR 438.114(a)).
- 1.33. **Encrypt** means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.
- 1.34. **Enrollee** means an individual who is enrolled in HO managed care through a Managed Care Organization (MCO) having a Contract with the Health Care Authority (42 CFR 438.10(a)).
- 1.35. **Enrollee with Special Health Care Needs** means an enrollee having a chronic and disabling condition that meets all of the following conditions (WAC 388-538-050):
- 1.35.1. Have a biologic, psychologic, or cognitive basis;
 - 1.35.2. Have lasted or are virtually certain to last for at least one year; and
 - 1.35.3. Produce one or more of the following conditions stemming from a disease:
 - 1.35.3.1. Significant limitation in areas of physical, cognitive, or emotional function;
 - 1.35.3.2. Dependency on medical or assistive devices to minimize limitation of function or activities; or
 - 1.35.3.3. In addition, for children, any of the following:

- 1.35.3.3.1. Significant limitation in social growth or developmental function;
- 1.35.3.3.2. Need for psychological, educational, medical, or related services over and above the usual for the child's age; or
- 1.35.3.3.3. Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.
- 1.36. **External Quality Review (EQR)** means the analysis and evaluation by an EQRO of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to enrollees (42 CFR 438.320).
- 1.37. **External Quality Review Organization (EQRO)** means an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both (42 CFR 438.320).
- 1.38. **External Quality Review Protocols** means a series of nine (9) procedures or guidelines for validating performance. Two of the nine protocols must be used by state Medicaid agencies. These are: 1) Determining Contractor compliance with federal Medicaid managed care regulations; and 2) Validation of performance improvement projects undertaken by the Contractor. The current External Quality Review Protocols can be found at the Centers for Medicare and Medicaid Services (CMS) website.
- 1.39. **External Quality Review Report - (EQRR)** means a technical report that describes the manner in which the data from all EQR activities are aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor. the Health Care Authority will provide a copy of the EQRR to the Contractor, through print or electronic media.
- 1.40. **Grievance** means an expression of dissatisfaction about any matter other than an action. 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 (42 CFR 438.400(b)).
- 1.41. **Grievance Process** means the procedure for addressing enrollees' grievances (42 CFR 438.400(b)).

- 1.42. **Grievance System** means the overall system that includes grievances and appeals handled by the Contractor and access to the hearing system (42 CFR 438, Subpart F).
- 1.43. **Hardened Password** means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.
- 1.44. **Health Care Authority (HCA)** means the State of Washington Health Care Authority and its employees and authorized agents.
- 1.45. **Health Care Professional** means a physician or any of the following acting within their scope of practice; a podiatrist, optometrist, 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 certified social worker, registered respiratory therapist, pharmacist and certified respiratory therapy technician (42 CFR 438.2).
- 1.46. **Health Employer Data and Information Set - (HEDIS®)** means a set of standardized performance measures designed to ensure that healthcare 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).
- 1.47. **Health Employer 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 capabilities assessment (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HD standards).
- 1.48. **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.

- 1.49. **Health Home** means coordinated health care provided by a licensed primary care provider coordinating all medical care services, and a multidisciplinary health care team comprised of clinical and nonclinical staff. At a minimum, primary care health home services include:
- 1.49.1. Comprehensive care management including, but not limited to, chronic care treatment and management;
 - 1.49.2. Extended hours of service;
 - 1.49.3. Multiple ways for patients to communicate with the team, including electronically and by phone;
 - 1.49.4. Education of patients on self-care, prevention, and health promotion, including the use of patient decision aids;
 - 1.49.5. Coordinating and assuring smooth transitions and follow-up from inpatient to other settings;
 - 1.49.6. Individual and family support including authorized representatives;
 - 1.49.7. The use of information technology to link services, track tests, generate patient registries, and provide clinical data; and
 - 1.49.8. Ongoing performance reporting and quality improvement.
- 1.50. **Integrated Healthcare Homes** means an enhanced system of care designed to provide healthcare services to enrollees with special health care needs and at-risk, vulnerable populations, including people with physical or developmental disabilities, people whose functional abilities are limited due to mental health and substance use disorders, children with chronic conditions or those in foster care, individuals living in poverty / low income and individuals representing diverse ethnicities, racial backgrounds and/or languages.
- 1.51. **Managed Care** means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty and ancillary health services.
- 1.52. **Managed Care Organization (MCO)** means an organization having a certificate of authority or certificate of registration from the Office of Insurance Commissioner that contracts with the Health Care Authority under a comprehensive risk contract to provide prepaid health care services to eligible the Health Care Authority clients under the Health Care Authority' managed care programs..

- 1.53. **Marketing** means any communication from the Contractor to a potential enrollee or enrollee with another the Health Care Authority contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or end enrollment with another the Health Care Authority contracted MCO (42 CFR 438.104(a)).
- 1.54. **Marketing Materials** means materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing (42 CFR 438.104(a)).
- 1.55. **Material Provider** means a Participating Provider whose loss would degrade access to care in the Service Area.
- 1.56. **Maternity Benefits Program** means the federal aid medical care program (also known as BH S-Medical Program) jointly administered by the HCA and Department of Social and Health Services for pregnant women who qualify for Medical Assistance as defined under Title XIX of the federal social security act.
- 1.57. **Medically Necessary Services** means services that are “medically necessary” as is defined in WAC 388-500-0005. In addition, medically necessary services shall include services related to the enrollee’s ability to achieve age-appropriate growth and development.
- 1.58. **National CAHPS® Benchmarking Database - (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 NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.
- 1.59. **National Committee for Quality Assurance - (NCQA)** means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.
- 1.60. **Participating Provider** means a person, health care provider, practitioner, or entity, acting within their scope of practice, with a written agreement with the Contractor to provide services to enrollees under the terms of this Contract.
- 1.61. **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.

- 1.62. **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.
- 1.63. **Physically Secure** means that access is restricted through physical means to authorized individuals only.
- 1.64. **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.
- 1.65. **Physician Incentive Plan** 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.
- 1.66. **Post-stabilization Services** means contracted services, related to an emergency medical 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 CFR 438.114 and 422.113).
- 1.67. **Potential Enrollee** means any individual eligible for enrollment under this Contract who is not enrolled with a health care plan having a contract with the Health Care Authority (42 CFR 438.10(a)).
- 1.68. **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, 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 CFR 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

- 1.69. **Provider** means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.
- 1.70. **Quality** 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 (42 CFR 438.320).
- 1.71. **Referral Provider** means a provider, who is not the Enrollee's PCP, to whom an enrollee is referred for covered services.
- 1.72. **Regulation** means any federal, state, or local regulation, rule, or ordinance.
- 1.73. **RCW** means the Revised Code of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at <http://slc.leg.wa.gov/>.
- 1.74. **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 herein.
- 1.75. **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.
- 1.76. **Service Areas** means the geographic areas in which the Contractor serves eligible clients as described in this Contract.
- 1.77. **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.
- 1.78. **Subscriber** means that person or those persons defined in the Certificate of Coverage (Exhibit B) as the person on a BH account who is responsible for payment of premiums and copayments and to whom BH sends all notices and communications.
- 1.79. **Substantial Financial Risk:** A physician or physician group as defined in this Section is at substantial financial risk when more than twenty-five

percent (25%) 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:

- 1.79.1. Withholds greater than twenty-five percent (25%) of total potential payments.
 - 1.79.2. Withholds less than twenty-five percent (25%) of total potential payments but the physician or physician group is potentially liable for more than twenty-five percent (25%) of total potential payments.
 - 1.79.3. Bonuses greater than thirty-three percent (33%) of total potential payments, less the bonus.
 - 1.79.4. Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of total potential payments.
 - 1.79.5. Capitation arrangements if the difference between the minimum and maximum possible payments is more than twenty-five percent (25%) of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.
- 1.80. **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.
- 1.81. **Transitional Healthcare Services (THS)** means a set of actions designed 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 care conditions or complications, re-institutionalization or re-hospitalization, and recidivism following substance use disorder treatment.
- 1.82. **Transport** means the movement of Confidential Information from one entity to another, or within an entity, that:
- 1.82.1. Places the Confidential Information outside of a Secured Area or system (such as a local area network), and
 - 1.82.2. Is accomplished other than via a Trusted System.

- 1.83. **Trusted Systems** include only the following methods of physical delivery:
- 1.83.1. Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt, and
 - 1.83.2. United States Postal Service ("USPS") delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail.
 - 1.83.3. Any other method of physical delivery will not be deemed a Trusted System.
- 1.84. **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.
- 1.85. **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 CFR 438.320).
- 1.86. **WAC** means the Washington Administrative Code. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at <http://slc.leg.wa.gov/>.

2. **GENERAL TERMS AND CONDITIONS:**

- 2.1. **Amendment:** Any amendment to this Contract shall require the approval of both HCA and Contractor. 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
- 2.2. **Assignment:** The Contractor shall not assign this Contract to a third party without the prior written consent of the Health Care Authority.
- 2.3. **Billing Limitations:**
- 2.3.1. The Health Care Authority shall pay the Contractor only for services provided in accordance with this Contract.

- 2.3.2. The Health Care Authority 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 shall not bill and the Health Care Authority shall not pay for services performed under this Contract, if the Contractor has charged or will charge another agency of the state of Washington or any other party for the same services.
- 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 or that come into effect during the term of this Contract (42 CFR 438.6(f)(1) and 438.100(d)). 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 is will not be deemed a conflict. Applicable laws and regulations include, but are not limited to:
- 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 False Claim Act
 - 2.4.8. The Health Insurance Portability and Accountability Act (HIPAA)
 - 2.4.9. The American Recovery and Reinvestment Act (ARRA)
 - 2.4.10. The Patient Protection and Affordable Care Act (PPACA or ACA)
 - 2.4.11. Health Care and Education Reconciliation Act

- 2.4.12. RCW 70.02 and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews.
- 2.4.13. 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:
- 2.4.13.1. 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 CFR Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to the Health Care Authority, DHHS, and the EPA.
 - 2.4.13.2. 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.
 - 2.4.13.3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).
 - 2.4.13.4. Those specified in Title 18 RCW for professional licensing.
 - 2.4.13.5. Industrial Insurance – Title 51 RCW.
 - 2.4.13.6. Reporting of abuse as required by RCW 26.44.030.
 - 2.4.13.7. Federal Drug and Alcohol Confidentiality Laws in 42 CFR Part 2.
 - 2.4.13.8. EEO Provisions.
 - 2.4.13.9. Copeland Anti-Kickback Act.
 - 2.4.13.10. Davis-Bacon Act.
 - 2.4.13.11. Byrd Anti-Lobbying Amendment.
 - 2.4.13.12. All federal and state nondiscrimination laws and regulations.

- 2.4.13.13. Americans with Disabilities Act: 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.
- 2.4.13.14. Any other requirements associated with the receipt of federal funds.

2.5. Confidentiality:

- 2.5.1. The Contractor will protect and preserve the confidentiality of the Health Care Authority's data or information that is defined as confidential under state or federal law or regulation or data that the Health Care Authority has identified as confidential.
- 2.5.2. The Contractor shall comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 CFR Sec. 160.103, as may be amended from time to time. Personal Information or PHI collected, used, or acquired in connection with this Agreement shall be used solely for the purposes of this Agreement. The Contractor shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Agreement or as permitted or required by state or federal law or regulation. The Contractor shall implement appropriate physical, electronic, and managerial safeguards to prevent unauthorized access to Personal Information and PHI. CONTRACTOR shall require the same standards or confidentiality of all its Subcontractors.
- 2.5.3. The Contractor agrees to share Personal Information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 USC 1320(d) et.seq. and 45 CFR parts 160, 162, and 164., the HIPAA regulations, 42 CFR 431 Subpart F, 42 CFR 438.224, RCW 5.60.060(4), and RCW 70.02). The Contractor and the Contractor's subcontractors shall fully

cooperate with the Health Care Authority efforts to implement HIPAA requirements.

- 2.5.4. The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss. This duty requires that Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:
 - 2.5.4.1. Encrypting electronic Confidential Information during Transport;
 - 2.5.4.2. Physically Securing and Tracking media containing Confidential Information during Transport;
 - 2.5.4.3. Limiting access to staff that have an authorized business requirement to view the Confidential Information;
 - 2.5.4.4. Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;
 - 2.5.4.5. Physically Securing any computers, documents or other media containing the Confidential Information; and
 - 2.5.4.6. Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices;
 - 2.5.4.7. Upon request by the Health Care Authority the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a Health Care Authority approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the Health Care Authority contact identified in this Contract.
- 2.5.5. In the event of a theft, loss, unauthorized disclosure, or other potential or known compromise of Confidential Information, the Contractor shall notify the Health Care Authority in writing, as described in accord with the Notices section of the General Terms and Conditions, within one (1) business day of the discovery of the event. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law.

- 2.5.6. The Health Care Authority 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 term of this Agreement. All Health Care Authority 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.
- 2.5.7. Any material breach of this confidentiality provision may result in termination of this Agreement. CONTRACTOR shall indemnify and hold HCA harmless from any damages related to CONTRACTOR'S or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.
- 2.6. **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.
- 2.7. **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 by any Federal department or agency from participating in transactions (Debarred). The Contractor also agrees to include the above requirement in any and all Subcontracts into which it enters. The Contractor shall immediately notify the Health Care Authority if, during the term of this Contract, Contractor becomes Debarred. the Health Care Authority may immediately terminate this Contract by providing Contractor written notice if Contractor becomes Debarred during the term hereof.
- 2.8. **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.

