Washington State Health Care Authority	**AMENDED AND RESTATED STATE MEDICAID AGENCY CONTRACT**	HCA Contract Number: «Contract» Amendment Number: «Amendment_» MA Health Plan/Vendor Contract Number:

THIS AMENDED AND RESTATED STATE MEDICAID AGENCY CONTRACT (SMAC) is made by and between Washington State Health Care Authority, (HCA) and «Organization_Name», (MA Health Plan).

MA HEALTH PLAN NAME «Organization_Name»		MA HEALTH PLAN DOING BUSINESS AS (DBA)		
MA HEALTH PLAN ADDRESS «Mailing_AddressSt_Address»	Street	City «City»	State «State»	Zip Code «Zip_Code»
MA HEALTH PLAN CONTACT «Contact_Fname» «Contact_LName»	MA HEALTH PLAN TELEPHONE «PhoneNo»	MA HEALTH PLAN E-MAIL ADDRESS «EmailAddress»		
Is MA Health Plan a Subrecipient under this Contract? ☐YES ☒NO	CFDA NUMBER(S):	FFATA Form Required ☐YES ☒NO		

HCA PROGRAM Managed Care Program	HCA DIVISION/SECTION Medicaid Programs Division
HCA CONTACT NAME AND TITLE «ContractMgr»	HCA CONTACT ADDRESS Health Care Authority 626 8th Avenue SE PO Box «CM_Mailstop» Olympia, WA 98504-____
HCA CONTACT TELEPHONE (360) 725-0480	HCA CONTACT E-MAIL ADDRESS johnny.shults@hca.wa.gov

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
January 1, 2023	December 31, 2023	N/A
PURPOSE OF CONTRACT: To provide, or arrange for the provision of, covered health care services to qualified Dual Eligible Beneficiaries		

The parties signing below warrant that they have read and understand this SMAC, and have authority to execute this SMAC. This SMAC will be binding on HCA only upon signature by both parties.

MA HEALTH PLAN SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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Recitals. These Recitals are hereby incorporated by reference into this State Medicaid Agency Contract (SMAC).

WHEREAS, MA Health Plan is a 501(c)(4) tax exempt entity and a certified health care services contractor organized and operating under the laws of the State of Washington, to provide or arrange for provision of covered health care services to qualified Dual Eligible Beneficiaries enrolled in its benefit plans (Members);

OR

WHEREAS, MA Health Plan is an organization having a certificate of authority or certificate of registration from the Office of the Washington State Insurance Commissioner and operating under the laws of the State of Washington, to provide or arrange for the provision of covered health care services to qualified Dual Eligible Beneficiaries enrolled in its benefit plans (Members).

WHEREAS, MA Health Plan (or another organization under same parent company) and HCA have a current Apple Health Medicaid Integrated Managed Care (IMC) Contract (HCA Contract Number «IMC_K»). Regions for which MA Health Plan has an IMC contract for Behavioral Health (BH) Services are referenced in Exhibit 2.

WHEREAS, MA Health Plan has entered into or has applied to enter into a Medicare Advantage Plan Agreement (MA Agreement) with the Centers for Medicare & Medicaid Services ("CMS") whereby MA Health Plan provides or desires to provide Medicare Covered health care benefits to qualified Dual Eligible Beneficiaries under a Dual Eligible SNP in the state of Washington.

WHEREAS, MA Health Plan holds an agreement with CMS to provide a Dual Special Needs Plan covered under this SMAC (or another organization under same parent company) and receives direct capitation from HCA to provide coverage of the Medicaid benefits described in the Integrated Managed Care (IMC) Contract including BH Services listed in Exhibit 5.

WHEREAS, MA Health Plan will retain responsibility for providing, or arranging for Medicare covered health care benefits to be provided to qualified Dual Eligible Beneficiaries under its Dual Eligible SNP.

WHEREAS, MA Health Plan will seek CMS designation as a Highly Integrated Dual Eligible Special Needs Plan as defined in this SMAC and 42 C.F.R. § 422.2.

WHEREAS, MA Health Plan will (i) ensure cost sharing protections for all qualified Dual Eligible Beneficiaries in the event MA Health Plan offers Medicaid Covered Benefits under its Dual Eligible SNP; and (ii) ensure MA Health Plan can appropriately and accurately identify Medicare beneficiary qualification for HCA's Medicaid benefits and MA Health Plan's Dual Eligible SNP.

WHEREAS, MA Health Plan and HCA acknowledge the requirements of 42 C.F.R. § 422 whereby MA Health Plan must enter into an agreement with HCA to offer and provide a Dual Eligible SNP to qualified Dual Eligible Beneficiaries.

NOW, THEREFORE, IN CONSIDERATION of the mutual promises as set forth in this Contract, the parties agree as follows:

Definitions

1. Care Coordination

1.1 "Care Coordination" means an approach to healthcare in which all of a Member's needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Member and the Member's caregivers, and works with the Member to ensure that the Member gets the most appropriate treatment, while ensuring care is not duplicated.

Care Management

1.2 "Care Management" means a set of services, delivered by Care Coordinators, designed to improve the health of Members. Care Management includes a health assessment, development of a care plan and monitoring of Member status, Care Coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the Member to a less intensive level of Care Management as warranted by Member improvement and stabilization.

1.3 Case Management

"Case Management" means ongoing processes to assist Members with access to and effective use of necessary health and related social services.

1.4 Confidential Information

1.5 "Confidential Information" means information that may be exempt from disclosure to the public or other unauthorized persons under RCW 42.56, RCW 70.02, or other federal or state laws. Confidential Information includes, but is not limited to, Personal Information and Protected Health Information.

Cost Sharing Obligations

"Cost Sharing Obligations" means those financial payment obligations incurred by HCA in satisfaction of the deductibles, coinsurance, and co-payments for the Medicare Part A and Part B programs with respect to Dual Eligible Members. For purposes of this SMAC, Cost Sharing Obligations do not include: (1) Medicare premiums that HCA is required to pay under the Washington State Plan on behalf of qualified Dual Eligible Beneficiaries, or (2) wrap-around services that are covered by Medicaid.

Covered Services

"Covered Services" means those services and benefits that MA Health Plans are required to provide to Dual Eligible SNP Members under this SMAC and the contract with CMS. Coordination of Medicaid benefits is required per 42 C.F.R. § 422.107.

1.6 Data

"Data" means information produced, furnished, acquired, or used by MA Health Plan in meeting the requirements under this SMAC. For the purposes of this SMAC, "Data" is construed and treated the same as "Confidential Information."

1.7

Department of Social and Health Services (DSHS)

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

1.8.1 Aging and Long-Term Support Administration (ALTSA) is responsible for providing a safe home, community, and nursing facility array of long-term supports for Washington citizens.

1.8.1.1 Home and Community Services (HCS), a division of ALTSA, is responsible for promoting, planning, developing, and providing long-term care services for Washington citizens with disabilities and/or the elderly.

1.8.2

Development Disabilities Administration (DDA) is responsible for providing a safe, high-quality array of home, community, and facility-based residential services and
1.9 employment support for Washington citizens with disabilities.

Dual Eligible Beneficiary

"Dual Eligible Beneficiary" means a Medicare managed care recipient who is also eligible for
1.9.1 Medicaid, and for whom HCA has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this SMAC, Dual Eligibles are limited to the categories of recipients identified in Exhibit 1.

Qualified Medicare Beneficiary (QMB Only) and Qualified Medicare Beneficiary with Comprehensive Medical Benefits (QMB+). The QMB benefits covered by this SMAC are limited to the Cost Sharing Obligations as defined by the Washington State Plan.

1.9.1.1 Qualified Medicare Beneficiary without other Medicaid (QMB only): An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplemental Social Security (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through HCA. Medicaid pays their

Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.9.1.2 Qualified Medicare Beneficiary with Comprehensive Medical Benefits (QMB+): An individual entitled who meets the standards for QMB eligibility, and who also meets the criteria for Medicaid benefits covered under the program for which they become eligible, e.g., the Medically Needy (MN) for those who meet spenddown requirements. These individuals often qualify for Medicaid benefits by meeting Medically Needy standards, or by spending down excess income to the Medically Needy level. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. See also Full Benefit Dual Eligible #7. Medicaid does not pay towards the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.9.2 Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only): An individual entitled to Medicare Part A, with an income that exceeds 100% FPL but less than 120% FPL, with resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Medicare Part B premium only. They do not qualify for any additional Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium,

1.9.3 coinsurance, or copayments for Medicare Part D prescription drug coverage.

Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+): An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full HCA Medicaid benefits. The individuals are entitled to payment of the Medicare Part B premium, in addition to HCA Medicaid benefits covered under the program for which they become eligible, e.g., the Medically Needy (MN) for those who meet spenddown requirements. These individuals often qualify

1.9.4 for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. See also Full Benefit Dual Eligible #7. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

Qualifying Individual (QI): An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible

for Medicaid payment of the Medicare Part B premium only; they cannot also be eligible for other Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, copayments for Medicare Part D prescription drug coverage.

1.9.5 Qualified Disabled and Working Individual (QDWI): An individual who has lost Medicare Part A benefits due to a return to work, but is eligible to enroll in and purchase Medicare Part A. The individual's income may not exceed 200% FPL and resources may not exceed twice the SSI limit. The individual may not be otherwise eligible for Medicaid. These individuals are eligible for Medicaid payment of the Part A premium only; they cannot also be eligible for other Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.9.6 Other Full Benefit Dual Eligible (FBDE): An individual who does not meet the income and/or resource criteria for QMB or SLMB, but is eligible for Categorically Needy (CN) Medicaid or Medically Needy (MN) through coverage groups based on MN spenddown status, special income levels for institutionalized individuals, home and community-based waivers, or those with blindness or disability who are working and enrolled in Apple Health for Workers with Disabilities. HCA funded buy-in pays for Part A, if not free to the individual, and Part B premiums. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

1.10 Dual Eligible Special Needs Plan (Dual Eligible SNP)

1.11 "Dual Eligible Special Needs Plan (Dual Eligible SNP)" means the Medicare Part C and other health plan services provided to MA Health Plan Members under a SNP as defined and pursuant to an MA Agreement, as defined in 42 C.F.R. § 422.2.

Highly Integrated Dual Eligible Special Needs Plan

1.11.1 "Highly Integrated Dual Eligible Special Needs Plan" means a Dual Eligible SNP offered by an MA Health Plan that provides coverage, consistent with HCA policy, of long-term services and
1.11.2 supports, behavioral health services, or both, under a capitated agreement that meets one of the following arrangements:

The capitated agreement is between the MA Health Plan and HCA; or

The capitated agreement is between the MA Health Plan's parent organization, or another entity that is owned and controlled by its parent organization, and HCA.

MA Agreement

"MA Agreement" means the Medicare Advantage Plan Agreement between the MA Health Plan and CMS to provide MA benefit plans.

Medically Necessary Services

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

Member

1.14 "Member" means a full or partial dual eligible individual who has elected to enroll with the MA Health Plan.

Personal Information

1.15 "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's license numbers, credit card numbers, any other identifying numbers,
1.16 and any financial identifiers.

Service Area

1.17 "Service Area" means those counties or zip codes where MA Health Plan operates as approved by CMS and HCA and described in Exhibit 2, attached hereto.

Subcontractor

1.18 "Subcontractor" means an individual or entity that has a contract with the Contractor that relates directly or indirectly with the performance of the MA Health Plan's obligations under this SMAC.

Supplemental Benefits

"Supplemental Benefits" means services or benefits that are mandatory or optional health care services that are intended to maintain or improve the health status of members, for which the MA Health Plan incurs a cost or liability under an MA Health Plan (not solely an administrative processing cost) consistent with 42 CFR 422.102. See Exhibits 3 and 4 for Supplemental Benefits offered under this SMAC.

Trusted Systems

1.19 “Trusted Systems” include only the following methods of physical delivery: (1) hand delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service (“USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail;(3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington Stale Governmental Network (SGN) is a Trusted System for communications within that Network.

Value-Added Items and Services (VAIS)

1.20 “Value-Added Items and Services (VAIS)” are items and services that are not plan benefits, are not part of the MAO plan’s benefit package and may not be marketed to prospective members or used as an inducement or incentive for enrollment. VAIS are non-Medicare covered services or items, typically discounts, offered by a VAIS provider to the members of an MA Health Plan. VAIS must be offered in accordance with Federal Guidance. See Exhibits 3 and 4 for VAIS offered under this SMAC.

Washington Apple Health – Integrated Managed Care (AH-IMC)

1.21 “Washington Apple Health – Integrated Managed Care (AH-IMC)” means the public health insurance programs, intended to meet the physical and behavioral health needs of eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the Children’s Health Insurance program (CHIP), and the state-only funded health care programs.

General Terms and Conditions

Amendments

2. No provision of this SMAC may be modified, amended, or waived except in writing and when signed by the parties to this SMAC. No course of dealing between the parties will modify, amend, or waive any provision of this SMAC or any rights or obligations of any party under or by reason of this SMAC.

