Washington State Health Care Authority	**Washington Apple Health Expansion Care Contract**	HCA Contract Number: «Contract»

THIS CONTRACT is made by and between the Washington State Health Care Authority ("HCA") and the party whose name appears below ("Contractor").

CONTRACTOR NAME «Organization_Name»		CONTRACTOR doing business as (DBA)
CONTRACTOR ADDRESS «City», «State» «Zip_Code»	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) UBI»	HCA INDEX NUMBER
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»	CONTRACTOR TELEPHONE «PhoneNo»	CONTRACTOR E-MAIL ADDRESS «EmailAddress»

HCA PROGRAM Medicaid Contracts Unit	HCA DIVISION/SECTION Medicaid Programs Division/Apple Health Expansion
HCA CONTACT NAME AND TITLE Angela Castro AHE Contract Manager	HCA CONTACT ADDRESS PO Box 45530 Olympia, WA 98504-5502
HCA CONTACT TELEPHONE 360-725-9703	HCA CONTACT E-MAIL ADDRESS angela.castro@hca.wa.gov
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S) ; ; ;
CONTRACT START DATE July 1, 2024	**CONTRACT END DATE** December 31, 2025

PRIOR MAXIMUM CONTRACT AMOUNT N/A	**AMOUNT OF INCREASE OR DECREASE** N/A	**TOTAL MAXIMUM CONTRACT AMOUNT** Per Member Per Month

PURPOSE OF CONTRACT: Healthcare services to Apple Health Expansion Enrollees.

ATTACHMENTS/EXHIBITS. When the box below is marked with an X, the following Exhibits/Attachments are attached and are incorporated into this Contract by reference:

☒ Exhibit(s) (specify): Exhibit A, State-Only AHEMC; Exhibit B, Instructions for Medical Loss Ratio (MLR) Reporting; Exhibit C, Data Use, Security and Confidentiality; Exhibit D, AHE Regional Service Areas; Exhibit E, Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs); Exhibit F, Scope of Benefits; Exhibit G, Non-Contracted Drugs; Exhibit H, ASO Non-Contracted Drugs; and Exhibit I, Behavioral Health vs Physical Health Capitation Rate Components.

☒ Attachment(s) (specify): Attachment 1, Performance Measures

The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties, superseding and merging all previous agreements, writings, and communications, oral or otherwise, regarding the subject matter of this Contract. The parties signing below warrant that they have read and understand this Contract, and have authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
HCA SIGNATURE	**PRINTED NAME AND TITLE**	**DATE SIGNED**

TABLE OF CONTENTS

Exhibits

Attachments

1 DEFINITIONS

The words and phrases in this section shall have the following meanings for purposes of this Contract. In addition, in any Subcontracts and in any other documents that relate to this Contract, the Contractor shall use the following definitions and any other definitions that appear in this Contract.

1.1 Abuse

"Abuse" when used in the context of program integrity, means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the AHE program.

1.2 Access

"Access" when used in the context of external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by the Contractor's successful demonstration and reporting on outcome information for the availability and timeliness elements defined in the Network Adequacy Standards and Availability of Services described in this Contract.

1.3 Accountable Community of Health (ACH)

"Accountable Community of Health (ACH)" means a regionally governed, public-private collaborative that is tailored by the region to achieve healthy communities. ACHs coordinate systems that influence health, including: public health, health care providers and systems that influence social determinants of health.

1.4 Acute Withdrawal Management

"Acute Withdrawal Management" means services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Acute withdrawal management provides medical care and physician supervision for withdrawal from substances.

1.5 Administrative Day

"Administrative Day" means one or more days of a hospital stay in which an acute inpatient or observation level of care is not medically necessary, and a lower level of care is appropriate.

1.6 Administrative Hearing

"Administrative Hearing" means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by chapter 34.05 RCW, and the agency's hearings rules found in chapter 182-526 WAC, or other law.

1.7 Advance Directive

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the state of Washington, relating to the provision of health care when an individual is incapacitated.

1.8 Adverse Benefit Determination

"Adverse Benefit Determination" means any of the following:

1.8.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service; requirements for medical

necessity, appropriateness, setting, or effectiveness of a covered benefit;

1.8.2 The reduction, suspension, or termination of a previously authorized service;

1.8.3 The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service, except when the denial of payment is solely because the claim does not meet the definition of a "clean claim".

1.8.4 The denial of request for "good cause" designation that would preclude usual third-party liability procedures;

1.8.5 The failure to provide services or act in a timely manner as required herein, including failure to issue an authorization or denial within required timeframes;

1.8.6 The failure of the Contractor to act within the timeframes for resolution and notification of appeals and grievances;

1.8.7 The denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities; and

1.8.8 For a rural area resident with only one Apple Health Expansion Health Plans (AHEHPs) available, the denial of an Enrollee's request to obtain services outside the Contractor's network; or, for a plan's denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the Enrollee seeks, when receiving all care in-network would subject the Enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

1.9 **Affiliate Pharmacy**

"Affiliate Pharmacy" means a pharmacy in which the Contractor, PBM or Subcontractors have an ownership interest.

1.10 **Allegation of Fraud**

"Allegation of Fraud" means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the individual, entity or provider.

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

1.10.1 Fraud hotline complaints;

1.10.2 Claims data mining;

1.10.3 Referral of potential fraud received from the Contractor; and

1.10.4 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

1.11 **American Society of Addiction Medicine (ASAM)**

"American Society of Addiction Medicine (ASAM)" means a professional society dedicated to increasing access and improving the quality of addiction treatment.

1.12 **American Society of Addiction Medicine (ASAM) Criteria**

"American Society of Addiction Medicine (ASAM)" are a comprehensive set of guidelines for determining placement, continued stay and transfer or discharge of Enrollees with SUD and co-occurring disorders.

1.13 Ancillary Services

"Ancillary Services" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy.

1.14 Appeal

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

1.15 Appeal Process

"Appeal Process" means the Contractor's procedures for reviewing an Adverse Benefit Determination.

1.16 Apple Health Expansion Health Plan (AHEHP)

"Apple Health Expansion Health Plan (AHEHP)" means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA Enrollees under HCA Managed Care programs.

1.17 Automatic Refill

"Automatic Refill" means any prescription refill the pharmacy initiates without the Enrollee requesting the prescription to be filled at that time.

1.18 Auxiliary Aids and Services

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

1.18.1 Qualified interpreters onsite or through video remote interpreting (VRI), note takers, real-time computer-aided transcription services, written materials, telephone handset amplifiers, assistive listening devices, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, telecommunications devices for deaf persons, videotext displays, or other effective methods of making aurally delivered materials available to individuals with hearing impairments;

1.18.2 Qualified readers, taped texts, audio recordings, Brailled materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments;

1.18.3 Acquisition or modification of equipment or devices; and

1.18.4 Other similar services and actions.

1.19 Behavioral Health

"Behavioral Health" means mental health and/or Substance Use Disorders and/or conditions and related benefits.

1.20 Behavioral Health Agency

"Behavioral Health Agency" means an entity licensed by the Department of Health (DOH) and identified on DOH's Behavioral Health Agencies Directory, to provide Behavioral Health services, including mental health disorders and Substance Use Disorders. HCA

relies on the current DOH Behavioral Health Agencies Directory to identify BHA providers.

1.21 **Behavioral Health Administrative Services Organization (BH-ASO)**

"Behavioral Health Administrative Services Organization (BH-ASO)" means an entity selected by HCA to administer behavioral health services and programs, including Crisis Services and in-home stabilization for individuals in a defined Regional Service Area. The BH-ASO administers Crisis Services for all individuals in its defined service area, regardless of ability to pay, including Medicaid eligible members.

1.22 **Behavioral Health Care Coordination and Community Integration**

"Behavioral Health Care Coordination and Community Integration" means a range of activities furnished to engage Enrollees in treatment and assist them in transitioning from a variety of inpatient, residential, or non-permanent settings back into the broader community. To be eligible, the Enrollee must need transition support services in order to ensure timely and appropriate Behavioral Health treatment and Care Coordination.

1.23 **Behavioral Health Data Systems (BHDS)**

"Behavioral Health Data System (BHDS)" means the data that retains non-encounter data submissions called Behavioral Health Supplemental Transactions (BHST).

1.24 **Behavioral Health Supplemental Transaction (BHST)**

"Behavioral Health Supplemental Transaction (BHST)" means non-encounter data submissions to the BHDS as outlined in the Behavioral Health Supplemental Transaction Data Guide. These transactions include supplemental data, including additional demographic and social determinant data, as well as service episode and outcome data necessary for federal Substance Abuse and Mental Services Administration (SAMHSA) block grant reporting and other state reporting needs.

1.25 **Blind**

"Blind" means being unable to see due to injury, disease, or genetic conditions.

1.26 **Breach**

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

1.27 **Business Associate Agreement**

"Business Associate Agreement" means an agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), between a HIPAA covered entity and a HIPAA business associate. The agreement protects Protected Health Information (PHI) in accordance with HIPAA guidelines.

1.28 **Business Day**

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

1.29 **Care Coordination**

"Care Coordination" means an Enrollee's healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Enrollee and the Enrollee's caregivers, and works with the Enrollee to ensure that the

Enrollee receives the most appropriate treatment, while ensuring that health care is not duplicated.

1.30 **Care Coordinator (CC)**

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

1.30.1 A Registered Nurse, Social Worker, Mental Health Professional or Substance Use Disorder Professional (SUDP) employed by the Contractor or primary care provider or Behavioral Health agency; and/or

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

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

1.31 **Care Management**

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

1.31.1 Actively assisting Enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

1.31.2 Utilization of evidence-based practices in screening and intervention;

1.31.3 Coordination of care across the continuum of medical, behavioral health, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;

1.31.4 Ready access to integrated behavioral and physical health services; and

1.31.5 Use of appropriate community resources to support individual Enrollees, families and caregivers in managing care.

1.32 **Care Manager (CM)**

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

1.33 Centers for Medicare and Medicaid Services (CMS)

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

1.34 Certified Electronic Health Record

"Certified Electronic Health Record" means an EHR certified under the Office of the National Coordinator's (ONC's) Health IT Certification Program. ONC updates the certification criteria approximately every two years. Products certified as meeting the ONC certification criteria and the edition to which they have been certified are listed on the Certified Health IT Products List (CHPL): https://www.healthit.gov/topic/certified-health-it-products-list-chpl

1.35 Certified Electronic Health Record Technology (CEHRT)

"Certified Electronic Health Record Technology (CEHRT)" means systems that meet the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services and are certified by the Office of the National Coordinator for Health Information Technology (ONC) as meeting health IT standards, implementation specifications and certification criteria adopted by the Secretary. The Electronic Health Record (EHR) Certification Program is a voluntary program established by the ONC to provide for the certification of health IT standards, implementation specifications and certification criteria adopted by the Secretary.

1.36 Certified Peer Counselor (CPC)

"Certified Peer Counselor (CPC)" means individuals who: have self-identified as a consumer of behavioral health services; have received specialized training provided/contracted by HCA, Division of Behavioral Health and Recovery (DBHR); have passed a written/oral test, which includes both written and oral components of the training; have passed a Washington State background check; have been certified by DBHR; and are a registered Agency Affiliated Counselor with the Department of Health (DOH).

1.37 Choice Counseling

"Choice Counseling" means the provision of information and services designed to assist beneficiaries in making enrollment decisions; it includes answering questions and identifying factors to consider when choosing among managed care plans and primary care providers. Choice Counseling does not include making recommendations for or against enrollment into a specific MCO.

1.38 Chronic Condition

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

1.39 Chronic Disease Self-Management Education (CDSME)

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

1.40 Clinical Data Repository (CDR)

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

1.41 Co-responder

"Co-responder" means teams consisting of law enforcement officer(s) and behavioral health professional(s) to engage with individuals experiencing behavioral health crises that does not rise to the level of need for incarceration.

1.42 Code of Federal Regulations (C.F.R.)

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

1.43 Cold Call Marketing

"Cold Call Marketing" means any unsolicited personal contact by the Contractor or its designee, with a potential Enrollee or a current Enrollee of another contracted Managed Care organization for the purposes of marketing (42 C.F.R. § 438.104(a)).

1.44 Community Behavioral Health Advisory (CBHA) Board

"Community Behavioral Health Advisory (CBHA) Board" means an advisory board representative of the demographic characteristics of the Regional Service Area (RSA).

1.45 Community Health Workers (CHW)

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

1.46 Community Mental Health Agency (CMHA)

"Community Mental Health Agency (CMHA)" is now referred to as Behavioral Health Agency.

1.47 Complex Case Management (CCM)

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

1.48 Comprehensive Assessment Report and Evaluation (CARE)

"Comprehensive Assessment Report and Evaluation (CARE)" means a person centered, automated assessment tool used for determining Medicaid functional eligibility, level of care for budget and comprehensive care planning, as defined in chapter 388-106 WAC.

1.49 Concurrent Review

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

1.50 Confidential Information

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under chapter 42.56 RCW, 42 C.F.R. Part 2, or other federal or state law. Confidential Information includes, but is not limited to, Personal Information, medical records, and any other health and enrollment information that identifies a particular Enrollee.

1.51 Continuity of Care

"Continuity of Care" means the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the Enrollee transitions between: facility to home; facility to facility; providers or service areas; Managed Care Contractors; and Medicaid fee for-service (FFS) and Managed Care arrangements. Continuity of Care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include but are not limited to: from acute care settings, such as inpatient physical health or behavioral Health Care Settings or emergency departments, to home or other Health Care Settings such as outpatient settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice to another; and from substance use care to primary and/or mental health care.

1.52 Continuity of Care Document (CCD)

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

1.53 Contract

"Contract" means the entire written agreement between HCA and the Contractor, including any Exhibits, documents, and materials incorporated by reference. The parties

may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitute as one agreement. E-mail (electronic mail) transmission of a signed copy of this Contract shall be the same as delivery of an original.

1.54 **Contract Year**

"Contract Year" means a twelve (12) month period of January 1 through December 31.

1.55 **Contractor**

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

1.56 **Contracted Services**

"Contracted Services" means Covered Services that are to be provided by the Contractor under the terms of this Contract.

1.57 **Copayment**

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

1.58 **Covered Services**

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

1.59 **Crisis Services**

"Crisis Services" also referred to as "Crisis Intervention Services" means screening, evaluation, assessment, and clinical interventions provided to Apple Health Expansion enrolled persons experiencing a Behavioral Health crisis. A Behavioral Health crisis is defined as a significant change in behavior in which instability increases and/or risk of harm to self or others increases. The reasons for this change could be external or internal to the person. If the crisis is not addressed in a timely manner, it could lead to significant negative outcomes or harm to the person or others. Crisis Services are available on a 24-hour basis, 365 days a year. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration, and provide immediate treatment and intervention, de-escalation, and coordination/referral efforts with health, social, and other services and supports as needed to affect symptom reduction, harm reduction, and/or to safely transition Persons in acute crisis to the appropriate environment for continued stabilization. Crisis intervention should take place in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation.

1.60 **Critical Access Pharmacy**

"Critical Access Pharmacy" means a pharmacy in Washington State that is further than a 25-mile radius from any other pharmacy, is the only pharmacy on an island, or provides critical services to vulnerable populations, as identified by HCA. If a pharmacy is in a rural area or serves vulnerable populations, as defined by HCA, and the 25-mile radius intersects with another pharmacy both are Critical Access Pharmacies.

1.61 **Critical Provider**

"Critical Providers" means the health care provider types without which an AHEHP cannot provide a viable program. For the purposes of this Contract, Critical Providers are:

Hospitals, Primary Care Providers, Mental Health Providers, outpatient Behavioral Health Agencies, and Pharmacy and Obstetrical providers.

1.62 **Cultural Humility**

"Cultural Humility" means the continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership-building, with an awareness of the limited ability to understand the patient's worldview, culture(s), and communities.

1.63 **Culturally and Linguistically Appropriate Services (CLAS)**

"Culturally and Linguistically Appropriate Services (CLAS)" means services that are respectful of and responsive to individual cultural health beliefs, practices, preferred languages, health literacy levels and communication needs.

1.64 **Culturally Appropriate Care**

"Culturally Appropriate Care" means health care services provided with Cultural Humility and an understanding of the patient's culture and community, and informed by Historical Trauma and the resulting cycle of ACEs.

1.65 **Deaf**

"Deaf" means having total or partial hearing loss.

1.66 **DeafBlind**

"DeafBlind" means an individual has combined hearing and vision loss, thus limiting access to both auditory and visual information.

1.67 **Debarment**

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

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

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

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

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

1.68.3 Behavioral Health Administration (BHA) is responsible for providing mental health services in state psychiatric hospitals.

1.69 **Designated Crisis Responder (DCR)**

"Designated Crisis Responder (DCR)" means a mental health professional appointed by the county or other authority authorized in rule, to perform the civil commitment duties described in chapters 71.05 and 71.34 RCW.

1.70 **Division of Behavioral Health and Recovery (DBHR)**

"Division of Behavioral Health and Recovery (DBHR)" means HCA-designated state behavioral health authority to administer state only, federal block grant, and Medicaid funded behavioral health programs.

1.71 Director

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

1.72 Duplicate Coverage

"Duplicate Coverage" means an Enrollee covered by the Contractor on a third party basis at the same time the Enrollee is covered by the Contractor under this Contract.

1.73 Durable Medical Equipment (DME)

"Durable Medical Equipment (DME)" means Medical Equipment as defined in the definition of Medical Equipment in this Section.

1.74 Electronic Health Record (EHR)

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

1.75 Electronic Prior Authorization Request

"Electronic Prior Authorization Request" means a Prior Authorization request that is delivered from the Provider to the Contractor or Contractor's Subcontractor via an internet webpage, internet webpage portal, or similar system.

1.76 Electronic Visit Verification (EVV)

"Electronic Visit Verification (EVV)" means the requirements under chapter 182-551 WAC, Subchapter II, under which in home visits conducted as part of delivery of Home Health Care services must be electronically verified with respect to: the type of service performed; the individual receiving the service; the date of the service; the location of the service delivery; the individual providing the service; and the time the service begins and ends.

1.77 Emergency Care for Behavioral Health Condition

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

1.78 Emergency Department Information Exchange™ (EDIE)

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

1.79 Emergency Fill

"Emergency Fill" means the dispensing of a prescribed medication to an Enrollee by a licensed pharmacist who has used his or her professional judgment in identifying that the Enrollee has an Emergency Medical Condition for which lack of immediate access to pharmaceutical treatment would result in, (a) placing the health of the individual (b)

serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.80 **Emergency Medical Condition**

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.81 **Emergency Medical Transportation**

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

1.82 **Emergency Services**

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition.

1.83 **Encounter Data Reporting Guide**

"Encounter Data Reporting Guide" means the published guide to assist contracted entities in the standard electronic encounter data reporting process required by HCA.

1.84 **Encrypt**

"Encrypt" means to encipher or encode electronic data using software that generates a minimum key length of one hundred twenty eight (128) bits.

1.85 **Enrollee**

"Enrollee" means an individual who is enrolled in Managed Care through an AHEHP having a contract with HCA.

1.86 **Essential Behavioral Health Administrative Functions**

"Essential Behavioral Health Administrative Functions" means utilization management, Grievance and appeals, network development and management, provider relations, quality management, data management and reporting, and claims and financial management.

1.87 **Evaluation and Treatment Facility**

"Evaluation and Treatment Facility" means any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a behavioral health disorder, and which is licensed or certified as such by the department.

1.88 **Evidence-Based Practices**

"Evidence-Based Practices (EBPs)" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-based" also means a program or practice that can be implemented with a set of procedures to allow

successful replication in Washington and, when possible, is determined to be cost-beneficial per the (Washington State Institute for Public Policy (WSIPP).

1.89 **Exception to Rule (ETR)**

"Exception to Rule (ETR)" means a request by an Enrollee or a requesting provider to receive a non-covered health care service.

1.90 **Excluded Service**

"Excluded Service" means a benefit that is not covered by HCA nor the Contractor as it is not part of the Enrollee's benefit package due to state direction.

1.91 **External Entities (EE)**

"External Entities (EE)" means organizations that serve eligible Apple Health clients and include the Department of Social and Health Services, Department of Health, local health jurisdictions, community-based service providers and HCA services/programs as defined in this Contract.

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

"External Quality Review Organization (EQRO)" means an organization that performs external quality review, other EQR-related activities External Quality Review Report (EQRR).