2.9. **Disputes:** When a dispute arises over an issue that pertains in any way to this Contract, the parties agree to the following process to address the dispute:

2.9.1. Except as otherwise provided in this Agreement, when a bona fide dispute arises between HCA and CONTRACTOR and it cannot be resolved, CONTRACTOR may request a dispute resolution hearing with the Administrator. The request for a dispute resolution hearing must be in writing and shall clearly state all of the following:

2.9.1.1. The disputed issue(s)

2.9.1.2. An explanation of the positions of the parties

2.9.1.3. Any additional facts necessary to explain completely and accurately the nature of the dispute.

2.9.2. Requests for a dispute resolution hearing shall be mailed to the Administrator, Washington State Health Care Authority (HCA), P.O. Box 42700, Olympia, WA 98504-2700 within 15 calendar days after CONTRACTOR receives notice of the disputed issue(s). The Administrator will determine a time that is mutually agreeable to the parties during which they may present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Administrator's reasonable discretion, but it is understood that such presentations will be informal in nature. The Administrator will provide written notice of the time, format, and location of the presentations. At the conclusion of the presentations, the Administrator will consider all of the evidence available and shall render a written recommendation as soon as practicable, but in no event more than 30 calendar days after the conclusion of the presentations. The Administrator may appoint a designee to hear and determine the matter.

2.9.3. 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.

2.10. **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 the Health Care Authority 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.

- 2.11. **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.
- 2.12. **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 Department. 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 Department 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 the Health Care Authority nor the State of Washington are guarantors of any obligations or debts of the Contractor.
- 2.13. **Insolvency:** If the Contractor becomes insolvent during the term of this Contract:
- 2.13.1. The State of Washington and enrollees shall not be in any manner liable for the debts and obligations of the Contractor (42 CFR 438.106(a) and 438.116(a)(1));
 - 2.13.2. 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 CFR 438.106(b)(1)).
 - 2.13.3. The Contractor shall, in accord with RCW 48.44.055, or RCW 48.46.245, provide for the continuity of care for enrollees.
- 2.14. **Inspection:** The Contractor and its subcontractors shall cooperate with audits performed by duly authorized representatives of the State of Washington, the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal

Office of the Inspector General and federal Office of Management and Budget. With reasonable notice, generally thirty (30) calendar days, the Contractor and its subcontractors shall provide access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, the quality, cost, use, health and safety and timeliness of services, and assessment of the Contractor's capacity to bear the potential financial losses. The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this Contract for State or Federal fraud investigators (42 CFR 438.6(g)).

- 2.15. **Insurance:** The Contractor shall at all times comply with the following insurance requirements:
- 2.15.1. **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, the Health Care Authority, its elected and appointed officials, agents, and employees shall be named as additional insureds expressly for, and limited to, Contractor's services provided under this Contract.
 - 2.15.2. **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.
 - 2.15.3. **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 the Health Care Authority shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.
 - 2.15.4. **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.
 - 2.15.5. **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 the Health Care Authority if requested.

- 2.15.6. Separation of Insureds: All insurance Commercial General Liability policies shall contain a “separation of insureds” provision.
- 2.15.7. 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 the the Health Care Authority. Exceptions include placement with a “Surplus Lines” insurer or an insurer with a rating lower than A-, Class VII.
- 2.15.8. 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.
- 2.15.9. Material Changes: The Contractor shall give the Health Care Authority, 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 the Health Care Authority ten (10) calendar days advance notice of cancellation.
- 2.15.10. General: By requiring insurance, the State of Washington and the Health Care Authority 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 the Health Care Authority 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.
- 2.15.11. 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 the Health Care Authority by January 15th, of 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 the

Health Care Authority as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for the Health Care Authority.

2.16. Maintenance of Records:

- 2.16.1. The Contractor and its subcontractors shall maintain financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each enrollee. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.
- 2.16.2. All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action.
- 2.17. **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.
- 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, the HCA Account Executive, 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 concerning the operation of the the Health Care Authority programs participating in 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 if any, as indicated on page one of this Contract.
- 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, 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: Confidentiality, Indemnification and Hold Harmless, Inspection and Maintenance of Records. 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 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.
- 2.22. **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 the Health Care Authority Chief Administrative Officer or designee has the authority to waive any term or condition of this Contract on behalf of the Health Care Authority.

- 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 the Health Care Authority 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).
- 2.25. **Indemnification and Hold Harmless:** The Health Care Authority 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 the Health Care Authority from any claims by Participating or non-Participating Providers related to the provision of services to Enrollees according to the terms of this Agreement. 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, the Health Care Authority may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. the Health Care Authority may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by the Health Care Authority 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 of 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 the Contractor Contact at the address for the Contractor on the first page of this Contract.

2.28.2. In the case of notice to the Health Care Authority, send notice to:

Office Chief
Health Care Authority
Division of Healthcare Services
Office of Quality and Care Management
P.O. Box 45530
Olympia, WA 98504-5530

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 forth 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. **Notification of Organizational Changes:**

2.29.1. The Contractor shall provide the Health Care Authority with ninety (90) calendar days prior written notice of any change in ownership or legal status.

2.29.2. The Contractor shall provide the Health Care Authority written notice of any changes to key personnel including, but not limited to,

Chief Executive Officer, the Health Care Authority government relations contact, and Medical Director as soon as reasonably possible.

2.30. **Notice of Overpayment:** If the Contractor receives a vendor overpayment notice or a letter communicating the existence of an overpayment from the Health Care Authority, the Contractor may protest the overpayment determination by requesting an adjudicative proceeding. The Contractor's request for an adjudicative proceeding must:

2.30.1. Be received by the Office of Financial Recovery (OFR) at Post Office Box 9501, Olympia, Washington 98507-9501, within twenty-eight (28) calendar days of service of the notice;

2.30.2. Be sent by certified mail (return receipt) or other manner that proves OFR received the request;

2.30.3. Include a statement as to why the Contractor thinks the notice is incorrect; and

2.30.4. Include a copy of the overpayment notice.

2.30.4.1. Timely and complete requests will be scheduled for a formal hearing by the Office of Administrative Hearings. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the overpayment dispute prior to the hearing.

2.30.4.2. Failure to provide OFR with a written request for a hearing within twenty-eight (28) calendar days of service of a vendor overpayment notice or other overpayment letter will result in an overpayment debt against the Contractor. the Health Care Authority may charge the Contractor interest and any costs associated with the collection of this overpayment. the Health Care Authority may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; or any other collection action available to the Health Care Authority to satisfy the overpayment debt.

2.31. **Proprietary Data or Trade Secrets**

2.31.1. 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.

- 2.31.2. The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. HCA will notify the Contractor upon receipt of any request under the Public Disclosure Law (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 order 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.
- 2.31.3. Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any lawsuit filed by the Contractor to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will immediately notify the Contractor of the filing of any such lawsuit.
- 2.32. **Ownership of Material:** DSHS recognizes that nothing in this Contract shall give the Health Care Authority 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 the Health Care Authority during the performance of this Contract.
- 2.33. **Solvency:**
- 2.33.1. 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.
- 2.33.2. The Contractor agrees that the Health Care Authority may at any time access any information related to the Contractor's financial condition, or compliance with OIC requirements, from OIC and consult with OIC concerning such information.
- 2.33.3. The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the Office of the Insurance

Commissioner (OIC). The Contractor's routine quarterly and annual statements submitted to the OIC are exempt from this requirement. The Contractor shall also deliver copies of related documents 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.

- 2.33.4. The Contractor shall notify HCA within 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 Agreement.
- 2.33.5. The Contractor shall notify HCA within 24 hours after any action by the Insurance Commissioner which may affect the relationship of the parties under this Contract.
- 2.33.6. 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 Insurance Commissioner in accordance with any enhanced reporting requirements and consult with OIC staff concerning information contained therein.

2.34. **State 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 (41 USC 423).

2.35. **Termination for Convenience:** Either party may terminate, upon one-hundred twenty (120) calendar days advance written notice, performance of work under this Contract in whole or in part, whenever, for any reason, either party determines that such termination is in its best interest.

2.35.1. In the event that either party terminates the Contract for convenience the other party may assert a claim for direct termination costs as follows:

2.35.1.1. In the event the Health Care Authority terminates this Contract for convenience, the Contractor shall have the right

to assert a claim for the Contractor's direct termination costs. Such claim must be:

- 2.35.1.1.1. Delivered to the Health Care Authority as provided in accord with the Notices section of the General Terms and Conditions.
 - 2.35.1.1.2. Asserted within ninety (90) calendar days of termination for convenience, or, in the event the termination was originally issued under the provisions of the, Termination by the Health Care Authority for Default provision of this Section, ninety (90) calendar days from the date the notice of termination was deemed to have been issued under this Section. the Health Care Authority may extend said ninety (90) calendar days if the Contractor makes a written request to the Health Care Authority and the Health Care Authority deems the grounds for the request to be reasonable.
 - 2.35.1.1.3. the Health Care Authority will evaluate the claim for termination costs and either pay or deny the claim. the Health Care Authority shall notify the Contractor of the Health Care Authority' decision within sixty (60) calendar days of receipt of the claim.
- 2.35.1.2. In the event the Contractor terminates this Contract for convenience, the Health Care Authority shall have the right to assert a claim for the Health Care Authority' direct termination costs. Such claim must be:
- 2.35.1.2.1. Delivered to the Contractor as described in the Notices section of the General Terms and Conditions.
 - 2.35.1.2.2. Asserted within ninety (90) calendar days of the date of termination for convenience. The Contractor may extend said ninety (90) calendar days if the Health Care Authority makes a written request to the Contractor and the Contractor deems the grounds for the request to be reasonable.
 - 2.35.1.2.3. The Contractor shall evaluate the claim for termination costs and either pay or deny the claim. The Contractor shall notify the Health Care Authority of the Contractor's decision within sixty (60) calendar days of receipt of the claim.

- 2.35.1.3. In the event that either party disagrees with the other party's decision to pay or deny termination costs the disagreeing party shall have the right to a dispute resolution as described in the Disputes section of the General Terms and Conditions.
- 2.35.1.4. In no event shall the claim for termination costs exceed the average monthly amount paid to the Contractor for the twelve (12) months immediately prior to termination.
- 2.35.1.5. In addition to the Health Care Authority' or Contractor's direct termination costs, the Contractor or the Health Care Authority shall be liable for administrative costs incurred by the other party in procuring supplies or services similar to and/or replacing those terminated.
- 2.35.1.6. Neither the Contractor nor the Health Care Authority shall be liable for any termination costs if it notifies the other party of its intent not to renew this Contract at least one hundred twenty (120) calendar days prior to the renewal date.
- 2.35.2. In the event this Contract is terminated for the convenience of either party, the effective date of termination shall be the last day of the month in which the one hundred twenty (120) day notification period is satisfied, or the last day of such later month as may be agreed upon by both parties.
- 2.36. **Termination by the Contractor for Default:** The Contractor may terminate this Contract whenever the Health Care Authority 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 the Health Care Authority to meet one or more material obligations of this Contract. In the event it is determined that the Health Care Authority was not in default, the Health Care Authority may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction. The procedure for determining damages shall be as described in the Termination for Convenience section of the General Terms and Conditions.
- 2.37. **Termination by the Health Care Authority for Default:** The Contract Administrator may terminate this Contract whenever the Contractor defaults in performance of this Contract and fails to cure the default

within a period of one hundred twenty (120) calendar days (or such longer period as the Health Care Authority may allow) after receipt from the Health Care Authority 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 the Contractor to meet one or more material obligations of this Contract. In the event it is determined that the Contractor was not in default, the Contractor may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction. The procedure for determining damages shall be as stated in accord with the Termination for Convenience Section of this Contract.

- 2.38. **Termination - Information on Outstanding Claims:** In the event this Contract is terminated, the Contractor shall provide the Health Care Authority, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 CFR 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.
- 2.39. **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 the intent to terminate this Contract and the reason for termination.
- 2.39.1. If either party disagrees with the other party's decision to terminate this Contract, other than a termination for convenience, that party will have the right to a dispute resolution as described in the Disputes section of the General Terms and Conditions.
- 2.39.2. If the Contractor disagrees with a the Health Care Authority decision to terminate this Contract and the dispute process is not successful, the Health Care Authority shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 CFR 438.708. the Health Care Authority shall:
- 2.39.2.1. Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;
- 2.39.2.2. 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

2.39.2.3. For an affirming decision, give enrollees notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving services following the effective date of termination.

2.40. **Treatment of Client Property:** Unless otherwise provided, the Contractor shall ensure that any adult client receiving services from the Contractor has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the client and/or the client's guardian or custodian all of the client's personal property.

3. **MARKETING AND INFORMATION REQUIREMENTS**

3.1. **Marketing:**

3.1.1. All marketing materials must be reviewed by and have the prior written approval of the Health Care Authority prior to distribution (42 CFR 438.104(b)(1)(i)).

3.1.2. Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 CFR 438.104(b)(2)).

3.1.3. Marketing materials must be distributed in all service areas the Contractor serves (42 CFR 438.104(b)(1)(ii)).

3.1.4. Marketing materials must be in compliance with the, Equal Access for Enrollees and Potential Enrollees with Communication Barriers provisions of this Section.

3.1.4.1. Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as identified by the Health Care Authority.

3.1.4.2. the Health Care Authority may determine, in its sole judgment, if materials that are primarily visual meet the requirements of this Contract.