Assignment

2.1 This SMAC and the rights and obligations of the parties under this SMAC will be assignable, in whole or in part, by the MA Health Plan only with the prior written consent of HCA point of contact identified in the Notices section.

2.2 This SMAC will be binding upon and inure to the benefit of the parties and their respective heirs, personal representatives and, to the extent permitted by this section.

Compliance with Applicable Law

2.3 The MA Health Plan and its subcontractors will comply with all applicable federal, state, and local laws, regulations, and rules, as amended.

Contract Management

2.4 MA Health Plan's SMAC Manager, identified below, will be the principle point of contact for the HCA SMAC Manager for all business matters performance matters and administrative activities. HCA's SMAC Manager, identified below, is responsible for monitoring MA Health Plan's performance and will be the contact person for all communications regarding contract performance and deliverables. The contact information provided below may be changed by written notice of the change, email acceptable, to the other party.

2.5

HCA SMAC Manager		MA Health Plan SMAC Manager	
Name:	Johnny Shults	Name:	«Contact_Fname» «Contact_LName»
Title:	Section Supervisor	Title:	«Working_Title»
Address:	626 8th Avenue SE P.O. Box 45530 Olympia, WA 98504	Address:	«Mailing_AddressSt_Address» «City», «State» «Zip_Code»
2.5.1 Phone:	(360) 725-0480	Phone:	«PhoneNo»
Email:	johnny.shults@hca.wa.gov	Email:	«EmailAddress»

Data Use, Confidentiality, and Security

Covered Entities

MA Health Plan and HCA each acknowledge that it is a "Covered Entity," as defined in the standards for Privacy of Individually Identifiable Health Information (45 C.F.R. Parts 160 and 164) pursuant to the Health Insurance Portability and Accountability Act

of 1996 and its implementing rules (the “Privacy Rule"). Each party will protect the confidentiality of Protected Health Information and will otherwise comply with the requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of PHI.

PRISM Access

2.5.2.1 Definitions.

2.5.2.1.1 “Medicare Data Use Requirements” refers to the documents attached and incorporated into this SMAC as Schedules 1, and 2, that set out the terms and conditions MA Health Plan must agree to for the access to and use of Medicare Data for the Members who are dually eligible in the Medicare and Medicaid programs.

2.5.2

2.5.2.1.2 “PRISM” means the DSHS secure, web-based clinical decision support tool that shows administrative data for each Medicaid Member and is organized to identify care coordination opportunities.

2.5.2.2 Purpose. To provide MA Health Plan, and subcontractors, with access to pertinent Member-level Medicaid and when appropriate Medicare Data via look-up access to the online PRISM application and to provide MA Health Plan staff and Subcontractor staff who have a need to know Member-level Data in order to coordinate care, improve quality, and manage services for their Members.

2.5.2.3 Justification. The Data being accessed is necessary for MA Health Plan to provide care coordination, quality improvement, and case management services for Members.

2.5.2.4 PRISM Data Constraints.

2.5.2.4.1 The Data contained in PRISM is owned and belongs to DSHS and HCA. Access to PRISM Data is administered by DSHS.

2.5.2.5 System Access. MA Health Plan may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.

2.5.2.5.1 MA Health Plan Contract Manager, or their designee, and the proposed Authorized User must complete and sign the PRISM Access Request Form, Schedule 2, for each proposed Authorized User. The completed form must be sent to prism.admin@dshs.wa.gov. HCA and DSHS will only accept requests from the MA Health Plan Contract Manager or their designee.

2.5.2.5.2 Authorized Users may view Medicare Data in PRISM once forms Schedule 1 and Schedule 2 are completed, submitted,

and accepted as complete. No Medicare Data is released to MA Health Plan's Authorized User(s) until the two forms are completed and accepted by DSHS.

2.5.2.5.3 MA Health Plan must access these systems through SecureAccessWashington (SAW) or through another method of secure access approved by the HCA and DSHS.

2.5.2.5.4 DSHS will grant the appropriate access permissions to MA Health Plan employees or Subcontractor employees.

2.5.2.5.5 HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. MA Health Plan must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or Subcontractors who are not authorized to borrow a User ID or password to access any systems.

2.5.2.5.6 MA Health Plan will notify the prism.admin@dshs.wa.gov within five business days whenever an Authorized User who has access to the Data is no longer employed or contracted by the MA Health Plan, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

2.5.2.6 MA Health Plan's access to the systems may be continuously tracked and monitored. HCA and DSHS reserve the right at any time to terminate the Data access for an individual, conduct audits of systems access and use, and to investigate possible violations of this Exhibit, federal, or state laws and regulations governing access to Protected Health Information.

2.5.3

Confidentiality

2.5.3.1 The MA Health Plan will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this SMAC for any purpose that is not directly connected with MA Health Plan's operations as a Dual Eligible SNP under its MA Agreement with CMS and this SMAC, except:

2.5.3.1.1 As provided by law; or

2.5.3.1.2 In the case of Personal Information, with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information.

2.5.3.2 Data Shared by the MA Health Plan

If Data access is to be provided to a Subcontractor or contracted provider under this SMAC, the MA Health Plan must include all of the Data security terms, conditions and requirements set forth in this SMAC in any such

Subcontract or agreement. In no event will the existence of the Subcontract operate to release or reduce the liability of the MA Health Plan to HCA for any breach in the performance of the MA Health Plan's responsibilities.

Constraints

2.5.4.1 This SMAC does not constitute a release of the Data for the MA Health Plan's discretionary use. MA Health Plan must use the Data received or accessed under this SMAC only to carry out the purpose of this SMAC. Any ad hoc analysis or other use or reporting of the Data is not permitted without HCA's prior written consent. Any ad hoc analyses or other use or reporting of PRISM Data is not permitted without DSHS's and HCA's prior written consent.

2.5.4

2.5.4.2 Requirements for Access. Access to Data will be limited to the MA Health Plan's Designated Staff whom the MA Health Plan whose duties specifically require access to such Data in the performance of their assigned duties.

2.5.4.3 The MA Health Plan will not link the Data with Personal Information or individually identifiable data from any other source nor re-disclose or duplicate the Data unless specifically authorized to do so in this SMAC or by the prior written consent of HCA. Any disclosure of Data contrary to this SMAC is unauthorized and is subject to penalties identified in law.

2.5.4.4 Data shared under this SMAC includes data protected by 42 C.F.R. Part 2. In accordance with 42 C.F.R. § 2.32, this Data has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit Receiving Party from making any further disclosure of the Data that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (42 C.F.R. § 2.31). The federal rules restrict any use of the SUD Data to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at 42 C.F.R. §§ 2.12(c)(5) and 2.65.

2.5.5

Security

2.5.5.1 The MA Health Plan will protect and maintain all Confidential Information gained by reason of this SMAC against unauthorized use, access, disclosure, modification, or loss. This duty requires the MA Health Plan to employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.5.1.1 Allowing access only to staff that have an authorized business requirement to view the Confidential Information.

2.5.5.1.2 Physically Securing any computers, documents, or other media containing the Confidential Information.

2.5.5.2 The MA Health Plan will exercise due care to protect Data from unauthorized physical and electronic access. Due care includes establishing and maintaining security policies, standards, and procedures which describe how the MA Health Plan will comply with the requirements set forth in Attachment 1 Data Security Requirements and OCIO Security Standard 141.10.

Data Disposition

2.5.6

2.5.6.1 The Data provided will remain the property of the HCA and will be promptly destroyed or returned to the HCA by the MA Health Plan when the work for which the Data was required, as fully described herein, is completed.

2.5.6.2 If the MA Health Plan and the HCA Contact agree that the Data will be destroyed by the MA Health Plan after the work for which the Data was required is completed; then the MA Health Plan will destroy the Data In accordance with the approved destruction methods described in Attachment 1, Data Security Requirements.

2.5.6.3 If applicable federal or state law or regulations prohibit the MA Health Plan from either returning or destroying the Data after the work for which the Data was required is completed; then the MA Health Plan will continue to protect Data from unauthorized physical and electronic access in accordance with this section and Attachment 1, Data Security Requirements, until such time as the applicable federal or state law or regulations would permit the Data's return or destruction.

2.5.7

Notification of Compromise or Potential Compromise

2.5.8

The compromise or potential compromise of Confidential Information must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov within one business day of discovery. MA Health Plan must also take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA.

Penalties for Unauthorized Disclosure of Data

State laws (including RCW 74.04.060 and RCW 70.02.020) and federal regulations (including HIPAA Privacy and Security Rules, 45 C.F.R. Part 160 and Part 164, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and Safeguarding Information on Applicants and Beneficiaries, 42 C.F.R. Part 431 Subpart F) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines. MA Health Plan

accepts full responsibility and liability for any noncompliance by itself, its employees, and its Subcontractors with these laws and any violations of this SMAC.

Disputes

When a dispute arises between HCA and the MA Health Plan over an issue that pertains in any way to this SMAC, the parties agree to the following process to address the dispute:

2.6 The MA Health Plan shall request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.6.1 2.6.1.1 The disputed issue(s).

2.6.1.2 An explanation of the positions of the parties.

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

2.6.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within 15 calendar days after the MA Health Plan receives notice of the disputed issue(s).

2.6.3 The Director, in his or her sole discretion, shall determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director shall provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

2.6.4 The Director shall consider all of the information provided at the conference and shall issue a written decision on the disputed issue(s) within 30 calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional 60 calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director determines, in his or her sole discretion, that an additional period of up to 60 calendar days is needed for review, he or she shall notify the MA Health Plan, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

2.6.5 2.6.4.1 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

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.

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

Entire Agreement

2.6.6 This SMAC contains the entire understanding between the parties hereto with respect to the subject matter of this SMAC and supersedes any prior understandings, agreements, or representations, written or oral, relating to the subject matter of this SMAC.

2.7 Force Majeure

A party will not be liable for any failure of or delay in the performance of this SMAC, and such failure or delay shall not be cause for termination, for the period that such failure or delay is due
2.8 to causes beyond its reasonable control, including but not limited to acts of God, war, strikes or labor disputes, embargoes, government orders or any other force majeure event.

Governing Law and Venue

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

2.10 Headings

The headings and any table of contents contained in this SMAC are for reference purposes only and will not in any way affect the meaning or interpretation of this SMAC.

2.11 Incorporation of Documents and Order of Precedence

Each of the documents listed below is by this reference incorporated into this Contract. In the
2.11.1 event of an inconsistency, the inconsistency will be resolved in the following order of
2.11.2 precedence:

2.11.3 Applicable federal and state statutes and regulations;

2.11.4 Recitals;

2.11.5

2.11.6 SMAC Terms and Conditions;

2.11.7 Attachment 1, Data Security Requirements;

Exhibit 1, Covered Dual Eligible Recipient Aid Categories;

Exhibit 2, Service Area Washington;

Exhibit 3, Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Full Dual Eligible Members;

Exhibit 4, Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Partial Dual Eligible Members;

Exhibit 5, Summary of Behavioral Health Benefits Covered Under IMC Contract;

Exhibit 6, MA Health Plan Health Home; and

2.11.8 Any other provision, term, or material incorporated herein by reference or otherwise incorporated.

2.11.9

2.11.10 Indemnification and Hold Harmless

2.11.11 Each party will be responsible for its own acts and omissions and the acts and omissions of their agents and employees. Each party to this SMAC will defend, protect, and hold harmless the other party 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 acts and omissions of the first party, or agents of the first party, while performing under the terms of this SMAC 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. 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 MA Health Plan 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.

2.12

2.13 Inspection

HCA, HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under MA Health Plan's CMS contract, or as the Secretary *may* deem necessary to enforce MA Health Plan's CMS contract. MA Health Plan agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the end of the final contract period or completion of audit, whichever is later. (42 C.F.R. § 422.504(d), 42 C.F.R. §§ 422.504(e)(2), 422.504(e)(3), 422.504(e)(4), and 422.504(i)(2)(ii)).

2.14

Legal Notices

All notices, consents, requests, instructions, approvals, or other communications provided for herein will be in writing and delivered by personal delivery, overnight courier, mail, or electronic facsimile addressed to the receiving party at the address set forth herein. All such communications will be effective when received.

HCA:
Attn: HCA Contracts Administrator
Health Care Authority
Division of Legal Services
P.O. Box 42702

MA Health Plan:

Olympia, Washington 98504-2702

A party may change the contact information set forth above by giving written notice to the ether party.

Maintenance of Records

MA Health Plan agrees to maintain for 10 years from the expiration or termination of the SMAC: books, records, documents, and other evidence of accounting procedures and practices that:

2.15 Are sufficient to the following:

2.15.1 2.15.1.1 Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the bid) of MA Health Plan.

2.15.1.2 Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the MA Health Plan's CMS contract, and the facilities of the MA Health Plan.