1.93 **External Quality Review Report (EQRR)**

"External Quality Review Report (EQRR)" means a detailed technical report that describes the manner in which the data from all activities described in External Quality Review provisions of Subsection 7.6 were aggregated and analyzed and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor.

1.94 **Facility**

"Facility" means but is not limited to: a hospital, a behavioral health acute inpatient facility, an inpatient medical rehabilitation center, Long-Term and Acute Care (LTAC) center, skilled nursing facility, and nursing home. For the purposes of subsections 16.4 and 16.6, Facility does not include Evaluation and Treatment Facilities, Inpatient/Residential Substance Use Treatment Services, intensive inpatient residential services, and residential mental health services.

1.95 **Family Connect**

"Family Connect" means enrolling a family member into the same Apple Health Expansion Health Plan that other family members are enrolled in.

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

"Federally Qualified Health Center (FQHC)" means a community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.

1.97 **Fee-for-Service**

"Fee-for-Service Program" means the state program which pays for services furnished to patients not enrolled in a managed care plan, in accordance with the fee-for-service methodology.

1.98 **Foundation for Health Care Quality**

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

1.99 **Fraud**

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

1.100 **Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)**

"Global Appraisal of Individual Needs Shorter Screener (GAIN-SS)" means the integrated, comprehensive screening for behavioral health conditions.

1.101 **Grievance**

"Grievance" means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision.

1.102 **Grievance and Appeal System**

"Grievance and Appeal System" means the processes the Contractor implements to handle appeals of Adverse Benefit Determinations and Grievances, as well as the processes to collect and track information about them.

1.103 **Grievance Process**

"Grievance Process" means the procedure for addressing Enrollees' Grievances.

1.104 **Guideline**

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

1.105 **Hard of Hearing**

"Hard of Hearing" means hearing loss where there may be enough residual hearing that an auditory device, such as a hearing aid or frequency modulated (FM) system, provides adequate assistance to process speech.

1.106 **Health Care Authority (HCA)**

"Health Care Authority (HCA)" means the Washington State Health Care Authority, any division, section, office, unit or other entity of HCA, or any of the officers or other officials lawfully representing HCA.

1.107 **Health Care Plan (Plan)**

"Health Care Plan (Plan)" means the pairing of health care benefits and payment structure in a product with provider networks in a service area offered to Enrollees.

1.108 **Health Care Professional**

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

1.109 **Health Care Provider (HCP)**

"Health Care Provider (HCP)" for purposes of this Contract, means a Primary Care Provider, Mental Health Professional, or SUDP.

1.110 **Health Care Services**

"Health Care Services" means all Apple Health Expansion services provided by the AHEHP entity under contract with HCA in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

1.111 **Health Care Settings (HCS)**

"Health Care Settings (HCS)" for the purpose of this Contract, means health care clinics where primary care services are delivered, community mental health agencies, or certified SUD agencies.

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

"Healthcare Effectiveness Data and Information Set (HEDIS®)" means a set of standardized performance measures designed to ensure that health care purchasers and Enrollees have the information they need to reliably compare the performance of health care plans. HEDIS® also includes a standardized survey of Enrollees' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

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

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

1.114 **Health Equity**

"Health Equity" means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

1.115 **Health Disparities**

"Health Disparities" means preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

1.116 **Health Information Technology (HIT)**

"Health Information Technology" means the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making. Certified HIT (including certified EHR technology (CEHRT)) are systems that meet the technological capability, functionality, and security requirements adopted by the U.S. Department of Health and Human Services. Certification gives providers and patient's confidence that the Health IT products and systems they use are secure and can work with other systems to share information (interoperability). The Health IT Certification Program is a voluntary program established by the Office of the National Coordinator for Health IT (ONC) to provide for the certification of health IT standards, implementation specifications and certification criteria adopted by the Secretary. The ONC Health IT Certification Program supports the availability of certified health IT for its encouraged and required use under federal, state and private programs.

1.117 **Health Insurance**

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

1.118 **Health Technology Assessment (HTA)**

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

1.119 **Historical Trauma**

"Historical Trauma" means situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

1.120 **Home Health Care**

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

1.121 **Hospice Services**

"Hospice Services" means services associated with an Enrollee's terminal illness and related conditions.

1.122 **Hospitalization**

"Hospitalization" means an admission to a hospital for treatment.

1.123 **Hospital Outpatient Care**

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

1.124 **In Lieu of Service or Setting**

"In Lieu of Service or Setting (ILOS)" means a service or setting that is provided to an Enrollee as a substitute for a Covered Service An ILOS can be used as an immediate or longer-term substitute for a Covered Service or setting that is covered, or when the ILOS can be expected to reduce or prevent the future need to utilize the Covered Services.

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

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

1.126 **Indian Health Service (IHS)**

"Indian Health Service (IHS)" means the federal agency in the Department of Health and Human Services, including contracted Tribal health programs, entrusted with the responsibility to assist eligible AI/ANs with health care services.

1.127 **Individual Service Plan (ISP)**

"Individual Service Plan (ISP)" means a written agreement between the Enrollee and his or her healthcare team to help guide and manage the delivery of diagnostic and therapeutic services and the Enrollee's engagement in self-management of his or her health (may also be called treatment plan).

1.128 **Individuals with Intellectual or Developmental Disability (I/DD)**

"Individuals with Intellectual or Developmental Disability (I/DD)" means people with a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills. This disability originates before the age of 18.

1.129 **Individual with Special Health Care Needs**

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

1.129.1 Has a biologic, psychological, or cognitive basis;

1.129.2 The Enrollee is likely to continue to have the chronic disease or disabling healthcare condition for more than one (1) year; and

1.129.3 Produces one or more of the following conditions stemming from a disease:

1.129.3.1 Significant limitation in areas of physical, cognitive, or emotional functions; or

1.129.3.2 Dependency on medical or assistive devices to minimize limitations of function or activities.

1.130 **Inpatient/Residential Substance Use Treatment Services**

"Inpatient/Residential Substance Use Treatment Services" means rehabilitative services, including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Enrollees who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with an SUD. Techniques have a goal of assisting Enrollees in their recovery for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board.

Residential treatment services require additional program-specific certification by DOH and include:

1.130.1 Intensive inpatient services;

1.130.2 Recovery house treatment services;

1.130.3 Long-term residential treatment services; and

1.131 **Intake Evaluation, Assessment, and Screenings (Mental Health)**

"Intake Evaluation, Assessment, and Screenings (Mental Health)" means an evaluation of an Enrollee's Behavioral Health, along with their ability to function within a community, to establish the medical necessity for treatment, determine service needs, and formulate recommendations for treatment. Intake evaluations must be initiated prior to the provision of any other Behavioral Health services, except those specifically stated as being available prior to an intake. Services may begin before the completion of the intake once medical necessity is established.

1.132 **Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder)**

"Intake Evaluation, Assessment, and Screenings (Substance Use or Problem Gambling Disorder)" means a comprehensive evaluation of an Enrollee's behavioral health, along with their ability to function within a community, to determine current priority needs and formulate recommendations for treatment. The intake evaluation for substance use disorder includes a review of current intoxication and withdrawal potential, biomedical complications, emotional, behavioral, cognitive complications, readiness to change, relapse potential, and recovery environment. Intake evaluations for problem gambling disorders includes a biopsychosocial clinical assessment. Information from the intake is used to work with the Enrollee to develop an individualized service plan to address the identified issues. Intake evaluations must be initiated prior to the provision of any other substance use or problem gambling disorder services. Services may begin before the completion of the intake once medical necessity is established.

1.133 **Intensive Residential Treatment (IRT) Team**

"Intensive Residential Treatment (IRT) team" means a team-based model for delivering existing Medicaid State Plan services to Enrollees. These teams also provide some non-Medicaid treatment activities, which are funded through GFS. This delivery model focuses on Enrollees being discharged or diverted from state hospitals to an ALTSA-licensed adult family home or assisted living facility.

1.134 **Interpretation**

"Interpretation" means the facilitation of oral or sign language communication, either simultaneously or consecutively, between users of different languages. This process requires an ability to receive information in one language and transfer it to another.

1.135 **Interpreter Services (IS)**

"Interpreter Services (IS)" means the delivery of spoken or signed language communication by a professional interpreter to convey a message from the language of the original speaker or writer, into the language of the listener.

1.136 **Institute for Mental Disease (IMD)**

"Institute for Mental Disease (IMD)" means, per P.L. 100-360, an institution for mental diseases as a hospital, nursing Facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is

an IMD if its overall character is that of a Facility established and maintained primarily for the care and treatment of Individuals with mental diseases.

1.137 **Involuntary Treatment Act (ITA)**

"Involuntary Treatment Act (ITA)" allows Enrollees to be committed by court order to a facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of Enrollees with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to one hundred twenty (120) hours, but, if necessary, Individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days.

1.138 **Large Rural Geographic Area**

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

1.139 **Less Restrictive Alternative Treatment**

"Less Restrictive Alternative Treatment" means the minimum services that all individuals who are under a less restrictive order must be offered as per RCW 71.05.585.

1.140 **Limitation Extension (LE)**

"Limitation Extension (LE)" means a request by an Enrollee or the Enrollee's health care provider to extend a covered service with a limit.

1.141 **Limited English Proficient (LEP)**

"Limited English Proficient (LEP)" means Potential Enrollees and Enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English.

1.142 **List of Excluded Individuals/Entities (LEIE)**

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

1.143 **Local IHCP Provider**

"Local IHCP Provider" means an IHCP Provider with a Facility in the Contractor's Regional Service Area or with a client residing in the Contractor's Regional Service Area.

1.144 **Managed Care**

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

1.145 **Marketing**

"Marketing" means any promotional activity or communication with a potential Enrollee that is intended to increase a Contractor's membership or to "brand" a Contractor's name or organization. These activities are directed from the Contractor to a Potential Enrollee or Enrollee who is enrolled with another HCA-Contracted AHEHP that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either not enroll or to end their enrollment with another HCA-Contracted AHEHP. Marketing communications include: written, oral, in-person (telephonic or face-to-face) or electronic

methods of communication, including email, text messaging, and social media (Facebook, Instagram and Twitter).

1.146 **Marketing Materials**

"Marketing Materials" means materials that are produced in any medium, including written or electronic, such as email, social media and text messaging, by or on behalf of the Contractor, that can be reasonably interpreted as intended to market the Contractor to Potential Enrollees.

1.147 **Material Provider**

"Material Provider" means a Participating Provider whose loss would negatively affect access to care in the service area in such a way that more than 50 Enrollees would have to change their Primary Care office/clinic or Behavioral Health Agency, receive services from a Non-Participating Provider, or consistently receive services outside the service area.

1.148 **Maternity Support Services (MSS)**

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

1.149 **Medical Equipment**

"Medical Equipment" means medical equipment and appliances, and medical supplies as defined in WAC 182-543-1000.

1.149.1 Medical equipment and appliances:

1.149.1.1 Are primarily and customarily used to serve a medical purpose;

1.149.1.2 Generally are not useful for a person in the absence of illness or injury;

1.149.1.3 Can withstand repeated use;

1.149.1.4 Can be reusable or removable; and

1.149.1.5 Are suitable for us in any setting where normal life activities take place;

1.149.2 Medical Supplies:

1.149.2.1 Are consumable or disposable or cannot withstand repeated use by more than one person;

1.149.2.2 Are required to address an individual medical disability, illness, or injury;

1.149.2.3 Are suitable for use in any setting which is not a medical institution and in which normal life activities take place; and

1.149.2.4 Generally are not useful to a person in the absence of illness or injury.

1.150 **Medically Appropriate**

"Medically Appropriate" means a term for describing a requested service or setting for which care is intended to address the health care needs of the Enrollee, including physical, Substance Use Disorder, mental health, as well as health-related social needs. The service or setting, including the level or intensity, must be appropriate to the Enrollee's health care needs, social needs, and condition. The service or setting must be reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the Enrollee that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.

1.151 **Medically Necessary Services**

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

1.152 **Medical Loss Ratio (MLR)**

"Medical Loss Ratio (MLR)" means the measurement of the share of Enrollee premiums that the Contractor spends on medical claims, as opposed to other non-claims expenses such as administration or profits.

1.153 **Medication Assisted Treatment (MAT)**

"Medication Assisted Treatment (MAT)" means the use of FDA-approved opioid agonist medications (e.g., methadone), partial agonists (buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono-product formulations) for the treatment of opioid use disorder and the use of opioid antagonist medication (e.g., naltrexone products including extended-release and oral formulations) to prevent relapse to opioid use.

1.154 **Medication Management**

"Medication Management" means the prescribing and/or administering of psychiatric medications and reviewing of medications and their side effects. This service may be provided in consultation with primary therapists, case managers, and/or natural supports, without the Enrollee present, but the service must be for the benefit of the Enrollee.

1.155 **Medication Monitoring**

"Medication Monitoring" means one-on-one cueing, observing, and encouraging an Enrollee to take their psychiatric medications as prescribed. Also includes reporting back to persons licensed to perform Medication Management services for the direct benefit of the enrolled individual. This service is designed to facilitate medication compliance and positive outcomes.

1.156 **Mental Health Advance Directive**

"Mental Health Advance Directive" means a written document in which the principal makes a declaration of instructions, or preferences, or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of chapter 71.32 RCW.

1.157 **Mental Health Parity**

"Mental Health Parity" means the Washington Office of the Insurance Commissioner rules for behavioral health parity, inclusive of mental health and SUD benefits shall apply to this Contract.

1.158 **Mental Health Professional**

"Mental Health Professional" means and individual practicing within their statutory scope of practice who is:

1.158.1 A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

A mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapy associate, as defined in RCW 18.225.010; or a certified or licensed agency affiliated counselor, as defined in RCW 18.19.020.

1.158.2 A certified or licensed agency affiliated counselor, as defined in RCW 18.19.020.

1.159 **Mental Health Treatment Interventions**

"Mental Health Treatment Interventions" means services delivered in a wide variety of settings that promote recovery, using therapeutic techniques. These services are provided, as Medically Necessary, along a continuum from outpatient up through inpatient levels of care and include evaluation, stabilization, and treatment. Services provided in facility settings must have the appropriate state facility licensure.

1.160 **National Committee for Quality Assurance (NCQA)**

"National Committee for Quality Assurance (NCQA)" is an organization responsible for the accreditation of AHEHPs and other health care related entities and for developing and managing health care measures that assess the quality of care and services that Managed Care Enrollees receive. HCA requires contracted AHEHPs to achieve and maintain NCQA accreditation.

1.161 **National Correct Coding Initiative (NCCI)**

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

1.162 **Natural Supports**

"Natural Supports" means personal associations and relationships developed in the community that enhance quality and security of life.

1.163 **Network**

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

1.164 **Network Adequacy**

"Network Adequacy" means a network of providers for the Contractor that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Enrollees without unreasonable delay. Adequacy is determined by a number of factors including, but not limited to provider/patient ratios, geographic accessibility and travel distance.

1.165 **Neurodevelopmental Centers**

"Neurodevelopmental Centers" means a group of community non-profit and hospital-based agencies as designated by the Department of Health who provide therapy and related services up to age 21 with neuromuscular or developmental disorders. Services may include speech, occupational and physical therapies, along with other specialties such as nutrition, social work, and adaptive equipment.

1.166 **New Individual**

"New Individual" means a person who was not enrolled in an AHEHP program within the six (6) months immediately preceding enrollment, and who does not have a family member enrolled in Apple Health Expansion Heath Plan.

1.167 **Non-Contracted Drug**

"Non-Contracted Drug" means a drug that HCA excludes from the premium payments described in subsection 5.2.1 of this Contract for the AHE population.

1.168 **Non-Covered Service**

"Non-Covered Service" means a service that HCA has determined is not covered for the Enrollee.

1.169 **Non-Electronic Prior Authorization Request**

"Non-Electronic Prior Authorization Request" means a Prior Authorization request delivered from the Provider to the Contractor or Contractor's Subcontractor via phone call or fax.

1.170 **Non-Participating Provider**

"Non-Participating Provider" means a person, Health Care Provider, practitioner, Facility, Pharmacy, or entity acting within their scope of practice and licensure, that does not have a written agreement with the Contractor to participate in an AHEHP's provider network, but provides health care services to Enrollees.

1.171 **Non-Quantitative Treatment Limits (NQTL)**

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

1.172 **Office of Inspector General (OIG)**

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

1.173 **OneHealthPort (OHP)**

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

1.174 **Opiate Substitution Treatment Program (OSTP)**

"Opiate Substitution Treatment Program (OSTP)" means a designated program that dispenses approved medication for opioid treatment programs.

1.175 **Outcomes**

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

1.176 **Overpayment**

"Overpayment" means any payment from HCA to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this Contract, including amounts in dispute. Overpayment can also mean a payment from the Contractor to a Provider or Subcontractor to which the Provider or Subcontractor is not legally entitled.

1.177 **Participating Provider**

"Participating Provider" means a person, medical or behavioral Health Care Provider, practitioner, Pharmacy or entity, acting within their scope of practice and licensure, with a written agreement with the Contractor to provide services to Enrollees under the terms of this Contract.

1.178 **Patient Activation Measure (PAM)**

"Patient Activation Measure (PAM)" means an assessment that gauges the knowledge, skills and confidence essential to managing one's own health and health care. The PAM assessment categorizes consumers into one of four progressively higher activation levels. A PAM score can also predict healthcare outcomes including medication adherence, emergency department usage, and hospital utilization. The PAM is used to:

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

1.178.2 Target tools and resources commensurate with the Enrollee's level of activation; and

1.178.3 Provide insight into how to improve unhealthy behaviors, and grow and sustain healthy behaviors to lower medical costs and improve health.

1.179 **Patient Days of Care**

"Patient Days of Care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the State Hospital they reside. Patients who are committed to the State Hospital under chapter 10.77 RCW are not included in the Patient Days of Care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the Patient Days of Care until a petition for ninety (90) calendar days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the Patient Days of Care until the patient is civilly committed under chapter 71.05 RCW.

1.180 **Patient Health Questionnaire (PHQ-9)**

"Patient Health Questionnaire (PHQ-9)" means a nine-item depression scale of the Patient Health Questionnaire used by primary care clinicians in diagnosing depression as well as selecting and monitoring treatment.

1.181 **Peer Support Services**

"Peer Support Services" means scheduled activities that promote wellness, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Services are provided by Certified Peer Counselors, as noted in the Enrollees' ISP, or without an ISP when provided during/post crisis episode. In this service, Certified Peer Counselors model skills in recovery and self-management to help individuals meet their self-identified goals.

1.182 **Personal Information**

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

1.183 **Pharmacy Benefit Manager**

"Pharmacy Benefit Manager (PBM)" means a person, corporation, partnership, or other legal entity that contracts with pharmacies on behalf of an insurer, a third-party payor, or the prescription drug purchasing consortium to:

1.183.1 Process claims for prescription drugs or medical supplies or provide retail network management for pharmacies or pharmacists;

1.183.2 Pay pharmacies or pharmacists for prescription drugs or medical supplies; or

1.183.3 Negotiate rebates with manufacturers for drugs paid for or procured as described in this subsection.

"Pharmacy benefit manager" does not include a health care service contractor

1.184 **Physician Group**

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

1.185 **Physician Incentive Plan**

"Physician Incentive Plan" means any compensation arrangement between the Contractor and a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services to Enrollees under the terms of this Contract.

1.186 **Physician's Orders for Life Sustaining Treatment (POLST)**

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

1.187 **Physician Services**

"Physician Services" means health services provided by a licensed medical physician (M.D.) or Doctor of Osteopathic Medicine (D.O.).

1.188 **Plan Reconnect**

"Plan Reconnect" means an individual who has regained eligibility for Apple Health - Integrated Managed Care and who was enrolled in an Apple Health contractor (Apple

Health Managed Care or Apple Health - Integrated Managed Care) within the six (6) months immediately preceding reenrollment.