3.1.5. The Contractor shall not offer anything of value as an inducement to enrollment.

- 3.1.6. The Contractor shall not offer the sale of other insurance to attempt to influence enrollment (42 CFR 438.104(b)(1)(iv)).
- 3.1.7. The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 CFR 438.104(b)(1)(v)).
- 3.1.8. The Contractor shall 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 CFR 438.104(b)(2)(i)).
- 3.1.9. 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 CFR 438.104(b)(2)(ii)).
- 3.2. Information Requirements for Enrollees and Potential Enrollees:**
- 3.2.1. As determined by the Health Care Authority, either the Health Care Authority or the Contractor shall provide sufficient, accurate written information to potential enrollees to assist them in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932(d)(2) and 42 CFR 438.10 and 438.104(b)(1)(iii)). If the enrollee is not able to understand written information or only understands a language that is not translated, the Contractor will provide the necessary information in an alternative format that is understandable to the enrollee.
- 3.2.2. As determined by the Health Care Authority, either the Health Care Authority or the Contractor shall provide to potential enrollees upon request and to each enrollee, within fifteen (15) working days of enrollment, at any time upon request, and at least once a year, the information needed to understand benefit coverage and obtain care in accord with the provisions of this Section (42 CFR 438.10(b)(3) and 438.10(f)(3)). If the enrollee or potential enrollee is not able to understand written information or only understands a language that is not translated, the Contractor will provide the necessary information in an alternative format that is understandable to the enrollee or potential enrollee.
- 3.2.3. At least thirty (30) calendar days prior to distribution, all enrollee information shall be submitted to the Health Care Authority for written approval. the Health Care Authority may waive the thirty day requirement if, in the Health Care Authority' sole judgment, it is in the best interest of the Health Care Authority and its clients.

- 3.2.4. Changes to State or Federal law shall be reflected in information 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 the Health Care Authority, the change is significant in regard to the enrollees' quality of or access to care. the Health Care Authority shall notify the Contractor of any significant change in writing (42 CFR 438.6(i)(4) and 438.10(f)(4)).
- 3.2.5. As determined by the Health Care Authority, either the Health Care Authority or the Contractor shall provide to enrollees and potential enrollees written information about:
- 3.2.5.1. Choosing a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.
 - 3.2.5.2. Changing PCPs.
 - 3.2.5.3. Accessing services outside the Contractor's service area.
 - 3.2.5.4. Accessing Emergency, after hours and urgent services.
 - 3.2.5.5. Accessing hospital care and how to get a list of hospitals that are available to enrollees.
 - 3.2.5.6. Specialists available to enrollees, including mental health providers and how to obtain specific information including a list of specialists, their identity, location, languages spoken, qualifications, practice restrictions and availability.
 - 3.2.5.7. Pharmacies available to enrollees and how to obtain specific information including a list of pharmacies that includes their identity, location, and hours of operation.
 - 3.2.5.8. Limitations to the availability of or referral to specialists to assist the enrollee in selecting a PCP, including any medical group restrictions.
 - 3.2.5.9. Direct access to a Woman's Healthcare specialist within the Contractor's network.
 - 3.2.5.10. Obtaining information regarding Physician Incentive Plans (42 CFR 422.208 and 422.210).

- 3.2.5.11. Obtaining information on the Contractor's structure and operations (42 CFR 438.10(g)).
- 3.2.5.12. Informed consent guidelines.
- 3.2.5.13. Conversion rights under RCW 48.46.450 or RCW 48.44.370.
- 3.2.5.14. Requesting a termination of enrollment.
- 3.2.5.15. Information regarding advance directives to include (42 CFR 422.128 and 438.6(i)(1 and 3)):
 - 3.2.5.15.1. A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.
 - 3.2.5.15.2. The Contractor's written policies and procedures concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive.
 - 3.2.5.15.3. An enrollee's rights under state law, including the right to file a grievance with the Contractor or the Health Care Authority regarding compliance with advance directive requirements in accord with the Advance Directive provisions of the Enrollee Rights and Protections Section of this Contract.
- 3.2.5.16. How to recommend changes in the Contractor's policies and procedures.
- 3.2.5.17. Health promotion, health education and preventive health services available.
- 3.2.5.18. Information on the Contractor's Grievance System including (42 CFR 438.10(f)(2), 438.10(f)(6)(iv), 438.10(g)(1) and SMM2900 and 2902.2):
 - 3.2.5.18.1. How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential except as needed to process the grievance, appeal or independent review).

- 3.2.5.18.2. The enrollees' right to and how to initiate a grievance or file an appeal, in accord with the Contractor's the Health Care Authority approved policies and procedures regarding grievances and appeals.
- 3.2.5.18.3. The enrollees' right to and how to request a hearing after the Contractor's appeal process is exhausted, how to request a hearing and the rules that govern representation at the hearing.
- 3.2.5.18.4. The enrollees' right to and how to request an independent review in accord with RCW 48.43.535 and WAC 246-305 after the hearing process is exhausted and how to request an independent review.
- 3.2.5.18.5. The enrollees' right to appeal an independent review decision to the Board of Appeals and how to request such an appeal.
- 3.2.5.18.6. The requirements and timelines for grievances, appeals, hearings, independent review and Board of Appeals.
- 3.2.5.18.7. The enrollees' rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or a hearing.
- 3.2.5.18.8. The availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.
- 3.2.5.19. The enrollee's rights and responsibilities with respect to receiving contracted services.
- 3.2.5.20. Information about covered benefits and how to contact the Health Care Authority regarding services that may be covered by the Health Care Authority, but are not covered benefits under this Contract.
- 3.2.5.21. Specific information regarding EPSDT and childhood immunizations as described in the Benefits Section of this Contract.
- 3.2.5.22. Information regarding the availability of and how to access or obtain interpretation services and translation of written

information at no cost to the enrollee (42 CFR 438.10(c)(5)(i and ii)).

3.2.5.23. How to obtain information in alternative formats (42 CFR 438.10(d)(2)).

3.2.5.24. The enrollee's right to and procedure for obtaining a second opinion free of charge.

3.2.5.25. The prohibition on charging enrollees for contracted services, except for enrollee cost sharing as described in the Contract, the procedure for reporting charges the enrollee receives for contracted services to the Contractor and circumstances under which an enrollee might be charged for services.

3.2.5.26. Information regarding the Contractors appointment wait time standards.

3.2.6. If the Health Care Authority produces the information to be provided to enrollees and potential enrollees, the Contractor agrees to pay a mutually agreed upon assessment once a year to reimburse the Health Care Authority for the Contractor's share of production and mailing costs.

3.3. **Equal Access for Enrollees & Potential Enrollees with Communication Barriers:** The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 CFR 438.10).

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, free of charge (42 CFR 438.10(c)(4)). Interpreter services 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 appointments with any provider for any covered service

- 3.3.1.1.3. Emergency services
- 3.3.1.1.4. All steps necessary to file grievances and appeals.
- 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. The Health Care Authority is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.
- 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.
- 3.3.1.6. Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired at no cost to the enrollee or potential enrollee (42 CFR 438.10(c)(4)).
- 3.3.2. Written Information:
 - 3.3.2.1. The Contractor shall provide all generally available and client-specific written materials in a language and format which may be understood by each individual enrollee and potential enrollee (42 CFR 438.10(c)(3) and 438.10(d)(1)(ii)).
 - 3.3.2.1.1. If five percent (5%) or more of the Contractor's enrollees speak a specific language other than English, generally available materials will be translated into that language.
 - 3.3.2.1.2. For enrollees whose primary language is not translated or whose need cannot be addressed by translation as required by the provisions of this Section, the Contractor may meet the requirement of this Section by doing any one of the following:
 - 3.3.2.1.2.1. Translating the material into the enrollee's or potential enrollee's primary reading language.

- 3.3.2.1.2.2. Providing the material on tape in the enrollee's or potential enrollee's primary language.
- 3.3.2.1.2.3. Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.
- 3.3.2.1.2.4. Providing the material in another alternative medium or 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 CFR 438.10(d)(1)(ii)).
- 3.3.2.1.2.5. 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, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, and is written at the sixth grade reading level and fulfils other requirements of the Contract as may be applicable to the materials (42 CFR 438.10(b)(1)).
- 3.3.2.3. the Health Care Authority may make exceptions to the sixth grade reading level when, in the sole judgment of the Health Care Authority, the nature of the materials do not allow for a sixth grade reading level or the enrollees' needs are better served by allowing a higher reading level. the Health Care Authority approval of exceptions to the sixth grade reading level must be in writing.
- 3.3.2.4. Disease Management materials, preventative services or other education materials used by the Contractor for health promotion efforts 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.
- 3.3.2.5. All written materials must have the written approval of the Health Care Authority prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by the Health Care Authority. The Contractor must provide the Health Care Authority with a copy of all approved materials in final form.

4. PAYMENT AND SANCTIONS

4.1. Rates/Premiums:

- 4.1.1. Subject to the Sanctions provisions of this Section, the Health Care Authority shall pay a monthly premium for each enrollee in full consideration of the work to be performed by the Contractor under this Contract. the Health Care Authority shall pay the Contractor, on or before the tenth (10th) working day of the month based on the the Health Care Authority 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 CFR 438.726(b) or 42 CFR 438.730(e).
- 4.1.2. The Contractor shall reconcile the electronic benefit enrollment file with the premium payment information and submit a claim to the Health Care Authority for any amount due the Contractor within three hundred sixty-five (365) calendar days of the month of service. Any claim submitted after the 365-day period will be denied. When the Health Care Authority' records confirm the Contractor's claim, the Health Care Authority shall remit payment within thirty (30) calendar days of the receipt of the claim.
- 4.1.3. Information regarding monthly premiums for each program will be found in the specific Exhibits for that program. The Basic Health the information is in Exhibit B and for Healthy Options the information is in Exhibit H.
- 4.1.4. The program specific premiums established through the Request for Proposals that resulted in the this Contract are effective for the initial eighteen month term of the Contract, July 1, 2012 through December 31, 2013. The Health Care Authority will make a reasonable effort to provide the Contractor program specific premiums for any renewal period one hundred and twenty (120) calendar days prior to the beginning of that renewal period. If the Contractor will not continue to provide services to the Health Care Authority in the renewal period, the Contractor shall notify the Health Care Authority no later than thirty (30) calendar days after the publication of the rates and factors as required under the Notices provisions of the General Terms and Conditions Section of this Contract. If the Contractor notifies the Health Care Authority, this Contract shall terminate, without penalty to either party,

effective midnight at the end of the current term of the Contract.
Neither party shall have the right to assert a claim for costs.

- 4.2. **Medical Loss Ratio Limitation:** The Contractor medical loss ratio for each program is limited to eighty-three percent (83%) in each calendar year. Medical loss ratio shall be as defined by the Office of the Insurance Commissioner (OIC) in RCW 48.43.049 with the additional inclusion of any quality incentive payments made directly to Participating Providers prior to the end of the year. If the Contractor's actual medical loss ratio in calendar years 2009 or 2010, as determined by the Health Care Authority and its actuaries using the Contractor's financial information, is less than eighty-three (83) percent, the Health Care Authority will calculate an amount due from the Contractor by subtracting the Contractor's actual medical loss ratio related to its performance under this Contract in the calendar year from eighty-three (83) percent and multiplying the result by the total premiums paid to the Contractor for the calendar year, including the Delivery Case Rate. The Contractor shall remit to the Health Care Authority the amount due within ninety (90) days of the date that the Health Care Authority provides notice to the Contractor of that amount. This provision shall survive the expiration or termination of this Contract.
- 4.3. **Renegotiation of Rates:** The base rate set forth herein shall be subject to renegotiation during the Contract period only if the Health Care Authority, 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.
- 4.4. **Reinsurance/Risk Protection:** The Contractor may obtain reinsurance for coverage of enrollees only to the extent that it obtains such reinsurance for other groups enrolled by the Contractor, provided that the Contractor remains ultimately liable to the Health Care Authority for the services rendered.
- 4.5. **Information for Rate Setting and Methodology:** For rate setting only, 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 the Health Care Authority. The designated actuary will determine the timing, content, format and medium for such information. the Health Care Authority sets actuarially-sound managed care rates.
- 4.6. **Payments to Critical Access Hospitals (CAH):** For services provided by CAH to enrollees, the Contractor shall pay the CAH the prospective

Inpatient and Outpatient Departmental Weighted Cost-to-Charge rates published by the Health Care Authority for the fee-for-service program.

- 4.7. **Emergency Services by Non-Contracted Providers:** 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 the Health Care Authority' Medicaid FFS program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).
- 4.8. **Data Certification Requirements:** Any information and/or data required by this Contract and submitted to the Health Care Authority shall be certified by the Contractor as follows (42 CFR 438.242(b)(2) and 438.600 through 438.606):
- 4.8.1. Source of certification: The information and/or data shall be certified by one of the following:
 - 4.8.1.1. The Contractor's Chief Executive Officer.
 - 4.8.1.2. The Contractor's Chief Financial Officer.
 - 4.8.1.3. An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.
 - 4.8.2. 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.
 - 4.8.3. Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.
 - 4.8.4. the Health Care Authority will identify the specific data that requires certification.
- 4.9. **Sanctions:**
- 4.9.1. If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, the Health Care Authority may impose sanctions by withholding up to five percent of its scheduled payments to the Contractor.
 - 4.9.1.1. the Health Care Authority may withhold payment from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

- 4.9.1.2. the Health Care Authority 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 the Health Care Authority' position.
- 4.9.2. the Health Care Authority, CMS or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with 42 CFR 438.700, 42 CFR 438.702, 42 CFR 438.704, 45 CFR 92.36(i)(1), 42 CFR 422.208 and 42 CFR 422.210 against the Contractor for:
- 4.9.2.1. 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.
- 4.9.2.2. Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.
- 4.9.2.3. 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.
- 4.9.2.4. Misrepresenting or falsifying information that it furnishes to CMS, the Health Care Authority, an enrollee, potential enrollee or any of its subcontractors.
- 4.9.2.5. Failing to comply with the requirements for physician incentive plans.
- 4.9.2.6. Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Health Care Authority or that contain false or materially misleading information.

4.9.2.7. Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

4.9.2.8. Intermediate sanctions may include:

4.9.2.8.1. Civil monetary penalties in the following amounts:

4.9.2.8.1.1. A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

4.9.2.8.1.2. A maximum of \$100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or the Health Care Authority.

4.9.2.8.1.3. A maximum of \$15,000 for each potential enrollee the Health Care Authority determines was not enrolled because of a discriminatory practice subject to the \$100,000 overall limit.