2.15.1.3 Enable CMS to audit and inspect any books and records of the MA Health Plan that pertain to the ability of the organization to bear the risk of potential financial losses, or for services performed or determinations of amounts payable under MA Health Plan's CMS contract.

2.15.1.4 Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the bid proposal.

2.15.1.5 Establish component rates of the bid for determining additional and supplementary benefits.

2.15.2 2.15.1.6 Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers.

Include at least records of the following:

2.15.2.1 Ownership and operation of the MA Health Plan's financial, medical, and other record keeping systems.

2.15.2.2 Financial statements for the current contract period and 10 prior periods.

2.15.2.3 Federal income tax or informational returns for the current contract period and 10 prior periods.

2.15.2.4 Asset acquisition, lease, sale, or other action.

2.15.2.5 Agreements, contracts, and subcontracts.

2.15.2.6 Franchise, marketing, and management agreements.

2.15.2.7 Schedules of charges for the MA Health Plan's fee-for-service patients.

2.15.2.8 Matters pertaining to costs of operations.

2.15.2.9 Amounts of income received by source and payment.

2.15.2.10 Cash flow statements.

2.15.2.11 Any financial reports filed with other federal programs or State authorities.

No Endorsement

Nothing in this SMAC will be construed as an endorsement by HCA of the products, services, or personnel of MA Health Plan.

2.16 No Third-Party Beneficiaries

2.17 Nothing in this SMAC, express or implied, is intended to confer upon any other person any rights, remedies, obligations, or liabilities of any nature whatsoever.

Public Disclosure

2.18 MA Health Plan acknowledges that this SMAC is a public record pursuant to chapter

2.18.1 42.56 of the Revised Code of Washington. Any documents submitted to HCA by the MA Health Plan may be construed as "public records" and therefore subject to public disclosure, except as otherwise provided in 42.56 RCW or other applicable law. HCA may post a "model" contract of this SMAC on the HCA website.

2.18.2 Except as required by law, regulation, or court order, data identified by the MA Health Plan, as proprietary trade secret information, will be kept strictly confidential, unless the MA Health Plan provides prior written consent of disclosure to specific parties.

2.18.3 Any release or disclosure of data shall include the MA Health Plan's interpretation.

MA Health Plan shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the MA Health Plan upon receipt of any request under the Public Records Act (42.56 RCW) or otherwise for data identified by the MA Health Plan as proprietary trade secret information and will not release any such information until five business days after it has notified MA Health Plan of the receipt of such request. If MA Health Plan files legal proceedings within the

2.18.4 aforementioned five business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the MA Health Plan dismisses its lawsuit, or the MA Health Plan agrees that the data may be released.

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

Notwithstanding other requirements in this Section, nothing in this SMAC prohibits HCA from making the following types of disclosures:

2.18.5.1 Disclosures required by law, including disclosures in the course of:

2.18.5.1.1 Litigation, with an appropriate court order;

2.18.5 2.18.5.1.1.1 HCA will provide the MA Health Plan with notice and opportunity to file legal proceedings in accordance with subsection 2.18.3.

2.18.5.1.2 Oversight review or audits, including reviews by the State Auditor's Office (SAO), the Office of the Inspector General (OIG), or CMS; or

2.18.5.1.3 Medicaid Fraud Control Division (MFCD) review or investigation.

2.18.5.2 Disclosures of information that is not directly identifiable by MA Health Plan, including disclosures;

2.18.5.3 Disclosures to contractors working on behalf of HCA, to the minimum extent necessary for the performance of services. HCA will use best efforts to ensure continued confidential treatment of MA Health Plan's disclosed proprietary information or trade secrets;

2.18.5.4 Disclosures of aggregated information; and

2.18.5.5 Any other disclosure of paid amount information with the prior written consent of MA Health Plan.

2.19 Publicity

MA Health Plan agrees to submit to HCA all advertising, sales promotion, and other publicity materials relating to this SMAC or any Service furnished by the MA Health Plan in which HCA's name is mentioned, language is used, or Internet links are provided from which the connection of HCA's name with MA Health Plan's Services may, in HCA's judgment, be inferred or implied.

2.20 MA Health Plan further agrees not to publish or use such advertising, marketing, sales promotion materials, publicity or the like through print, voice, the Web, and other communication media in existence or hereinafter developed without the express written consent of HCA prior to such use.

2.21 Reservation of Rights and Remedies

The remedies provided in this SMAC are not exclusive, but are in addition to all other remedies available under law.

Severability

Whenever possible, each provision of this SMAC will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this SMAC is held to be invalid,

illegal, or unenforceable under any applicable law or rule, the validity, legality, and enforceability of the other provisions of this SMAC will not be affected or impaired thereby.

Term and Termination

Term

The term of this SMAC will begin on January 1, 2023 (the "Effective Date") and end on December 31, 2023. The term of this SMAC may be extended by mutual agreement of the parties, in writing.

2.22

2.22.1

Termination. This SMAC may be terminated under the following conditions:

2.22.2.1 The SMAC will automatically terminate the day the MA Agreement expires or is terminated.

2.22.2

2.22.2.2 This SMAC may be terminated by mutual agreement of the parties. Such agreement must be in writing.

2.22.2.3 HCA may terminate the SMAC in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of HCA. The termination will be effective on the date specified in HCA's notice of termination. HCA will provide the MA Health Plan written notice of such termination at least 30 calendar days prior to the effective date of termination, unless HCA determines that circumstances warrant a shorter notice period.

2.22.2.4 In addition to the reasons set forth above, HCA reserves the right to terminate this SMAC, in whole or in part, upon the following conditions:

2.22.2.4.1 HCA may terminate this SMAC at any time if a court of competent jurisdiction finds MA Health Plan failed to adhere to any laws, ordinances, rules, regulations, or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of MA Health Plan's duties under this SMAC.

2.22.2.4.2 HCA may terminate the SMAC at any time if the MA Health Plan: files for bankruptcy; becomes or is declared insolvent; or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar Officer for it; makes an assignment for the benefit of all or substantially all of its creditors; or enters into an agreement for the composition, extension, or readjustment of substantially all of its obligations.

2.22.2.4.3 HCA will have the right to terminate the SMAC at any time and in whole or in part if it determines, at its sole discretion, that the MA Health Plan has materially breached the SMAC.

2.22.2.5 The MA Health Plan may terminate this SMAC by providing HCA written notice at least 30 calendar days prior to termination. The termination will be effective on the date specified in the MA Health Plan's notice of termination.

Corrective Action Plan (CAP)

2.23 If HCA determines, in HCA's sole discretion, MA Health Plan is out of compliance with one or more terms or conditions of this SMAC, HCA may require MA Health Plan to adhere to a Corrective Action Plan (CAP). HCA will specify the requirements of any such CAP in a written communication to the MA Health Plan.

Waiver

2.24 No delay on the part of either party in exercising any right under this SMAC will operate as a waiver of such right. No waiver, express or implied, by either party of any right or any breach by the other party will constitute a waiver of any other right or breach by the other party.

MA Health Plan Obligations

3. Eligibility and Enrollment

3.1 Service Area

3.1.1 MA Health Plan may offer a Dual Eligible SNP to eligible beneficiaries who reside in those counties where the MA Health Plan offers such benefit plan under its MA Agreement as described in this SMAC. Specific counties or zip codes covered by this SMAC are described in Exhibit 2.

3.1.2 Eligibility Verification

3.1.3 HCA will provide MA Health Plan a method of verifying Medicaid eligibility which may include, but is not limited to, verification through a systems query to a State eligibility data system.

Enrollment

3.1.3.1 Unless a Dual Eligible is otherwise excluded under federal Medicare Advantage plan rules, the MA Health Plan will accept all Full and Partial Dual Eligibles who: (i) are eligible for enrollment per SMAC, Exhibit 2; and (ii) select the MA Health Plan's SNP, without regard to physical or mental condition, health status or need for or receipt of health care services, claims experience, medical history, genetic information, disability, marital status, age, sex, national origin, race, color, or religion, and will not use any policy or practice that has the effect of such discrimination.

3.1.3.1.1 MA Health Plan to verify Dual Eligible Member eligibility and plan enrollment as needed using the verification process identified in the Eligibility and Enrollment Section of this SMAC.

3.1.3.1.2 MA Health Plan to report to HCA any changes in Dual Eligible Member eligibility. Changes include but are not limited moving out of state, deaths, or loss of eligibility.

3.1.3.2 Upon receiving written approval from HCA, the MA Health Plan may operate separate Plan Benefit Packages (PBP) for full dual eligible Members and partial dual eligible Members. The MA Health Plan's PBPs and eligible Member categories are detailed in Exhibit 2. Each PBP must meet requirements under this SMAC. To receive approval, the request must:

3.1.3.2.1 Be submitted in writing via email to HCA MC Programs hcamcprograms@hca.wa.gov;

3.1.3.2.2 Clearly delineate any differences, including cost sharing between the PBPs; and

3.1.3.2.3 Meet all Medicare requirements.

Behavioral Health Services

3.1.4

3.1.4.1 When Member is enrolled with MA Health Plan with respect to both D-SNP and Integrated Managed Care, where applicable, MA Health Plan will coordinate BH services and provide the BH services under the Integrated Managed Care contract when medically necessary as defined in the IMC and Behavioral Health Wraparound contracts. Benefits may be found in Exhibit 5.

3.1.4.1.1 Services not covered by this SMAC. These services are in the capitated rate paid to the Behavioral Health Services Only Managed Care Organization by HCA for behavioral health under the IMC contract for Behavioral Health Services. The MA Health Plan is not required to provide these services, but is responsible for ensuring coordination of these services, in accordance with 42 C.F.R. § 422.107(c)(1).

3.1.4.2 MA Health plan will develop the necessary agreements to coordinate with HCA Behavioral Health Administrative Services Organizations (BH-ASO) to support crisis and ombuds services. A template will be provided to HCA by Jan 30, 2023. Final contracts will be made available to HCA upon request.

3.2

3.2.1

Cost Sharing

Beneficiary Enrollment and Financial Protection

MA Health Plan must provide each prospective Dual Eligible SNP Member, prior to enrollment, with a comprehensive written statement of benefits and cost sharing protections under MA Health Plan's SNP as compared to protections under the relevant State Medicaid plan. MA Health Plan is prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the State Medicaid plan if the Member were not enrolled in the MA Health Plan's Dual Eligible

SNP. This requirement is to assist a prospective dual-eligible Member to determine if they will receive any value from enrolling in the Dual Eligible SNP that is not already available under the State Medicaid program.

MA Health Plan Member Financial Protections

3.2.2 MA Health Plan assures that its contracts with MA Health Plan participating providers contain provisions that require such participating providers to accept Medicare fee schedules plus Member cost sharing as payment in full. Under MA Health Plan's Dual Eligible SNP the participating providers may only collect such Member cost sharing as specified by MA Health Plan and pursuant to the limitations of Beneficiary Enrollment and Financial Protection section of this SMAC.

Network and Access to Care

MA Health Plan Participating Providers

3.3

3.3.1 MA Health Plan maintains contracts with participating providers whereby MA Health Plan assures adequate access and availability to Members for all medically necessary Covered Services, following CMS access standards and guidelines. MA Health Plan maintains policies and procedures to regularly monitor access and availability of such participating providers to ensure MA Health Plan consistently meets such access standards and guidelines. MA Health Plan agrees to maintain a contracted participating provider network which is qualified to serve the Members enrolled in MA Health Plan under the SNP, including any specific special medical care needs of such membership which are covered benefits under the SNP.

3.3.2 MA Health Plan will include in its Model of Care (MOC) a health home program, in alignment with the Medicaid Health Homes program, for at least those individuals engaged in Medicaid Health Homes program at the time of enrollment in the MA Health Plan.

3.3.3

MA Health Plan must:

3.3.3.1 Contract with all HCA contracted Health Home (HH) Lead Entities in the service areas their DSNP covers.

3.3.3.2 Use template health home contract provided by HCA to contract with the CCO to provide Health Home Services. Any changes to the template will require advance written approval from HCA.

3.3.4

3.3.3.3 Pay at least the Medicaid rates for HH services according to the definition of said services.

Health Home program shall be community-based, integrated and coordinated across medical, behavioral health, and long-term services and supports to members based on the services described in Section 1945(h)(4) of the Social Security Act. See exhibit 6 for program specific requirements.

MA Health Plan will provide a status update quarterly on contracting status by the last day of each quarter. This HH Contracting report will be due to HCAMCPrograms@hca.wa.gov.

MA Health Plan will have access to and ensure utilization of the Predictive Risk Intelligence System (PRISM).

3.3.5 MA Health Plan will seek to align their Medicare and Medicaid networks. By December 31 of each calendar year, MA Health Plan will provide a list of all counties and relative percentages where less than 80 percent of their Medicare providers also accept Medicaid clients for the current plan year. This will be provided to HCA via email to HCAMCPrograms@hca.wa.gov, utilizing the Network Alignment Template.