1.189 **Post-service Review**

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

1.190 **Post-Stabilization Services**

"Post-Stabilization Services" means contracted services, related to an Emergency Medical Condition and emergency care for a health condition that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

1.191 **Potential Enrollee**

"Potential Enrollee" means any individual who HCA determines is eligible for enrollment in Apple Health - Integrated Managed Care and who, at the time of HCA's determination, is not enrolled with any Apple Health

1.192 **Predictive Risk Intelligence System (PRISM)**

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

1.193 **Premium**

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

1.194 **Prescription Drug**

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

1.195 **Prescription Drug Coverage**

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

1.196 **Primary Care Provider (PCP)**

"Primary Care Provider (PCP)" means a Participating Provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNPs), as designated by the Contractor. The definition of PCP is inclusive of primary care physician All federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

1.197 **Primary/Preferred Language**

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

1.198 **Primary Point of Contact**

"Primary Point of Contact" means the Health Care Provider that the Enrollee self-identifies as the provider that the Enrollee most often sees and views as his/her current Health Care Provider. The provider may be a Mental Health Professional (MHP), Primary Care Provider (PCP) or a Certified SUDP. If the Enrollee does not self-identify a Primary Point of Contact, then the Contractor shall facilitate referrals to a PCP for an assessment and if appropriate, referrals to other providers such as MHPs or SUDPs to meet unmet needs or gaps in health care services identified through screening of the Enrollee.

1.199 **Prior Authorization**

"Prior Authorization" means the requirement that a provider must request, on behalf of an Enrollee and when required by rule or HCA billing instructions, HCA or HCA's designee's approval to provide a health care service before the Enrollee receives the health care service, prescribed drug, device, or drug-related supply. HCA or HCA's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization.

1.200 **Program Integrity**

"Program Integrity" means a system of reasonable and consistent oversight of the program. Program Integrity effectively encourages compliance; maintains accountability; protects public funds; supports awareness and responsibility; ensures Providers, Contractors and Subcontractors meet participation requirements; ensures services are medically necessary; and ensures payments are for the correct amount and for Covered Services. The goal of Program Integrity is to reduce and eliminate Fraud, Waste, and Abuse (FWA) in the program.

1.201 **Promising Practice**

"Promising Practice" means a practice that, based on statistical analyses or a well-established theory of change, shows potential for meeting the evidence-based or research-based criteria that may include the use of a program that is evidence-based for outcomes. (WSIPP 3/2015).

1.202 **Protocols for Coordination with Tribes and non-Tribal IHCPs**

"Protocols for Coordination with Tribes and non-Tribal IHCPs" means the protocols that HCA and a Tribe or non-Tribal IHCP develop and agree on, with input from the Contractor, for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning. See Subsection 15.1.2, Protocols for the Coordination with Tribes and non-Tribal IHCPs.

1.203 **Provider**

"Provider" means any individual or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

1.204 **Provider Access Payment (PAP) Program**

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

1.205 **ProviderOne**

"ProviderOne" means HCA's Medicaid Management Information Payment Processing System, or any superseding platform as may be designated by HCA.

1.206 **Provider Performance Profile (PPP)**

"Provider Performance Profile (PPP)" means administrative (claims/encounters) or service-level data (surveys) analyzed at the individual health care provider or group provider level (in the case of multiple providers in a single health care setting) and portrayed in a form understood by the health care provider or group.

1.207 **Quality of Care**

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

1.208 **Recovery**

"Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to meet their full potential.

1.209 **Regional Behavioral Health Entities**

"Regional Behavioral Health Entities" means AHEHPs, BH-ASOs, and their contracted behavioral health providers.

1.210 **Regional Service Area (RSA)**

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

1.211 **Regulation**

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

1.212 **Rehabilitation Services**

"Rehabilitation Services" means services focused on improving an Enrollee's physical and mental strength, skills or functions, lost or impaired due to illness, injury or disability. Rehabilitation services include physical or occupational therapy and speech-language pathology, as well as specialty Behavioral Health services.

1.213 **Research-Based Practice**

"Research-Based Practice" means a program or practice that has been tested with a single randomized, or statistically controlled evaluation, or both, demonstrating sustained desirable outcomes; or where the weight of the evidence from a systemic review supports sustained outcomes but does not meet the full criteria for evidence-based. (Washington State Institute for Public Policy (WSIPP) 3/2015).

1.214 **Resilience**

"Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

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

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

1.216 **Risk**

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a Physician Incentive Plan, as defined in this Contract.

1.217 **Rural Area**

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

1.218 **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

"Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means a comprehensive, evidenced-based public health practice designed to identify through screening, adults who are at risk for or have some level of SUD that can lead to illness, injury, or other long-term morbidity or mortality. If a person is found to be at risk of harm from their use, they receive several Brief Interventions to reduce their risk or if necessary, a referral for further evaluation for treatment. SBIRT services are provided in a wide variety of medical and community health care settings.

1.219 **Secure Withdrawal Management and Stabilization Facility**

"Secure Withdrawal Management and Stabilization Facility" means a facility operated by either a public or private agency as defined in RCW 71.05.020 that provides involuntary treatment to individuals detained for SUD ITA. This service does not include cost of room and board.

1.220 **Secured Area**

"Secured Area" means an area such as a building, room or locked storage container to which only authorized representatives of the entity possessing the Confidential Information have access.

1.221 **Security Incident**

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

1.222 **Service Encounter Reporting Instructions (SERI)**

"Service Encounter Reporting Instructions (SERI)" means the guide published by HCA to provide assistance to contracted entities for reporting specialty behavioral health service encounters.

1.223 **Sign Language**

"Sign Language" means Languages that use the visual-manual modality to convey meaning, instead of spoken words; sign languages are expressed through manual articulation in combination with non-manual markers.

1.224 **Single Case Agreement**

"Single Case Agreement" means a written agreement between the Contractor and a non-Participating Provider to deliver services to an Enrollee.

1.225 **Specialist**

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

1.226 **Stabilization Services**

"Stabilization Services" (also referred to as Crisis Stabilization), means services provided to individuals who are experiencing a Behavioral Health crisis. This service includes follow-up after a crisis intervention. These services are to be provided in the person's own home, or another home-like setting, or a setting that provides safety for the individual and the Behavioral Health Professional. Stabilization Services may include short-term assistance with life skills training and understanding of medication effects. It may also include providing services to the Enrollee's natural and community supports, as determined by a Behavioral Health Professional, for the benefit of supporting the Enrollee that experienced the crisis. Stabilization services may be provided prior to an intake evaluation for Behavioral Health services. Stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a Behavioral Health Professional.

1.227 **Subcontract**

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

1.228 **Subcontractor**

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

1.229 **Substance Use Disorder (SUD)**

"Substance Use Disorder (SUD)" means a problematic pattern of use of substances that causes clinical and functional impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or home. Clinicians use criteria from the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5) to diagnose SUD.

1.230 **Substance Use Disorder Brief Intervention**

"Substance Use Disorder Brief Intervention" means a time limited, structured behavioral intervention designed to address risk factors that appear to be related to Substance Use Disorders, using SUD screening tools and brief intervention techniques, such as evidence-based motivational interviewing and referral to additional treatment services options when indicated. This service may be provided prior to an intake evaluation or assessment.

1.231 **Substance Use Disorder Professional**

"Substance Use Disorder Professional (SUDP)" means an individual who is certified according to RCW 18.205.020 and the certification requirements to provide substance use disorder (SUD) counseling.

1.232 **Substance Use Disorder Withdrawal Management**

"Substance Use Disorder Withdrawal Management" means services required for the care and/or treatment of Enrollees intoxicated or incapacitated by alcohol or other drugs that are provided during the initial period of care and treatment while the Enrollee recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in state certified facilities. Services include:

1.232.1 Screening of Enrollees in need of withdrawal management;

1.232.2 The use of different counseling and treatment strategies, such as motivational interviewing and developing an ISP for Enrollees admitted to a program. These

services are used to refer, stimulate motivation to guide Enrollees to additional treatment, and sustain recovery; and

1.232.3 Different levels of withdrawal management are provided in a variety of settings, including residential, sub-acute and acute locations.

1.233 **Substantial Financial Risk**

"Substantial Financial Risk" means a physician or Physician Group at Substantial Financial Risk when more than 25 percent of the total maximum potential payments to the physician or Physician Group depend on the use of referral services. When the panel size is fewer than 25,000 Enrollees' arrangements that cause Substantial Financial Risk include, but are not limited to the following:

1.233.1 Withholds greater than 25 percent of total potential payments; or

1.233.2 Withholds less than 25 percent of total potential payments but the physician or Physician Group is potentially liable for more than 25 percent of total potential payments; or

1.233.3 Bonuses greater than 33 percent of total potential payments, less the bonus; or

1.233.4 Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of total potential payments; or

1.233.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than 25 percent of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

1.234 **Substance Use or Problem Gambling Disorder Treatment Interventions**

"Substance Use or Problem Gambling Disorder Treatment Interventions" means services delivered in a wide variety of settings across the continuum that promote recovery, using therapeutic techniques. These services are provided, as Medically Necessary, along a continuum from outpatient up through inpatient levels of care. Treatment interventions include intentional intervention in the health, Behavioral Health, and personal and/or family life of an Enrollee with a substance use or problem gambling disorder. Services provided in inpatient levels of care are provided in state certified facilities.

1.235 **SUPPORT for Patients and Communities Act (SUPPORT Act)**

"SUPPORT for Patients and Communities Act (SUPPORT Act)", also known as Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, is a United States federal law, enacted during the 115th United States Congress, to make medical treatment for opioid addiction more widely available while also preventing access to illicit drugs.

1.236 **System for Award Management (SAM)**

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

1.237 **Tracking**

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

1.238 **Transitional Age Youth (TAY)**

"Transitional Age Youth" means individuals between the ages of 15 and 25 years who present unique service challenges because they are too old for pediatric services but are often not ready or eligible for adult services.

1.239 **Transitional Healthcare Services (THS)**

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

1.240 **Translation**

"Translation" means the process of rendering written communication from one language into another language.

1.241 **Transport**

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

1.241.1 Places the Confidential Information outside of a Secured Area or system (such as a local area network), and

1.241.2 Is accomplished other than via a Trusted System.

1.242 **Trauma-Informed Care**

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

1.243 **Tribal 638 Facility**

"Tribal 638 Facility" means a facility operated by a Tribe or Tribal organization, funded by Title I or V of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, amended), and enrolled in the state Medicaid program as a facility type other than an FQHC or Tribal FQHC.

1.244 **Tribal FQHC**

"Tribal FQHC" means a Tribal 638 Facility enrolled in the state program both as a FQHC, covered by the Social Security Act § 1902(bb), and as a Tribal FQHC that has agreed to receive payment for outpatient services under the Tribal FQHC Alternative Payment Methodology (APM).

1.245 **Tribal FQHC Alternative Payment Methodology (APM)**

"Tribal FQHC Alternative Payment Methodology (APM)" means the FQHC Alternative Payment Methodology (APM) authorized in the Medicaid State Plan that is the published outpatient IHS encounter rate. The Tribal FQHC APM pays for the same outpatient services and the same number of encounters per day that Tribal 638 Clinics provide.

1.246 **Tribal Organization**

"Tribal Organization" means the recognized governing body of any Tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by one or

more federally recognized Tribes or whose governing body is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities.

1.247 **Tribe**

"Tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

1.248 **Unique User ID**

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

1.249 **Urban Indian Health Program (UIHP)**

"Urban Indian Health Program (UIHP)" means a nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, that is operating a facility delivering health care.

1.250 **Urgent Care**

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

1.251 **Urgent Medical Condition**

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

1.252 **Validation**

"Validation" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accordance with standards for data collection and analysis.

1.253 **Washington Administrative Code (WAC)**

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

1.254 **Washington Apple Health Expansion (AHE)**

"Washington Apple Health Expansion (AHE)" means the state-funded health care coverage that provides the scope of care as described in WAC 182-501-0060, chapters 182-525, 182-525A, and 182-525B WAC, and other rules relating to Washington apple health expansion. This coverage is for individuals age 19 and older who do not meet the citizenship, immigration, or social security requirements to receive benefits under federally funded programs. Eligibility for this program is limited and is subject to available funds.

1.255 **Washington Healthplanfinder (HPF)**

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

1.256 **Washington State Institute for Public Policy (WSIPP)**

"Washington State Institute for Public Policy (WSIPP)" means the entity that carries out non-partisan research at the direction of the legislature or Board of Directors. WSIPP works closely with legislators, legislative and state agency staff, and experts in the field to ensure that studies answer relevant policy questions. Fiscal and administrative services for WSIPP are provided by a state college.

1.257 **Waste**

"Waste" when used in the context of program integrity, means an act resulting in overutilization, inappropriate utilization of services or misuse of resources that result, directly or indirectly, in unnecessary costs to the Medicaid program.

1.258 **Wraparound with Intensive Services (WISe)**

"Wraparound with Intensive Services (WISe)" means a range of services designed to provide Behavioral Health services and support individuals 20 years of age or younger, and the individual's family. For the purposes of WISe, Youth means a child aged 20 or younger. WISe provides intensive Behavioral Health in home and community settings to Youth who are Apple Health eligible under WAC 182-505-0210 and meet medical necessity criteria for WISe.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

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

2.1.1 Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

2.1.2 HCA reserves the right to issue unilateral amendments that provide corrective or clarifying information.

2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov.

2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.

2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA Contracts Office.

2.2 Loss of Program Authorization

2.2.1 Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., reduction or elimination of funding from the Legislature, or vacated by a court of competent jurisdiction), Contractor must do no work on that part after the effective date of the loss of program authority.

2.2.2 If HCA determines that available funding for AHE has been or will be exhausted, this will result, as of the date specified by HCA, in the automatic termination of any authorization, appeals process, independent review, or administrative hearing process related to a request to authorize a service or benefit. Upon making any such determination, HCA will notify enrollees, providers, health plans, and the general public through a posting on its website or in any other manner that the HCA deems appropriate.

2.2.3 HCA must adjust rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If HCA paid Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work must be returned to HCA. However, if Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

2.3 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA. HCA may withhold its consent at its sole discretion.

2.4 Billing Limitations

2.4.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.

2.4.2 HCA shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.

2.4.3 The Contractor must waive the timeliness rule for processing a claim and prior authorization requirements when HCA program integrity activities result in recoupment of an improperly paid claim HCA paid but should have been paid by the Contractor:

2.4.3.1 The Contractor shall pay for Medically Necessary Services submitted beyond the standard claims payment timeframes in these circumstances. If the Contractor is unable to systematically identify and waive the timeliness rules in this scenario, it is acceptable for the Contractor to address the waiver of the timeliness rule within its provider payment dispute processes.

2.4.3.2 The servicing provider must submit a claim to the Contractor within one hundred twenty (120) calendar days from HCA's notification of improper payment. The Contractor must have in place a process to administer these claims.

2.4.3.3 If the Contractor is unable to waive the timeliness rule to process an improperly paid claim identified by HCA, HCA may at any time request a refund from the Contractor of the improperly paid claim.

2.5 Compliance with Applicable Law

During the term of this Contract, the Contractor and its subcontractors must comply with all applicable federal, state, and local statutes, regulations, and ordinances (collectively, Laws) as existing on the date of execution of this Contract and as enacted, amended, and issued during the term of this Contract. Any provision of this Contract that is in conflict with any Law is hereby deemed amended to conform to the minimum requirements of such Laws. Any provision of this Contract that is stricter than any Law will not be deemed a conflict. The applicable Laws include, but are not limited to, the following:

2.5.1 Title VI of the Civil Rights Act of 1964;

2.5.2 The Age Discrimination Act of 1975;

2.5.3 The Rehabilitation Act of 1973;

2.5.4 Title 182 WAC applicable to Apple Health Expansion program;

2.5.5 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews;

2.5.6 Chapter 71.05 RCW Mental Illness;

2.5.7 Chapter 71.24 RCW Community Mental Health Services Act;

2.5.8 Chapter 74.09 RCW Medical Care;

2.5.9 Community Mental Health and Involuntary Treatment Programs;

2.5.10 Behavioral Health Services Administrative Requirements;

2.5.11 Outpatient Mental Health Services;

2.5.12 Substance Use Disorder Services;

2.5.13 Senate Bill 6312 (Chapter 225, Laws of 2014) State Purchasing of Mental Health and SUD Treatment Services;

2.5.14 All state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including, but not limited to:

2.5.14.1 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

2.5.14.2 Those specified in Title 18 RCW for professional licensing.

2.5.15 Industrial Insurance – Title 51 RCW;

2.5.16 Reporting of abuse as required by RCW 26.44.030 and chapter 74.34 RCW;

2.5.17 Equal Employment Opportunity (EEO) Provisions;

2.5.18 All federal and state nondiscrimination laws and regulations; and

2.5.19 Americans with Disabilities Act of 1990, as amended: The Contractor shall make reasonable accommodation for Enrollees with disabilities, in accordance with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining contracted services;

2.6 Covenant Against Contingent Fees

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

2.7 Data Use, Security, and Confidentiality

Exhibit C, Data Use, Security, and Confidentiality, sets out Contractor's obligations for compliance with Data security and confidentiality terms.

2.8 Debarment Certification

The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for Debarment, declared ineligible or voluntarily excluded in any Washington state or federal department or agency from participating in transactions (debarred). The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accordance with Subsection 2.41 of this Contract if the Contractor becomes debarred during the term hereof.

2.9 Defense of Legal Actions

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

2.10 Disputes

When a dispute arises between HCA and the Contractor over an issue that pertains in any way to this Contract (other than Overpayments by HCA to the Contractor), the parties agree to the following process to address the dispute:

2.10.1 The Contractor shall request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.10.1.1 The disputed issue(s).

2.10.1.2 An explanation of the positions of the parties.

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

2.10.2 Requests for a dispute resolution conference must be mailed in a manner providing proof of receipt to the Director, Washington State HCA, P.O. Box 45502, Olympia, WA 98504-5502. Any such requests must be received by the Director within fifteen (15) calendar days after the Contractor receives notice of the disputed issue(s).

2.10.2.1 The Contractor shall email a copy of the request for a dispute resolution conference to the email address(s) provided in the notice of the HCA decision the Contractor is disputing.

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

2.10.3.1 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).

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

2.10.5 Disputes regarding Overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Section.

2.11 Force Majeure

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

2.12 Governing Law and Venue

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

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

2.13 Independent Contractor

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

2.14 Insolvency

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

2.14.1 The state of Washington and Enrollees shall not be, in any manner, liable for the debts and obligations of the Contractor.

2.14.2 In accordance with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge Enrollees for Contracted services.

2.14.3 The Contractor shall provide for the Continuity of Care for Enrollees.

2.14.4 The Contractor shall cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.15 Inspection

The Contractor and its subcontractors shall permit the state of Washington, including HCA and the state auditor to access, inspect and audit any records or documents of the

Contractor or its subcontractors, and shall permit inspection of the premises, physical facilities, and equipment where AHE-related activities or work is conducted, at any time.

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

2.16 **Insurance**

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

2.16.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed under an insured Contract. The state of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.

2.16.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

2.16.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

2.16.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.16.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA if requested.

2.16.5.1 The Contractor shall ensure that adult family homes (AHF) maintain insurance appropriate to the services to be performed and consistent with the requirements in WAC 388-76-10192. The Contractor shall not require insurance exceeding what is required by WAC 388-76-10192.

2.16.6 Separation of Insureds: All insurance Commercial General Liability policies shall contain a “separation of insured’s” provision.

2.16.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the state of Washington, with a “Best’s Reports” rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a “Surplus Lines” insurer or an insurer with a rating lower than A-, Class VII.

2.16.8 Evidence of Coverage: Upon request, Contractor shall submit certificates of insurance in accordance with the Notices section of the General Terms and Conditions, for each coverage required under this Contract. If requested, each certificate of insurance shall be executed by a duly authorized representative of each insurer.

2.16.9 Material Changes: The Contractor shall give HCA, in accordance with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

2.16.10 General: By requiring insurance, the state of Washington and HCA do not represent that the coverage and limits specified shall be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor’s liability under the indemnities and reimbursements granted to the state and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-insurance programs afforded to or maintained by the State.

2.16.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this Section, shall treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

2.16.12 Privacy Breach Response Coverage. For the term of this Contract and three (3) years following its termination Contractor shall maintain insurance to cover costs incurred in connection with a security incident, privacy Breach, or potential compromise of Data including:

2.16.12.1 Computer forensics assistance to assess the impact of a data breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach Notification Laws (RCW 42.56.590; RCW 19.255.010; and WAC 284-04-625).

2.16.12.2 Notification and call center services for individuals affected by a security incident, or privacy Breach.

2.16.12.3 Breach resolution and mitigation services for individuals affected by

a security incident, or privacy Breach, including fraud prevention, credit monitoring and identity theft assistance.