4.9.2.8.1.4. 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. the Health Care Authority will deduct from the penalty the amount charged and return it to the enrollee.

4.9.2.8.2. Appointment of temporary management for the Contractor as provided in 42 CFR 438.706. the Health Care Authority 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.

4.9.2.8.3. Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. the Health Care Authority shall notify current enrollees of the sanctions and that they may terminate enrollment at any time.

4.9.2.8.4. Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS or the Health Care Authority is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

4.10. **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally-qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

5. ACCESS TO CARE AND PROVIDER NETWORK

5.1. Network Capacity:

5.1.1. The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract (42 CFR 438.206(b)(1)).

5.1.2. 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 CFR 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.

5.1.3. The Contractor must submit documentation regarding its maintenance, monitoring and analysis of the network to determine compliance with the requirements of this Section, at any time upon Health Care Authority request or when there has been a change in the Contractor's network or operations that, in the sole judgment of the Health Care Authority, would affect adequate capacity and/or the Contractor's ability to provide services (42 CFR 438.207(b & c)).

5.2. **Service Delivery Network:** In the maintenance and monitoring of its network, the Contractor must consider the following (42 CFR 438.206(b)):

5.2.1. Expected enrollment.

- 5.2.2. Adequate access to all services covered under this Contract.
- 5.2.3. 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.
- 5.2.4. The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services.
- 5.2.5. The number of network providers who are not accepting new enrollees.
- 5.2.6. The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by potential enrollees, and whether the location provides physical access for the Contractor's enrollees with disabilities.
- 5.2.7. The cultural, ethnic, race and language needs of enrollees.
- 5.3. **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 CFR 438.206(b) & (c)(1)(i)). The Contractor shall ensure that:
 - 5.3.1. Network providers offer access comparable to that offered to commercial enrollees or, if the Contractor serves only Medicaid enrollees, comparable to Medicaid fee-for-service (42 CFR 438.206(b)(1)(iv) & (c)(1)(ii)).
 - 5.3.2. Mechanisms are established to ensure compliance by providers.
 - 5.3.3. Providers are monitored regularly to determine compliance.
 - 5.3.4. Corrective action is initiated and documented if there is a failure to comply.
- 5.4. **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 CFR 438.206(c)(1)(iii)).
- 5.5. **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 CFR 438.206(c)(1)(iii)).

- 5.5.1. Medical advice for enrollees from licensed health care professionals.
 - 5.5.2. Triage concerning the emergent, urgent or routine nature of medical conditions by licensed health care professionals.
 - 5.5.3. Authorization of services.
 - 5.5.4. Emergency drug supply, as described in the General Description of Contracted Services provisions of the Benefits Section of this Contract.
- 5.6. **Customer Service**
- 5.6.1. The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8 a.m. to 5 p.m., Pacific Standard Time or Daylight Savings Time (depending on the season), 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. Work days for state employees shall include days designated as “temporary lay-off” or “furlough” days under state law.
 - 5.6.2. Toll free numbers shall be provided at the expense of the Contractor.
- 5.7. **Appointment Standards:** The Contractor shall comply with appointment standards that are no longer than the following (42 CFR 438.206(c)(1)(i)):
- 5.7.1. Transitional healthcare by a primary care provider shall be available for clinical assessment and care planning within forty-eight (48) hours of discharge from inpatient care for physical or behavioral health disorders or discharge from a substance abuse disorder program.
 - 5.7.2. Transitional health care by a home care nurse or home care registered counselor within forty-eight (48) hours of discharge from inpatient care for physical or behavioral health disorders or discharge from a substance abuse disorder program, if ordered by the enrollee’s primary care provider or as part of the discharge plan.
 - 5.7.3. 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.

- 5.7.4. 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.
- 5.7.5. Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life threatening.
- 5.7.6. Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.
- 5.8. **Provider Database:** The Contractor shall have and maintain an up-to-date database of its provider network, which includes the identity, location, languages spoken, qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 CFR 438.242(b)(1)).
- 5.9. **Provider Network - Distance Standards:**
 - 5.9.1. The Contractor network of providers shall meet the distance standards below in every service area. The designation of a zip code in a service area as rural or urban is in Exhibit A, Premiums, Service Areas, and Capacity.
 - 5.9.1.1. PCP
 - Urban: 2 within 10 miles for 90% of enrollees in the Contractor's service area.
 - Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.
 - 5.9.1.2. Obstetrics
 - Urban: 2 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

5.9.1.3. Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

Urban: 2 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

5.9.1.4. Hospital

Urban/Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

5.9.1.5. Pharmacy

Urban: 1 within 10 miles for 90% of enrollees in the Contractor's service area.

Rural: 1 within 25 miles for 90% of enrollees in the Contractor's service area.

- 5.9.2. the Health Care Authority may, in its sole discretion, grant exceptions to the distance standards. the Health Care Authority' approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as the Health Care Authority may require to support 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.

5.10. **Distance Standards for High Volume Specialty Care Providers:** The Contractor shall establish and meet measurable distance standards for high volume Specialty Care Providers to enrollees. The Contractor shall analyze performance against standards at minimum, annually.

5.11. **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.

5.12. Access to Specialty Care:

- 5.12.1. 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, the Contractor shall provide the necessary services with a qualified specialist outside the Contractor's provider network.
- 5.12.2. The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

5.13. Capacity Limits and Order of Acceptance:

- 5.13.1. The Contractor shall provide care to all enrollees who voluntarily choose the Contractor and all enrollees assigned by DSHS.
- 5.13.2. Enrollees will be accepted in the order in which they apply.
- 5.13.3. the Health Care Authority shall enroll all eligible clients with the contractor of their choice except as provided herein.unless the Health Care Authority determines, in its sole judgment, that it is in the Health Care Authority' best interest to withhold or limit enrollment with the Contractor.
- 5.13.4. The Health Care Authority may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, it is in the best interest of the Health Care Authority and/or its clients. The Contractor will present any information the Health Care Authority requires to exercise its judgment within thirty (30) calendar days of the Contractor's receipt of the request for information.
- 5.13.5. The Contractor may request in writing that the Health Care Authority suspend voluntary enrollment and/or assignments in any service area. The Health Care Authority will approve the temporary suspension when, in the sole judgment of the Health Care Authority, it is in the best interest of the Health Care Authority and/or its clients. The Contractor will present any information the Health Care Authority requires to exercise its judgment.
- 5.13.6. The Contractor shall accept clients who are enrolled by the Health Care Authority in accord with this Contract, WAC 388-538, and

WAC 388-542, except as specifically provided in the Enrollment Data and Requirements for Contractor's Response provisions in the Enrollment Section of this Contract.

- 5.13.7. 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 mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 CFR 438.6(d)(1 and 3)).

5.14. Assignment of Enrollees:

- 5.14.1. Potential enrollees who do not select a HO plan shall be assigned to a HO plan by the Health Care Authority as follows:

- 5.14.1.1. For the period July 1, 2012 through June 30, 2013:

- 5.14.1.1.1. See RFP needs refinement of calculation

5.15. Provider Network Changes:

- 5.15.1. The Contractor shall give the Health Care Authority 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. A material provider is one whose loss would impair the Contractor's ability to provide continuity of and access to care for the Contractor's current enrollees and potential enrollees.

- 5.15.2. 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 CFR 438.10(f)(5)). Enrollee notices shall have prior approval of the Health Care Authority. 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. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

6.1. Quality Assessment and Performance Improvement (QAPI) Program:

- 6.1.1. The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the physical and behavioral health services it furnishes to its enrollees that meets the provisions of 42 CFR 438.240.
 - 6.1.1.1. The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.
 - 6.1.1.2. The QAPI program structure shall include the following elements:
 - 6.1.1.2.1. A written description of the QAPI program including identification and description of the roles of designated physician and behavioral health practitioners. The QAPI program description shall include:
 - 6.1.1.2.1.1. A listing of all quality-related committee(s);
 - 6.1.1.2.1.2. Descriptions of committee responsibilities;
 - 6.1.1.2.1.3. Contractor staff and practicing provider committee participant titles;
 - 6.1.1.2.1.4. Meeting frequency; and
 - 6.1.1.2.1.5. Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.
 - 6.1.1.2.2. A Quality Improvement Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:
 - 6.1.1.2.2.1. Recommend policy decisions
 - 6.1.1.2.2.2. Analyze and evaluate the results of QI activities
 - 6.1.1.2.2.3. Institute actions
 - 6.1.1.2.2.4. Ensure appropriate follow-up

- 6.1.1.2.3. An annual quality work plan, including objectives for serving enrollees with special health care needs and enrollees from diverse communities.
- 6.1.1.2.4. An annual written report of the overall evaluation of the effectiveness of the contractor QAPI program. (42 CFR 438.240(e)(2)). The report shall include at minimum performance and utilization data pictorially displayed and trended over time; accompanying written analysis, data comparisons to national and/or regional benchmarks, interventions planned or undertaken during the review period to address under or over-utilization patterns and a report of the evaluation of the impact of the interventions, including any follow-up action or interventions: The report, at a minimum should contain:
 - 6.1.1.2.4.1. Performance measure data,
 - 6.1.1.2.4.2. Comprehensive inpatient and outpatient utilization data,
 - 6.1.1.2.4.3. The success of performance improvement projects, including documented actions taken to address under-performance, as appropriate.
- 6.1.1.2.5. .
- 6.1.2. Upon request, the Contractor shall make available to providers, enrollees, or the Department, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.
- 6.1.3. The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:
 - 6.1.3.1. A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity;
 - 6.1.3.2. Evaluation of the delegated organization prior to delegation;
 - 6.1.3.3. An annual evaluation of the delegated entity;
 - 6.1.3.4. Evaluation of regular delegated entity reports; and

- 6.1.3.5. Follow-up on issues out of compliance with delegated agreement or the Health Care Authority contract specifications.

6.2. Performance Improvement Projects:

- 6.2.1. The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas. The Contractor shall conduct at least two (2) Performance Improvement Projects (PIPs) of which at least one (1) is clinical and at least one (1) is non-clinical as described in 42 CFR 438.240 (b)(1) and as specified in the CMS protocol.
- 6.2.2. The projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Through implementation of performance improvement projects, the Contractor shall:
 - 6.2.2.1. Measure performance using objective, quality indicators.
 - 6.2.2.2. Implement system interventions to achieve improvement in quality.
 - 6.2.2.3. Evaluate the effectiveness of the interventions.
 - 6.2.2.4. Plan and initiate activities for increasing or sustaining improvement.
 - 6.2.2.5. Report the status and results of each project to the Health Care Authority (42 CFR 438.240(d)(2)).
 - 6.2.2.6. Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year (42 CFR 438.240(d)(2)).
- 6.2.3. Annually, the Contractor shall submit to the Health Care Authority one (1) clinical and one (1) non-clinical performance improvement project which, in the judgment of the Contractor, best meet the requirements of a performance improvement project. Each project will be documented on a performance improvement project worksheet found in the CMS protocol entitled "Conducting Performance Improvement Projects".

- 6.2.4. If any of the Contractor's Health Plan Employer Data and Information Set (HEDIS®) rates on Well Child Visits in the first fifteen (15) months, six (6) or more well child visits measure, Well Child Visits in the third (3rd), fourth (4th), fifth (5th) and sixth (6th) years of life, or Adolescent Well Care Visits are below a sixty percent (60%) benchmark in 2013, the Contractor shall implement a clinical PIP designed to increase the rates.
- 6.2.5. If the HEDIS® Well-Child Measure does not meet contractually required benchmarks, the Contractor is required to conduct one clinical PIP focused on well-child care. The Contractor may count the HEDIS® Well-Child PIP towards meeting one of two (2) required clinical PIPs.
- 6.2.6. The Contractor is required to conduct one statewide PIP on Transitional Healthcare Services (THS) focused on enrollees with special health care needs or at risk for re-institutionalization, re-hospitalization or substance use disorder recidivism. The Contractor will collaborate with peer Medicaid managed care organizations, primary care providers, and state institutions, hospitals, and substance use disorder programs to plan, execute and evaluate the project. The Contractor in collaboration with peer Contractors shall:
- 6.2.6.1. Appoint or hire a leader to manage the PIP including development of a project plan, budget, intervention activities and a plan for evaluating the impact of the PIP.
 - 6.2.6.2. Participate in a planning group organized by the leader in collaboration with all team members.
 - 6.2.6.3. Define the target populations for the study.
 - 6.2.6.4. Define intervention(s) used in the PIP.
 - 6.2.6.5. Evaluate the success of interventions at reducing re-institutionalization, re-hospitalization, and substance use disorder recidivism.
 - 6.2.6.6. Collectively, all contractors shall provide adequate funding, resources and staff to plan execute and evaluate the PIP.

6.2.6.7. The Contractor shall begin PIP planning efforts, including selection of the leader, development of a project plan and budget by September 30, 2012 and submit a PIP reporting form annually, including measures of effectiveness. The first measurement will be reported by June 30, 2014.

6.2.6.8. The Contractor will submit one collaborative PIP data collection tool representing all plans participating in the study and submit to the State as part of its annual TeaMonitor review by July 30, 2014.

6.2.7. In addition to the PIPs required under this Section the Contractor shall participate in a yearly statewide PIP.

6.2.7.1. The PIP will either be conducted by the Department of Health or by an organization selected by the Health Care Authority.

6.2.7.2. The PIP shall be designed to maximize resources and reduce cost to contractors.

6.2.7.3. The Contractor shall cooperate with the Health Care Authority' designated External Quality Review Organization (EQRO) and the organization conducting the PIP.

6.2.7.4. The Contractor will receive copies of aggregate data and reports produced from these projects.

6.2.7.5. The Contractor shall provide financial support to the organization conducting the PIP annually in the following manner:

6.2.7.5.1. If the Contractors enrollment is less than 10,000 the Contractor shall provide \$30,000 each year to support the PIP.