3.3.6

3.3.7

The MA Health Plan will have fifty percent (50%) of their Medicare network aligned with their Medicaid network in each county it offers a DSNP by June 1, 2023. If the MCO does not offer a Medicaid option, they will still need to complete all required reports.

3.3.8

MA Health Plans with greater than 90% alignment in a county may work with HCA and their Medicaid 834 file to conduct outreach to clients who are reaching Medicare age in that county based on their annual Network Alignment report. If the contractor makes substantial gains in their alignment, they may annually make a onetime request for HCA reconsider their alignment report to support marketing for the remainder of the contract year. The outreach shall be conducted in accordance with the marketing section of the SMAC.

3.3.9

3.4 Quality Assurance

3.4.1

Quality Measures:

3.4.1.1 MA Health Plan will submit via email to HCAMCPrograms@hca.wa.gov annual HEDIS® reports, CAHPS®, if participating, and *any* other quality strategies and evaluations. HEDIS® and CAHPS® reports must be submitted within 30 calendar days of report completion.

3.4.1.2 Additionally, annually by January 31, MA Health Plan will submit a notification via email to HCAMCPrograms@hca.wa.gov which CAHPS® survey(s) they intend to conduct for that calendar year.

3.4.1.3 MA Health Plan will submit the CMS annual Star report to HCA within 30 days of receipt of final draft.

3.4.2

3.4.1.3.1 If Star report is less than 3 stars, the MA Health Plan will consult with HCA and provide an action plan on steps the MA Health Plan is taking to raise score in the State of Washington.

CMS Model of Care Approval (MOC) or NCQA Accreditation

MA Health Plan will submit to HCA via email - HCAMCPrograms@hca.wa.gov:

3.4.2.1 The approved Model of Care; and

3.4.2.2 One of the following:

3.4.2.2.1 Written approval from CMS of the Model of Care, or

3.4.2.2.2 The full NCQA accreditation report and accreditation status results within 30 days of each accreditation visit for any accreditation applicable to this SMAC; or

3.4.2.2.3 NCQA Medicare Advantage Deeming status; and

3.4.2.3 If the MA Health Plan makes any changes to their MOC, the MA Health Plan will resubmit their MOC to HCA with thirty (30) days of submission to CMS.

3.4.3 The MA Health Plan will include as part of its DSNP Model of Care and training for staff and providers the following:

3.4.3.1 The MA Health Plan's responsibility for coordination of Medicare and Medicaid benefits and grievances for Dual Eligible SNP Members;

3.4.3.2 Health Homes;

3.4.3.3 The MA Health Plan's policies and processes for coordination of Medicare and Medicaid benefits for Washington DSNP Members, including services provided by the Behavioral Health Administrative Services Organizations, Behavioral Health Services Only, prescription drug benefits, and other services paid for by the state of Washington; and

3.4.3.4 Programs to address social and health disparities, especially where evidence of inequity of health outcomes is measured.

3.5 Policies and Procedures

3.6 MA Health Plan will submit to HCA a list of internal policies and procedures and, make available for viewing any policy and procedure pertaining to this SMAC upon request from HCA.

3.6.1 Member Communication

3.6.2 MA Health Plan will ensure all Member communications are in accordance with 42 C.F.R. Subpart V and the Medicare Communications and Marketing Guidelines (MCMG).

MA Health Plan will publish, on MA Health Plan's website, a contact phone number that will be available for Members' questions around care coordination, provider access, billing questions, and for providers to inquire about Medicaid or Medicare benefit coordination or billing.

3.6.2.1 MA Health Plan will begin developing a Washington specific information webpage to support members and members accessing services in

Washington State. Webpage will be developed and posted to the MA Health Plan's website by 10/1/2023.

In areas where DSNP aligns with the MA Health Plan's Medicaid IMC contract, HCA will collaborate on marketing materials to support aligned enrollment and care coordination.

3.6.3 In areas where network alignment is greater than ninety percent (90%), the MA Health Plan may market its approved, companion MA Health Plan product to its aligned Dual Eligible Members enrolled in its aligned IMC benefit plan and members who are within ninety (90) days of Medicare eligibility. Materials prepared and

3.6.4 methods used for this purpose must meet all relevant federal Medicare requirements and must be submitted to HCA for approval within thirty (30) business days prior to use.

3.6.5 MA Health Plan will develop and provide a Washington specific summary of provider networks, drug coverages, plan benefits, care coordination, and VAIS to assist with helping potential Members make plan choices to the Statewide Health Insurance Benefits Advisors (SHIBA). This information will be developed in a format decided by HCA and SHIBA to best support outreach efforts. This will be provided to HCAMCPrograms@hca.wa.gov via email annually in advance of open enrollment no later than October 5th of each calendar year.

3.6.6 Information sharing or communication about D-SNP benefits and care coordination benefits with Medicaid and Medicare for Members or potential Members is allowable under this SMAC and does not constitute marketing by the MA Health Plan per 42 C.F.R. §§ 422.2260 and 423.2260. Provisions in this SMAC do not set-aside MA Health Plan's obligations or requirements for communication and marketing under Medicare rules.

3.7 Member Rights and Protections

3.7.1 MA Health Plan will comply with state and federal laws pertaining to Member rights under the Washington State Patient Bill of Rights and ensure its staff and affiliated providers or subcontractors protect and promote those rights when furnishing services to Members.

General Member Rights. Member will:

3.7.1.1 Be treated with dignity and respect at all times;

3.7.1.2 Be protected from discrimination;

3.7.1.3 Have personal and health information kept private;

3.7.1.4 Receive information in a way they can easily understand, including information to help Members make health care decisions;

3.7.1.5 Have adequate access to doctors, specialists, and hospitals according to CMS network adequacy standards;

3.7.1.6 Learn about treatment choices in clear language that Member can understand, and participate in treatment decisions;

3.7.1.7 Get health care services in a language Member understands and in a culturally sensitive way;

3.7.1.8 Get Medicare-covered services in an emergency;

3.7.1.9 Get a decision about health care payment, coverage of services, or prescription drug coverage, including the ability to file an appeal if Member disagrees with the decision of the claim;

3.7.1.10 Request an appeal of decisions about health care payment, coverage of services, or prescription drug coverage; and

3.7.1.11 File grievances, including complaints about quality of care, and other concerns with MA Health Plan

Member Provider Choice. Member has the right to:

3.7.2 3.7.2.1 Choose health care providers within the plan;

3.7.2.2 Receive treatment from their provider:

3.7.2.2.1 For complex or serious medical condition(s), a treatment plan allows Member to see a specialist within the plan as many times as needed, as determined by Member and their provider;

3.7.2.2.2 Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

3.8

3.7.2.3 Know how their doctors are paid.

3.8.1

Grievance and Appeals

3.8.2

MA Health Plan will assist Members in accessing the Medicaid and/or Medicare Grievance and Appeals System(s).

3.8.3

HCA will coordinate with MA Health Plan to develop appropriate HCA contacts for the grievance and appeal system.

The MA Health Plan will develop policies and procedures around assisting members in accessing Grievance and Appeal systems for both Medicare and Medicaid. These shall be provided to HCA upon request.

3.8.3.1 Trainings should clearly outline how to assist clients with accessing grievance Systems.

3.8.3.2 MA Health Plan will also have policies on how to work with BH Ombuds in the state of Washington.

Care Coordination

Coordination of Health Care Services

MA Health Plan will provide the Dual Eligible SNP benefits to all Dual Eligible MA Health Plan Members who are qualified to receive such services under the terms of the MA Agreement.

3.9

3.9.1

3.9.1.1 MA Health Plan responsibility to coordinate services:

3.9.1.1.1 The MA Health Plan is responsible for the coordination of both Medicare and Medicaid integrated health care benefits, regardless of whether a Dual Eligible Member is enrolled with the MA Health Plan's Behavioral Health Services Only (BHSO) health plan for Medicaid benefits.

3.9.1.1.2 If a Dual Eligible Member is enrolled with the MA health Plan for both Medicare and Medicaid benefits, the MA Health Plan is responsible for coordinating all benefits covered by both Medicare and Medicaid.

3.9.1.1.3 If a Dual Eligible Member is enrolled with the MA Health Plan for both Medicare and Medicaid benefits, the MA Health Plan will utilize Medicare Parts A, B and D data, and Medicaid health care and other data received from HCA, to coordinate all aspects of the Dual Eligible Member's integrated health care benefits, including, but not limited to transition planning, disease management, and care management.

3.9.1.1.4 If a Dual Eligible Member is not enrolled with the MA Health Plan companion Medicaid MCO for Medicaid benefits, the MA health shall coordinate Medicaid only benefits with the Dual Eligible Member's assigned MCO for BH services. Coordination of Medicaid benefits is not the Dual Eligible Member's responsibility.

3.9.1.2 Care Coordination General Requirements. MA Health Plan will:

3.9.1.2.1 Provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices;

3.9.1.2.2 Deliver services in a culturally competent manner that addresses health disparities by, for example, interacting directly and in-person with the Member and their family in the Member's primary language, with appropriate consideration of literacy and cultural preference; and

3.9.1.2.3 Use and promote recovery and resiliency principles to mitigate future risk of the development of physical or behavioral health care conditions.

3.9.1.3 Information Sharing to Improve Care Coordination and Care Outcomes

MA Health Plan will establish and maintain health services programs and resources to ensure appropriate and adequate coordination and integration of Medicare and Medicaid benefits available to Dual Eligible Members under this SMAC. Such health services programs and resources include but are not limited to dedicated programs and staff to support care management and case management services. MA Health Plan will establish care management programs for Dual Eligible SNP Members to assist in accessing services offered by the MA Health Plan, or the State's Medicaid program where benefits and services may be available. MA Health Plan will offer care coordination to Members accessing any services through the State's Medicaid Program.

3.9.1.3.1 MA Health Plan will have policies and implement mechanisms to provide care management and care coordination to Members in consultation with any providers caring for the Member, including for Members currently receiving Medicaid-funded long-term care or long-term services and supports from DSHS, to meet CMS goals for reducing duplication of assessment and care planning activities for improved coordination and Member outcomes.

3.9.1.3.2 MA Health Plan will have policies and protocols to coordinate services between settings of care, and include all relevant parties involved in discharge or transition planning, including HCS if the member receives HCBS services. This coordination will include appropriate discharge planning for short-term and long-term hospital and institutional stays:

3.9.1.3.2.1 With the services the Member receives from any other Medicaid MCO;

3.9.1.3.2.2 With the services the Member receives in fee-for-service (FFS) Medicaid, including long-term care and long-term services and supports; and

3.9.1.3.2.3 With the services the Member receives from community and social support providers.

3.9.1.3.3 MA Health Plan will have policies and protocols for sharing information with Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA), Home Community Services (HCS), and

Developmental Disabilities Administration (DDA), and other MCOs serving the Member to reduce duplication of assessment and care planning activities for improved coordination and Member outcomes and address high-priority health concerns identified through Member health risk assessments.

3.9.1.3.4 MA Health Plan will have mechanisms to receive referrals for health care screening or assessment for Members receiving long-term care of long-term services and supports, work closely with HCA or MCO intensive care management for coordination around health risk screenings and assessment requirements within 30 calendar days for referrals and 90 calendar days for new Members, or as quickly as the Member's health condition requires.

3.9.1.3.5 For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, MA Health Plan will have a mechanism in place to allow Members to directly access a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. MA Health Plan will work to ensure the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports.

3.9.1.4 For all Dual Eligible Members receiving Medicaid-covered Long-Term Care (LTC) and Long-Term Services and Supports (LTSS) through State programs, MA Health Plan will make reasonable efforts to coordinate benefits and services, which include:

3.9.1.4.1 Outreach, coordination, and making a direct connection with Medicaid LTC and LTSS programs for services and care coordination; and

3.9.1.4.2 Provide HCA with a contact, including email address, for HCS staff to coordinate care for discharges or contact the MA Health Plan regarding care coordination needs of shared Members.

3.9.1.5 MA Health Plan will ensure any MCO have information to access care coordination services as needed by connecting with MCO care coordination leads for integration of care. This includes provision of phone number(s), email address(es), and name(s) of key care coordination staff assigned to support Members in care navigation or care coordination activities. MA Health Plan will notify MCO care coordination leads of any changes within 30 calendar days.

Benefits Comparison Charts Information Sharing

3.10

3.10.1

3.10.1.1 On an annual basis, MA Health Plan will determine its benefits, including Value-Added Items and Services (VAIS), and supplemental benefits for the chronically ill for the calendar year that will be provided to Dual Eligible Members under the Dual Eligible SNP. Such benefits will be approved by CMS prior to January 1 of each successive calendar year.