2.16.12.4 Regulatory defense, fines, and penalties from any claim in the form of a regulatory proceeding resulting from a violation of any applicable privacy law(s).

2.17 Records

2.17.1 The Contractor and its Subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.17.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of ten (10) years after final payment is made under this Contract. However, when an inspection, audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action.

2.17.3 The Contractor and the Contractor's Subcontractors shall retain, as applicable, Enrollee grievance and appeal records for a period of no less than ten (10) years.

2.18 Public Records

The Contractor acknowledges that HCA is subject to the Public Records Act (chapter 42.56 RCW). This Contract is a "public record" as defined in chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as "public records" and therefore be subject to public disclosure.

2.19 Mergers and Acquisitions

The Contractor must provide HCA with written notice anytime it intends to be involved in an acquisition of assets or a merger with another health plan doing business in the state of Washington. However, if the Contractor is involved in an acquisition of assets or merger with another HCA contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each party to any such transaction maintain its separate business lines for the remainder of the term of this Contract. The Contractor does not have an automatic right to a continuation of the Contract after any such transaction.

2.20 Locations Outside of the United States

The Contractor assures HCA that it is not located outside the United States. In addition, the Contractor shall not include in its encounter data reporting to HCA, or to HCA's contracted Actuary, any claims paid to any provider located outside the United States.

2.21 Notification of Organizational Changes

The Contractor shall provide HCA with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor shall provide HCA written notice of any changes to the Contractor's key personnel within seven (7) Business Days, including, but not limited to, the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, HCA government relations contact, HCA Account Executive, Compliance Officer, Medical Director, behavioral health Medical Director, behavioral health Clinical Director, and Tribal Liaison. The Contractor shall provide HCA

with an interim contact person that will be performing the key personnel member's duties and a written plan for replacing key personnel, including expected timelines. If key personnel will not be available for work under the Contract for a continuous period exceeding thirty (30) Business Days, or are no longer working full-time in the key position, the Contractor shall notify HCA within seven (7) Business Days after the date of notification of the change.

2.22 **Order of Precedence**

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

2.22.1 Any federal statutes and regulations that are listed in Subsection 2.5, Compliance with Applicable Law;

2.22.2 State of Washington statutes and regulations applicable to the services provided under this Contract;

2.22.3 Applicable state of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers;

2.22.4 General Terms and Conditions of this Contract;

2.22.5 Any other term and condition of this Contract and exhibits; and

2.22.6 Any other material incorporated herein by reference.

2.23 **Severability**

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

2.24 **Survivability**

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

2.24.1 Cover hospitalized Enrollees until discharge consistent with this Contract.

2.24.2 Submit all data and reports required in this Contract.

2.24.3 Provide access to records required in accordance with the Inspection provisions of this Section.

2.24.4 Provide the administrative services associated with Contracted services (e.g., claims processing, Enrollee appeals) provided to Enrollees prior to the effective date of termination under the terms of this Contract.

2.24.5 Repay any Overpayments within sixty (60) calendar days of discovery by the Contractor or its subcontractors of the Overpayment, or within sixty (60) calendar days of notification by HCA or other law enforcement agency, and that:

2.24.5.1 Pertain to services provided at any time during the term of this Contract; and

2.24.5.2 Are identified through an HCA audit or other HCA administrative review at any time on or before ten (10) years from the date of the termination of this Contract or

2.24.5.3 Are identified through a Fraud investigation conducted by other law enforcement entity, based on the timeframes provided by federal or state law.

2.24.6 Reimburse providers for claims erroneously billed to and paid by HCA within the twenty-four (24) months before the expiration or termination of this Contract.

2.25 Waiver

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

2.26 Contractor Certification Regarding Ethics

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

2.27 Health and Safety

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

2.28 Indemnification and Hold Harmless

2.28.1 HCA and the Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party. The Contractor shall indemnify and hold harmless HCA from any claims by Participating or non-Participating Providers related to the provision of services to Enrollees according to the terms of this Contract. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the state and its agencies, officials, agents, or employees.

2.28.2 In accordance with RCW 71.05.026 and RCW 71.24.370, the Contractor will have no claim for declaratory relief, injunctive relief, or judicial review under chapter 34.05 RCW, or civil liability against the state, state agencies, state

officials, or state employees for actions or inactions performed pursuant to the administration of chapter 71.05 RCW and chapter 71.24 RCW with regards to:

2.28.2.1 The allocation of federal or state funds;

2.28.2.2 The use of state hospital beds; or

2.28.2.3 Financial responsibility for the provision of inpatient mental health care.

2.29 Industrial Insurance Coverage

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

2.30 No State Endorsement

The award of this Contract does not indicate an endorsement of the Contractor by the state of Washington. No federal funds have been used for lobbying purposes in connection with this Contract.

2.31 Notices

Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if sent via email with the "delivery receipt" and/or "read receipt" feature enabled, or sent by a recognized United States Postal Service. If notice is sent by email, the receiving party must confirm receipt by accepting the "read receipt" notice.

2.31.1 In the case of notice from HCA to the Contractor, notice will be sent to:

«email address»

OR

«CEO»
«Organization_Name»
«Mailing_AddressSt_Address»
«City», «State» «Zip_Code»

2.31.2 In the case of Notice from the Contractor to HCA, notice will be sent to:

contracts@hca.wa.gov and hcaprograms@hca.wa.gov

OR

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

2.31.3 Notices delivered through the United States Postal Service will be effective on the date delivered as evidenced by the return receipt. Notices delivered by email will be deemed to have been received based on the electronic return receipt or when the recipient acknowledges, by email reply, having received that email.

2.31.4 Either party may, at any time, change its mailing address or email address for notification purposes by sending a notice in accordance with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) Business Day following the effective date of such notice unless a later date is specified.

2.32 **Notice of Overpayment**

2.32.1 For purposes of this Contract, the term "Overpayment" may include any payments made to the Contractor by HCA that were in an amount in excess of what the Contractor was entitled to and is not limited to the definition of "Overpayment" in RCW 41.05A.010.

2.32.2 HCA will issue a notice of Overpayment to the Contractor if HCA determines that it made an Overpayment to the Contractor. The Contractor is responsible for repaying the amount specified in the Notice of Overpayment within sixty (60) calendar days from the date of receipt.

2.32.3 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:

2.32.3.1 Comply with all of the instructions contained in the Notice of Overpayment, in accordance with RCW 41.05A.170(1);

2.32.3.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor, in accordance with RCW 41.05A.170(3);

2.32.3.3 Be sent to HCA by certified mail (return receipt) or in a manner providing proof of receipt, to the location specified in the Notice of Overpayment;

2.32.3.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and

2.32.3.5 Include a copy of the Notice of Overpayment.

2.32.4 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The adjudicative proceeding will be governed by the Administrative Procedure Act, chapter 34.05 RCW, and chapter 182-526 WAC. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding.

2.32.5 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment the amount specified in the Notice of Overpayment will become a final debt to HCA subject to collection from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an

Overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this Contract; or any other collection action available to HCA to satisfy the Overpayment debt.

2.32.6 Nothing in this Contract limits HCA's ability to recover Overpayments under applicable law.

2.33 **Proprietary Data or Trade Secrets**

2.33.1 Except as required by law, regulation, or court order, data identified by the Contractor, as proprietary trade secret information, shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of such proprietary information shall include the Contractor's interpretation.

2.33.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) Business Days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5) Business Day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.

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

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

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

2.33.4.1.1 Litigation, with an appropriate court order;

2.33.4.1.1.1 HCA will provide the Contractor with notice and opportunity to file legal proceedings in accordance with subsection 2.32.2.

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

2.33.4.2 Disclosures of information that is not directly identifiable by AHEHP, including disclosures:

2.33.4.2.1 In response to request from the Legislature or Governor's Office; and

2.33.4.2.2 Washington State Institutional Review Board (WSIRB) approved research projects.

2.33.4.3 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 Contractor's disclosed proprietary information or trade secrets.

2.33.4.4 Disclosures of aggregated information; and

2.33.4.5 Any other disclosure of paid amount information with the prior written consent of Contractor.

2.34 Ownership of Material

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

2.35 Solvency

2.35.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21A, 48.44 or 48.46 RCW, as amended.

2.35.2 The Contractor agrees that HCA may at any time access any information related to the Contractor's financial condition, or compliance with the Office of the Insurance Commissioner (OIC) requirements, from OIC and consult with OIC concerning such information.

2.35.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC or National Association of Insurance Commissioners (NAIC) per the HCSC required filing checklist for financial reports. The Contractor's routine quarterly and annual statements submitted to the OIC and NAIC are exempt from this requirement. The Contractor shall also deliver copies of related documents, reports and correspondence (including, but not limited to, Risk-Based Capital (RBC) calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC or NAIC.

2.35.4 The Contractor shall notify HCA within ten (10) Business Days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

2.35.5 The Contractor shall notify HCA within 24 hours after any action by the OIC that may affect the relationship of the parties under this Contract.

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

2.36 Conflict of Interest Safeguards

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public contracting.

2.37 Reservation of Rights and Remedies

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

2.38 Termination by Default

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

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

2.38.2.1 The Contractor did not fully and accurately make any disclosure required.

2.38.2.2 The Contractor failed to timely submit accurate information required.

2.38.2.3 One of the Contractor's owners failed to timely submit accurate information required.

2.38.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information required.

2.38.2.5 One of the Contractor's owners did not cooperate with any screening methods required.

2.38.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years.

2.38.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program.

2.38.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) calendar days of an HCA request.

2.38.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits.

2.38.2.10 The Contractor has falsified any information provided on its application.

2.39 Termination for Convenience

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

2.40 Contractor's Non-Renewal of Contract

Contractor must provide to HCA prior written notice of at least 120 calendar days if Contractor intends to not renew the Contract beyond the Contract End Date. If such notice is provided, Contractor will continue to be paid at the approved rates for that period for the remaining days of the Contract. During the period between Contractor's notice of non-renewal and the Contract End Date, Contractor will follow all required and requested HCA procedures to ensure a smooth transition for Enrollees to another AHEHP. Nothing in this subsection shall be construed as (a) giving the Contractor any automatic right to the renewal of this Contract, (b) giving the Contractor any automatic right to entering into a new contract with HCA, or (c) restricting HCA's ability to terminate or not renew this Contract.

2.41 Terminations: Pre-termination Processes

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

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

2.41.1 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes section of this Contract.

2.41.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract. HCA shall:

2.41.2.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

2.41.2.2 Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

2.41.2.3 For an affirming decision, give Enrollees notice of the termination and information on their options for receiving services following the effective date of termination.

2.42 **Savings**

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

2.43 **Termination - Information on Outstanding Claims**

In the event this Contract is terminated or not renewed, the Contractor shall provide HCA, within 365 calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to Enrollees. Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.44 **Administrative Simplification**

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

2.44.1 To maximize understanding, communication, and administrative economy among all Health Plans, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:

2.44.1.1 Current Procedural Terminology (CPT);

2.44.1.2 International Classification of Diseases (ICD);

2.44.1.3 Healthcare Common Procedure Coding System (HCPCS);

2.44.1.4 CMS Relative Value Units (RVUs);

2.44.1.5 CMS billing instructions and rules;

2.44.1.6 The Diagnostic and Statistical Manual of Mental Disorders;

2.44.1.7 NCPDP Telecommunication Standard D.0; and

2.44.1.8 Medi-Span® Master Drug Data Base or other nationally recognized drug database with approval by HCA.

2.44.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to

control improper coding, unless otherwise directed in writing by the HCA. Any Contractor requested exceptions to NCCI policies must be approved by HCA. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing Apple Health Expansion claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

2.44.2.1 For codes with a Medically Unlikely Edit Adjudication Indicator (MAI) of "1" or "3", the Contractor must allow a provider appeal process to perform case by case evaluation for exceptions based on medical necessity.

2.44.3 HCA will share the non-public NCCI edit files received from CMS with the Contractor, when available.

2.44.3.1 The Contractor will not:

2.44.3.1.1 Disclose, publish, or share with any party not involved in the implementation of the quarterly state NCCI methodologies covered by this Contract, the non-public Medicaid NCCI edit files;

2.44.3.1.2 Use any non-public information from the non-public NCCI edit files for any business purposes unrelated to the implementation of the NCCI methodologies in the state;

2.44.3.1.3 Implement new, revised, or deleted non-public NCCI edits prior to the first calendar day of the quarter;

2.44.3.1.4 Allow use of new, revised, or deleted NCCI edits by reviewers in non-Medicaid programs prior to the posting of the public Medicaid NCCI edit files on the Medicaid NCCI webpage (www.medicaid.gov);

2.44.3.1.5 Release to the public any non-public NCCI edit files, at any time; and

2.44.3.1.6 Use the non-public NCCI edit files for any non-Medicaid purpose, at any time.

2.44.3.2 Contractor and their Subcontractors may disclose only non-confidential information that is also available to the general public about the NCCI edit files on the NCCI webpage.

2.44.3.3 HCA will impose sanctions in accordance with the Sanctions section of this Contract, up to and including termination of this Contract, for violations of this section.

2.44.4 In lieu of the most recent versions, Contractor may request an exception. HCA's consent thereto will not be unreasonably withheld.

2.44.5 Drug database requirements are specific to values used as reference file in adjudication of pharmacy claims and storage of pharmacy claim data. Drug databases used for other purposes are not subject to this requirement and do not require approval.

2.44.6 Contractor may set its own conversion factor(s), including special code-specific

or group-specific conversion factors, as it deems appropriate.

2.45 **Corrective Action Plans and Penalties**

2.45.1 HCA has the authority to require the Contractor to devise a Corrective Action Plan (CAP) whenever HCA concludes that the Contractor is out of compliance with one or more terms or conditions of this Contract. HCA will specify the requirements of any such CAP in a written communication to the Contractor.

2.45.2 If HCA concludes that the Contractor has failed to comply with any of the terms of a CAP for which the Contractor has control, then HCA may (i) impose sanctions under the Sanctions section of this Contract, (ii) impose liquidated damages under the Liquidated Damages section of this Contract, or (iii) take any other remedial action allowed by this Contract or by governing law.

2.46 **Requirements to be Accurate, Complete, Truthful, and Timely**

2.46.1 All reports, documents, data or other information that the Contractor must submit to HCA (or to a third party designated by HCA) under this Contract must be accurate, complete, truthful and timely.

3 ENROLLEE MATERIALS, MARKETING AND INFORMATION REQUIREMENTS

3.1 Enrollee Materials

3.1.1 All Enrollee materials must be developed and submitted in accordance with the Apple Health Material Guidelines developed and distributed by HCA. All materials and information subject to the Apple Health Material Guidelines must be pre-approved by HCA and be consistent with state and federal statutes, regulations, and subregulatory guidance.

3.1.1.1 HCA does not require submission or approval for storyboards or scripts on Enrollee materials when electronic media ads are used to develop name recognition (branding) and no reference is made to the Apple Health (Medicaid) managed care program(s) or benefits.

3.1.2 The Contractor shall ensure all submissions are fully vetted and include correct references that align with the set material standards.

3.2 Marketing

3.2.1 Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by HCA.

3.2.2 Marketing material must not contain an invitation, implied or implicit, for an Enrollee to change from one AHEHP to the Contractor, or imply that the Contractor's benefits are substantially different from any other AHEHP. This does not preclude the Contractor from distributing (i) state-approved Enrollee materials regarding the scope of their own value-added benefits or (ii) Medicare and state-approved marketing regarding the scope of their supplemental benefits in compliance with the Medicare Communications and Marketing Guidelines (MCMG).

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

3.2.3.1 Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as identified by HCA.

3.2.3.2 HCA may determine, in its sole judgment, if materials that are primarily visual, auditory, or tactile meet the requirements of this Contract.

3.2.4 Marketing Materials shall not contain misrepresentations, or false, inaccurate, or misleading information.

3.2.5 Marketing Materials must be distributed in all service areas the Contractor serves.

3.2.6 The Contractor shall not offer or accept (other than the payment by HCA) anything of value as an inducement to enrollment.

3.2.7 The Contractor must not seek to influence enrollment in conjunction with the sale or offering of any other insurance.

3.2.8 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment.

3.2.9 The Contractor must not make any assertion or statement, whether written or

oral, in marketing materials that a Potential Enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits.

3.2.10 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by state government.

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

3.3 Value-Added Benefits (VAB)

3.3.1 All value-added benefits (VAB) must be pre-approved by the HCA and be consistent with Applicable laws.

3.3.2 Subject to the prior approval of HCA, the Contractor may provide services to Enrollees that are in addition to those covered under this contract or otherwise included in a Contracted Service. For each VAB, the Contractor must:

3.3.2.1 Describe the full scope of the services to be provided;

3.3.2.2 Identify the category or group to receive the proposed VAB(s) if is a type of service that is not appropriate for all Enrollees (age, gender, service area, pilot area); and

3.3.2.3 Identify the length of time the VAB(s) will be provided to the Enrollee.

3.3.2.3.1 A minimum of twelve (12) months from approval date is required. Contractor cannot reduce or delete any VAB during the year without prior written approval from HCA and may request a shorter duration in special circumstances.

3.3.3 If a VAB(s) timeframe has come to an end and the Contractor no longer intends to offer the VAB(s), they must provide written notification to HCA and all Enrollees who the service was available to that the VAB(s) will no longer be available thirty (30) calendar days prior to its expiration.

3.3.4 The cost of a VAB provided by the Contractor will not be reflected in rate setting.

3.3.5 If the Contractor will provide a VAB on a routine basis and/or includes the benefit in the Managed Care handbook, the VAB must be prior approved in writing by the state. Any changes to an approval VAB must also be prior approved in writing by the state.

3.3.6 The Contractor shall not require an Enrollee to accept a VAB instead of a Contracted Service.

3.4 Value-Added Benefits (VAB) Web Page

3.4.1 Contractor will develop and maintain a web page with an emphasis on the value-added benefits (VAB) they offer to Enrollees. The web page must be placed in a separate section, distinguishable from the Contracted Services, and will at a minimum:

3.4.1.1 Display the name of each VAB;

3.4.1.2 Have a detailed description of the VAB with a frequently asked

questions (FAQ) section, if applicable. This information may be placed in a link if its length makes inclusion on the main VAB webpage impractical;

3.4.1.3 Explain service area, if not the entire state;

3.4.1.4 Display current expiration date of the VAB if it will sunset before January 1 of the coming year;

3.4.1.5 Have links to any needed forms; and

3.4.1.6 Provide current contact information for Contractor's resource for questions on VABs.

3.5 Value-Added Benefits (VAB) Comparison Chart

3.5.1 The Contractor will support efforts to ensure Enrollees have access to the Apple Health Managed Care Value-Added Benefits Comparison Chart.

3.5.2 The Contractor will be given the opportunity to update the Apple Health Managed Care Value-Added Benefits Comparison Chart once per State Fiscal Year (SFY) with changes due no later than August 31.

3.6 Information Requirements for Enrollees and Potential Enrollees

3.6.1 The Contractor shall provide to Potential Enrollees and new Enrollees the information needed to understand benefit coverage and obtain care. The information shall be provided at least once a year, upon request and within fifteen (15) Business Days after the Contractor was notified of enrollment.

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

3.6.3 The HCA will produce and the Contractor shall use managed care handbook templates. HCA-produced templates and HCA-approved Contractor handbooks will provide sufficient, accurate and current written information to assist Potential Enrollees in making an informed decision about enrollment.

3.6.4 The Contractor shall provide to each Enrollee, and to each Potential Enrollee who requests it, HCA-approved Managed Care handbooks.

3.6.4.1 The Contractor shall provide HCA-approved Managed Care handbooks in a translated version or through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and Potential Enrollees with disabilities or limited English proficiency.

3.6.4.2 The Contractor shall develop content for the Managed Care handbooks in the sections labeled for Contractor use in the templates.

3.6.5 The Contractor may develop supplemental materials specific to the Contractor's programs, in addition to the Managed Care handbooks that are sent to newly enrolled and assigned Enrollees. The supplemental, plan-specific, material shall

be incorporated into the Managed Care handbook templates as instructed by HCA. The supplemental, plan-specific, materials will include mandatory materials such as NCQA-required materials and the annual notices that the Contractor is required to send to Enrollees.

3.6.5.1 Supplemental, plan–specific, materials may not duplicate information, such as covered benefits, contained in HCA's approved handbook templates and the Contractor's approved Managed Care handbooks, but may include contact numbers for Contractor's customer service, information about the Contractor's authorization processes, network Providers and/or VABs that the Contractor provides.