6.2.7.5.2. If the Contractors enrollment is more than 10,000 but less than 100,000 the Contractor shall provide \$40,000 each year to support the PIP.

6.2.7.5.3. If the Contractors enrollment is more than 100,000 the Contractor shall provide \$50,000 each year to support the PIP.

6.3. **Performance Measures using Health Employer Data & Information Set (HEDIS®):**

- 6.3.1. In accord with the Notices provisions of the General Terms and Conditions Section of this Contract, the Contractor shall report to the Health Care Authority HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by the Health Care Authority. For the HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDIS® Technical Specifications, unless directed otherwise by the Health Care Authority (42 CFR 438.240(b)(2)). The Contractor shall make its best effort to maximize data collection.
- 6.3.2. In addition, the Contractor shall collect and report the non-HEDIS® measures, identified as such, following specifications provided by the Health Care Authority.
- 6.3.3. No later than June 15 of each year, HEDIS® measures shall be submitted electronically to the Health Care Authority using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method.
- 6.3.4. The following HEDIS® measures shall be submitted to the Health Care Authority:
- 6.3.4.1. Childhood Immunization Status (Hybrid measure required)
 - 6.3.4.2. Adolescent Immunizations
 - 6.3.4.3. Weight assessment and counseling for nutrition and physical activity for children and adolescents
 - 6.3.4.4. Chlamydia screening
 - 6.3.4.5. Appropriate testing for pharyngitis
 - 6.3.4.6. Developmental screening
 - 6.3.4.7. Children and Adolescents' Access to Primary Care Practitioners
 - 6.3.4.8. Well Child Visits in the First 15 Months of Life (Hybrid measure required)
 - 6.3.4.9. Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (Hybrid measure required)

- 6.3.4.10. Adolescent Well Care Visits (Hybrid measure required)
- 6.3.4.11. Comprehensive Diabetes Care (Hybrid measure required)
- 6.3.4.12. Plan All Cause Readmission
- 6.3.4.13. Inpatient Utilization – General Hospital Acute Care
- 6.3.4.14. Inpatient Utilization – Nonacute Care
- 6.3.4.15. Ambulatory Care
- 6.3.4.16. Mental Health Utilization – Outpatient
- 6.3.4.17. Antidepressant Medication Management
- 6.3.4.18. Follow-Up After Hospitalization for Mental Illness
- 6.3.4.19. Medication Reconciliation Post-Discharge
- 6.3.4.20. Race/Ethnicity diversity of membership
- 6.3.4.21. Preventable Non-Emergent Emergency Room Rates – non-HEDIS®
- 6.3.4.22. Generic Prescription Fill Rates – non-HEDIS®
- 6.3.4.23. Medication Possession Ratios – non-HEDIS®
- 6.3.5. The Contractor shall submit raw HEDIS® data to DSHS electronically for all measures, no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data according to specifications provided by DSHS.
- 6.3.6. All HEDIS® measures by a designated certified HEDIS® Compliance Auditor, a licensed organization in accord with methods described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures. The Health Care Authority will fund and the Health Care Authority designated EQRO will conduct the audit.
- 6.3.7. The Contractor shall cooperate with the Health Care Authority' designated EQRO to validate the Contractor's Health Employer Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

- 6.3.7.1. If the Contractor does not have NCQA accreditation for its Medicaid/CHIP product from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.
- 6.3.7.2. If the Contractor has NCQA accreditation for its Medicaid/CHIP product or is seeking accreditation with a scheduled NCQA visit during the Contract term, the Contractor shall receive a full audit.
- 6.3.7.3. Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the Centers for Medicare and Medicaid (CMS) Validating Performance Measures protocol identified by the Health Care Authority designated EQRO.
- 6.3.8. The Contractor shall provide evidence of trending of measures to assess performance in quality and safety of clinical care and quality of non-clinical or service-related care.
- 6.3.9. The Contractor shall collect and maintain data on ethnicity, race and language markers as established by the Health Care Authority on all enrollees. The Contractor shall record and maintain enrollee self-identified data as established by the Contractor and maintain unique data fields for self-identified data.
- 6.3.10. The Contractor shall rotate HEDIS® measures only with the advance written permission of the Health Care Authority. The Contractor may request permission to rotate measures by making a written request to the Health Care Authority contact named in the Notices provisions of the General Terms and Conditions Section of this Contract. Childhood Immunization and well-child measures shall not be rotated.
- 6.4. External Quality Review:**
- 6.4.1. 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 the Health Care Authority, its agent, or an EQRO.
- 6.4.2. The following required activities will be validated (42 CFR 438.358(b)(1)(2)(3)):
- 6.4.2.1. Performance improvement projects.
- 6.4.2.2. Performance measures.

- 6.4.2.3. A monitoring review of standards established by the Health Care Authority and included in this Contract to comply with 42 CFR 438.204 (g) and a comprehensive review conducted within the previous three-year period.
- 6.4.3. The Health Care Authority reserves the right to include additional optional activities described in 42 CFR 438.358 if additional funding becomes available and as mutually negotiated between the Health Care Authority and the Contractor.
- 6.4.4. The Contractor shall submit to annual Health Care Authority TeaMonitor and EQRO monitoring reviews. The monitoring review process uses standard 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 CFR 438.204).
- 6.4.4.1. The Contractor shall, during an annual monitoring review of the Contractor's compliance with contract standards or upon request by the Health Care Authority 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.
- 6.4.4.2. The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report (EQRR). The EQRR 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 CFR 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.
- 6.4.4.3. the Health Care Authority will provide a copy of the EQRR 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, recipient advocacy groups, and members of the general public. the Health Care Authority must make this information available

in alternative formats for persons with sensory impairments, when requested.

6.4.4.4. 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 the Health Care Authority. 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 the Health Care Authority, Department of Health (DOH), and The Health Care Authority (HCA) as needed to reduce duplicated work for both the Contractor and the state.

6.5. **Enrollee Mortality:** The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to the Health Care Authority upon request. The Contractor shall assist the Health Care Authority in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

6.6. **Practice Guidelines:**

6.6.1. The Contractor shall adopt physical and behavioral health practice guidelines. The Contractor may develop or adopt guidelines developed by organizations such as the American Diabetes Association or the American Lung Association. Practice guidelines shall meet the following requirements (42 CFR 438.236):

6.6.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

6.6.1.2. Consider the needs of enrollees and support client and family involvement in care plans;

6.6.1.3. Are adopted in consultation with contracting health care professionals;

6.6.1.4. Are reviewed and updated at least every two years and as appropriate;

6.6.1.5. Are disseminated to all affected providers and, upon request, to the Health Care Authority, enrollees and potential enrollees (42 CFR 438.236(c)); and

- 6.6.1.6. Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply (42 CFR 438.236(d)).
- 6.6.1.7. Are distributed to affected providers within 60 days of adoption or revision. Are distributed to new providers. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers. The Contractor must maintain a record of notification and distribution of guidelines.
- 6.6.2. To facilitate the activities of the work group assigned to complete the Standardized Screening and Intervention for Depression PIP, the Contractor, in collaboration with peer contractors, shall adopt a common, evidence-based guideline for the screening for depression, as well as interventions to manage depression.
- 6.7. **Drug Formulary Review and Approval:** The Contractor shall submit its drug formulary, for use with enrollees covered under the terms of this Contract, to the Health Care Authority for review and approval by January 31 of each year of this Contract or upon the Health Care Authority' request. The formulary shall be submitted to:
- Donna Sullivan, Pharmacy Policy Manager (or her successor)
Health Care Authority
Division of Medical Management
P.O. Box 45506
Olympia, WA 98504-5506
E-mail: donna.sullivan@hca.wa.gov
- 6.8. **Health Information Systems:** The Contractor shall maintain, and shall require subcontractors to maintain, a health information system that complies with the requirements of 42 CFR 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:
- 6.8.1. 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.

- 6.8.2. Ensure data received from providers is accurate and complete by:
 - 6.8.2.1. Verifying the accuracy and timeliness of reported data;
 - 6.8.2.2. Screening the data for completeness, logic, and consistency; and
 - 6.8.2.3. Collecting service information on standardized formats to the extent feasible and appropriate.
- 6.8.3. The Contractor shall make all collected data available to the Health Care Authority and the Center for Medicare and Medicaid Services (CMS) upon request.
- 6.9. **Technical Assistance:** The Contractor may request technical assistance for any matter pertaining to this Contract by contacting the Health Care Authority by e-mail at hrsaogcm@dshs.wa.gov.

7. POLICIES AND PROCEDURES

- 7.1. The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract.
- 7.2. The Contractor's policies and procedures shall:
 - 7.2.1. Direct and guide the Contractor's employees, subcontractors and any non-contracted providers' compliance with all applicable federal, state and contractual requirements.
 - 7.2.2. Fully articulate the Contractor's understanding of the requirements.
 - 7.2.3. Have an effective training plan related to the requirements and maintain records of the number and type of providers and staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training.
 - 7.2.4. Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.
- 7.3. The Contractor shall complete a self-assessment of its policies and procedures related to this Contract to the Health Care Authority for review and approval. The self-assessment will be developed by the Health Care Authority. The Contractor shall complete and submit the self-assessment no later than September 30, 2012 and, thereafter, in

response to corrective action and anytime there is a new policy and procedure or a change to an existing policy and procedure.

8. SUBCONTRACTS

- 8.1. **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 shall terminate the Contractor's legal responsibility to the Health Care Authority for any work performed under this Contract (42 CFR 434.6 (c) & 438.230(a)).
- 8.2. **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.
- 8.3. **Provider Nondiscrimination:**
- 8.3.1. 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 CFR 438.12(a)(1)).
- 8.3.2. 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 CFR 438.12(a)(1)).
- 8.3.3. The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42CFR 438.214(c)).
- 8.3.4. Consistent with the Contractor's responsibilities to the enrollees, this Section may not be construed to require the Contractor to:
- 8.3.4.1. Contract with providers beyond the number necessary to meet the needs of its enrollees.
- 8.3.4.2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

8.3.4.3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 CFR 438.12(b)(1)).

8.4. **Required Provisions:** Subcontracts shall be in writing, consistent with the provisions of 42 CFR 434.6. All subcontracts shall contain the following provisions:

- 8.4.1. Identification of the parties of the subcontract and their legal basis for operation in the State of Washington.
- 8.4.2. Procedures and specific criteria for terminating the subcontract.
- 8.4.3. Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor.
- 8.4.4. Reimbursement rates and procedures for services provided under the subcontract.
- 8.4.5. Release to the Contractor of any information necessary to perform any of its obligations under this Contract.
- 8.4.6. Reasonable access to facilities and financial and medical records for duly authorized representatives of the Health Care Authority or DHHS for audit purposes, and immediate access for Medicaid fraud investigators (42 CFR 438.6(g)).
- 8.4.7. The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all the Health Care Authority required data to enable the Contractor to meet the reporting requirements in the Encounter Data Transaction Guide published by the Health Care Authority.
- 8.4.8. The requirement to comply with the Contractor's the Health Care Authority approved fraud and abuse policies and procedures.
- 8.4.9. No assignment of the subcontract shall take effect without the the Health Care Authority' written agreement.
- 8.4.10. The subcontractor shall comply with the applicable state and federal rules and regulations as set forth in this Contract, including the applicable requirements of 42 CFR 438.6(i).

- 8.4.11. 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 CFR 438.6(1)).
- 8.4.12. The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 CFR 438.414 and 42 CFR 438.10(g)(1)):
- 8.4.12.1. The toll-free numbers to file oral grievances and appeals.
 - 8.4.12.2. The availability of assistance in filing a grievance or appeal.
 - 8.4.12.3. The enrollee's right to request continuation of benefits during an appeal or hearing and, if the Contractor's action is upheld, the enrollee's responsibility to pay for the continued benefits.
 - 8.4.12.4. The enrollee's right to file grievances and appeals and their requirements and timeframes for filing.
 - 8.4.12.5. The enrollee's right to a hearing, how to obtain a hearing, and representation rules at a hearing.
- 8.5. **Health Care Provider Subcontracts**, including those for facilities and pharmacy benefit management, shall also contain the following provisions:
- 8.5.1. A quality improvement system 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.
 - 8.5.2. A statement that primary care and specialty care provider subcontractors shall cooperate with QI activities.
 - 8.5.3. A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.
 - 8.5.3.1. Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

- 8.5.3.1.1. Assigned responsibilities
- 8.5.3.1.2. Delegated activities
- 8.5.3.1.3. A mechanism for evaluation
- 8.5.3.1.4. Corrective action policy and procedure
- 8.5.4. Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.
- 8.5.5. The subcontractor accepts payment from the Contractor as payment in full and shall not request payment from the Health Care Authority or any enrollee for contracted services performed under the subcontract.
- 8.5.6. The subcontractor agrees to hold harmless the Health Care Authority 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 the Health Care Authority and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Health Care Authority or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors (42 CFR 438.230(b)(2)).
- 8.5.7. If the subcontract includes physician services, provisions for compliance with the PCP requirements stated in this Contract.
- 8.5.8. A ninety (90) day termination notice provision.
- 8.5.9. A specific termination provision for termination with short notice when a subcontractor is excluded from participation in the Medicaid program.
- 8.5.10. The subcontractor agrees to comply with the appointment wait time standards of this Contract. 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 CFR 438.206(c)(1)).
- 8.5.11. 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 years and must identify deficiencies or areas for improvement and provide for corrective action (42 CFR 438.230(b)).

8.6. Health Care Provider Subcontracts Delegating Administrative Functions:

8.6.1. Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:

8.6.1.1. For those subcontractors at financial risk, that the subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

8.6.1.2. 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.

8.6.1.3. How frequently and by what means the Contractor will monitor compliance with solvency requirements and requirements related to any administrative function delegated in the subcontract.