3.10.1.2 MA Health Plan will develop comparison charts (“Comparison Charts") summarizing the products and services offered under the various MA Health Plan's Dual Eligible SNP plans for each service area in the state. To be included on the comparison chart are:

3.10.1.2.1 A list of benefits offered by the MA Health Plan;

3.10.1.2.2 A list of Medicaid benefits offered by HCA to qualified Dual Eligible beneficiaries;

3.10.1.2.3 MA Health Plan's defined cost sharing for each benefit;

3.10.1.2.4 HCA's Medicaid Cost Sharing Obligations for each benefit; and

3.10.1.2.5 Identification of overlap between MA Health Plan's benefits, services, and cost sharing with HCA's Medicaid Cost Sharing Obligations for each benefit and each qualified beneficiary.

3.10.1.3 MA Health Plan will submit to HCA, with their SMAC or Amendment to SMAC, in an agreed upon format and HCA will review and approve the draft comparison charts with regard to appropriate documentation of Medicaid benefits and cost sharing offered by HCA. The MA Health Plan will provide the final version via email to HCAMCPrograms@hca.wa.gov by August 1 with CMS approval.

3.10.1.3.1 MA Health Plan will distribute such Comparison Charts to appropriate MA Health Plan departments and personnel for the express purpose of providing education and resources to MA Health Plan staff to enable efficient and appropriate coordination of benefits that may be available to Dual Eligible Members under their State Medicaid program.

3.10.1.3.2 MA Health Plan will distribute such Comparison Charts to MA Health Plan participating providers for the express purpose of providing education and resources to MA Health Plan participating providers to enable efficient and appropriate collection of applicable cost sharing under MA Health Plan's Dual Eligible SNP plan benefits and as required

by the Beneficiary Enrollment and Financial Protection section of this SMAC.

3.10.1.3.3 MA Health Plan will distribute such Comparison Charts to Dual Eligible Members under the Dual Eligible SNP and make available to staff for Member questions regarding benefits and the Comparison Chart.

3.10.1.3.4 Comparison Charts must be distributed by December 1, or upon enrollment. MA Health Plan may meet the requirements of distribution to participating providers and Members by posting the Comparison Charts on their website and providing information on accessing services.

Medicaid Benefit Information

3.10.2 HCA will provide MA Health Plan with information summarizing the products and services offered under the various State Medicaid benefit plans to support MA Health Plan's production of the Comparison Charts, via Medicaid Program or billing instructions on the HCA website.

Telehealth

3.10.3

MA Health Plan will provide and encourage the use of telehealth solutions to allow long-distance patient and clinician contact to include but is not limited to care, advice, reminders, education, intervention, and monitoring. “Telehealth” includes the distribution of health-related services and information via electronic information and telecommunication technologies.

3.11

3.11.1 Reporting Requirements

3.11.2 MA Health Plan shall provide all SMAC Reporting Deliverables timely, as directed by the HCA. All emails submissions must include HCA MC Programs hcamcprograms@hca.wa.gov in addition to any identified contacts.

MA Health Plan shall provide timely notification of all admissions to a hospital or skilled nursing facility (SNF) for a subpopulation of Members receiving Medicaid Long Term Services and Supports with RAC and Group Codes, in Exhibit 1.

3.11.2.1 MA Health Plan will provide a report via SFT in the established HCA template on a weekly basis due close of business Monday for the previous week, Sunday through Saturday. The report will contain all full dual Members who are currently receiving HCBS services and are currently admitted to a hospital or SNF for any reason. This report shall only include those Members who are currently admitted, all members who transition from an inpatient setting will be removed prior to the next submission. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Reports will include:

3.11.2.1.1 Name of Member;

3.11.2.1.2 ProviderOne ID;

3.11.2.1.3 Hospital or Skilled Nursing Facility (SNF);

3.11.2.1.4 Date of Admission;

3.11.2.1.5 Admitting Diagnosis;

3.11.2.1.6 Diagnosis Code;

3.11.2.1.7 Point of Contact;

3.11.2.1.8 County the Member resides in; and

3.11.2.1.9 Client-enrolled BHSO.

3.11.3 MA Health Plan will provide a summary report in HCA's established template via SFT to HCA and DSHS ALTSA on semi-annual basis due July 31st and January 31st for the previous six-month period to HCA and DSHS ALTSA for Members hospitalized or in a skilled nursing facility for behavioral health needs. If the date falls on a weekend, the report will be due by close of business on the next business day. This report will be broken into a report on full-dual-eligible and a report for partial-dual-eligible Members. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Report will include:

3.11.3.1 Number and Percentage of population hospitalized;

3.11.3.2 Percentage of population having care coordination prior to hospitalization;

3.11.3.3 Number and percentage of populations offered care coordination following hospitalization;

3.11.3.4 Number and percentage of population accepting care coordination;

3.11.3.5 Number and percentage of populations readmitted from the prior year;

3.11.3.6 Average length of stay;

3.11.4 3.11.3.7 Number and percentage of clients that remain hospitalized when not medically necessary; and

3.11.3.8 A summary of steps MA Health plan will or are taking to address re-admittance and stays exceeding medically necessary guidelines.

MA Health Plan will provide a Membership Churn report via SFT to HCA and DSHS ALTSA on an annual basis due July 31st for the prior contract year. If the date falls on a weekend, the report will be due by close of business on the next business day. An email will be sent to HCA at HCAMCPrograms@hca.wa.gov and DSHS ALTSA at

DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Report will include:

3.11.4.1 Annual state level reporting;

3.11.4.2 Disenrollment for cause vs. loss of eligibility as a percentage;

3.11.4.3 Narrative analysis of areas of the state based on their percentage of loss or gain;

3.11.4.4 Root cause analysis and connection to quality strategy.

MA Health Plan will provide their Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings via SFT to HCA 30 calendar days after federal publish by email to HCAMCPrograms@hca.wa.gov.

3.11.5 MA Health Plan will submit a semi-annual Health Home Services report, due August 15 for January through June, and February 15 for July through December, on an HCA-provided template by email to HCAMCPrograms@hca.wa.gov. HCA may request off-cycle updates to this report.

3.11.6

Encounter Submission

3.12

3.12.1 The MA Health Plan shall submit and maintain accurate, timely, and complete encounter data. The MA Health Plan shall comply with all of the following:

3.12.1.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of encounter data submitted to HCA.

3.12.1.2 Submit to HCA complete, accurate, and timely data for all services for which the MA Health Plan provided services under this SMAC as reported to CMS.

3.12.1.3 Encounter data must be submitted to HCA via SFT upload monthly, at a minimum, and no later than 30 calendar days from the end of the month in which the MA Health Plan submitted encounter data to CMS.

3.12.1.4 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter.

3.12.1.5 The MA Health Plan shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the MA Health Plan's submission to CMS with the exception of adding the Medicaid enrolled ProviderOne ID.

3.12.1.5.1 Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA

Transaction Standards.

The data quality standards listed within this SMAC and are incorporated by reference into this SMAC. The MA Health Plan shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended.

3.13 Additional detail can be found in the Encounter Data Reporting Guide published by

3.13.1 HCA. The Encounter Data Reporting Guide, as currently existing and hereafter amended, is hereby incorporated by reference into this SMAC.

3.13.2 3.13.2.1 HCA may change the Encounter Data Reporting Guide with 90 calendar days' written notice to the MA Health Plan.

3.13.2.2 The Encounter Date Reporting Guide may be changed with less than 90 calendar days' notice by mutual agreement of the MA Health Plan and HCA.

3.13.2.3 The MA Health Plan shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

HCA Obligations

4.

HCA's Financial Responsibility

4.1

HCA will retain financial responsibility for applicable Medicaid Cost Sharing Obligations, including coordination of benefits, coinsurance and/or copayments to healthcare providers as detailed in the State Plan. Providers will submit claims eligible for coordination of cost sharing directly to HCA for payment of any applicable payments as determined by HCA.

4.2

Medicaid Provider Participation

4.3 HCA will provide MA Health Plan with access to available information to enable MA Health Plan to verify provider participation in the State's Medicaid programs.

SMAC Monitoring

HCA reserves the ability to schedule Washington specific Readiness Reviews and On-Site Reviews as needed to ensure Network Adequacy in alignment with federal guidance and this SMAC. HCA's monitoring will not duplicate monitoring efforts completed by CMS.

Exhibit 1

Covered Dual Eligible Recipient Aid Categories

Coverage Group	RAC Code	RAC Description
L01	1065	Categorically Needy; SSI eligible person age 65+ in LTC facility
L01	1066	Categorically Needy SSI eligible 65+; in Inst for Mental Disease
L01	1067	Categorically Needy SSI eligible person Blind/Disabled in LTC facility
L01	1068	Categorically Needy SSI age 65+ in LTC facility; plus PNA
L01	1069	Categorically Needy SSI age 65+; Inst for Mental Disease; plus PNA
L01	1070	Categorically Needy SSI Blind/Disabled in LTC facility; plus PNA
L01	1168	Categorically Needy SSI eligible person Blind/Disabled age <=22, IMD LTC
L01	1169	Categorically Needy SSI Blind/Disabled age <=22 in IMD; plus PNA
L02	1071	Categorically Needy LTC; 65+; inc>SSI CNIL <= SIL
L02	1072	Categorically Needy 65+; Mental Disease Inst; inc>SSI CNIL<= SIL
L02	1073	Categorically Needy LTC; 65+; inc< = SSI CNIL
L02	1074	Categorically Needy 65+; Mental Disease Inst; inc <=SSI CNIL
L02	1164	Categorically Needy Blind/Disabled, age <=22, IMD LTC; inc >SSI CNIL<= SIL
L02	1165	Categorically Needy Blind/Disabled, age <=22, IMD LTC; inc <= SSI CNIL
L21	1146	Categorically Needy HCS Waiver; 65+; SSI cash eligible
L21	1147	Categorically Needy HCS Waiver; Blind/Disabled; SSI cash eligible
L21	1152	Categorically Needy HCS Waiver/Hospice; AREQ and SSI cash recipient; 65+
L21	1153	Categorically Needy HCS Waiver; AREQ cash; Blind or Disabled
L21	1218	Categorically Needy DDA Waiver; 65+; SSI cash eligible
L21	1219	Categorically Needy DDA Waiver; Blind/Disabled; SSI cash eligible
L21	1220	Categorically Needy DDA Waiver; AREQ and SSI cash recipient; 65+
L21	1221	Categorically Needy DDA Waiver; AREQ cash; Blind or Disabled

L22	1148	Categorically Needy HCS Waiver; 65+; Inc < = SSI CNIL
L22	1149	Categorically Needy HCS Waiver; 65+; Inc >SSI CNIL, <SIL
L22	1150	Categorically Needy HCS Waiver; Blind/Disabled; < = SSI CNIL
L22	1151	Categorically Needy HCS Waiver; Blind/Disabled; >CNIL,< SIL
L22	1174	Categorically Needy HCS Waiver; 65+; Inc >SIL
L22	1175	Categorically Needy HCS Waiver; Blind/Disabled; Inc > SIL
L22	1222	Categorically Needy DDA Waiver; 65+; Inc < = SSI CNIL
L22	1223	Categorically Needy DDA Waiver; 65+; Inc >SSI CNIL, <SIL
L22	1224	Categorically Needy DDA Waiver; Blind/Disabled; < = SSI CNIL
L22	1225	Categorically Needy DDA Waiver; Blind/Disabled; >CNIL,< SIL
L31	1236	Categorically Needy Hospice; 65+; SSI cash eligible
L31	1237	Categorically Needy Hospice; Blind/Disabled; SSI cash eligible
L31	1238	Categorically Needy Hospice; AREQ and SSI cash recipient; 65+
L31	1239	Categorically Needy Hospice; AREQ cash; Blind or Disabled
L32	1240	Categorically Needy Hospice; 65+; Inc < = SSI CNIL,
L32	1241	Categorically Needy Hospice 65+; Inc >SSI CNIL, <SIL
L32	1242	Categorically Needy Hospice; Blind/Disabled; < = SSI CNIL
L32	1243	Categorically Needy Hospice; Blind/Disabled; >CNIL,< SIL
L41	1260	Categorically Needy RCL; 65+; SSI cash eligible
L41	1261	Categorically Needy RCL Blind/Disabled; SSI cash eligible
L41	1262	Categorically Needy RCL; AREQ and SSI cash recipient; 65+
L41	1263	Categorically Needy RCL; AREQ cash; Blind or Disabled
L42	1264	Categorically Needy RCL; 65+; Inc < = SSI CNIL,
L42	1265	Categorically Needy RCL; 65+; Inc >SSI CNIL, <SIL
L42	1266	Categorically Needy RCL; 65+; Inc >SIL