3.6.5.1.1 Contractor may not include a VAB in any material distributed to Enrollees or prospective Enrollees until it has been approved in writing by the HCA.

3.6.5.1.2 HCA-approved VABs may be included in supplemental, plan-specific materials, with information to distinguish what is offered above the Medicaid-covered service.

3.6.6 The Contractor shall include with all written materials a tagline and information on how the Enrollee can request Auxiliary Aids and Services including the provision of information in an alternative language and format that is understandable to the Enrollee. If the Enrollee requests the tagline in a conspicuously visible font size, the Contractor shall provide it to the Enrollee in either paper form or electronically within five (5) Business Days.

3.6.7 The Contractor shall submit Enrollee information developed by the Contractor that specifically mentions AH-IMC or the specific benefits provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval, including any Enrollee materials regarding Utilization Management activities that are developed by the Contractor or its delegates. All other Enrollee materials shall be submitted as informational. HCA may waive the thirty day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.

3.6.8 The Contractor shall notify all new AH-IMC Health Home-eligible Enrollees of their eligibility for the Health Home program. The notice shall include all of the following:

3.6.8.1 A description of the benefits of the program;

3.6.8.2 Confirmation that program participation is voluntary and not a condition for the Enrollee's receipt of any other covered service;

3.6.8.3 Information about how to file Grievances and appeals;

3.6.8.4 A statement that a participant has the right to change Care Coordination Providers and the procedure for doing so; and

3.6.8.5 How to obtain more information about the program.

3.6.9 The Contractor shall notify all known pregnant Enrollees about their eligibility to participate and receive Maternity Support Services (MSS) through HCA First

Steps program.

3.6.9.1 The Contractor must use HCA MSS informational letter template to notify these Enrollees. HCA will provide the template to the Contractor. No later than the twentieth of each month, the Contractor shall submit to HCA a list of all Enrollees who are newly identified within the preceding month as pregnant or are within sixty (60) calendar days postpartum. The Contractor shall submit the list to HCA using HCA First Steps Maternity Support Services report template. HCA will provide the Support Services report template to the Contractor.

3.6.10 The Contractor shall communicate changes to state or federal law to Enrollees no more than ninety (90) calendar days after the effective date of the change and Enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the Enrollees' quality of or access to care, which may include changes to: enrollment rights, Grievance and hearing procedures, benefits, authorizations or coverage of Emergency Services. HCA shall notify the Contractor in writing of any significant change.

3.6.11 The Contractor shall create a link on the front page of its website for providers and Enrollees that directs said providers and Enrollees to a behavioral health website. The behavioral health website shall:

3.6.11.1 Contain information on how to access behavioral health services;

3.6.11.2 Inform the Enrollee about Ombuds services and how to access these services;

3.6.11.3 Include information on how to contact the Contractor should the provider or Enrollee have difficulty accessing such care;

3.6.11.4 Include information about the behavioral health resource line; and

3.6.11.5 Include link to the HCA WISe webpage.

3.6.12 The Contractor will have a written process for development, review, and approval of all marketing and Enrollee information including those provided by a third party. This process shall be provided to HCA upon request. It must include the names of the approving source for all internal and third party documents. All documents must be approved by the Contractor as meeting all contract terms, and federal, state, and local laws prior to submission to HCA.

3.7 Language Access for Enrollees and Potential Enrollees

The Contractor shall assure equal access for all Enrollees and Potential Enrollees when oral or written language communications creates a barrier to such access. The Contractor must also participate in a workgroup with HCA to achieve alignment on data collection and reporting for Language Access services utilization.

3.7.1 Interpretation

3.7.1.1 The Contractor shall ensure interpreter services are provided free of charge for Enrollees and Potential Enrollees who need interpretation in a language other than English or those who are Deaf, DeafBlind, or Hard of Hearing. This includes oral

interpretation, Sign Language (SL), and the use of Auxiliary Aids and Services as defined in this Contract. Interpreter services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and the Contractor or any of its providers including, but not limited to:

3.7.1.1.1 Customer service,

3.7.1.1.2 All interactions or appointments with any provider for any covered service,

3.7.1.1.3 Emergency Services, and

3.7.1.1.4 All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions.

3.7.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters, including, but not limited to, handling Enrollee Grievances and Appeals.

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

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

3.7.2 Translations

3.7.2.1 The Contractor shall provide all generally available and Enrollee-specific written materials through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and Potential Enrollees. For the purposes of this subsection, the Enrollee's preferred language may not be the same as their primary language. The Contractor must translate materials into the Enrollee's preferred language.

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

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

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

language.

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

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

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

3.7.2.1.4.3 Having an interpreter read the material to the Enrollee or Potential Enrollee in the Enrollee's preferred language.

3.7.2.1.4.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Enrollee or Potential Enrollee. The Contractor shall document the Enrollee's or Potential Enrollee's acceptance of the material in an alternative medium or format Providing the material in English, if the Contractor documents the Enrollee's or Potential Enrollee's preference for receiving material in English.

3.7.2.2 The Contractor shall ensure that all written information provided to Enrollees or Potential Enrollees is: accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth (6th) grade reading level, provided in a font size no smaller than 12 point, and fulfills other requirements of the Contract as may be applicable to the materials HCA may make exceptions to the sixth grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth (6th) grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth (6th) grade reading level must be in writing.

3.7.2.3 Educational materials about topics such as preventative services or other information used by the Contractor for health promotion efforts must be submitted to HCA within thirty (30) calendar days of use, but do not require HCA approval as long as they do not specifically mention AH-IMC or the benefits provided under this Contract.

3.7.2.4 Educational materials that are not developed by the Contractor or developed under contract with the Contractor are not required to

meet the sixth grade reading level requirement and do not require HCA approval.

3.7.2.5 All other written materials must have the written approval of HCA prior to use. For Enrollee-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

3.7.2.6 The Contractor may provide the Enrollee handbook information in any of the following ways:

3.7.2.6.1 Mailing a printed copy of the information to the Enrollee's mailing address;

3.7.2.6.2 Providing the information by email after obtaining the Enrollee's agreement to receive the information by email;

3.7.2.6.3 Posting the information on its website and advising the Enrollee in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided Auxiliary Aids and Services upon request at no cost, or

3.7.2.6.4 Providing the information by any other method that can reasonably be expected to result in the Enrollee receiving the information.

3.7.3 If the Contractor provides this information electronically, it must meet the following requirements:

3.7.3.1 The format is readily accessible and takes into consideration the special needs of Enrollees and Potential Enrollees with disabilities or limited English proficiency;

3.7.3.2 The information is placed in a location on the Contractor's website that is prominent and readily accessible;

3.7.3.3 The information is provided in an electronic form which can be electronically retained and printed;

3.7.3.4 The information is consistent with the content and language requirements of; and

3.7.3.5 The Enrollee must be informed that the information is available in paper form without charge within five (5) Business Days of Enrollee request.

3.8 Electronic Outbound Calls

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

3.8.1 The Contractor must submit call scripts to HCA no less than thirty (30) calendar

days prior to the date the automated calls will begin. Approvable reasons for automated calls include:

3.8.1.1 Recertification of eligibility;

3.8.1.2 Outreach to new Enrollees;

3.8.1.3 Reminders of events such as flu clinics;

3.8.1.4 Initial health screening;

3.8.1.5 Surveys;

3.8.1.6 Appointment reminders/immunizations; and

3.8.1.7 Notification of new programs or assistance offered.

3.8.2 Under no circumstances will the Contractor use automated calls for Care Coordination activities, behavioral health-related calls or prescription verifications.

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

3.9 Medication Information

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

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

3.9.2 Information must be consistent with content and language requirements.

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

3.10 Conscience Clause

The Contractor shall notify Enrollees at least sixty (60) calendar days before the effective date when it adopts a policy to discontinue coverage of a counseling or referral service based on moral or religious objections (RCW 48.43.065).

4 ENROLLMENT

4.1 Regional Service Areas (RSA)

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

4.1.1 The Contractor's RSAs are identified in Exhibit D, AHE Regional Service Area.

4.2 RSA Changes

4.2.1 The Contractor must offer services to all Enrollees within the boundaries of the RSA covered by this Contract.

4.2.2 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's RSA, HCA shall alter the RSA zip code numbers or the boundaries of the RSA with input from the affected contractors.

4.2.3 HCA shall determine which zip codes fall within each RSA.

4.2.4 HCA will use the Enrollee's residential zip code to determine whether an Enrollee resides within a RSA.

4.2.5 Regional Service Area Changes.

4.2.5.1 The timing of the RSA changes will be at HCA's sole discretion.

4.2.5.2 At HCA's sole discretion, and upon execution of a formal contract amendment, HCA may either expand a Contractor's RSA, when HCA determines it is in the best interest of HCA.

4.2.5.3 HCA may solicit Contractors when considering RSA changes to expand into an RSA to meet goals for improved access, improved quality of care and service, or to meet the target goal for the number of Contractors per region per HCA policy.

4.3 Eligible Client Groups

4.3.1 HCA shall determine AHE eligibility for enrollment under this Contract, and Enrollees will be identified by Recipient Aid Categories (RACs) codes: 1284 or 1285 if they are eligible to enroll in Apple Health Expansion to receive full scope benefits. Enrollees in this eligibility group at the time of enrollment are eligible for enrollment under this Contract. Client Notification

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

4.4 Enrollment Period

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

4.5 Enrollment Process

4.5.1 Eligible clients may choose an AHE plan through the AHE plan selection process. All eligible family members will be enrolled to the same AHE Contractor.

4.5.2 The HCA will assign the clients who do not make an AHE plan selection. All eligible family members will be assigned to the same AHE Managed Care Contractor in accordance with the Assignment of Enrollees provisions of this Contract.

4.5.3 An Enrollee may change his or her AHEHP, with or without cause, at any time. The effective date of the change in AHEHP shall be consistent with HCA's established enrollment timelines.

4.5.4 The Enrollee, the Enrollee's representative must notify HCA if they want to choose another AHEHP.

4.5.5 The HCA will attempt to enroll all family members with the same AHE Managed Care plan unless the following occurs:

4.5.5.1 A family member is placed into the Patient Review and Coordination (PRC) program by the Contractor or HCA. The PRC placed family member shall follow the enrollment requirements described in the PRC provisions of this Contract. The remaining family members shall be enrolled with a single AHE Managed Care plan of their choice.

4.5.5.2 The HCA grants an exception because the family members have conflicting medical needs that cannot be met by a single AHE Managed Care Contractor.

4.6 Effective Date of Enrollment

4.6.1 HCA shall enroll all newly eligible AHE clients subject to this Contract into AHE effective the first day of the month, if both the date of initial AHE eligibility and the managed care enrollment take place in the current month.

4.6.2 The Contractor is responsible for payment, medical necessity determinations and service authorizations for all services provided on and after the effective date of enrollment.

4.6.3 No retroactive coverage is provided under this Contract, except as described in this Section or by mutual, written agreement by the parties.

4.6.3.1 Applicants who are denied or delayed coverage and then through HCA's Administrative Hearing Process determined to be eligible shall be enrolled with a retroactive effective date to the original application.

4.7 Newborns Effective Date of Enrollment

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

4.7.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur, effective when the newborn is reported to HCA.

4.7.2 If the newborn does not receive a separate client identifier from HCA, the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.

4.7.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from HCA, the newborn's enrollment shall end the last day of the month in which the twenty-first (21st) day of life occurs or when the mother's

enrollment ends, whichever is sooner, except as provided in the provisions of Subsection 16.6, Enrollee in Facility at Termination of Enrollment of this Contract.

4.7.4 A newborn whose mother is enrolled with the Contractor when the baby is born and the newborn is placed in foster care during the month of birth, the newborn is enrolled with the Contractor for the month of birth. The newborn will be enrolled with the Apple Health Foster Care (AHFC) program effective the first of the month that follows placement. Subject to the terms in Subsection 16.4, Enrollee in Facility at Enrollment: Medical and Acute Behavioral Health Conditions, the MCO with which a newborn was enrolled at birth is responsible for hospital costs until the newborn is discharged from the birth hospitalization.

4.7.5 A newborn, whose mother is not covered by Apple Health or any comparable coverage, and the newborn is determined eligible in the month of birth for Apple Health Medicaid prior to discharge from their initial birth hospitalization shall be enrolled according to HCA enrollment rules. The Contractor will be responsible for hospital costs for the newborn starting from the month of enrollment.

4.8 AHEHP Enrollment Data and Requirements for Contractor's Response

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

4.8.1 Data files will be sent to the Contractor at intervals specified within HCA 834 Benefit Enrollment and Maintenance Companion Guide, published by HCA and incorporated by reference into this Contract.

4.8.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format.

4.8.3 The data file will be transferred per specifications defined within HCA Companion Guides.

4.8.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify HCA in writing of the refusal of an application for enrollment or any discrepancy regarding HCA's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by HCA. The effective date of enrollment specified by HCA shall be considered accepted by the Contractor and shall be binding if the notice is not timely or HCA does not agree with the reasons stated in the notice. Subject to HCA approval, the Contractor may refuse to accept an Enrollee for the following reasons:

4.8.4.1 HCA has enrolled the Enrollee with the Contractor in a RSA where the Contractor is not contracted.

4.8.4.2 Enrollee is not eligible for enrollment under the terms of this Contract.

4.9 Termination of Enrollment

4.9.1 AHEHP Involuntary Termination Initiated by the Contractor from Apple Health Expansion

4.9.1.1 To request involuntary termination of enrollment of an Enrollee, the Contractor shall send written notice to HCA at hcamcprograms@hca.wa.gov.

4.9.1.1.1 HCA shall review each involuntary termination

request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) Business Days of HCA's receipt of such notice and the documentation required to substantiate the request. HCA shall approve the request for involuntary termination of the Enrollee when the Contractor has substantiated in writing any of the following:

4.9.1.1.1.1 The Enrollee purposely puts the safety or property of the Contractor, or the Contractor's staff, providers, patients, or visitors at risk, and the Contractor's attempts to address this behavior with reasonable accommodations of any disability of the Enrollee have not been successful; and continued enrollment would seriously impair the Contractor's ability to furnish services to the Enrollee or any other Enrollees;

4.9.1.1.1.2 The Enrollee engages in intentional misconduct, including refusing without good cause to provide information to the Contractor about third party insurance coverage; or

4.9.1.1.1.3 The Enrollee received written notice from the Contractor of its intent to request the Enrollee's termination of enrollment, unless the requirement for notification has been waived by HCA because the Enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the Enrollee shall include the Enrollee's right to use the Contractor's Grievance Process to review the request to end the Enrollee's enrollment.

4.9.1.2 The Contractor shall continue to provide services to the Enrollee until HCA has notified the Contractor in writing that enrollment is terminated.

4.9.1.3 HCA will not terminate enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or behavioral health condition).

4.9.1.4 The Contractor shall have in place, and provide upon HCA's request, written methods by which it assures it does not request

disenrollment for reasons other than those permitted under this Contract.

4.9.2 An Enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive contracted services, at the Contractor's expense, through the end of that month.

4.9.3 In no event will an Enrollee be entitled to receive services and benefits under this Contract after the last day of the month, in which his or her enrollment is terminated, except:

4.9.3.1 When the Enrollee is hospitalized or in another inpatient Facility covered by this Contract at termination of enrollment and continued payment is required in accordance with the provisions of this Contract.

4.9.3.2 For the provision of information and assistance to transition the Enrollee’s care with another provider.

4.9.3.3 As necessary to satisfy the results of an appeal or hearing.

4.9.4 Regardless of the procedures followed or the reason for termination, if a disenrollment request is granted, or the Enrollee’s enrollment is terminated by HCA for one of the reasons described in subsection 4.9.1 of this Contract, the effective date of the disenrollment will be no later than the first day of the second month following the month the request was made. If HCA fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

5 PAYMENT AND SANCTIONS

5.1 Rates/Premiums

5.1.1 Subject to the Sanctions provisions of this Section, HCA shall pay a monthly premium for each Enrollee under this Contract in full consideration of the work to be performed by the Contractor under this Contract. HCA will only pay monthly premium payments for Enrollees under this Contract in the eligible client groups detailed in Subsection 4.3 of this Contract. HCA shall pay the Contractor, on or before the fifteenth calendar day of the month based on HCA list of Enrollees whose enrollment is ongoing or effective on the first day of said calendar month.

5.2 Monthly Premium Payment Calculation

5.2.1 The capitation rates are identified and developed, and payment is made in accordance with generally accepted actuarial principles and practices.

5.2.1.1 The Behavioral Health component of the capitation rate is based on services provided by DOH licensed Behavioral Health Agencies as described on Exhibit I.

5.2.2 The monthly premium payment for each Enrollee under this Contract will equal the capitation rates for each age band.

5.2.2.1 Premium Payment = Capitation Rate (at the age cell level)

5.2.3 Additional premium payments include Wraparound with Intensive Services (WISe), and New Journeys as described in the WISe Payment, and New Journeys subsections in this Contract.

5.2.4 The premium payment formula is established by HCA and will vary between age bands within the AHE population. The base rates will be the same for all Contractors. Risk adjustment and withhold factors will not be applied during the initial program year.

5.2.5 HCA shall make a full monthly payment to the Contractor for the month in which an Enrollee's enrollment is terminated except as otherwise provided in this Contract.

5.2.6 The Contractor shall be responsible for contracted services provided to the Enrollee in any month for which HCA paid the Contractor for the Enrollee's care under the terms of this Contract.

5.3 Audited Financial Report

5.3.1 The Contractor shall submit an Audited Financial Report annually to HCA that is specific to this Contract. The Contractor shall submit the report to HCA via MC-Track no later than June 5 of each year for the previous calendar year. The reports shall adhere to accepted accounting principles or, statutory accounting principles and generally accepted auditing standards.

5.4 Risk Corridor Calculation

5.4.1 AHEHPs must report MLR experience calculated in accordance with Exhibit B. Any settlements which result from the risk corridor calculation will be limited such that the Contractor’s minimum MLR will not be less than 85 percent when the settlement amount is included in the MLR calculation. Effective January 1, 2025, the Contractor must impose reporting requirements on any Subcontractor

adjudicating claims equivalent to the requirements specified in Exhibit B, Instructions for Medical Loss Ratio (MLR) Reporting, of this Contract as applicable to the Subcontractor. Effective January 1, 2025, the Contractor shall impose the remittance requirements on any Subcontractors adjudicating claims, consistent with the risk corridor provisions described in Subsection 5.4 of this contract. Effective January 1, 2025, the Contractor shall impose the remittance requirements on any Subcontractors adjudicating claims.

5.4.2 HCA performs a two-sided Risk Corridor calculation which includes downside protection for excess medical cost losses incurred by the Contractor The initial Risk Corridor calculation will cover an eighteen-month period (July 2024 through December 2025). Effective January 1, 2026, HCA will perform the Risk Corridor calculation on an annual basis. HCA will perform Risk Corridor calculations for the AHE populations. A single calculation of gain or loss will be done for the entire population. The Risk Corridor is calculated separately for each Contractor.

5.4.3 The following methods will be used to calculate risk corridor components. The initial Risk Corridor calculation will be based on 18 months of experience (July 2024 through December 2025). Effective January 1, 2026, the calculation will be based on 12 months of experience:

5.4.3.1 Total Revenue is the sum of all Pre-Tax Capitation Rates. Total revenue should include administrative costs. Pre-tax capitation rates means that the B&O Tax, and Premium Tax related revenue will be excluded from this risk corridor computation.

5.4.3.2 Total Net Revenue is equal to Total Revenue, net of the following components of capitation revenue: WSHIP.

5.4.3.3 Revenue for Health Care Expenses is defined as the Total Net Revenue less an assumed administrative load, consistent with the administrative load assumptions applied and documented in the actuarial rate certification. [(Total Net Revenue) x (1- administrative load)] Actual administrative expenses will not be included in the computation. The administrative load varies by population and rate period. The assumed administrative load is shown on Exhibit A.