8.6.1.4. Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 CFR 438.230(b)(2)).

8.6.1.5. Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

8.6.1.6. Prior to delegation, an evaluation of the subcontractors ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.

8.6.2. 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 Health Care Authority for review by February 28th of each year.

8.7. Excluded Individuals and Entities:

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

8.7.1.1. Monitor for excluded individuals and entities by:

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

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

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

8.7.1.2. Report to the Health Care Authority:

8.7.1.2.1. Any excluded individuals and entities discovered in the screening within ten (10) business days.

8.7.1.2.2. Any payments made by the Contractor that directly or indirectly benefit excluded individuals and entities and the recovery of such payments.

8.7.1.2.3. Any actions taken by the Contractor to terminate relationships with Contractor and subcontractor's employees and individuals with an ownership or control interest discovered in the screening.

8.7.1.2.4. Any Contractor and subcontractor's employees and individuals with an ownership or control interest convicted of any criminal or civil offense described in

SSA section 1128.with ten (10) business days of the Contractor becoming aware of the conviction.

- 8.7.1.2.5. Any subcontractor terminated for cause within ten (10) business days of the effective date of termination to include full details of the reason for termination.
- 8.7.1.2.6. Any Contractor and subcontractor's individuals and entities with an ownership or control interest. The Contractor must provide a list with details of ownership and control no later than September 1, 2010 and keep that list up-to-date thereafter.
- 8.7.2. The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.
- 8.7.3. The Contractor will immediately terminate any employment, contractual, and control relationships with an excluded individual and entity that it discovers.
- 8.7.4. 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 CFR 1003.102(a)(2))
- 8.7.5. 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), 42 CFR 455.104(a), and 42 CFR 1001.1001(a)(1)).
- 8.7.6. In addition, if the Health Care Authority notifies the Contractor that an individual or entity is excluded from participation in HO by the Health Care Authority, the Contractor shall terminate all beneficial, employment and contractual, and control relationships with the excluded individual or entity immediately (WAC 388-502-0030).
- 8.7.7. The list of excluded individuals will be found at:
<http://www.oig.hhs.gov/fraud/exclusions.asp>

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

8.8. **Home Health Providers:** If the pending Medicaid home health agency surety bond requirement (Section 4708(d) of the Balanced Budget Act of 1997) becomes effective before or during the term of this Contract, beginning on the effective date of the requirement the Contractor may not subcontract with a home health agency unless the state has obtained a surety bond from the home health agency in the amount required by federal law. the Health Care Authority will provide a current list of bonded home health agencies upon request to the Contractor.

8.9. **Physician Incentive Plans:** Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section in accord with federal regulations (42 CFR 438.6(h), 42 CFR 422.208 and 42 CFR 422.210).

8.9.1. **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.

8.9.2. **Disclosure Requirements:** Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by the Health Care Authority. 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 the Health Care Authority:

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

8.9.2.2. If the incentive plan includes referral services, the information provided to the Health Care Authority shall include:

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

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

- 8.9.2.2.3. Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.
- 8.9.2.2.4. 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 and Basic Health members.
- 8.9.3. If the Contractor, or any subcontractor (e.g. IPA, PHO), 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.
- 8.9.3.1. If aggregate stop-loss protection is provided, it must cover ninety percent (90%) of the costs of referral services that exceed twenty-five percent (25%) of maximum potential payments under the subcontract.
- 8.9.3.2. If stop-loss protection is based on a per-member limit, it must cover ninety percent (90%) 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.
- 8.9.3.2.1. 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.
- 8.9.3.2.2. 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.
- 8.9.3.2.3. 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.
- 8.9.3.2.4. 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.

8.9.3.2.5. 10,001 - 25,000, the threshold is \$25,000 for professional services and \$200,000 for institutional services, or \$150,000 for combined services.

8.9.3.2.6. 25,001 members or more, there is no risk threshold.

8.9.3.3. For a physician or physician group at substantial financial risk, the Contractor shall periodically conduct surveys of enrollee satisfaction with the physician or physician group. the Health Care Authority shall require such surveys annually. the Health Care Authority may, at its sole option, conduct enrollee satisfaction surveys that satisfy this requirement. If the Contractors enrolled population is too small to allow a valid survey by the Health Care Authority, the Contractor shall conduct an enrollee satisfaction survey. . the Health Care Authority shall notify the Contractor in writing if the Health Care Authority will be conducting the survey that satisfies the requirement for the Contractor. If the Contractor conducts the survey it shall:

8.9.3.3.1. Be approved by the Health Care Authority.

8.9.3.3.2. Be conducted according to commonly accepted principles of survey design and statistical analysis.

8.9.3.3.3. Address enrollees satisfaction with the physician or physician groups:

8.9.3.3.3.1. Quality of services provided.

8.9.3.3.3.2. Degree of access to services.

8.10. **Payment to FQHCs/RHCs:** The Contractor shall not pay a federally-qualified health center or a rural health clinic less than the Contractor would pay non-FQHC/RHC providers for the same services (42 USC 1396(m)(2)(A)(ix)).

8.11. **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 with the training process.

8.11.1. The Contractor shall maintain a system for keeping participating providers informed about:

- 8.11.1.1. Covered services for enrollees served under this Contract.
- 8.11.1.2. Coordination of care requirements.
- 8.11.1.3. the Health Care Authority and the Contractor's policies and procedures as related to this Contract.
- 8.11.1.4. Interpretation of data from the quality improvement program.
- 8.11.1.5. Practice guidelines as described in the provisions of the Quality of Care Section of this Contract.
- 8.11.1.6. Mental health services through the Contractor.
- 8.11.1.7. Mental health services through DSHS Regional Support Networks including a list of Regional Support Networks and contact information in counties served by the Contractor.
- 8.11.1.8. DSHS substance use disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by the Contractor.
- 8.11.1.9. Contractor care coordination staff for assistance in care transitions and care management activity.
- 8.11.1.10. 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.

8.12. **Claims Payment Standards:** The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) of receipt and ninety-nine percent (99%) 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.

- 8.12.1. A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

- 8.12.2. 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.
- 8.12.3. The date of receipt is the date the Contractor receives the claim from the provider.
- 8.12.4. The date of payment is the date of the check or other form of payment.
- 8.13. **FQHC/RHC Report:** The Contractor shall provide the Health Care Authority with information related to subcontracted federally-qualified health centers (FQHC) and rural health clinics (RHC), as required by the the Health Care Authority Federally Qualified Health Center and Rural Health Center Billing Guides, published by the Health Care Authority and incorporated by reference.
- 8.14. **Provider Credentialing:** The Contractor shall follow the requirements related to the credentialing and recredentialing of providers who have signed contracts or participation agreements with the Contractor (42 CFR 438.12(a)(2) 438.206(a & b) and 438.214).
- 8.14.1. The Contractor shall ensure compliance with the requirements described in this section:
- 8.14.1.1. The Contractor's medical director or other designated physician's shall have direct responsibility and participation in the credentialing process.
- 8.14.1.2. The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.
- 8.14.1.3. The identification of the type of providers that are credentialed and recredentialed.
- 8.14.1.4. The verification sources used to make credentialing decisions, including any evidence of provider sanctions.
- 8.14.1.5. Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Providers provisions of this Section.
- 8.14.2. The criteria used by the Contractor to credential and recredential providers shall include (42 CFR 438.230(b)(1)):

- 8.14.2.1. Evidence of a current valid license to practice
 - 8.14.2.2. A valid DEA or CDS certificate if applicable
 - 8.14.2.3. Evidence of appropriate education and training
 - 8.14.2.4. Board certification if applicable
 - 8.14.2.5. An Evaluation of work history
 - 8.14.2.6. A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider.
- 8.14.3. The Contractor's process for making credentialing determinations, to include a signed, dated attestation statement from the provider that addresses:
- 8.14.3.1. The lack of present illegal drug use
 - 8.14.3.2. A history of loss of license and felony convictions
 - 8.14.3.3. A history of loss or limitation of privileges or disciplinary activity
 - 8.14.3.4. Current malpractice coverage
 - 8.14.3.5. Accuracy and completeness of the application
- 8.14.4. The Contractor's process for delegation of credentialing or recredentialing.
- 8.14.5. The Contractor's provider selection policies and procedures that are consistent with 42 CFR 438.12, and must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.
- 8.14.6. The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials, including:
- 8.14.6.1. Communication of the provider's right to review materials
 - 8.14.6.2. Correct incorrect or erroneous information
 - 8.14.6.3. Be informed of their credentialing status

- 8.14.6.4. The ability to appeal an adverse determination by the Contractor
- 8.14.7. The Contractor's process for notifying providers within sixty (60) days of the credentialing committee's decision.
- 8.14.8. The Contractor's process to ensure confidentiality.
- 8.14.9. 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.
- 8.14.10. The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.
- 8.14.11. The Contractor's process to ensure that offices of all primary care providers, obstetricians/gynecologists and high volume providers meet office site standards established by the Contractor.
- 8.14.12. A system for monitoring sanctions or 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.

9. ENROLLEE RIGHTS AND PROTECTIONS:

9.1. General Requirements:

- 9.1.1. The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to enrollees (42 CFR 438.100(a)(2)).
- 9.1.2. The Contractor shall guarantee each enrollee the following rights (42 CFR 438.100(b)(2)):
 - 9.1.2.1. To be treated with respect and with consideration for their dignity and privacy (42 CFR 438.100(b)(2)(ii)).
 - 9.1.2.2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand (42 CFR 438.100(b)(2)(iii)).

- 9.1.2.3. To participate in decisions regarding their health care, including the right to refuse treatment (42 CFR 438.100(b)(2)(iv)).
- 9.1.2.4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 CFR 438.100(b)(2)(iv)).
- 9.1.2.5. To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 CFR 164 (42 CFR 438.100(b)(2)(iv)).
- 9.1.2.6. 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 CFR 438.100(c)).
- 9.2. **Cultural Considerations:** The Contractor shall participate in and cooperate with the Health Care Authority' efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds (42 CFR 438.206(c)(2)).
- 9.3. **Advance Directives:**
- 9.3.1. The Contractor shall meet the requirements of WAC 388-501-0125, 42 CFR 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section:
- 9.3.2. The Contractor's advance directive policies and procedure shall be disseminated to all affected providers, enrollees, the Health Care Authority, and, upon request, potential enrollees (42 CFR 438.6(i)(3)).
- 9.3.3. The Contractor's written policies respecting the implementation of advance directive rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience (42 CFR 422.128). At a minimum, this statement must do the following:
- 9.3.3.1. Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.
- 9.3.3.2. Identify the state legal authority permitting such objection.

- 9.3.3.3. Describe the range of medical conditions or procedures affected by the conscience objection.
- 9.3.4. 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, 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.
- 9.3.5. 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.
- 9.3.6. 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.
- 9.3.7. 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.
- 9.3.8. The Contractor shall provide for education of staff concerning its policies and procedures on advance directives.
- 9.3.9. 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 CFR 438.6(i)(3)).
- 9.3.10. 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.

- 9.3.11. 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 Health Care Authority if they believe the Contractor is non-compliant with advance directive requirements.

9.4. **Enrollee Choice of PCP:**

- 9.4.1. The Contractor must implement procedures to ensure each enrollee has a source of primary care appropriate to their needs (42 CFR 438.207(c)).
- 9.4.2. The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP (42 CFR 438.6(m)).
- 9.4.3. In the case of newborns, the parent shall choose the newborn's PCP.
- 9.4.4. 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) working days after coverage begins.
- 9.4.5. The Contractor shall allow an enrollee to change PCP or clinic at anytime with the change becoming effective no later than the beginning of the month following the enrollees request for the change (WAC 388-538-060 and WAC 284-43-251(1)).
- 9.4.6. The Contractor may limit enrollees' ability to change PCP's in accord with the Patient Review and Coordination provisions of the Benefits Section of this Contract.

- 9.5. **Direct Access for Enrollees with Special Health Care Needs:** The Contractor shall allow enrollees with special health care needs, including children with special health care needs, whose treatment plan indicates utilization of a specialist frequently to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care. The Contractor shall also allow enrollees with special health care needs,

including children with special health care needs, to retain a specialist as a PCP or be allowed direct access to a specialist if the assessment and treatment plan required under the provisions of this Contract demonstrates a need for a course of treatment or regular monitoring by such specialist (42 CFR 438.208(c)(4) and 438.6(m)).

9.6. Prohibition on Enrollee Charges for Contracted Services:

- 9.6.1. 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 except for allowable copayment and coinsurance (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 CFR 438.106(c), 438.6(1), 438.230, and 438.204(a) and WAC 388-502-0160).
- 9.6.2. Except for allowable copayments and coinsurance, the Contractor shall require providers to report, and will maintain a central record of the charged amount, enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor and be prepared at any time to report to the Health Care Authority any and all instances where an enrollee is charged for services, whether those charges are appropriate or not.
- 9.6.3. 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.
- 9.6.4. 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.
- 9.6.5. 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 contracted services, including other insurers copayments and coinsurance.

9.7. 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 CFR 438.102(a)(1)(i)):

- 9.7.1. The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 CFR 438.102(a)(1)(i)).

- 9.7.2. Any information the enrollee needs in order to decide among all relevant treatment options (42 CFR 438.102(a)(1)(ii)).
- 9.7.3. The risks, benefits, and consequences of treatment or non-treatment (42 CFR 438.102(a)(1)(iii)).
- 9.7.4. 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 CFR 438.102(a)(1)(iv)).
- 9.8. **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 (RCW 70.122) and state and federal Medicaid rules concerning advance directives (WAC 388-501-0125 and 42 CFR 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (RCW 68.50.540).

10. UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

- 10.1. **Utilization Management Program:** The Contractor shall follow the Utilization Management requirements described in this section.
 - 10.1.1. The Contractor's policies and procedures related to Utilization Management shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this section.
 - 10.1.2. The Contractor shall have and maintain a Utilization Management Program (UMP) for the physical and behavioral services it furnishes its enrollees.
 - 10.1.3. The Contractor shall define its UMP structure and assign responsibility for UMP activities to appropriate individuals.
 - 10.1.4. Upon request the Contractor shall provide the Health Care Authority with meeting minutes and a written description of the UMP that includes identification of designated physician and behavioral health practitioners and evidence of the physician and behavioral health practitioner's involvement in program development and implementation.

10.1.5. The UMP program description shall include:

- 10.1.5.1. A written description of all UM-related committee(s);
- 10.1.5.2. Descriptions of committee responsibilities;
- 10.1.5.3. Contractor staff and practicing provider committee participant title(s);
- 10.1.5.4. Meeting frequency;
- 10.1.5.5. Maintenance of meeting minutes reflecting decisions made by each committee, as appropriate.

10.1.6. UMP behavioral health and non-behavioral health policies and procedures at minimum, shall address the following requirements:

- 10.1.6.1. 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.
- 10.1.6.2. Where appropriate, the Contractor shall review and follow the recommendations of the Health Technology Assessment (HTA) program promulgated by the Washington State Health Care Authority.
- 10.1.6.3. Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same.
- 10.1.6.4. Mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.
- 10.1.6.5. 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.
- 10.1.6.6. Mechanisms to verify that claimed services were actually provided.

- 10.1.6.7. Mechanisms to detect both underutilization and over-utilization of services, including pharmacy underutilization and over-utilization.
- 10.1.6.8. Produce an annual report which identifies and reports findings on quality and utilization measures and includes completed or planned interventions to address under or over-utilization patterns of care (42 CFR 438.240(b)(3)).
- 10.1.6.9. Specify the type of personnel responsible for each level of UM decision-making.
- 10.1.6.10. A physician or behavioral health practitioner or pharmacist as appropriate reviews any behavioral health denial of care based on medical necessity.
- 10.1.6.11. Use of board certified consultants to assist in making medical necessity determinations.
- 10.1.6.12. Appeals of adverse determinations evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease (PBOR, WAC 284-43-620(4)).
- 10.1.6.13. Documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance System Section of this Contract.
- 10.1.7. Annually evaluate and update the UMP.
- 10.1.8. 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 CFR 438.210(e)).
- 10.1.9. 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 (PBOR, WAC 284-43-210(6)).

- 10.2. **Authorization of Services:** The Contractor shall follow the authorization of services requirements described in this section.
- 10.2.1. The Contractor's policies and procedures related to authorization of services shall include the compliance with 42 CFR 438.210 and WAC 388-538, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this section.
- 10.2.2. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions (42 CFR 438.210(b)(1)(i)).
- 10.2.3. The Contractor shall consult with the requesting provider when appropriate (42 CFR 438.210(b)(1)(ii)).
- 10.2.3.1. 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 clinical expertise in treating the enrollee's condition or disease (42 CFR 438.210(b)(3)).
- 10.2.3.2. 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, except that the notice to the provider need not be in writing (42 CFR 438.210(c) and 438.404):
- 10.2.3.2.1. The notice to the enrollee shall be in writing and shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees, provisions of the Marketing and Information Requirements Section, of this Contract to ensure ease of understanding.
- 10.2.3.2.2. The notice shall explain the following (42 CFR 438.404(b)(1-3)(5-7)):
- 10.2.3.2.2.1. The action the Contractor has taken or intends to take.
- 10.2.3.2.2.2. The reasons for the action, in easily understood language.

- 10.2.3.2.2.3. A statement whether or not an enrollee has any liability for payment.
- 10.2.3.2.2.4. A toll free telephone number to call if the enrollee is billed for services.
- 10.2.3.2.2.5. The enrollee's right to file an appeal.
- 10.2.3.2.2.6. If services are denied as non-covered, inform enrollees how to access the Contractor's Exception to Rule or Limitation Extension process.
- 10.2.3.2.2.7. The procedures for exercising the enrollee's rights.
- 10.2.3.2.3. The circumstances under which expedited resolution is available and how to request it.
- 10.2.3.2.4. 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.
- 10.2.3.2.5. In denying services and notices to enrollees, the Contractor will only deny a service as non-covered if the the Health Care Authority has determined that the service is non-covered under the fee-for-service program. For services that are excluded from this Contract, but are covered by the Health Care Authority, the Contractor will direct the enrollee to those services and coordinate receipt of those services.
- 10.2.4. The Contractor shall provide for the following timeframes for authorization decisions and notices:
 - 10.2.4.1. For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.
 - 10.2.4.2. For termination, suspension, or reduction of previously authorized services, five (5) business days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice shall be mailed within this ten (10) calendar day period by a method that certifies receipt and assures delivery within three (3) calendar days.

10.2.4.2.1. For standard authorization, determinations are to be made within two (2) business days of the receipt of necessary information, but may not exceed fourteen (14) calendar days following receipt of the request for services (42 CFR 438.210(d)(1)).

10.2.4.2.2. Beyond the fourteen (14) calendar day period, a possible extension of up to fourteen (14) additional calendar days (equal to a total of twenty-eight (28) calendar days) is allowed under the following circumstances (42 CFR 438.210(d)(1)(i-ii)):

10.2.4.2.2.1. The enrollee, or the provider, requests extension; or

10.2.4.2.2.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10.2.4.2.2.3. If the Contractor extends that timeframe, it shall(438.408(c)(2):

10.2.4.2.2.3.1. Give the enrollee 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; and

10.2.4.2.2.3.2. Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

10.2.4.2.3. For standard authorization decisions, notification of the decision shall be made to the attending physician, ordering provider, facility and enrollee within two (2) business days (PBOR, WAC 284-43-410).

10.2.4.3. 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 and no later than twenty-four hours after receipt of the request for service. The

Contractor may extend the twenty-four hours by up to fourteen (14) calendar days under the following circumstances (42 CFR 438.210(d)(2)):

- 10.2.4.3.1. The enrollee requests the extension; or
- 10.2.4.3.2. The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

10.3. **Fraud and Abuse Requirements:** The Contractor shall have and follow the Fraud and Abuse requirements described in this section.

10.3.1. The Contractor's policies and procedures related to fraud and abuse shall include compliance with 42 CFR 438.608(a) and section 1902(a)(68) of the Social Security Act and include the requirement of compliance of staff and subcontractors with the requirements described in this section.

10.3.2. The Contractor shall have:

- 10.3.2.1. In effect a process to inform employees and subcontractors regarding the False Claims Act.
- 10.3.2.2. Administrative and management arrangements or procedures, and a mandatory compliance plan.
- 10.3.2.3. Standards of conduct that articulates the Contractor's commitment to comply with all applicable federal and state standards.
- 10.3.2.4. The designation of a compliance officer and a compliance committee that is accountable to senior management.
- 10.3.2.5. Effective training for the compliance officer and the Contractor's employees and subcontractors.
- 10.3.2.6. Effective lines of communication between the compliance officer and the Contractor's staff and subcontractors.
- 10.3.2.7. Enforcement of standards through well-publicized disciplinary guidelines.
- 10.3.2.8. Provision for internal monitoring and auditing.

- 10.3.2.9. Provision for prompt response to detected offenses, and for development of corrective action initiatives.
- 10.3.2.10. Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act.
- 10.3.3. The Contractor shall report in writing to the Health Care Authority all alleged cases of fraud and abuse, including fraud and abuse by the Contractor's employees, subcontractors and subcontractor's employees, within seven (7) calendar days of the date the Contractor first becomes aware of the allegation according to the Notices provisions of the General Terms and Conditions Section of this Contract. The report shall include the following information:
 - 10.3.3.1. Subject(s) of complaint by name and either provider/subcontractor type or employee position.
 - 10.3.3.2. Source of complaint by name and provider/subcontractor type or employee position, if applicable.
 - 10.3.3.3. Nature of complaint.
 - 10.3.3.4. Estimate of the amount of funds involved.
 - 10.3.3.5. Legal and administrative disposition of case.
- 10.3.4. The Contractor must fully cooperate with any federal, the Health Care Authority or Attorney General Medicaid Fraud Control Unit (MFCU) investigation and promptly supply all data and information requested for their investigation.

11. GRIEVANCE SYSTEM

11.1. **General Requirements:** The Contractor shall have a grievance system which complies with the requirements of 42 CFR 438 Subpart F and WACs 388-538 and 284-43, insofar as those WACs are not in conflict with 42 CFR 438 Subpart F. The grievance system shall include a grievance process, an appeal process, and access to the hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

- 11.1.1. The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. the Health Care Authority must approve, in writing, all

grievance system policies and procedures and related notices to enrollees regarding the grievance system.

- 11.1.2. The Contractor shall give enrollees any assistance necessary in completing forms and other procedural steps for grievances and appeals (42 CFR 438.406(a)(1) and WAC 284-43-615(2)(e)).
- 11.1.3. The Contractor shall acknowledge receipt of each grievance, either orally or in writing, and appeal, in writing, within five (5) working days (42 CFR 438.406(a)(2) and (WAC 284-43-620)).
- 11.1.4. The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making (42 CFR 438.406(a)(3)(i)).
- 11.1.5. Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply (42 CFR 438.406(a)(3)(ii)):
 - 11.1.5.1. If the enrollee is appealing an action concerning medical necessity.
 - 11.1.5.2. If an enrollee grievance concerns a denial of expedited resolution of an appeal.
 - 11.1.5.3. If the grievance or appeal involves any clinical issues.
- 11.2. **Grievance Process:** The following requirements are specific to the grievance process:
 - 11.2.1. 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 CFR 438.402(b)(3)).
 - 11.2.2. The Contractor shall accept, document, record and process grievances forwarded by the Health Care Authority.
 - 11.2.3. The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615).
 - 11.2.4. The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615).
 - 11.2.5. The Contractor shall investigate and resolve all grievances whether received orally or in writing (WAC 284-43-615).

- 11.2.6. The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the enrollees health condition requires, but no later than ninety (90) calendar days from receipt of the grievance.
- 11.2.7. The Contractor may notify enrollees of the disposition of grievances. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.
- 11.2.8. Enrollees do not have the right to a hearing in regard to the disposition of a grievance.
- 11.3. **Appeal Process:** The following requirements are specific to the appeal process:
- 11.3.1. 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 action (42 CFR 438.406(b)(1)).
- 11.3.2. If the Health Care Authority receives a request to appeal an action of the Contractor, the Health Care Authority will forward relevant information to the Contractor and the Contractor will contact the enrollee.
- 11.3.3. For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal (42 CFR 438.406(b)(1)).
- 11.3.4. 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 action. 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 CFR 438.408).
- 11.3.5. Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution (42 CFR 438.406(b)(1)).
- 11.3.6. 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 in the case of expedited resolution (42 CFR 438.406(b)(2)).

- 11.3.7. The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process (42 CFR 438.406(b)(3)).
- 11.3.8. 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 CFR 438.406(b)(4)).
- 11.3.9. The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes (42 CFR 438.408(b)(2-3):
 - 11.3.9.1. 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) 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 thirty (30) days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.
 - 11.3.9.2. For expedited resolution of appeals, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal. This timeframe may not be extended.
- 11.3.10. The notice of the resolution of the appeal shall (42 CFR 438.408(d)):
 - 11.3.10.1. Be in writing. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.
 - 11.3.10.2. Include the date completed and reasons for the determination in easily understood language.

- 11.3.10.3. A written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the Utilization Management clinical review or decision-making criteria.
- 11.3.10.4. For appeals not resolved wholly in favor of the enrollee (42 CFR 438.408(e)(2)):
 - 11.3.10.4.1. Include information on the enrollee's right to request a hearing and how to do so.
 - 11.3.10.4.2. Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.
 - 11.3.10.4.3. 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 action.

11.4. Expedited Appeal Process:

- 11.4.1. The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines, for a request from the enrollee, or the provider indicates, in making the request on the enrollee's behalf or supporting the enrollee's request, that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (42 CFR 438.410(a)).
- 11.4.2. The Contractor shall make a decision on the enrollee's request for expedited appeal and provide notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice.
- 11.4.3. 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 CFR 438.410(b)).
- 11.4.4. If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution 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 (42 CFR 438.410(c)).

11.4.5. 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.

11.5. Hearings:

11.5.1. 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.

11.5.2. 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 388-538-112 for the hearing process for enrollees):

11.5.2.1. For hearings regarding a standard service, within ninety (90) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal 42 CFR 438.402 (b)(2)).

11.5.2.2. 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 CFR 438.420)

11.5.3. If the enrollee requests a hearing, the Contractor shall provide to the Health Care Authority upon request and within three (3) working days, 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.

11.5.4. The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.

11.5.5. The Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals, when medical necessity is an issue.

- 11.5.6. The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with the Health Care Authority (42 CFR 438.402(b)(2)(ii)).
- 11.5.7. the Health Care Authority will notify the Contractor of hearing determinations. The Contractor will be bound by the hearing determination, whether or not the hearing determination upholds the Contractor's decision. Implementation of such a hearing decision shall not be the basis for termination of enrollment by the Contractor.
- 11.5.8. If the hearing decision is not within the purview of this Contract, then the Health Care Authority will be responsible for the implementation of the hearing decision.
- 11.6. **Independent Review:** After exhausting both the Contractor's appeal process and the hearing process an enrollee has a right to independent review in accord with RCW 48.43.535 and WAC 284-43-630.
- 11.7. **Board of Appeals:** An enrollee who is aggrieved by the final decision of an independent review may appeal the decision to the the Health Care Authority Board of Appeals in accord with WAC 388-02-0560 through 388-02-0590. Notice of this right will be included in the written determination from the Contractor or Independent Review Organization.
- 11.8. **Continuation of Services:**
- 11.8.1. The Contractor shall continue the enrollee's services if all of the following apply (42 CFR 438.420):
- 11.8.1.1. An appeal, hearing or independent review is requested on or before the later of the following:
- 11.8.1.1.1. Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.
- 11.8.1.1.2. The intended effective date of the Contractor's proposed action.
- 11.8.1.2. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.
- 11.8.1.3. The services were ordered by an authorized provider.