L42	1267	Categorically Needy RCL; Blind/Disabled; < = SSI CNIL
L42	1268	Categorically Needy RCL; Blind/Disabled; >CNIL,< SIL
L42	1269	Categorically Needy RCL; Blind/Disabled; Inc > SIL
L51	1104	Categorically Needy Medicaid => 65 SSI cash eligible
L51	1105	Categorically Needy Medicaid Blind/Disabled; SSI cash eligible
L51	1106	Categorically Needy age 65+; SSI cash eligible; with AREQ cash;
L51	1107	Categorically Needy Blind/Disabled; SSI cash eligible; with AREQ cash;
L51	1244	Categorically Needy CFC; 65+; SSI cash eligible
L51	1245	Categorically Needy CFC; Blind/Disabled; SSI cash eligible
L51	1246	Categorically Needy CFC; AREQ and SSI cash recipient; 65+
L51	1247	Categorically Needy CFC; AREQ cash; Blind or Disabled
L52	1046	Categorically Needy ALF, 65 or older
L52	1047	Categorically Needy ALF, blind/disabled
L52	1108	Categorically Needy age 65+; under SSI CNIL; Income disregards
L52	1109	Categorically Needy age 65+; SSI related; income =< SSI CNIL
L52	1110	Categorically Needy Blind/Disabled; =< SSI CNIL; Income disregards
L52	1111	Categorically Needy Blind/Disabled; SSI related; income =< SSI CNIL
L52	1248	Categorically Needy CFC; 65+; Inc < = SSI CNIL
L52	1249	Categorically Needy CFC; 65+; Inc < = SSI CNIL, Special Income Disregard
L52	1250	Categorically Needy CFC ;65+, SIPI Spouse
L52	1251	Categorically Needy CFC ;65+, SIPI Spouse, Special Income Disregard
L52	1252	Categorically Needy CFC; Blind/Disabled; < = SSI CNIL
L52	1253	Categorically Needy CFC; Blind/Disabled; < = SSI CNIL, Special Income Disregard
L52	1254	Categorically Needy CFC Blind/Disabled; SIPI Spouse
L52	1255	Categorically Needy CFC Blind/Disabled; SIPI Spouse, Special Income Disregard

L52	1256	Categorically Needy CFC in an ALF, 65 or older
L52	1257	Categorically Needy CFC in an ALF, 65 or older, SIPI spouse
L52	1258	Categorically Needy CFC in an ALF, blind/disabled
L52	1259	Categorically Needy CFC in an ALF, blind/disabled, SIPI spouse
L95	1166	Medically Needy Inst for Mental Disease; Blind/disabled, age <=22;
S08	1121	Categorically Needy Health Care for Workers with Disabilities (HWD); basic group
S08	1134	Categorically Needy Health Care for Workers with Disabilities (HWD); Improved group
S08	1271	Categorically Needy Health Care for Workers with Disabilities (HWD); basic group =>65
S03	1112	Medicare Savings Program; QMB; 65+
S03	1113	Medicare Savings Program; QMB Blind/Disabled
S05	1115	Medicare Savings Program; SLMB; 65+
S05	1116	Medicare Savings Program; SLMB; Blind/Disabled
S06	1117	Medicare Savings Program; QI-1; 65+
S06	1118	Medicare Savings Program; QI-1; Blind/Disabled

Exhibit 2

Service Area Washington

The following counties define the Service Area covered under this SMAC:

Exhibit 3

Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Full Dual Eligible Members

To be finalized between HCA and MA Health Plan by December 31 each year for the following year. Thereafter MA Health Plan will notify HCA upon any changes to the Supplemental Benefits and VAIS. Services will be listed in the following format.

Supplemental Benefit/VAIS Name	Description	Service Limits	Copay/Co-Insurance
Example: Transportation	One-way non-emergency trips to plan services	100 one-way trips do not exceed 100 miles. Member must contact MA Health plan to arrange.	$0

Exhibit 4

Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Partial Dual Eligible Members

To be finalized between HCA and MA Health Plan by December 31 each year for the following year. Thereafter MA Health Plan will notify HCA upon any changes to the Supplemental Benefits and VAIS. Services will be listed in the following format.

Supplemental Benefit/VAIS Name	Description	Service Limits	Copay/Co-Insurance
Example: Transportation	One-way non-emergency trips to plan services	100 one-way trips do not exceed 100 miles. Member must contact MA Health plan to arrange.	$0

Exhibit 5

Summary of Behavioral Health Benefits Covered Under IMC Contract

The following services are required by the Integrated Managed Care (IMC) contract with the HCA. The IMC contractor is required to coordinate Members access to these services with the members identified Behavioral Health Services Organization (BHSO). Services may be found in the Integrated Managed Care found at https://www.hca.wa.gov/billers-providers-partners/programs-and-services/model-managed-care-contracts. Services include but are not limited to:

1. Behavioral health services as described in Section 13d, Rehabilitative Services, of the Medicaid State Plan
2. Inpatient Behavioral Health Services as defined by the Medicaid State Plan:
    a. Consultations with specialty providers, including psychiatric or psychology consultations, are covered during hospital stays.
    b. Inpatient professional mental health services associated with an AH-IMC behavioral health approved ITA or voluntary inpatient psychiatric admission.
    c. Inpatient psychiatric mental health services except when the Member is approved for placement in a state hospital.
    d. Covered services provided during an inpatient admission for medical detoxification services.
    e. Inpatient Withdrawal Management (substance acute withdrawal management) Services required for the care and/or treatment of individuals intoxicated or incapacitated by substances while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from substances. Services are provided in facilities with sixteen (16) beds or less and exclude room and board. Services include:
        i. Screening and acute withdrawal management; and
        ii. Counseling of persons admitted to a program within a certified Facility, regarding their illness in order to stimulate motivation to obtain further treatment, and referral of detoxified persons with SUD to other appropriate substance use disorder treatment service providers.
    f. Inpatient/Residential Substance Abuse Treatment Services: Rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Members who are harmfully affected by the use of mood-altering substances or have been diagnosed with a SUD. Techniques have a goal of recovery for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board.
    g. Court-ordered behavioral health Involuntary Treatment Act (ITA) commitment inpatient admission, except those identified as exclusions to the BHSO.
    a. IMD Services. Covered Services provided to Members who are primarily receiving short-term treatment and withdrawal management services for SUD in facilities that meet the definition of an IMD which are not otherwise matchable expenditures under Section 1903 of the Social Security Act. Excludes room and board.
3. Medication Assisted Treatment, including assessment, counseling, medical management, and prescribing to assist clients in treatment for SUD in a medical office setting.
4. MAT including medications prescribed or administered as part of a MAT protocol, except for methadone, when treatment is provided in
    a. a SUD clinic setting.
5. Outpatient Behavioral Health Services as defined in the Medicaid State Plan:

a. Brief Intervention Treatment.

b. Day Support, including in a club house setting.

c. Family Treatment.

d. Freestanding Evaluation and Treatment.

e. Mental Health Group Treatment Services.

f. High Intensity Treatment.

g. Individual Treatment Services.

h. Intake Evaluation.

i. Medication Management.

j. Medication Monitoring.

k. Mental Health Peer Support Services.

l. Psychological Assessment.

m. Rehabilitation Case Management.

n. Residential Mental Health Services.

o. Stabilization Services.

p. Special Population Evaluation.

q. Therapeutic Psychoeducation.

r. Substance Use Disorder Case Management.

s. Substance Use Disorder Outpatient Services.

t. Opiate Substitution Treatment;

u. Medication Assisted Treatment;

v. Collaborative Care Services;

w. The IMC contractor shall ensure Medication Management is:

   i. Provided by the PCP; or

   ii. Provided in conjunction with a Mental Health

   iii. Professional or SUDP contracted with the IMC contractor; or

   iv. Provided by an appropriate behavioral health specialist; and

   v. In accord with the requirements of pharmacists under RCW 69.41.190(3).

x. Substance Use Disorder Peer Support Services.

6. Wraparound with Intensive Services (WISe) provides a combination of the services identified in the current Mental Health State Plan including evaluation and Provision of WISe services.

Exhibit 6

Health Homes Program

1. Health Home Definitions

1.1. "Area Agency on Aging (AAA)" means a network of state and local programs that help older people to plan and care for their lifelong needs.

1.2. "Behavioral Health Services" means services that address the promotion of emotional health; the prevention of mental illness and substance use disorders; and the treatment of substance abuse, addiction, substance use disorders, mental illness, and/or mental disorders.

1.3. "Care Coordinator (CC)" means an individual employed by the Lead organization or a CCO who provides Health Home Services.

1.4. "Care Coordination Organization (CCO)" means an organization within the Qualified Health Home network that is responsible for delivering Health Home services.

1.5. "Caregiver Activation Measure® (CAM®)" means an assessment that gauges the knowledge, skills and confidence essential to a caregiver providing care for a person with chronic conditions.

1.6. "Comprehensive Assessment Report and Evaluation (CARE)" means a person- centered tool used by case managers to document a beneficiary's functional ability, determine eligibility for long-term care services, evaluate what and how much assistance a beneficiary will receive, and develop a plan of care, as defined in chapter 388-106 WAC.

1.7. "Department of Social and Health Services (DSHS)" means the Washington State Department of Social and Health Services.

1.8. "Eligibility" Means an member who was engaged in the HCA HH program at the time HCA notifies the HH Lead the member enrolled in a DSNP and had an encounter within the 3 months prior to HCA notification of enrollment in the DSNP.

1.9. "Engagement" means the member's agreement to participate in Health Homes as demonstrated by the completion of the member's Health Action Plan and that the beneficiary had an encounter in the last 3 months.

1.10. "Hallmark Events" means elevated episodes of care that have potential to seriously affect the member's health or health outcomes.

1.11. "Health Action Plan (HAP)" means an member-prioritized plan identifying what the member plans to do to improve his or her health and well-being.

1.12. "Health Home Care Coordinator" means an individual employed by a lead organization or a CCO who provides Health Home Services.

1.13. "Health Home Participation Authorization and Information Sharing Consent Form" means a release form signed by the member to confirm the Member's consent to participate in the Health Home program and to authorize the release of information to facilitate the sharing of the member's health information.

1.14. "Health Home Services" means a group of six services defined under Section 2703 of the Affordable Care Act. The six Health Home Services are:

1.14.1. Comprehensive Care Management

1.14.2. Care Coordination and Health Promotion

1.14.3. Comprehensive transitional care from inpatient to other settings including appropriate follow-up

1.14.4. Individual and Family Support

1.14.5. Referral to Community and Social Support Services

1.14.6. The use of Health Information Technology to link services, as appropriate

1.15. "Katz Index of Independence in Activities of Daily Living (Katz ADL)" means a screening instrument used to assess basic activities of daily living in older adults in a variety of care settings.

1.16. "Long Term Services and Supports (LTSS)" means the variety of services and supports that help people with functional impairments meet their daily needs for assistance in community-based settings and improve the quality of their lives.

1.17. "Parent Patient Activation Measure® (PPAM®)" means an assessment that gauges the knowledge, skills and confidence of the parent's management of their child's health.

1.18. "Patient Activation Measure® (PAM®)" means an assessment that gauges the knowledge, skills and confidence essential to managing one's own health and health care.

1.19. "Patient Protection and Affordable Care Act" or "ACA" means Public Laws 111-148 and 111-152 (both enacted in March 2010).

1.20. "Qualified Health Home" means an entity qualified by the state to administer the Health Home program to eligible beneficiaries.

2. Health Home Program for DSNP MA Health Members

2.1. Health Home Services shall be community-based, integrated and coordinated across medical, behavioral health, and long-term services and supports to members based on the services described in Section 1945(h)(4) of the Social Security Act.

2.2. The MA Health Plan shall ensure that the following are operational:

2.2.1. A system to track and share member information and care needs among providers, to monitor processes of care and outcomes, and to initiate recommended changes in care as necessary to support health action goals, including the member's preferences and identified needs;

2.2.2. A system to track Health Home Services through claims paid or services rendered and report the utilization data;

3. Health Homes Eligibility and Enrollment

3.1. HCA shall communicate a care coordination file and identify members who are potentially eligible for the MA Health Plan's DSNP Health Home program.

3.1.1. HCA identifies Health Home (HH) beneficiaries that have enrolled in DSNP and notifies HH Lead and MA Health Plan which MA Health Plan the beneficiary enrolled with. MA Health Plan receives list of beneficiaries who have enrolled in DSNP and which HH lead the beneficiary is assigned to.

3.1.1.1. File will be sent monthly in a non-standard file format and will be delivered via Secure File Transfer (SFT).

3.1.1.2. MA Health Plan and leads will establish a communication process to determine which beneficiaries are engaged in HH services at the time of enrollment in the MA Health Plan.

3.2. MA Health Plan 834 file will include a HH "Y" indicator.

3.2.1. The MA Health Plan will use the 270/271 to identify which Lead members who are eligible for HHs are active with (HH Y indicator and Lead is included in the response file).

3.2.2. The MA Health Plan will contact the Lead to determine which members are engaged.

3.3. The MA Health Plan shall ensure Health Home members continue to be assigned a Health Home Care Coordinator through a Qualified Health Home.

3.4. Members who have agreed to participate may disenroll from the Health Home program at any time. The MA Health Plan shall maintain a record of all members who choose to disenroll from the Health Home program and the reason why.