5.4.3.4 Net Health Care Expenses will be based on the actual medical service expenses incurred during the contract year less any disbursements for separate payment terms, reimbursements from third-party reimbursements (including, but not limited, to pharmacy rebates, pricing guarantee payments from pharmacies and PBM, Overpayment or audit recoveries from providers, net reinsurance costs or third-party liability offsets) and less provider pass-through or directed payments that are not minimum fee schedules plus activities that improve health care quality , excluding any overhead allocations. Reduction must also be made for claims costs represented by encounters that are rejected by ProviderOne. Subcontractor expenses will be handled in accordance with Exhibit D. Upon request by HCA, the Contractor will report its health care expenses for the year with any adjustments and run out claims as specified in the request from HCA. The template for providing the data and due date for the report will be included in the request from

HCA.

5.4.3.5 If the Contractor has a material recovery after the final Risk Corridor calculation has been completed by the designated actuary for items which include, but are not limited to, pharmacy rebates, pricing guarantee payments from pharmacies and PBM, Overpayment or audit recoveries from providers, net reinsurance costs or third-party liability offsets, then the material recovery may be remitted to HCA in full by the Contractor. HCA will make the determination of whether the material recovery is remitted to HCA in full by the Contractor. For purposes of this paragraph, the term 'material recovery' means a recovery for which the Contractor's calculated gain would exceed the minimum threshold of the Risk Corridor when the gain is adjusted to reflect any such recovery.

5.4.3.6 Contractor's Gain/Loss will be calculated for each population using the following formula: **Revenue for Health Care Expenses - Net Health Care Expenses** (based on the actual incurred expenses for health care) = **Net Gain/Loss** (for the health care services provided by population).

5.4.3.7 The Net Gain/Loss divided by the Total Net Revenue will provide a percentage of the gain/loss, which will be compared to the appropriate gain sharing/risk corridor thresholds established by HCA.

5.4.4 Under the Risk Corridor, HCA will share in both gain and loss as defined in subsection 5.5.5 of this Contract. Six (6) months following the end of the calendar year, using the financial reports provided by the Contractor, a simple profit and loss statement will be developed for the health services portion for each of the applicable populations.

5.4.5 For the Risk Corridor, after aggregating the results for all populations, if the Contractor experiences gain exceeding 1 percent, HCA will share equally in the gain between 1 percent and 2 percent. HCA will recover all gains exceeding 2 percent. The Contractor will only be required to reimburse HCA if it experiences an actual gain above 1 percent. If the Contractor experiences loss exceeding 1 percent, HCA will cover all losses exceeding 1 percent. The Contractor will only receive reimbursement from HCA if it experiences an actual loss exceeding 1 percent.

5.4.5.1 Following the completion of the final draft Risk Corridor calculations, HCA will share the report from HCA's designated actuaries and supporting information with the Contractor via email. Additional Contractor-specific data files in support of the calculations will be provided to the Contractor vis HCA Managed File Transfer (MFT) sites on the same day. Upon receipt of the emailed files, the Contractor will have sixty (60) calendar days to provide any new information to HCA that it deems relevant to the calculations. HCA will not consider any additional new information after that point.

5.4.5.2 Following the completion of the final Risk Corridor calculations, HCA will share the report from HCA's designated actuaries and

supporting information with the Contractor via email. Additional Contractor-specific data files in support of the calculations will be provided to the Contractor via HCA Managed File Transfer (MFT) sites. An Invoice Voucher form (A-19) will be provided to each Contractor indicating the amount due to, or due from, the Contractor.

5.4.5.2.1 To convey agreement with the final calculations, the Contractor shall sign and return an electronic copy of the Invoice Voucher (A-19) form within fifteen (15) calendar days of receipt of the final Risk Corridor documentation.

5.4.5.2.2 To convey disagreement with the final calculations, the Contractor may request a dispute resolution conference by submitting a written request to HCA within fifteen (15) calendar days of receipt of the final Risk Corridor documentation, in accordance with Subsection 2.10 of this Contract.

5.4.5.3 If HCA owes reimbursement to the Contractor, payment will be initiated via a gross adjustment in ProviderOne within thirty (30) calendar days of receipt of the signed Invoice Voucher (A-19).

5.4.5.4 If the Contractor owes a remittance to HCA, they can choose to either send payment via wire transfer or ask HCA to recoup the amount due via a gross adjustment in ProviderOne. Contractors that owe a remittance amount shall indicate the method of payment to HCA when they return the signed Invoice Voucher (A-19). If the Contractor chooses to pay via wire transfer, HCA financial services staff will provide the correct coding to use for the transfer of funds. Payment of the remittance amount owed is due within thirty (30) calendar days of the receipt of the signed Invoice Voucher (A-19) form.

5.5 Recoupments

5.5.1 Unless mutually agreed by the parties in writing, HCA shall only recoup premium payments and retroactively terminate enrollment for an individual Enrollee:

5.5.1.1 With Duplicate Coverage as defined in this Contract.

5.5.1.2 Who is deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the Enrollee's date of death.

5.5.1.3 Who retroactively has their enrollment terminated consistent with this Contract.

5.5.1.4 Who has been found ineligible for enrollment with the Contractor, provided HCA has notified the Contractor before the first day of the month for which the premium was paid.

5.5.1.5 Who is an inmate at a correctional facility in any full month of

enrollment.

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

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

5.5.2.1 Shall void the invalid encounters;

5.5.2.2 May recoup payments made to providers.

5.5.2.2.1 If the Contractor recoups said payments:

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

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

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

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

5.6 WISe payment

5.6.1 A separate monthly case rate payment will be made through ProviderOne for Enrollees in the WISe program as defined in this Contract and further described in Subsection 17.1 of this Contract. A single monthly case rate payment will be paid to the Contractor only for months with qualifying encounters that meet the criteria as outlined in the Encounter Data Reporting Guide.

5.7 New Journeys

5.7.1 A separate case or encounter rate up to the specified maximum payment will be made monthly through Provider One for Enrollees in New Journeys, which includes certain mental health Outpatient services rehabilitation services. The actual services delivered to client(s) will vary depending upon their individual needs and treatment plan. The case rate or encounter paid to the Contractor will vary depending on the length of the enrollment in the program, as well as intensity of the services. A single monthly case rate or encounter payment up to the specified maximum will be paid to the Contractor only for months with qualifying encounters that meet the criteria as outlined in the Encounter Data Reporting Guide.

5.8 HCA Non-Contracted Drugs

5.8.1 The prescription drugs included in Exhibit H, HCA Administrative Services Only (ASO) Non-Contracted Drugs, are excluded from the premium payments described in subsection 5.2 of this Contract for the Apple Health Expansion population when not administered in an inpatient setting, except when indicated on Exhibit H, ASO HCA Non-Contracted Drugs.

5.9 Apple Health ASO Non-Contracted Drug List Payment

5.9.1 The cost of all outpatient pharmacy products included on the ASO Non-Contracted Drugs list included in Exhibit H and described in subsection 17.4.3.13 of this Contract, are excluded from the monthly premium payments described in Subsection 5.2 of this Contract for the Apple Health Expansion Population.

5.9.2 The Contractor shall continue to administer the ASO Non-Contracted pharmacy products listed on Exhibit H of this Contract and submit paid encounters for pharmacy products in the National Council for Prescription Drug Programs (NCPDP) Batch format as required in Subsection 5.11.

5.9.3 HCA shall reimburse the Contractor for the expenditures for outpatient prescription drugs on the ASO Non-Contracted drugs listed in Exhibit H of this Contract that were dispensed beginning July 1, 2024.

5.9.3.1 The Contractor shall be reimbursed for qualifying accepted NCPDP pharmacy encounters including an administrative fee in the amount shown on Exhibit A by generating a Service Based Enhancement (SBE) payment for encounters for pharmacy products on the ASO Non-Contracted Drugs listed in Exhibit H of this Contract.

5.10 Prospective or Retrospective Premium Adjustments

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

5.11 Encounter Data

5.11.1 For purposes of this Subsection:

5.11.1.1 "Encounter" means a single physical or behavioral health care service or a period of examination or treatment.

5.11.1.2 "Encounter Data" means records of physical or behavioral health care services submitted as electronic data files created by the Contractor's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.

5.11.1.3 "Encounter Record" means the number of service lines or products

submitted as line items in the standard 837 format or the National Council for Prescription Drug Programs (NCPDP) Batch format.

5.11.1.4 "Duplicate Encounter" means multiple encounters where all fields are alike except for the ProviderOne Transaction Control Numbers (TCNs) and the Contractors Claim Submitter's Identifier or Transaction Reference Number.

5.11.2 The Contractor shall submit and maintain accurate, timely, and complete encounter data to facilitate appropriate rate development and development of enhanced payment amounts that are dependent upon accurate and complete encounter data. The Contractor shall comply with all of the following:

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

5.11.2.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:

5.11.2.2.1 Encounter data must be submitted to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability;

5.11.2.2.2 Submitted encounters and encounter records shall have all fields required and found on standard healthcare claim billing forms or in electronic healthcare claim formats to support proper adjudication of an encounter. The Contractor shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the provider's original claim submission to the Contractor;

5.11.2.2.3 Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Contractor; and

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

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

5.11.3 For dates of service beginning January 1, 2025, the Contractor must conduct an

annual audit for the previous calendar year of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, the Contractor, which will align with the following requirements:

5.11.3.1 The Contractor shall submit the Audited Encounter Data Report annually to HCA via MC-Track no later than June 5.

5.11.3.2 The retrospective review must compare accepted and rejected encounters to the claims paid by, or on behalf of, the Contractor for all dates of service within the calendar year.

5.11.3.3 The report shall address all discrepancies between the accepted or rejected encounters to the claims paid by, or on behalf of, the Contractor, and provide a summary of measures implemented to mitigate future discrepancies.

5.11.4 The Contractor must report the paid date, paid unit, and paid amount for each encounter. Paid amount shall not be utilized in the consideration of a Contractor's assignment percentage.

5.11.5 HCA shall perform encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.

5.11.6 The Contractor must certify the accuracy and completeness of all encounter data concurrently with each file upload. The certification must affirm that:

5.11.6.1 The Contractor has reported to HCA for the month of (indicate month and year) all paid claims for all claim types;

5.11.6.2 The Contractor has reviewed the claims data for the month of submission; and

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

5.11.6.3.1 The Contractor shall submit this certification via MC-Track using the Daily Encounter Upload Notification template. The certification is to be submitted whenever Encounter data files are submitted in Provider One.

5.11.7 The Contractor shall submit a signed Monthly Certification Letter, a template is available through MC-Track. This letter must include a list of all submitted encounter data files and is due within five (5) Business Days from the end of each month. The purpose of this letter is to certify that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful in accordance with this Contract.

5.11.8 The Contractor must validate the accuracy and completeness of all encounter data for physical health care services compared to the year-to-date general

ledger of paid claims for the health care services.

5.11.8.1 Within sixty (60) calendar days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounter data submitted and accepted within required timing in subsection 5.11.2.2 of this Section during that quarter using the Apple Health Apple Health Expansion Quarterly Encounter/General Ledger Reconciliation (Form D), available through MC-Track, and shall reconcile the cumulative encounter data submitted and accepted for the quarter and Contract year with the general ledger paid claims for the quarter. The Contractor shall provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the Contractor of the decision 120 calendar days of the end of each calendar quarter.

5.11.8.2 The Contractor's encounter data submitted and accepted on Form D will be validated against submitted and accepted data captured within HCA's ProviderOne System and must be within 1 percent of what HCA captured.

5.11.8.2.1 If the Contractor's encounter data submitted and accepted on Form D is not within 1 percent of the submitted and accepted encounter data captured within HCA's ProviderOne System, HCA will provide the Contractor a list of ProviderOne TCNs and associated Contractor's Transaction Reference Numbers. The Contractor must explain the difference in the encounter data provided by HCA with the encounter data submitted and accepted on Form D for that quarter. HCA will approve or reject the Contractor's explanation. If approved, the reconciliation process will use the submitted and accepted encounter data on the Contractor's Form D. If rejected, the reconciliation process will use the submitted and accepted encounter data captured within HCA's ProviderOne System.

5.11.8.3 Following the completion of the quarterly validation process described in subsections 5.11.7.1 through 5.11.7.2 of this Section, HCA may charge the Contractor $25,000 for nonperformance if the Contractor fails to demonstrate that the encounter data submitted and accepted within required timing reconciles to the general ledger amounts within 1 percent. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

5.11.9 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other Program Integrity activities, rate setting and risk adjustment, service verification, Managed Care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies.

5.11.10 Additional detail can be found in the Encounter Data Reporting Guide and Service Encounter Reporting Instructions (SERI) Guide published by HCA and

incorporated by reference into this Contract:

5.11.10.1 HCA may change the Encounter Data Reporting Guide and SERI Guide with ninety (90) calendar days' written notice to the Contractor. The SERI Guide can be found at: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/service-encounter-reporting-instructions-seri.

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

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

5.12 Retroactive Premium Payments for Enrollee Categorical Changes

5.12.1 Enrollees may have retroactive changes in their eligibility category. With the exception of the Recoupment categories listed in Subsection 5.5, such changes will only affect premium payments prospectively.

5.13 Renegotiation of or Changes in Rates

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

5.14 Reinsurance/Risk Protection

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

5.15 Provider Payment Reform

5.15.1 HCA intends to reform provider payment. The Contractor shall work with HCA to implement cost-effective payment reform models. The Contractor will provide in a timely manner any information necessary to support HCA's analyses of provider payment.

5.16 Prohibition of Certain Payment Mechanisms

5.16.1 HCA is committed to ensuring alignment between payment structures and service delivery. This includes an emphasis on improving encounter data quality such that sufficient information exists to understand the utilization of services being provided. Contracting arrangements that are not connected to the underlying utilization of services being provided and that lack sufficient encounter data to validate the utilization of services being delivered are inconsistent with this goal. Effective July 1, 2025, the Contractor shall not make payments to Behavioral Health Providers that are based on a percent of the premium payment that the Contractor received from HCA.

5.17 Experience Data Reporting

5.17.1 The Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. HCA

requires this information in order to be able to set actuarially sound rates. The Contractor shall provide the cost experience information to HCA and its designated actuary based on the requirements in this Section.

5.17.2 HCA or its designated actuary, by March 5 of each calendar year, will provide instructions the Contractor must follow concerning the timing, content, format and medium for reporting cost experience information. The instructions will address the reporting requirements, including for the categories of information identified in the subsections below, and will define the prospective rating period, if relevant. This information will be used for annual rate development and Risk Corridor calculations.

5.17.2.1 The Contractor must submit all report modules and attestations through the secure file transfer portal (SFTP) of HCA's designated actuary, with an email to HCA and HCA's designated actuary confirming completion of the submission for the reports identified in subsection 5.16.3 through 5.16.18. The Contractor must also submit a signed PDF of all attestations for each module to HCA through MC-Track.

5.17.2.1.1 All reporting must be submitted by May 1 of each year unless a different date is specified in the subsections below or in further instructions from HCA or its designated actuary.

5.17.2.1.2 The reporting period for all reports is January 1 through December 31 of the prior two calendar years, unless otherwise specified in the subsections below or by further instructions from HCA or its designated actuary.

Experience Data Reporting Modules	
All report modules and attestations are due May 1 of each year unless a different date is specified in the Contract or in further instructions from HCA or its designated actuary.	
Narrative containing issues with potential impact to rate development	Provider incentive and VBP payment details. • Draft due by May 15 of the current calendar year. • Final version by July 14 of the current calendar year.
Administrative expense summary	Sub-capitated provider arrangement details and payment summary
Summary enrollment data	Pharmacy benefit management
Claim Lag Triangle	Value-added Benefits, or Benefits limit extension
Non-Lag Experience	In-lieu of services
Considerations for reviewing BH Data	Third-party liability cost avoidance and recovery information
BH enhancement funding payments	Finance statement information • Due no later than May 22 of each calendar year.
BH non-claims provider payments	Subcontracted providers non-FFS payment detail files
BH provider payments made by subcontracted integrated care networks	Financial reconciliation

Experience Data Reporting Modules	
BH program change implementation status	Quality of reported information
FFS provider reimbursement estimates	BH Involuntary Treatment Act (ITA) inpatient claims
State Directed Payments	Non-participating and out-of-state provider encounters rejected from ProviderOne. • Preliminary version of the claims annually by May 15 of the current calendar year; • Final version by July 14 of the current calendar year.
BH quarterly request • BH non-claims quarterly attestation • BH ICN non-claims quarterly attestation •	Reports due no later than August 1, November 1, February 1, and May 1 of each year.

5.17.3 Narrative containing issues with potential impact to rate development.

5.17.3.1 The Contractor shall submit a narrative addressing any issues with a potential impact to rate development, for the purpose of assisting in the timely development of actuarially sound rates.

5.17.3.2 The Contractor shall submit the narrative related to any issues or changes that impact any portion of the prospective rating period.

5.17.3.3 Examples of the issues that the narrative must address include, but are not limited to, capitation rate setting, Risk Corridor calculations, and emerging experience analysis.

5.17.4 Administrative expense summary.

5.17.4.1 The Contractor shall submit administrative expense summary reports. The Contractor must include a summary that lists any changes that are expected to impact any portion of the prospective rating period and an explanation as to why those changes are expected.

5.17.5 Summary enrollment data.

5.17.5.1 The Contractor shall submit the narrative related to any issues or changes that impact any portion of the prospective rating period.

5.17.6 Annual encounter experience summary.

5.17.6.1 The Contractor shall submit annual encounter experience summary for the reporting period. Additionally, annual encounter experience summary must be reported from January through March of the current calendar year.

5.17.6.1.1 Claim Lag Triangle: A claim lag triangle is a method of summarizing paid claims by both incurred and paid month to demonstrate historical completion patterns.

The claim lag summaries include actual paid claims and an estimate of ultimate incurred claim volume by the AHEHP, by population and high-level service category.

5.17.6.1.2 Non-Lag Experience: Non-lag experience includes summarized AHEHP revenues, benefit cost expenses, non-benefit cost expenses, and membership by incurred month.

5.17.7 Annual Behavioral Health (BH) experience information.

5.17.7.1 The Contractor shall submit the annual behavioral health experience information for the reporting period. Additional annual BH experience information must be reported from January through March of the current calendar year.

5.17.7.1.1 Considerations for reviewing BH Data;

5.17.7.1.2 BH enhancement funding payments;

5.17.7.1.3 BH non-claims provider payments;

5.17.7.1.4 BH provider payments made by subcontracted integrated care networks; and

5.17.7.1.5 BH program change implementation status.

5.17.8 Provider contracting information.

5.17.8.1 The Contractor must provide the following contracting information:

5.17.8.1.1 FFS provider reimbursement estimates;

5.17.8.1.2 A draft of the provider incentive and VBP payment details shall be submitted by May 15 of the current calendar year, and the final version shall be submitted by July 14 of the current calendar year;

5.17.8.1.3 Sub-capitated provider arrangement details and payment summary; and

5.17.8.1.4 Pharmacy benefit management.

5.17.8.2 In addition, the Contractor must provide a narrative explaining any changes in provider contracting, including, but not limited to, professional, hospital, and pharmacy reimbursement rates and payment methodology expected to impact any portion of the prospective rating period.

5.17.9 Extended service coverage information.

5.17.9.1 The Contractor must submit the following extended services coverage information:

5.17.9.1.1 Value-Added Benefits, or benefits limit extension; and

5.17.9.1.2 In-lieu of services.

5.17.10 Third-party liability cost avoidance and recovery information.

5.17.10.1 The Contractor shall submit third-party liability cost avoidance and

recovery information. In addition to the reporting period described above, the Contractor shall provide reporting for January through March of the current calendar year.

5.17.11 Finance statement information.

5.17.11.1 To be addressed in instructions to be provided by HCA's designated actuary.

5.17.11.2 Finance statement information is required to be submitted no later than May 22 of each calendar year.

5.17.12 Subcontracted providers non-FFS payment detail files.

5.17.12.1 The subcontracted providers non-FFS payment details initial filing submission will include two years of payment history for ongoing provider payment tracking. The reporting period for the subcontracted providers non-FFS includes payments and/or transactions made during the previous month from the current calendar month. The subcontracted providers non-FFS payment detail files must be submitted annually.

5.17.12.2 The recurring file submission for the subcontracted providers non-FFS payment details will include monthly payment history for ongoing provider payment tracking. The reporting period for the subcontracted providers non-FFS payment detail files include payments and/or transactions made during the previous month from the current calendar month. The subcontracted providers non-FFS payment detail files must be submitted annually.