- 11.8.1.4. The original period covered by the original authorization has not expired.
- 11.8.1.5. The enrollee requests an extension of services.
- 11.8.2. If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing, independent review or the Health Care Authority Board of Appeals is pending, the services shall be continued until one of the following occurs:
 - 11.8.2.1. The enrollee withdraws the appeal, hearing or independent review request.
 - 11.8.2.2. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days.
 - 11.8.2.3. Ten (10) calendar days pass after the Health Care Authority mails the notice of resolution of the hearing and the enrollee has not requested an independent review (with continuation of services until the independent review decision is reached) within the ten (10) calendar days.
 - 11.8.2.4. Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the independent review and the enrollee has not requested a the Health Care Authority Board of Appeals (with continuation of services until the the Health Care Authority Board of Appeals decision is reached) within ten (10) calendar days.
 - 11.8.2.5. The time period or service limits of a previously authorized service has been met.
- 11.8.3. If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

11.9. Effect of Reversed Resolutions of Appeals and Hearings:

- 11.9.1. If the Contractor, the Health Care Authority Office of Administrative Hearings (OAH), independent review organization (IRO) or the

Health Care Authority Board of Appeals 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 (42 CFR 438.424(a)(b)).

- 11.9.2. If the Contractor, OAH, IRO or the Health Care Authority Board of Appeals reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services.

11.10. Recording and Reporting Actions, Grievances, Appeals and Independent Reviews: The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

- 11.10.1. The records shall include actions, grievances and appeals handled by delegated entities.
- 11.10.2. The Contractor shall provide a report of all actions, grievances, appeals and independent reviews to the Health Care Authority in accord with the Grievance System Reporting Requirements published by the Health Care Authority.
- 11.10.3. The Contractor is responsible for maintenance of records for and reporting of any grievance, actions and appeals handled by delegated entities.
- 11.10.4. Delegated actions, grievances and appeals are to be integrated into the Contractor's report.
- 11.10.5. Data shall be reported in the the Health Care Authority and Contractor agreed upon format. Reports that do not meet the Grievance System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to the Health Care Authority within 30 calendar days.
- 11.10.6. The report medium shall be specified by the Health Care Authority and shall be in accord with the Grievance System Reporting Requirements published by the Health Care Authority.
- 11.10.7. Reporting of actions 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 388-502-0160 and the provisions of this Contract.

- 11.10.8. The Contractor shall provide information to the Health Care Authority regarding denial of payment to providers upon request.
- 11.10.9. Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action. 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.

12. CARE MANAGEMENT

- 12.1. **Medical Necessity Determination:** The Contractor shall determine which services are medically necessary, according to utilization management requirements and 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.
- 12.2. **Women's Health Care Services:** The Contractor must provide female enrollees with direct access to a women's health specialist within the Contractor's network for covered care necessary to provide women's routine and preventive health care services in accord with the provisions of WAC 284-43-250 and 42 CFR 438.206(b)(2).
- 12.3. **Maternity Newborn Length of Stay:** The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.
- 12.4. **Continuity of Care:** The Contract shall ensure the Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted (42 CFR 438.208).
 - 12.4.1. For changes 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 Enrollment and Access and Capacity Sections of this Contract.
 - 12.4.2. If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

12.4.3. Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

12.4.4. The Contractor shall allow new enrollees with the Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

12.4.4.1. The enrollee's prescription expires.

A participating provider examines the enrollee to evaluate the continued need for the prescription. If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to fill the prescription.

12.5. **Transitional Care**

12.5.1. The Contractor will have written operational agreements, which include data sharing, with State and community physical and behavioral health hospitals, Regional Support Networks, and inpatient and outpatient Drug and Alcohol Treatment programs for the purpose of facilitating transitions of care for enrollees. The written operational agreements shall include at minimum:

12.5.1.1. Completion of an accepted, standardized, pre-institutional, pre-hospital, and pre-substance use disorder treatment discharge screening tool designated by the Health Care Authority that includes a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Such assessments will examine risks for re-hospitalization or re-institutionalization, including the presence of co-morbid conditions that influence substance abuse treatment recidivism, i.e., involuntary treatment, alcohol and opioid substance use disorder or the presence of a co-morbid psychiatric condition in those with substance abuse disorder; adequacy of social support to help foster recovery; adequacy of housing, including an assessment of homelessness; and the presence of serious and persistent behavioral health disorder.

12.5.1.2. An individual enrollee plan for interventions to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include scheduled outpatient mental health and/or primary care visits within forty-eight (48) hours of discharge and/or physical or mental health home health care services delivered with forty-eight (48) hours of discharge.

Individual. Planning shall actively include the patient and family caregivers in assessing needs.

12.5.1.3. Execution of hospital, primary care provider or Contractor-based interventions to include arrangements for follow-up primary care or home care appointments, medication reconciliation, patient education and a follow-up pharmacy telephone contact forty-eight (48) hours after discharge to reinforce discharge plan and review medications.

12.5.1.4. Notifications to the Contractor and primary care provider shall be made when enrollee is:

12.5.1.4.1. Admitted to a State or community physical or behavioral health hospital, Regional Support Network facility, skilled nursing facility and if appropriate patient releases signed, to a substance use disorder treatment facility.

12.5.1.4.2. Discharged from a State or community physical or behavioral health hospital, Regional Support Network facility, skilled nursing facility and if appropriate patient releases signed, from a substance use disorder treatment facility.

12.5.1.5. Obtaining of releases from enrollees to allow sharing of information to facilitate transitions in care.

12.6. **Coordination of Care:** The Contractor shall ensure that health care services are coordinated for enrollees as follows (42 CFR 438.208):

12.6.1. The Contractor shall ensure that PCPs are responsible for the provision, coordination, and supervision of health care to meet the needs of each enrollee, including initiation and coordination of referrals for medically necessary specialty care.

12.6.2. The Contractor shall ensure that enrollee health information is shared between providers in a manner that facilitates coordination of care while protecting confidentiality and enrollee privacy (42 CFR 438.208(b)(4) and 45 CFR 160 and 164 subparts A and E).

12.6.3. The Contractor shall provide support services to assist PCPs in providing coordination if it is not provided directly by the Contractor.

12.6.4. The Contractor shall ensure enrollees at high risk of re-hospitalization and/or substance abuse treatment recidivism have a

documented, individual plan for interventions to mitigate risk to include scheduled outpatient mental health and/or primary care visits within forty-eight (48) hours of discharge and/or physical or mental health home health care services delivered within forty-eight (48) hours of discharge.

12.6.5. The Contractor shall coordinate and ensure PCPs coordinate with community-based and DSHS services/programs including but not limited to services/programs described in this Section:

- 12.6.5.1. First Steps Maternity Services and Maternity Case Management;
- 12.6.5.2. Transportation services;
- 12.6.5.3. Regional Support Networks for mental health services;
- 12.6.5.4. Developmental Disability services;
- 12.6.5.5. Infant Toddler Early Intervention Program (ITEIP) for infants from the ages of birth to three;
- 12.6.5.6. Patient Review and Coordination (PRC) program, for enrollees who meet the criteria identified in WAC 388-501-0135;
- 12.6.5.7. Health Department services, including Title V services for children with special health care needs;
- 12.6.5.8. Home and Community Services for older and physically disabled individuals; and
- 12.6.5.9. Substance Use Disorder services.

12.6.6. The Contractor shall update and maintain its website and written resource materials to contain information on how to access both Regional Support Network and Substance Abuse Disorder services. Website and written resources must at minimum contain:

- 12.6.6.1. Names, addresses, phone numbers and web links to programs located in the Contractor's service area.
- 12.6.6.2. Information, provided by the State describing how to refer to the programs, including criteria for receiving approval for services.

- 12.6.6.3. Role of the primary care provider in coordinating with these programs.
- 12.6.6.4. Information on how the primary care provider can best support the enrollee in recovery.
- 12.6.7. The Contractor shall identify or shall ensure that providers identify enrollees with special health care needs as defined in WAC 388-538-050. The Contractor's obligation for identification of enrollees with special health care needs is limited to identification in the course of any contact or health care visit initiated by the enrollee and any information available to the Contractor regarding an enrollee's special health care needs. The Contractor shall maintain a record of all enrollee's identified as enrollee's with special health care needs.
- 12.6.8. The Contractor shall ensure that PCPs, in consultation with other appropriate health care professionals, assess and develop individualized treatment plans for children with special health care needs and enrollees with special health care needs as defined herein, which ensure integration of clinical and non-clinical disciplines and services in the overall plan of care (42 CFR 438.208(c)(2)).
- 12.6.8.1. Documentation regarding the assessment and treatment plan shall be in the enrollee's case file, including enrollee participation in the development of the treatment plan (42 CFR 438.208(c)(3)).
- 12.6.8.2. If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.
- 12.6.9. The Contractor must implement procedures to share with other MCOs and RSNs serving the enrollee the results of its identification and assessment of any children with special health care needs and enrollee with special health care needs so that those activities are not duplicated while protecting confidentiality and enrollee rights (42 CFR 438.208 (b)(3)).

12.7. **Enrollees with Special Health Care Needs**

- 12.7.1. Identification: To identify enrollees with special health care needs the Contractor shall:

- 12.7.1.1. Require that providers identify enrollees with special health care needs in the course of any contact or enrollee initiated health care visit and report to the Contractor the identification.
- 12.7.1.2. Identify enrollees with special health care needs, including Children with Special Health Care Needs, through information provided by DSHS.
- 12.7.1.3. Identify enrollees with special health care needs through review of the enrollees' utilization.
- 12.7.1.4. Document and maintain a record of all identifications of enrollees with special health care needs.
- 12.7.2. Assessment and Treatment Plan: When an enrollee with special health care needs is identified, the Contractor shall require that PCPs, in consultation with other appropriate health care professionals, assess the health care needs of and develop, document and maintain in the enrollee's medical record an individualized treatment plan for that enrollee with special health care needs that meets, at a minimum, the following elements (42 CFR 438.208(c)):
 - 12.7.2.1. The assessment shall include, at a minimum, an evaluation of the enrollee's physical and behavioral health status, clinical history, including medications, and an evaluation of the need for or use of supportive services and resources, such as those describe in the Coordination of Care provisions of this Contract.
 - 12.7.2.2. Includes short and long-term treatment goals, identification of barriers to meeting goals or complying with the treatment plan, and development of schedules for follow-up treatment and communication with the enrollees.
 - 12.7.2.3. Addresses integration and coordination of clinical and non-clinical disciplines and services.
 - 12.7.2.4. Is modified as needed to address emerging needs of the enrollee.
 - 12.7.2.5. Includes enrollee participation.
 - 12.7.2.6. Documents any communication barriers and how they were addressed.

12.7.2.7. If the Contractor requires approval of the treatment plan, approval must be provided in a timely manner appropriate to the enrollee's health condition.

12.7.3. **Coordination with Other HO Contractors, Other Insurers and RSNs:** The Contractor must implement procedures to share with other HO contractors, other insurers and RSNs serving the enrollee the results of its identification and assessment of enrollees with special health care needs, including children with special health care needs, so that those activities are not duplicated while protecting confidentiality and enrollee rights (42 CFR 438.208 (b)(3)).

12.7.4. **Quality Assurance and Monitoring:** The Contractor shall have in effect mechanisms to assess and monitor compliance with the requirements of this section and the quality and appropriateness of care furnished to enrollees with special health care needs, including children with special health care needs (42 CFR 438.240 (b)(4)), including the assessments, identifications, treatment plans and coordination of care.

12.8. **Second Opinions:**

12.8.1. 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 a qualified health care professional, at no cost to the enrollee.

12.8.2. 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 (42 CFR 438.206(b)(3)).

12.9. **Sterilizations and Hysterectomies:** The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 CFR 441 Subpart F, and that the DSHS Sterilization Consent Form (DSHS 13-364(x)) or its equivalent is used.

12.10. **Experimental and Investigational Services:**

12.10.1. 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 DSHS' medical necessity determinations for its fee-for-service program describe in

WAC 388-501-0165. 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 DSHS upon request.

- 12.10.2. 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.
- 12.10.3. An adverse determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing process and independent review.

12.11. Patient Review and Coordination (PRC):

- 12.11.1. The Contractor shall have a PRC program that meets the requirements of WAC 388-501-0135. PRC is authorized by 42 USC 1396n (a)(2) and 42 CFR 431.54.
- 12.11.2. If either the Contractor or the Health Care Authority places an enrollee into the PRC program, both parties will honor that placement.
- 12.11.3. The Contractor's placement of an enrollee into the PRC program shall be considered an action, which shall be subject to appeal under the provisions of the Grievance System section of this Contract. If the enrollee appeals the PRC placement the Contractor will notify the Health Care Authority of the appeal and the outcome.
- 12.11.4. 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 388-501-0135.
- 12.11.5. The Contractor shall send the Health Care Authority 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 Health Care Authority.
- 12.11.6. In accord with WAC 388-501-0135, the Health Care Authority will limit the ability of an enrollee placed in the PRC program to change their enrolled contractor for twelve months after the enrollee is in the PRC program by the Health Care Authority or the Contractor

unless the PRC enrollee moves to a residence outside the Contractor's service areas.

12.11.7. If the Health Care Authority limits the ability of an enrollee to change their enrolled contractor family members may still change enrollment as provided in this Contract.

12.12. **Special Provisions for American Indians and Alaska Natives:** In accord with the Section 5006 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 Indian health care providers for contracted services provided to American Indian and Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the Indian health care provider. 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 Indian health care provider.

DRAFT FOR COMMENT