3.5. The MA plan may re-enroll the beneficiary in services, if the member requests it, and the plan determines it is the most appropriate service. The MA Health Plan shall provide HH services to engaged members but may choose to provide Health Homes program to individuals that do not meet the required criteria, of engagement prior to enrollment in the MA Health Plan.

4. Assignment

4.1. The MA Health Plan shall ensure the Health Home eligible member is assigned to the same Health Home Lead (including community-based lead) and CCO as they were prior to enrollment within thirty (30) calendar days of initial date of Health Home identification and enrollment. If the CCO is not contracted with the community-based lead, then the lead may reassign the beneficiary/member to another CCO within their network.

4.1.1. Lead assignment should ensure continuity of the Care Coordinator for the member and reduce administrative burden.

4.1.2. MA Health Plan shall assign to a community-based lead:

4.1.2.1. If the member was served by a community-based lead in the Medicaid program,

4.1.2.2. If the member is transitioning from a non-aligned Medicaid plan and assignment to a community-based lead will create continuity for the beneficiary and Care Coordinator.

4.2. MA Health Plan shall assign to an internal lead:

4.2.1. If the member was served by a managed care lead in the Medicaid program.

4.2.2. If the member is transitioning from a non-aligned Medicaid plan and assignment to an internal lead will create continuity for the beneficiary and Care Coordinator

4.2.3. If at any time the Health Homes engaged MA Health Plan member changes MA Health Plan enrollment to another plan, the beneficiary's Health Home services will continue with the assigned lead and CCO.

5. Health Action Plan (HAP)

5.1. The MA Health Plan shall ensure the Health Home Lead follows Medicaid policy to develop member HAPs:

5.2. The Health Home Care Coordinator shall meet with the member in person to complete the HAP including the following:

5.2.1. The Health Home Care Coordinator meets in-person with each member at the member's choice of location;

5.2.2. The Health Home Participation Authorization and Information Sharing Consent form is reviewed and completed;

5.2.3. The Care Coordinator evaluates the member's support system;

5.2.4. The Care Coordinator explains, develops, and completes the HAP with input from the member and/or the member's caregiver(s);

5.2.5. The HAP documents the member's diagnosis, long-term goals, short-term goals, and related action steps to achieve those goals identifying the individual responsible to complete the action steps;

5.2.6. The HAP includes the required BMI, Katz ADL, PSC-17 and PHQ-9 screening scores;

5.2.7. The HAP includes the required Patient Activation Measure (PAM®), or Patient Parent Activation Measure (PPAM®), or Caregiver Activation Measure (CAM®) activation level and screening score;

5.2.8. The Health Home Care Coordinator also documents in the HAP all other screenings administered when medically indicated; and

5.2.9. The HAP includes the reason the member declined assessment or screening tools.

5.2.10. HAPs must be reviewed and updated by the Health Home Care Coordinator at a minimum:

5.2.10.1. After every four (4) month activity period to update the PAM®, PPAM®, or CAM®; BMI; Katz ADL; PSC-17 and PHQ-9 screening scores and reassess the member's progress towards meeting self-identified health action goals, add new goals or change in current goals; and

5.2.10.2. Whenever there is a change in the member's health status or a change in the member's needs or preferences.

5.2.11. A completed and updated HAP with the member's goals and action steps must be provided to the member and with the member's consent shared with the member's caregiver and family

in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.

5.2.12. Additional information not included in the State-developed HAP form must be included as an addendum.

5.2.13. Written information in the HAP must use language that is understandable to the member and/or the member's caregiver(s).

5.2.14. With Member's consent, completed and updated HAPs must be shared with other individuals identified and authorized by the member on the signed Health Home Participation Authorization and Information Sharing Consent form.

5.2.15. The Health Home Care Coordinator shall meet with the member in-person to complete the HAP, including the following:

5.2.15.1. Explain the HAP and the development process to the member;

5.2.15.2. Complete a Health Home Participation Authorization and Information Sharing Consent form;

5.2.15.3. Evaluate the member's support system; and

5.2.15.4. Administer and score either the PAM®, PPAM® or CAM®.

5.2.16. The Health Home Care Coordinator uses the PAM®; PPAM®; or CAM® to:

5.2.16.1. Measure activation and behaviors that underlie activation including ability to self-manage, collaborate with providers, maintain function, prevent declines and access appropriate and high quality health care;

5.2.16.2. Target tools and resources commensurate with the member's level of activation;

5.2.16.3. Provide insight into how to reduce unhealthy behaviors and grow and sustain healthy behaviors to lower medical costs and improve health;

5.2.16.4. Document health care problems through the combined review of medical records, PRISM and face-to-face visits with the member; and

5.2.16.5. As indicated by clinical judgment, complete HCA-approved screening tools for behavioral health conditions, if not already obtained from other sources.

6. Health Home Key Services

6.1. The following services are delivered by the HH Lead to HH enrolled beneficiaries based on needs and preferences identified in the HAP.

6.2. Comprehensive Care Management Services

6.2.1. Health Home Care Coordinators deliver comprehensive care management, primarily in-person with periodic follow-up. Care management services include state approved screens and development of a person-centered Health Action Plan (HAP). Care Coordinators provide continuity and coordination of care through face-to-face visits and telephonic support, assess beneficiary readiness for self-management and promote self-management skills so the

beneficiary is better able to engage with health and service providers. By working with beneficiaries, Care Coordinators support the achievement of self-directed, person-centered health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning.

6.3. Care coordination

6.3.1. The Care Coordinator plays a central and active role in development and execution of cross-system care coordination to assist the beneficiary to access and navigate needed services. Care Coordinators have the ability to accompany beneficiaries to health care appointments as needed. The Care Coordinator fosters communication between care providers including primary care providers, medical specialists, and entities authorizing behavioral health and Long Term Services and Supports (LTSS). Care coordination bridges all of the beneficiary's systems of care, including non-clinical support.

6.3.2. Care coordination shall provide informed interventions that recognize and are tailored for the medical, social, economic, behavioral health, functional impairment, cultural, and environmental factors that impact a beneficiary's health and health care choices. Joint office visits by the beneficiary and the Care Coordinator with health care providers offer opportunities for mentoring and modeling communication with providers. Care Coordinators may establish multidisciplinary care teams or participate on an existing team. Their participation aids to better coordinate services, identify and address gaps in care, and ensure cross-systems coordination to ensure continuity of care.

6.4. Health Promotion

6.4.1. Health promotion includes education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes. The Care Coordinator uses the beneficiary's activation score and level to determine the coaching methodology for each beneficiary to develop a teaching and support plan. Educational materials are customized and introduced according to the beneficiary's readiness for change and progress with a beneficiary's level of confidence and self-management abilities. The Health Home will provide wellness and prevention education specific to the beneficiary's chronic conditions and HAP. Health promotion and education includes assessment of need, facilitation of routine and preventive care, support for improving social connections to community networks, and linking beneficiaries with resources that support a health promoting lifestyle. Health promotion and education may also occur with parents, family members, caregivers, legal representatives, and other collaterals to support the beneficiary in achieving improved health outcomes.

6.5. Transitional Care

6.5.1. Comprehensive transitional care is provided to prevent beneficiary avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment, or residential habilitation setting) and to ensure proper and timely follow-up care.

6.5.2. Transitional care planning includes:

6.5.2.1. A notification system with managed care plans, hospitals, nursing facilities, and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient facility, skilled nursing or residential/rehabilitation facility,

and with proper, permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification. The HAP is updated as a part of transition planning.

6.5.2.2. Active participation of the Care Coordinator in appropriate phases of care transition including: discharge planning visits during hospitalizations or nursing facility stays, post discharge face-to-face visits, medication reconciliation and telephone calls.

6.5.2.3. Beneficiary education to support discharge care needs including: medication management, follow-up care, and self-management of chronic or acute conditions. Information on when to seek medical care and emergency care is also provided. Involvement of formal or informal caregivers is facilitated when requested by the beneficiary.

6.5.2.4. A systematic follow-up protocol to assure timely access to follow-up care post discharge.

6.6. Individual and family support

6.6.1. The Care Coordinator recognizes the unique role the beneficiary may give family members, identified decision makers, and caregivers in assisting the beneficiary to access and navigate the health care and social service delivery system as well as support health action planning.

6.6.2. The Care Coordinator will:

6.6.3. identify the role that parents, family members, informal supports, and paid caregivers provide to the beneficiary to achieve self-management and optimal levels of physical and cognitive function;

6.6.4. educate and support self-management, self-help, and recovery by accessing other resources necessary for the beneficiary, their family, and their caregivers;

6.6.5. discuss advance care planning with beneficiaries and their families within the first year of participation;

6.6.6. communicate and share information with beneficiaries, their families, and their caregivers with appropriate consideration of language, activation level, literacy, and cultural preferences.

6.7. Referral to community and social support services

6.7.1. The Care Coordinator identifies available community-based resources and actively manages referrals. They assist the beneficiary in advocating for access to care and promote engagement with community and social supports related to goal achievement documented in the HAP. When needed and not provided through other case management systems, the Care Coordinator provides assistance to obtain and maintain eligibility for health care services, Medicaid, disability benefits, housing, personal needs, and legal services. These services are coordinated with appropriate departments of local, state, and federal governments, and community-based organizations. Referral to community and social support services includes LTSS, mental health, substance use disorder, and other community and social service support providers needed to support the beneficiary in achieving health action goals.

7. Compensation and Payment

7.1. Payments to the contracted lead organizations are made in three Rate Tiers as follows:

7.1.1. Tier 1: Outreach, Engagement, and HAP Development includes:

7.1.1.1. Outreach by mail; phone; or other methods, continues until the eligible Beneficiary agrees to participate or declines participation in the Health Home program. Lead must document all attempts to contact Beneficiary.

7.1.1.2. Engagement occurs when the Beneficiary agrees to a face-to-face visit between the Beneficiary and the Health Home Care Coordinator in a location of the Beneficiary's choosing, such as their home or provider's office.

7.1.1.3. HAP Development includes face-to-face visits to complete the initial HAP, the Health Home Participation Authorization and Information Sharing Consent form, and coaching to assist the Beneficiary in identifying short and long-term goals and associated action steps.

7.1.1.4. The MA Health Plan will pay $870.38 for Outreach, Engagement, and HAP Development once in a lifetime per Beneficiary.

7.1.2. Tier 2: Intensive Health Home Care Coordination: This is the highest level of Health Home Care Coordination services using one (1) or more elements of the six defined Health Home Services.

7.1.3. Intensive Health Home Care Coordination includes evidence that the Care Coordinator, the Beneficiary and the Beneficiary's caregivers are:

7.1.3.1. Actively engaged in achieving health action goals,

7.1.3.2. Participating in activities that support improved health and well-being; and

7.1.3.3. Have value for the Beneficiary and caregivers, supporting an active level of care coordination through delivery of the Health Home Services.

7.1.4. Typically intensive Health Home Care Coordination includes a face-to face visit with the Beneficiary every month in which a Qualified Health Home Service is provided. Exceptions to the monthly face-to-face visit may be approved by the MA Health Plan as long the Health Home Services provided during the month achieve one or more of the following:

7.1.4.1. Clinical, functional, and resource use screens, including screens for depression, alcohol or substance use disorder, functional impairment, and pain appropriate to the age and risk profile of the individual;

7.1.4.2. Continuity and coordination of care through in-person visits, and the ability to accompany Beneficiaries to health care provider appointments, as needed; 4.4.5.4.3 Beneficiary assessments to determine readiness for self-management and to promote self-management skills to improve functional or health status, or prevent or slow declines in functioning;

7.1.4.3. Fostering communication between the providers of care, including the treating primary care provider, medical specialists, personal care providers and others; and entities authorizing behavioral health and long-term services and supports;

7.1.4.4. Promoting optimal clinical outcomes, including a description of how progress

toward outcomes will be measured through the HAP;

7.1.4.5. Health education and coaching designed to assist beneficiaries to increase self-management skills and improve health outcomes;

7.1.4.6. Use of peer supports, support groups and self-care programs to increase the Beneficiary's knowledge about their health care conditions and improve adherence to prescribed treatment; and

7.1.4.7. The MA Health Plan will pay $244.60 per Beneficiary per month for intensive Health Home Care Coordination.

7.1.5. Tier 3: Low-Level Health Home Care Coordination: Low-level Health Home Care Coordination occurs when the Beneficiary and Health Home Care Coordinator identify that the Beneficiary has achieved a sustainable level of progress toward meeting self-directed goals, or upon the Beneficiary's request.

7.1.5.1. Low-Level Health Home Care Coordination includes monitoring the Beneficiary's health care needs and progress toward meeting self-directed goals using one (1) or more of the six defined Health Home Services.

7.1.5.2. At least one (1) Qualified Health Home Service must be delivered during the month through face-to-face visits or telephone calls prior to submitting a claim for low-level Health Home Care Coordination.