5.17.13 Quality assessment and attestation of reported information.

5.17.13.1 Financial reconciliation; and

5.17.13.2 Quality of reported information.

5.17.14 BH Involuntary Treatment Act (ITA) inpatient claims.

5.17.14.1 Instructions to be provided by HCA's designated actuary.

5.17.15 Non-participating and out-of-state provider encounters rejected from ProviderOne.

5.17.15.1 The Contractor shall submit the non-participating and out-of-state provider claims from the reporting period according to the following schedule:

5.17.15.1.1 The Contractor shall submit a preliminary version of the claims annually by May 15 of the current calendar year and a final version by July 14 of the current calendar year.

5.17.16 State-Directed Payments

5.17.16.1 Instructions will be provided by HCA's designated actuary.

5.17.17 BH quarterly request

5.17.17.1 Instructions will be provided by HCA's designated actuary.

5.17.17.2 Beginning August 1, 2023, the Contractor shall submit BH information quarterly: August 1, November 1, February 1, and May 1 of each year.

5.17.18 Information Outside of the Experience Data Reporting Scope.

5.17.18.1 Information that the Contractor sends to HCA or HCA's designated actuary that is outside of the experience data reporting scope will be handled with full confidentiality and be discarded as HCA, or HCA's designated actuary, deems appropriate.

5.17.19 Additional Data Requests from the Contractor.

5.17.19.1 HCA or its designated actuary may require additional information from the Contractor if HCA determines such information is needed for setting actuarially sound rates.

5.17.20 Failure to Submit or Inadequate Experience Data Reporting.

5.17.20.1 If the Contractor fails to submit or submits inadequate experience data that results in harm to the rate setting process, HCA, in its sole discretion, may assess sanctions, impose liquidated damages, or require the Contractor to submit a corrective action plan.

5.17.21 Termination.

5.17.21.1 Upon termination of this Contract, the Contractor shall ensure that experience data reporting is complete and shall certify that any electronic or paper copies collected or maintained in connection with this Contract have been removed, confidentially secured and, if needed, destroyed.

5.18 Payments to Hospitals

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

5.18.2 Administrative Day Rate Criteria

5.18.2.1 The Contractor shall not impose additional criteria to that outlined in WAC 182-550-4550 to determine eligibility for Administrative Days, and shall provide payment to any hospital for allowable Medically Necessary Services performed during an Enrollee's hospital stay for which the Contractor is the payor of the hospital stay, if the hospital stay meets the following requirements:

5.18.2.1.1 Does not meet the criteria for acute inpatient level of care as determined by the Contractor; and

5.18.2.1.2 Meets the criteria for discharge, as determined by the Contractor, and is not discharged because appropriate placement is not available.

5.18.2.2 The Contractor shall adopt the rules, established by HCA, and

published in the Inpatient Hospital Services Billing Guide, identifying which allowable Medically Necessary Services performed during the hospital stay are included in the payments under this subsection and which services may be billed by and paid to the hospital separately by the Contractor. Allowable Medically Necessary Services may include, but are not limited to: pharmacy services, pharmaceuticals, hemodialysis, laboratory charges, and x-rays.

5.18.2.3 The requirements described under this subsection do not alter the requirements for inpatient care billing or payment.

5.18.3 Fourteen-Day Readmission Review Program

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

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

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

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

5.18.3.2.1.2 Completing adequate discharge planning with the prior admission;

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

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

5.18.3.3 The Contractor shall not classify a readmission as avoidable or within the provider's ability to affect, if the readmission is:

5.18.3.3.1 At a Critical Access Hospital (CAH);

5.18.3.3.2 Unrelated to conditions or care from the prior admission;

5.18.3.3.3 A planned readmission or necessary for repetitive

treatments such as cancer chemotherapy, transfusions for chronic anemia, burn therapy, dialysis, or other planned inpatient treatment documented in the record or as indicted using patient discharge status “81”-planned readmission;

5.18.3.3.4 A planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case;

5.18.3.3.5 A same-day planned admission to a different hospital unit for continuing care (can include mental health/SUD transfers, rehab transfers, etc. which may be technically coded as discharge/admission for billing reasons);

5.18.3.3.6 An admission for required treatments for cancer including treatment-related toxicities, or care for advanced-stage cancer;

5.18.3.3.7 End of life and hospice care;

5.18.3.3.8 Obstetrical readmissions for birth after an antepartum admission;

5.18.3.3.9 Admissions with a primary diagnosis of mental health or SUD issue;

5.18.3.3.10 Neonatal readmissions;

5.18.3.3.11 Transplant readmissions within 180 days of transplant;

5.18.3.3.12 Readmissions when the index admission occurred in a different hospital system;

5.18.3.3.13 To complete care for an Enrollee who left Against Medical Advice from a prior admission;

5.18.3.3.14 Due to Enrollee non-adherence despite appropriate discharge planning and supports. This also includes cases where the recommended discharge plan was refused by the Enrollee, and a less appropriate alternative plan was made to accommodate Enrollee preferences; this must be clearly documented in the record; or

5.18.3.3.15 Because the Contractor did not fulfill its responsibility for post discharge services that would have prevented the readmission.

5.18.3.4 The Contractor shall work with its providers to assure they understand their role and take the following actions to prevent the occurrence of a readmission within fourteen (14) calendar days of a prior admission:

5.18.3.4.1 Create a discharge summary including summary of diagnoses, care provided, medication list, and follow up plan;

5.18.3.4.2 Determine the Enrollee's needs to support a safe discharge and write orders accordingly;

5.18.3.4.3 Ensure the discharge summary is sent to the PCP or follow-up provider;

5.18.3.4.4 Provide all required prescriptions and educate the Enrollee about appropriate use of the medication(s);

5.18.3.4.5 Provide written discharge instructions, accompanied by an explanation, to the Client and family/guardian;

5.18.3.4.6 Provide appropriate contact telephone numbers to Enrollee or family/guardian to call for discharge related questions; and

5.18.3.4.7 Document clearly in a readable format the content of discussion with the Contractor (call, fax, etc.).

5.18.3.5 The Contractor shall share responsibility with its providers to successfully manage the discharge to prevent a readmission. The Contractor shall coordinate with the provider to remove any barriers the provider may face in implementing the discharge plan and the elements of care.

5.18.3.6 In addition to the services required in the Transitional Services section of this Contract, the Contractor shall:

5.18.3.6.1 Resolve any barriers to implementing ordered services;

5.18.3.6.2 Ensure a follow-up appointment is scheduled according to the discharge instructions (typically seven (7) calendar days);

5.18.3.6.3 Educate the Enrollee about the importance of attending the follow-up appointment, and provide assistance to the Enrollee in getting to the appointment, including helping with transportation arrangements;

5.18.3.6.4 Assure implementation of Medical Equipment and supply orders, and the Enrollee is given appropriate education on use;

5.18.3.6.5 Assess the need for and arrange, as indicated, an in-home safety assessment with appropriate follow up as needed;

5.18.3.6.6 Assess and address relevant financial and social needs of the Enrollee;

5.18.3.6.7 Respond timely to implement any changes required in the discharge plan to sustain a successful discharge; and

5.18.3.6.8 Provide case management services, as needed, to prevent readmission.

5.18.3.7 If a readmission occurs because of the Contractor's failure to fulfill

its responsibilities, or a component of its shared responsibilities, the Contractor shall not deny payment for the readmission.

5.18.3.8 The Contractor shall use the template letters created with HCA to support this program.

5.18.3.9 The Contractor must provide a first and second level re-review to the hospital or physician if the Contractor has deemed the provider failed to provide the level of care described above and was responsible for the readmission.

5.18.3.9.1 After exhausting the Contractor's first and second level re-review process, the hospital may request HCA to conduct a review if a dispute between the Contractor and the provider still exists about payment and assignment of responsibility. The Contractor shall appeal to HCA for a "Potentially Preventable" case review when the Contractor and the hospital or attending physician are unable to agree on assignation of responsibility for the readmission and the provider continues to dispute the Contractor's determination.

5.18.3.9.2 The Contractor and the hospital or attending physician will each present a written summary of their position and supporting clinical documentation to HCA. The Contractor shall collect the information and request submitted by the hospital or physician as well as the Contractor's information to HCA within fourteen (14) calendar days of the hospital's request. HCA shall convene an internal panel to review the documents and make a final assignment of responsibility.

5.18.3.10 The Contractor shall respond within fourteen (14) calendar days to any request from HCA for readmission review information and data required in response to a concern for a pattern of inappropriate adjudication presented to HCA by a hospital.

5.18.3.11 The Contractor shall submit a quarterly report, due thirty (30) days after the end of each quarter (January, April, July, and October) and a comprehensive annual report for the previous year, by January 31 of each year. The report must include:

5.18.3.11.1 Total number of patients readmitted to any hospital within fourteen (14) days of discharge from a prior hospitalization (regardless of preventability);

5.18.3.11.2 Number of readmissions reviewed by the Contractor for determination of Provider Potentially Preventable Readmission (PPPR) status;

5.18.3.11.3 Number of readmissions identified as PPPR with recoupment requested from the hospital;

5.18.3.11.4 For each readmission identified in subsection

5.18.3.11.3 above:

5.18.3.11.4.1 Recouped amount;

5.18.3.11.4.2 Hospital;

5.18.3.11.4.3 Primary and secondary diagnosis of admission; and

5.18.3.11.4.4 Rationale for denial (brief narrative description of what criteria were used to determine that the readmission was preventable and how the case met these criteria).

5.18.3.11.5 Number of cases contested by hospitals, how these were handled, and outcome of dispute; and

5.18.3.11.6 Estimated Contractor staffing time for PPPR process.

5.19 **Non-Hospital Payments**

5.19.1 The enhanced rates described in Subsection 5.19 only apply to eligible services delivered by Providers that are not either (i) already paid at an enhanced rate or (ii) eligible for supplemental payments (e.g., FQHC/RHC, FQHC licensed as BHA, Tribal Facilities, Tribal FQHC, PAP/ODP, Physician Services for Trauma Care).

5.19.2 The Contractor shall ensure that Subcontractors comply with applicable payment directives described in Subsection 5.19.

5.19.3 The Contractor shall pay Providers that provide Behavioral Health services to patients in primary care settings at a rate no less than those published by HCA for its FFS Mental Health and Psychology Services. The Contractor will also pay providers that provide the following services at a rate no less than those published by HCA for its FFS Physicians Services: 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171. The Contractor will also pay Providers that provide the following services at a rate no less than those published by HCA for its FFS Specialized Mental Health Services: H0004, H0023, H0036, H2015.

5.19.4 The Contractor shall increase Provider reimbursement rates previously increased by 7 percent effective January 1, 2023, by an additional 15 percent effective January 1, 2024, for providers that deliver contracted Behavioral Health services as described in subsections 9.10.1, 9.10.2, 17.1.3.3, , 17.1.4.4, , 17.1.13, 17.1.14, and17.1.15, of this Contract.

5.19.5 Effective July 1, 2024, the Contractor shall increase the Provider reimbursement rates for adults (aged 21 and older) to pay no less than those rates on the Enhanced Adult fee schedule published by HCA.

5.19.6 The Contractor shall maintain Provider reimbursement rates for in-home Private Duty Nursing agencies that were implemented January 1, 2023, so that the Contractor pays no less than the amounts listed on the fee schedule published by HCA.

5.19.7 The Contractor shall maintain the rate increase that was implemented January 1, 2023, to the daily rate paid to Providers who deliver nursing services to Enrollees in the MICP in medically fragile group homes to pay no less than the amounts listed on the fee schedule.

5.19.8 The Contractor shall maintain the 32 percent rate increase to Provider reimbursement rates paid to Opioid Treatment Providers that was implemented January 1, 2023. This rate increase applies to services delivered under subsection 17.1.14.

5.19.9 Effective January 1, 2024, the Contractor shall ensure that Provider reimbursement rates for Applied Behavioral Analysis services are no less than those published by HCA in the Applied Behavioral Analysis fee schedule.

5.19.10 Effective January 1, 2024, the Contractor shall ensure that Provider reimbursement rates for Developmental Screening services procedure codes 96110, 96127, 96160 and 96161 are no less than those published by HCA in the EPSDT, Mental Health and Psychology and Physician-Related/Professional Services fee schedule.

5.19.11 Effective January 1, 2024, the Contractor shall ensure that Provider reimbursement rates for Kidney Dialysis services for revenue codes 0821 (when billed with procedure code 90999), 0831, 0841 and 0851 are no less than those published by HCA in the Kidney Centers fee schedule.

5.19.12 Effective January 1, 2024, the Contractor shall ensure that Provider reimbursement rates for Pediatric Palliative Care services billed with revenue code 0659 are no less than those published by HCA in the Hospice fee schedule.

5.19.13 Effective July 1, 2024, the Contractor shall ensure that Provider reimbursement rates for Professional Services required by Laws of 2023, Chapter 475, Section 211(72) (Engrossed Substitute Senate Bill 5187) are no less than the rates for CPT codes in the 59XXX series published by HCA in the Physician-Related/Professional Services.

5.20 **Payment for Services by Non-Participating Providers**

5.20.1 The Contractor shall limit payment for Emergency Services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid FFS program.

5.20.2 Except as provided herein for Emergency Services, the Contractor shall coordinate with and pay a Non-Participating Provider that provides a service to Enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar Providers in the state, including Behavioral Health agencies in accordance with RCW 71.24.618. For the purposes of this subsection, "contracts with similar Providers in the state" means the Contractor's contracts with similar Providers to provide services under the Managed Care program when the payment is for services received by a Managed Care Enrollee.

5.20.3 The Contractor shall track and record all payments to Participating Providers and Non-Participating Providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to Participating Providers and Non-Participating Providers separately. The Contractor shall identify the type of providers and subspecialty according to specifications provided by HCA. The Contractor shall also track, document and report to HCA any known attempt by Non-Participating Providers to balance bill Enrollees.

5.20.4 The Contractor shall provide annual reports to HCA for the preceding state fiscal year (SFY) July 1 through June 30. The reports shall indicate the

proportion of services provided by the Contractor's Participating Providers and Non-Participating Providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to HCA no later than August 15 of each year, or as required by HCA.

5.21 Data Certification Requirements

Any information and/or data required by this Contract and submitted to HCA shall be certified by the Contractor as follows:

5.21.1 Source of certification: The information and/or data shall be certified by one of the following:

5.21.1.1 The Contractor's Chief Executive Officer.

5.21.1.2 The Contractor's Chief Financial Officer.

5.21.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

5.21.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

5.21.3 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

5.21.4 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

5.21.5 HCA will identify the specific data that requires certification.

5.21.6 Certification applies to this Contract and file submissions.

5.21.7 The Contractor must provide training and technical assistance to Subcontractors in order to ensure compliance with provisions of this Contract.

5.22 Sanctions

5.22.1 HCA may impose sanctions if the Contractor fails to meet one or more of its obligations under this Contract, a CAP, or applicable law, including but not limited to submitting reports, documents, data, or any other information that is inaccurate, incomplete, untruthful, or untimely. HCA will consider the Contractor's noncompliance as a default. Contractor will be in default, and HCA may impose reasonable sanctions (WAC 182-525A-0400).

5.22.1.1 Sanctions are distinct from liquidated damages and are not mutually exclusive.

5.22.1.2 Sanctions are intended as a penalty for a default, whereas liquidated damages are intended as a remedy for noncompliance.

5.22.2 HCA may base its determination regarding Contractor's default on its obligations under this Contract or applicable law on findings from onsite surveys, Enrollee or other complaints, financial status, or from any source.

5.22.3 HCA shall notify the Contractor in writing of any default by the Contractor. The notice will advise the Contractor of the basis of the determination of a default, if

a cure period is being allowed, if a CAP will be required, if any sanctions are being imposed, and of the dispute resolution process.

5.22.4 In its sole discretion, HCA may provide a reasonable cure period and impose a CAP on the Contractor before imposing sanctions.

5.22.4.1 HCA may require the Contractor to devise a CAP to be approved by HCA or impose a CAP devised by HCA.

5.22.4.2 Until the default is cured or any resulting dispute is resolved in the Contractor's favor, HCA may: (i) impose intermediate sanctions, monetary sanctions, and/or liquidated damages, (ii) withhold up to 5 percent of its scheduled payments to the Contractor, and/or (iii) suspend or terminate client assignments or re-enrollments.

5.22.5 HCA may impose intermediate sanctions against the Contractor for the following:

5.22.5.1 Failing to provide Medically Necessary Services that the Contractor is required to provide, under law or under this Contract, to an Enrollee covered under this Contract.

5.22.5.2 Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

5.22.5.3 Acting to discriminate against Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an Enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services.

5.22.5.4 Misrepresenting or falsifying information that it furnishes to HCA.

5.22.5.5 Misrepresenting or falsifying information that it furnishes to Enrollee, Potential Enrollee, or any of its Subcontractors.

5.22.5.6 Failing to comply with the requirements for physician incentive plans.

5.22.5.7 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or materially misleading information.

5.22.6 Intermediate sanctions penalties include:

5.22.6.1 Civil monetary sanctions in the following amounts:

5.22.6.1.1 A maximum of $25,000 for each determination of failure to provide services; distribution of marketing materials that have not been approved by HCA, or that contain false or misleading information, misrepresentation or false statements to Enrollees,

Potential Enrollees or healthcare providers; failure to comply with Physician Incentive Plan requirements; or marketing violations.

5.22.6.1.2 A maximum of $100,000 for each determination of discrimination and for each misrepresentation or false statements by the Contractor to HCA.

5.22.6.1.3 A maximum of $15,000 for each Potential Enrollee HCA determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

5.22.6.1.4 A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to Enrollees that are not allowed under Managed Care. HCA will deduct from the penalty the amount charged and return it to the Enrollee.

5.22.6.2 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA shall notify current Enrollees of the sanctions and that they may terminate enrollment at any time.

5.22.6.3 Suspension of payment for Enrollees enrolled after the effective date of the sanction and until HCA is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.22.7 HCA may impose other monetary sanctions if the Contractor defaults on any of its obligations under this Contract, a CAP, or applicable law or regulations.

5.22.7.1 The amount of monetary sanction HCA may impose is up to $100,000 per occurrence per day, or the amount specified in the Contract, a CAP, law, or regulation.

5.22.8 The Contractor may request a dispute resolution as described in the Disputes section of this Contract if the Contractor disagrees with HCA's determination.

5.23 **Contracting with FQHCs**

5.23.1 The Contractor is required to contract with at least one FQHC in their service area if any FQHC makes such a request.

5.24 **Payment of Physician Services for Trauma Care**

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

5.24.1.1 To qualify for the trauma care enhancement, a service must meet all of the following criteria:

5.24.1.1.1 The service must be provided by a physician or clinician;

5.24.1.1.2 The service must be hospital-based, with a billed place of service 21, 22, 23, 24, 51, 52, or 56;

5.24.1.1.3 The service must be provided in a Department of

Health designated or recognized trauma service center; and

5.24.1.1.4 The provider has indicated that the injury severity score (ISS) criteria has been met by billing with modifier ST in any position. The ISS must be:

5.24.1.1.4.1 Thirteen (13) or greater for clients age 15 and older;

5.24.1.1.4.2 Nine (9) or greater for clients younger than age 15; or

5.24.1.1.4.3 Zero or greater when the service is provided at a Level I, II, or III trauma service center when the trauma case is received as a transfer from another Facility.

5.24.1.2 Rehabilitation and surgical services provided within six (6) months of the date of an injury that meets all criteria in subsection 5.24.1 may also receive the enhancement rate if all of the following criteria are met:

5.24.1.2.1 The follow-up procedures are directly related to the qualifying traumatic injury;

5.24.1.2.2 The follow-up procedures were planned during the initial acute episode of care, i.e. the inpatient stay; and

5.24.1.2.3 The plan for the follow-up procedure(s) is clearly documented in the medical record of the client's initial hospitalization for the traumatic injury.

5.24.1.3 Exemptions. The following services are never subject to trauma care enhancements:

5.24.1.3.1 Laboratory and pathology services; or

5.24.1.3.2 Technical component (TC) only charges.

5.25 Nonpayment for Provider Preventable Conditions

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

5.25.1.1 The Contractor shall require all providers to report PPC associated with claims for payment or Enrollee treatments for which payment would otherwise be made.

5.26 Billing for Services Provided by Residents

5.26.1 The Contractor shall allow teaching physicians to submit claims for primary care services provided by interns and residents under supervision of the teaching

physician as described in HCA's Physician's Billing Guide.