7.1.5.3. The MA Health Plan will pay $200.94 per Beneficiary per month for Low-level Health Home Care Coordination.

7.1.6. Payment to Subcontracted Care Coordination Organizations (CCOs): The Lead may retain up to a maximum of 8.5% from each rate tier listed above for administrative costs.

Attachment 1

Data Security Requirements

1. Definitions

In addition to the definitions set out in section 1, *Definitions*, of the SMAC, the definitions below apply to this Attachment.

a. "Hardened Password" means a string of characters containing at least three of the following character classes: upper case letters; lower case letters; numerals; and special characters, such as an asterisk, ampersand or exclamation point.

   i. Passwords for external authentication must be a minimum of 10 characters long.

   ii. Passwords for internal authentication must be a minimum of 8 characters long.

   iii. Passwords used for system service or service accounts must be a minimum of 20 characters long.

b. "Portable/Removable Media" means any data storage device that can be detached or removed from a computer and transported, including but not limited to: optical media (e.g. CDs, DVDs); USB drives; or flash media (e.g. CompactFlash, SD, MMC).

c. "Portable/Removable Devices" means any small computing device that can be transported, including but not limited to: handhelds/PDAs/Smartphones; Ultramobile PCs, flash memory devices (e.g. USB flash drives, personal media players); and laptop/notebook/tablet computers. If used to store Confidential Information, devices should be Federal Information Processing Standards (FIPS) Level 2 compliant (FIPS 140-2).

d. "Secured Area" means an area to which only Authorized Users 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.

e. "Transmitting" means the transferring of data electronically, such as via email, SFTP, webservices, AWS Snowball, etc.

f. "Trusted System(s)" means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2) United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail, or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

g. "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.

2. Data Transmission

a. When transmitting HCA's Confidential Information electronically, including via email, the Data must be encrypted using NIST 800-series approved algorithms (http://csrc.nist.gov/publications/PubsSPs.html). This includes transmission over the public internet.

b. When transmitting HCA's Confidential Information via paper documents, the Receiving Party must use a Trusted System.

3. Protection of Data

The Receiving Party agrees to store and protect Confidential Information as described:

a. Data at Rest:

i. Data will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data. Access to the Data will be restricted to Authorized Users through the use of access control lists, a Unique User ID, and a Hardened Password, or other authentication mechanisms which provide equal or greater security, such as biometrics or smart cards. Systems which contain or provide access to Confidential Information must be located in an area that is accessible only to authorized personnel, with access controlled through use of a key, card key, combination lock, or comparable mechanism.

ii. Data stored on Portable/Removable Media or Devices:

A. Confidential Information provided by HCA on Removable Media will be encrypted with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the Data.

B. HCA's data must not be stored by the Receiving Party on Portable Devices or Media unless specifically authorized within the SMAC. If so authorized, the Receiving Party must protect the Data by:

1. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;
2. Control access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;
3. Keeping devices in locked storage when not in use;
4. Using check-in/check-out procedures when devices are shared;
5. Maintain an inventory of devices; and
6. Ensure that when being transported outside of a Secured Area, all devices with Data are under the physical control of an Authorized User.

b. **Paper documents.** Any paper records containing Confidential Information must be protected by storing the records in a Secured Area that is accessible only to authorized personnel. When not in use, such records must be stored in a locked container, such as a file cabinet, locking drawer, or safe, to which only authorized persons have access.

4. Data Segregation

HCA's Data received under this SMAC must be segregated or otherwise distinguishable from non-HCA Data. This is to ensure that when no longer needed by the Receiving Party, all of HCA's Data can be identified for return or destruction. It also aids in determining whether HCA's Data has or may have been compromised in the event of a security breach.

a. HCA's Data must be kept in one of the following ways:

i. on media (e.g., hard disk, optical disc, tape, etc.) which will contain only HCA Data; or

ii. in a logical container on electronic media, such as a partition or folder dedicated to HCA's Data; or

iii. in a database that will contain only HCA Data; or

iv. within a database and will be distinguishable from non-HCA Data by the value of a specific field or fields within database records; or

v. when stored as physical paper documents, physically segregated from non-HCA Data in a drawer, folder, or other container.

b. When it is not feasible or practical to segregate HCA's Data from non-HCA data, then both HCA's Data and the non-HCA data with which it is commingled must be protected as described in this Attachment.

5. Data Disposition

When the Confidential Information is no longer needed, except as noted below, the Data must be returned to HCA or destroyed. Media are to be destroyed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

a. For HCA's Confidential Information stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 3, above. Destruction of the Data as outlined in this section of this Attachment may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

SCHEDULE 1: MEDICARE PART D – CONFLICT OF INTEREST ATTESTATION

[Date]

Beverly Court
Department of Social and Health Services
Research and Data Analysis Division
1114 Washington Street SE
PO Box 45204
Olympia, WA 98504-5204

Dear Beverly Court,

As a contractor of Washington's Medicaid agency, [Lead Entity Name] intends to receive Centers for Medicare & Medicaid Services (CMS) data from Washington State for coordination of care, quality improvement and/or treatment of persons enrolled in both Medicare and Medicaid. We will also be subcontracting with entities who will also access CMS data for care coordination, quality improvement and/or treatment purposes.

We understand that CMS wants assurance that potential conflict of interest related to also operating or affiliation with Part D plans is mitigated when necessary through separation and security of CMS data used for clinical treatment, case management and care coordination, and quality improvement activities.

The contact person for conflict of interest matters within our organization is [Contact's First and Last Name] who can be reached by email at [email address] or by phone at [phone number].

The following organizations are covered in this attestation that no conflict of interest exists:

[Name of Contractor/Subcontractor with no conflict of interest]
[Name of Subcontractor with no conflict of interest]

The following organizations are covered in this attestation that conflict of interest potentially does exist, and steps to mitigate said conflict of interest, including separation and security of any CMS data acquired through its work with Washington State to isolate CMS data from unrelated activities in their organization, have been taken:

[Name of Contractor/Subcontractor with potential conflict of interest]
[Name of Subcontractor with potential conflict of interest]

Sincerely,
[Signature of person who can legally bind your Organization to the statements above, such as legal staff or organization officer]
[Title]

PRISM Access Request for Multiple Organizations

An Organization may request access to PRISM for its employees or employees of Subcontractors (**Users)** under its Data Share Agreement (DSA) with HCA. The Organization **PRISM Lead** reviews and completes the "Requesting Organization" section. The PRISM Access Request form must be signed by the **PRISM Lead** authorizing the request, which attests to the **Users**' business need for electronic Protected Health Information, and in the case of a Subcontractor User, attests that the contract with the Subcontractor includes a HIPAA Business Associate Agreement and Medicare data share language, as appropriate. The **User** completes the "User Registration Information" section below and signs the "User Agreement and Non-Disclosure of Confidential Information" page. The **PRISM Lead** then forwards the request to: PRISM.Admin@dshs.wa.gov.

Upon review and acceptance, DSHS and HCA will grant the appropriate access permissions to the User and notify the **PRISM Lead**.

Changes to Access for Users

The **PRISM Lead** must notify the **PRISM Administrator** within five (5) business days whenever a **User** with access rights leaves employment or has a change of duties such that the User no longer requires access. If the removal of access is emergent, please include that information with the request.

Requesting Organizations (to be completed by PRISM Lead)	
CONTRACTOR'S NAME	STREET ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)
1.	
2.	
3.	

User Registration Information (to be completed by User)		
USER'S NAME (FIRST, MIDDLE, LAST)		USER'S JOB TITLE
USER'S BUSINESS EMAIL ADDRESS		USER'S BUSINESS PHONE NUMBER (INCLUDE AREA CODE)
USER'S EMPLOYER		DATE IT SECURITY TRAINING COMPLETED (REQUIRED YEARLY)
If user will be completing Health Action Plans (HAPs), enter the date training was completed:	DATE HAP TRAINING COMPLETED	DATE HIPAA TRAINING COMPLETED (REQUIRED)
PRISM USER'S SIGNATURE DATE		PRISM USER'S PRINTED NAME

Authorizing Signature(s)

Protected Data Access Authorization

The HIPAA Security rule states that every employee that needs access to electronic Protected Health Information (ePHI) receives authorization from an appropriate authority and that the need for this access based on job function or responsibility is documented. I, the undersigned **PRISM Lead**, verify that the individual for whom this access is being requested (User or Subcontractor User) has a business need to access this data, has completed the required HIPAA Privacy training and the annual IT Security training and has signed the required *User Agreement and Non-Disclosure of Confidential Information* included with this Access Request. This User's access to this electronic Protected Health Information (ePHI) is appropriate under the HIPAA Information Access Management Standard and the Privacy Rule. In addition, if applicable, this employee has been instructed on 42 Code of Federal Regulations (CFR) Part 2 that governs the use of alcohol and drug use information and is aware that this type of data must be used only in accordance with these regulations. I have also ensured that the necessary steps have been taken to validate the User's identity before approving access to confidential and protected information. If a Subcontractor is indicated, I attest that the contract with the Subcontractor includes a HIPAA Business Associate Agreement, and where appropriate Medicare data share language.

PRISM LEAD SIGNATURE (CONTRACTOR 1)	DATE	PRISM LEAD NAME 1 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 2)	DATE	PRISM LEAD NAME 2 (PRINT)
PRISM LEAD SIGNATURE (CONTRACTOR 3)	DATE	PRISM LEAD NAME 3 (PRINT)

User Agreement and Non-Disclosure of Confidential Information

Your Organization has entered into a Data Share Agreement (DSA) with the state of Washington Health Care Authority (HCA) that will allow you to access data and records that are deemed Confidential Information as defined below. Prior to accessing this Confidential Information you must sign this **User Agreement and Non-Disclosure of Confidential Information** form.

Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state laws. Confidential Information includes, but is not limited to, Protected Health Information and Personal Information.

"Protected Health Information" means information that relates to: the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or the past, present or future payment for provision of health care to an individual and includes demographic information that identifies the individual or can be used to identify the individual.

"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, credit card numbers, any other identifying numbers, and any financial identifiers.

Regulatory Requirements and Penalties

State laws (including, but not limited to, RCW 74.04.060, RCW 74.34.095, RCW 70.02.020 and RC2.70.02.230) and federal regulations (including, but not limited to, HIPAA Privacy and Security Rules, 45 CFR Part 160 and Part 164; Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2; and Safeguarding Information on Applicants and Beneficiaries, 42 CFR Part 431, Subpart F) prohibit unauthorized access, use, or disclosure of Confidential Information. Violation of these laws may result in criminal or civil penalties or fines.

User Agreement and Assurance of Confidentiality

In consideration for DSHS and HCA granting me access to PRISM or other systems and the Confidential Information in those systems, I agree that I:

1) Will access, use, and disclose Confidential Information only in accordance with the terms of this Agreement and consistent with applicable statutes, regulations, and policies.
2) Have an authorized business requirement to access and use DSHS or HCA systems and view DSHS or HCA Confidential Information.
3) Will not use or disclose any Confidential Information gained by reason of this Agreement for any commercial, personal, or research purpose, or any other purpose that is not directly connected with client care coordination and quality improvement.
4) Will not use my access to look up or view information about family members, friends, the relatives or friends of other employees, or any persons who are not directly related to my assigned job duties.
5) Will not discuss Confidential Information in public spaces in a manner in which unauthorized individuals could overhear and will not discuss Confidential Information with unauthorized individuals, including spouses, domestic partners, family members, or friends.
6) Will protect all Confidential Information against unauthorized use, access, disclosure, or loss by employing reasonable security measures, including physically securing any computers, documents, or other media containing Confidential Information and viewing Confidential Information only on secure workstations in non-public areas.
7) Will not make copies of Confidential Information, or print system screens unless necessary to perform my assigned job duties and will not transfer any Confidential Information to a portable electronic device or medium, or remove Confidential Information on a portable device or medium from facility premises, unless the information is encrypted and I have obtained prior permission from my supervisor.
8) Will access, use or disclose only the "minimum necessary" Confidential Information required to perform my assigned job duties.
9) Will protect my DSHS and HCA systems User ID and password and not share them with anyone or allow others to use any DSHS or HCA system logged in as me.
10) Will not distribute, transfer, or otherwise share any DSHS software with anyone.
11) Will forward any requests that I may receive to disclose Confidential Information to my supervisor for resolution and will immediately inform my supervisor of any actual or potential security breaches involving Confidential Information, or of any access to or use of Confidential Information by unauthorized users.
12) Understand at any time, DSHS or HCA may audit, investigate, monitor, access, and disclose information about my use of the systems and that my intentional or unintentional violation of the terms of this Agreement may result in revocation of privileges to access the systems, disciplinary actions against me, or possible civil or criminal penalties or fines.
13) Understand that my assurance of confidentiality and these requirements will continue and do not cease at the time I terminate my relationship with my employer.

User's Signature

PRISM USER'S SIGNATURE	DATE	PRISM USER'S PRINTED NAME