5.27 **Payment for Supervision of Behavioral Health Providers**

5.27.1 The Contractor acknowledges that the capitation rate paid by HCA for BHA services includes funding, as an administrative component, which is intended to reimburse licensed behavioral health practitioners for their time supervising unlicensed practitioners. The Contractor will convey to the providers in their contracts the inclusion of this service.

5.28 **Primary Care Expenditure Report**

5.28.1 The Contractor shall complete HCA's Primary Care Expenditure report annually, by the last Business Day of July, using the template provided. The reporting period is January 1 through December 31. The report is available through MC-Track.

5.29 **Payments to Indian Health Care Providers**

5.29.1 The United States (including IHS), each Tribe, and each Tribal Organization, including IHCPs, has the right to recover from liable third parties, including the Contractor, notwithstanding network restrictions, pursuant to 25 U.S.C. § 1621e and 42 C.F.R. § 438.14(b)(2). The Contractor will pay IHS facilities and Tribal 638 Facilities, including Tribal FQHCs, in accordance and compliance with the Tribal Health Program Billing Guide, as follows:

5.29.1.1 The full IHS encounter rate for each qualifying outpatient service furnished to: (a) an AI/AN Enrollee by an IHS or Tribal 638 Facility, including a Tribal FQHC, and (b) a non-AI/AN Enrollee by a Tribal FQHC; provided that, for outpatient substance use disorder treatment services, the amount will be the federal portion of the IHS encounter rate as provided in the Tribal Health Program Billing Guide.

5.29.1.2 The full IHS inpatient hospital per diem rate for each day of a qualifying inpatient stay for an AI/AN Enrollee;

5.29.1.3 The full enhanced per diem rate for each day of qualifying inpatient or residential behavioral health treatment for an AI/AN Enrollee, for which an enhanced rate has been authorized in the Medicaid State Plan;

5.29.1.4 In the absence of a contracted rate, the amount the IHCP would receive if the qualifying services were provided in the Fee-for-Service Medicaid Program; or

5.29.1.5 The Contractor shall only pay Tribal FQHCs in accordance with the Tribal FQHC APM.

5.29.2 The Contractor will pay all UIHPs in accordance with the terms of Subsection 5.29.

5.29.3 HCA will inform the Contractor of the amounts of the IHS encounter rate, the IHS inpatient hospital per diem rate, and any enhanced per diem rates applicable to IHCPs. The rates will be provided in rate files consistent with federal guidance found at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-

schedules under Tribal Health Program (which includes guidance for the Tribal FQHC program) and updated annually.

5.29.4 For each Contractor-paid, clean claim for qualifying encounters (as outlined in the ProviderOne Billing Guides and the Encounter Data Reporting Guide) for which the encounter submission has been accepted by HCA and for which the Contractor paid at a rate described in subsections 5.9.1.1, 5.29.1.2, or 5.29.1.3, HCA will reimburse the Contractor for the difference between (a) the amount paid and (b) the greater of the rate negotiated for the service by the Contractor and the IHS or Tribal 638 Facility (including Tribal FQHC) and the rate payable for the service in the Fee-for-Service Medicaid Program.

5.29.5 The Contractor will ensure it has trained staff to handle calls or inquiries from IHCPs and other providers regarding the reimbursement process and how to ensure that claims for services furnished to AI/AN Enrollees are correctly processed.

5.30 Apple Health COVID19 Vaccine Administration and Payments

5.30.1 The costs for COVID19 vaccine administration are included in the premium rates described in subsection 5.2.1 of this Contract.

5.30.2 The Contractor will pay all Providers that administer COVID19 vaccines to Enrollees at rates no less than those published by HCA for its FFS program.

5.30.3 The Contractor will support the education of its members and in-network Providers regarding COVID19 vaccine availability and treatment including but not limited to: coverage and reimbursement, information about vaccines available, the prohibition on any member charges for COVID19 vaccine and administration, and how to obtain additional information.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate and adequate Provider network, supported by written agreements, sufficient to provide adequate access to all services covered under the Contract for all Enrollees, including those with limited English proficiency or physical or mental disabilities.

6.1.2 On a quarterly basis, the Contractor shall provide a narrative describing the state of the current network including any gaps specific to this population, any Material Provider network changes from the previous quarter; mitigation strategies to address gaps in the network or loss of providers; and any upcoming network improvements the Contractor intends to make to support the needs of Enrollees served under this contract for both physical health and behavioral health services.

6.1.2.1 A distinct network submission is also required quarterly for contractors that must make bi-lateral contract amendments, specific to this program, or must establish new networks. This submission must use the Combined Provider Submission report template and accompanying Data Definition instructions, herein incorporated by reference.

6.1.2.2 Reports are due: January 15 (January through March); April 15 (April through June); July 15 (July through September); and October 15 (October through December).

6.1.3 The Contractor shall have written policies and procedures for selection and retention of network providers that at a minimum addresses credentialing and recredentialing requirements, nondiscrimination, excluded providers, and any additional state requirements.

6.1.4 In addition to the quarterly documentation required under this Subsection, the Contractor shall submit provider network information using the Combined Provider Submission report template and data definitions, herein incorporated by reference, within five (5) Business Days when requested by HCA or in the following circumstances:

6.1.4.1 At the time it enters into a Contract with HCA; or

6.1.4.2 At any time there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would materially affect capacity or the Contractor's ability to provide services, including changes in services, benefits, geographic service area or payments.

6.1.5 AHEHP specific provider network information will be reviewed by HCA for:

6.1.5.1 Accuracy and completeness, including verifying the quarterly Combined Provider Submission template is submitted in the proper format, as described in the Data Definition instructions;

6.1.5.2 The need for HCA provision of technical assistance;

6.1.5.3 Removal of Providers who no longer contract with the Contractor;

6.1.5.4 The effect that the change(s) in the Provider network will have on the network's compliance with the requirements of this Section; and

6.1.5.5 Contractor's compliance with encounter validation against network submissions.

6.1.6 The Contractor shall provide contracted services through Non-Participating Providers, at a cost to the Enrollee that is no greater than if the contracted services were provided by Participating Providers, if its network of Participating Providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them. This provision shall not be construed to require the Contractor to cover such services without authorization except as required for Emergency Services.

6.1.7 The Contractor may offer contracts to Providers in bordering states that allow Enrollees to access care when care is appropriate, available, and cost-effective.

6.1.8 Inaccurate or Incomplete Submissions: The documentation submitted by the Contractor for the AHEHP must be accurate and complete.

6.1.8.1 For any AHEHP-specific quarterly network submission that is not accurate, complete, and submitted in the required format described in the Data Definitions instructions that accompany the Combined Provider Submission template, HCA may charge the Contractor $50,000 for nonperformance. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.1.8.2 If the submission must be returned to the Contractor for corrections, and the submission contained errors that reflect a material loss of Providers in a service area, the Contractor's assignments may be suspended for that service area. Suspension of assignments continue until the quarter in which the Contractor submits an accurate submission for that service area.

6.1.9 Late Submissions: For each quarterly report, including any AHEHP-specific network submission that is not submitted by the due date and does not have written approval from HCA prior to the due date for the late submission, HCA may charge the Contractor $1,000 for the first day, and an additional $1,000 per day thereafter for non-performance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor. If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of Providers in any contracted service area including Essential Behavioral Health Providers (EBHP) and all Critical Providers: Primary Care Providers, Hospitals, Pharmacies, individually licensed Mental Health Providers, adult outpatient Behavioral Health agency Providers, Obstetrician/Gynecologist, and high volume specialties identified by the Contract, for two (2) consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area.

6.1.10 The Contractor shall update and maintain the Contractor's Provider manual to include all relevant information regarding services and requirements.

6.1.11 The Contractor shall maintain an online provider directory with a link on the front page of the Contractor's website that immediately directs users to the Contractor's online, searchable Provider directory specific to AHEHP. The Contractor shall make all information in the online provider directory available on the Contractor's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. The Contractor shall also make copies of all Provider information in the online provider directory available to Enrollees in paper form upon request. The Provider directory must be updated at least quarterly if the Contractor has a mobile-enabled electronic directory, or monthly, if the Contractor does not have a mobile-enabled, electronic provider directory. The online provider directory must meet the following requirements:

6.1.11.1 Include information about available interpreter services, communication, and other language assistance services. Information must be provided for each of the Provider types covered under this Contract.

6.1.11.2 Include a list of all clinics and primary and specialty Providers, including Behavioral Health Providers, including street addresses, telephone numbers, and URLs, service types, clinical specialty, and areas of expertise, as available.

6.1.11.3 Include any in-network institutional affiliation of the Provider, such as hospitals where the Provider has admitting privileges, or provider groups with which a Provider is a member.

6.1.11.4 Includes a description of each primary and specialty Provider's languages spoken, including American Sign Language, and if appropriate, a brief description of the Provider's skills or experiences that would support the cultural or linguistic needs of its Enrollees, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili."

6.1.11.5 Includes information about whether the Contractor's network Providers' office/facilities have accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

6.1.11.6 Indicates whether each primary and specialty Provider, including Behavioral Health Providers, is accepting new patients, separated by pediatric/youth and adult populations.

6.1.11.7 Include a list of hospitals, pharmacies, and DME Providers.

6.1.11.8 Include Behavioral Health crisis contacts.

6.1.11.9 Include a specific description of any telemedicine services available from a listed Provider and at what facilities.

6.1.11.10 Update the provider directory within thirty (30) calendar days of a change in the Contractor's network, or the Contractor receives updated provider information, including Providers who are no longer under contract with the Contractor.

6.1.11.11 Be available to Providers, Enrollees, family members, and other community stakeholders.

6.1.11.12 Have in place a process for Enrollees, Potential Enrollees, and other individuals to identify and report potential inaccurate, incomplete, or misleading information in the Contractor's directory. The Contractor shall provide a dedicated email address and either a form on the website or a telephone number so that errors can be reported directly through the website. Errors must be corrected within ten (10) Business Days.

6.1.12 Contractor's program staff shall provide assistance to Enrollees and Potential Enrollees in conducting Provider searches based on office or facility location, clinical specialty, Provider discipline, Provider capacity, and available languages.

6.1.13 For each instance in which HCA finds inaccurate directory information, HCA may charge the Contractor $1,000 per error for non-performance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.2 Behavioral Health Network Analysis

6.2.1 The Contractor shall incorporate the following requirements when developing its AHEHP Behavioral Health network. Services may be provided by Behavioral Health Providers, including individually licensed Health Care Professionals, licensed behavioral health agencies or clinics, and non-licensed professionals operating under an agency-affiliated counselor credential.

6.2.1.1 The Contractor shall have sufficient Behavioral Health Providers in its AHEHP network to allow Enrollees a choice.

6.2.1.1.1 Contract with licensed Behavioral Health Providers, including individually licensed Health Care Professionals,, licensed behavioral health agencies or clinics, and non-licensed professionals operating under an agency-affiliated counselor credential. Establish and maintain contracts with Providers determined by HCA., including but not limited to: Certified SUD and mental health residential treatment Providers;

6.2.1.1.2 Licensed Behavioral Health Agencies, providing outpatient mental health services to adults;

6.2.1.1.3 Licensed Behavioral Health agencies, providing outpatient SUD services to adults;

6.2.1.1.4 Providers currently prescribing buprenorphine;

6.2.1.1.5 Licensed and certified Opioid Treatment Program (formerly referred to as Methadone Treatment programs or Opiate Substitution Treatment);

6.2.1.1.6 Licensed and certified free-standing facilities, hospitals, or psychiatric inpatient facilities that provide evaluation and treatment, including Freestanding Evaluation and Treatment Facilities;

6.2.1.1.7 Licensed and certified withdrawal management facilities (for acute and subacute), including Secure Withdrawal Management and Stabilization Facilities; and

6.2.1.1.8 Licensed Behavioral Health Agencies certified to provide crisis stabilization services.

6.2.1.2 The Contractor shall contract with an adequate number of Behavioral Health provider agencies that offer urgent and non-urgent same day, evening, and weekend services.

6.2.2 The Contractor shall contract with Integrated Care Providers to promote and advance bi-directional physical and Behavioral Health clinical integration as an essential Provider type.

6.3 Service Delivery Network

In establishing, maintaining, monitoring, and reporting of a specific AHEHP network, the Contractor must consider the following:

6.3.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.

6.3.2 Adequate access to all services covered under this Contract.

6.3.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the population, is represented by the Contractor's Enrollees and Potential Enrollees.

6.3.4 The number of network Providers who are not accepting new Enrollees, who have placed a limit, or have given the Contractor notice of the intent to limit their acceptance of Enrollees.

6.3.5 The geographic location of Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees or Potential Enrollees, and whether the location provides physical access for the Contractor's Enrollees with disabilities.

6.3.6 The cultural, racial/ethnic composition and language needs of Enrollees and the ability of network Providers to communicate with limited English proficient enrollees in their preferred language.

6.3.7 The ability of network Providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Enrollees with physical or mental disabilities.

6.3.8 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visit, and other evolving and innovative technological solutions.

6.3.9 With respect to a Behavioral Health network, the anticipated needs of special populations including, but not limited to:

6.3.9.1 Individuals with specialized cultural, ethnic, or linguistic needs;

6.3.9.2 TAY with Behavioral Health needs;

6.3.9.3 Adults and older adults with Serious Mental Illness;

6.3.9.4 Adults and TAY identified with first episode psychosis;

6.3.9.5 Individuals with co-occurring Behavioral Health conditions;

6.3.9.6 Individuals with Behavioral Health/Individuals with Developmental Disabilities in need of Behavioral Health services;

6.3.9.7 Individuals with a MH condition or a SUD and co-occurring chronic physical health condition;

6.3.9.8 Individuals with a SUD in need of medications to treat opioid use disorder;

6.3.9.9 Homeless individuals;

6.3.9.10 Individuals transitioning from state operated psychiatric facilities and other inpatient and residential settings;

6.3.9.11 Individuals with Behavioral Health conditions transitioning from jail/prison/courts; and

6.3.9.12 Individuals in permanent supported housing or other types of community housing.

6.4 Unavailable Detention Facilities Records

6.4.1 The Contractor shall coordinate with the Behavioral Health Administrative Service Organization (BH-ASO) to engage an Enrollee in appropriate treatment services following a notification from a Designated Crisis Responder (DCR) that an Enrollee met ITA detention criteria and there were no beds available in an Evaluation and Treatment Facility, Secure Withdrawal Management and Stabilization facility, psychiatric unit, or under a single bed certification, and the DCR was not able to arrange for a less restrictive alternative for the Enrollee.

6.4.1.1 The Contractor shall develop a plan for engaging the Enrollee in appropriate treatment services for which the person is eligible.

6.4.1.2 The Contractor shall report to HCA within seven (7) calendar days of receiving the notification from HCA, the plan and attempts made to engage the person in treatment, including involuntary treatment.

6.5 Hours of Operation for Network Providers

The Contractor must require that network Providers offer hours of operation for Enrollees that are no less than the hours of operation offered to any other patient.

6.6 24/7 Availability

The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week, 365 days a year basis by a toll-free telephone number. These services may be provided directly by the Contractor or may be delegated to Subcontractors.

6.6.1 Medical and Behavioral Health advice for Enrollees from licensed Health Care Professionals.

6.6.2 Triage concerning the emergent, urgent, or routine nature of medical and Behavioral Health conditions by licensed Health Care Professionals.

6.6.3 Authorization of urgent and Emergency Services, including emergency care and

services provided outside the Contractor's service area.

6.6.4 The toll-free line staff must be able to make a warm handoff to the regional crisis line.

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

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

6.7 Customer Service

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

6.7.1 The Contractor shall report by December 1 of each year its scheduled non-Business Days for the upcoming calendar year.

6.7.2 The Contractor must notify HCA via HCAMCPrograms@hca.wa.gov five (5) Business Days in advance of any non-scheduled closure during scheduled Business Days, except in the case when advanced notification is not possible due to emergency conditions.

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

6.7.3.1 Telephone abandonment rate – standard is less than 5 percent.

6.7.3.2 Telephone response time - average speed of answer within thirty (30) seconds.

6.7.4 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to: access information regarding Behavioral Health service requirements and benefits; facilitate navigation of the eligibility systems to access benefits and state-funded services; refer for needed Behavioral Health services; distinguish between a benefit inquiry, third party insurance issue, Appeal or Grievance for IMC or BHSO/D-SNP services; and resolve and triage Grievances and Appeals.

6.7.5 The Contractor shall submit its customer service policies and procedures to HCA for review at least ninety (90) calendar days before implementation. Customer service policies and procedures shall address the following:

6.7.5.1 Information on the array of covered services including where and how to access them.

6.7.5.2 Authorization requirements.

6.7.5.3 Requirements for responding promptly to family members and supporting linkages to other service systems including, but not limited to: Behavioral Health services, law enforcement, criminal

justice system, or social services.

6.7.5.4 Assisting and triaging Enrollees, who may be in crisis, with access to qualified clinicians, without placing the Enrollee on hold. The qualified clinician shall assess the crisis and warm transfer the call to the BH-ASO or its designated crisis Provider(s), call 911, refer the individual for services, refer the individual to his or her provider, or resolve the crisis over the telephone as appropriate.

6.7.6 The Contractor shall train customer service representatives on revised policies and procedures. The training shall incorporate the state's vision, mission, system goals, and operating principals for Behavioral Health programs and services.

6.8 Availability of Services

The Contractor shall have contracts in place with all Subcontractors that meet state standards for access, taking into account the urgency of the need for services. The Contractor shall ensure:

6.8.1 Network Providers offer access comparable to that offered to commercial Enrollees or, if the Contractor serves Medicaid Enrollees, comparable to Medicaid FFS.

6.8.2 Mechanisms are established to ensure compliance by Providers.

6.8.3 Providers are monitored regularly to determine compliance.

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

6.9 Appointment Standards

The Contractor shall comply with appointment standards that are no longer than the following. Nothing in this Section prohibits the Contractor from conducting assessments in alternate settings, such as the Enrollee's home or within an institutional setting:

6.9.1 Transitional Health Care Services by a Primary Care Provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or Behavioral Health disorders or discharge from a SUD treatment program.

6.9.2 Transitional Health Care Services by a home care nurse, home care registered counselor, a Mental Health Professional, or other Behavioral Health professional within seven (7) calendar days of discharge from inpatient or institutional care for physical or Behavioral Health care, if ordered by the Enrollee's Primary Care Provider or as part of the discharge plan.

6.9.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the Enrollee's PCP or another Provider within thirty (30) calendar days. A non-symptomatic visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or adult immunizations.

6.9.4 Non-urgent, symptomatic (i.e., routine care) office visits, shall be available from the Enrollee's PCP or another Provider within ten (10) calendar days, including Behavioral Health services from a Behavioral Health Provider. A non-urgent, symptomatic visit is associated with the presentation of medical signs not requiring immediate attention.

6.9.5 Urgent, symptomatic office visits shall be available from the Enrollee's PCP,

Behavioral Health or another Provider within 24 hours. An urgent, symptomatic visit is associated with the presentation of medical or Behavioral Health signs that require immediate attention, but are not emergent.

6.9.6 Emergency Services shall be available 24 hours per day, seven (7) days per week.

6.9.7 Second opinion appointments must occur within thirty (30) calendar days of the request unless the Enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days.

6.9.8 Failure to meet appointment standards may, at HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

6.10 Provider Database

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

6.11 Provider Network - Distance and Drive Time Standards

6.11.1 When the Contractor has a stand-alone AHEHP network, the Contractor's network of Providers shall meet the distance and drive time standards in this subsection in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide the Contractor a list of service areas, zip codes and their designation. The Contractor's ability to receive enrollment and/or assignment is based on the assignment provisions in this Contract. "Rural area" is defined as any area other than "urban area" or any area outside an urban area.

6.11.2 Distance Standards

6.11.2.1 PCP

6.11.2.1.1 Urban: 2 within 10 miles.

6.11.2.1.2 Non-urban: 1 within 25 miles.

6.11.2.2 Obstetrics (including non-emergent birthing services)

6.11.2.2.1 Urban: 2 within 10 miles.

6.11.2.2.2 Non-urban: 1 within 25 miles.

6.11.2.3 Hospital

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

6.11.2.4 Pharmacy

6.11.2.4.1 Urban: 1 within 10 miles.

6.11.2.4.2 Non-urban: 1 within 25 miles.

6.11.2.5 Mental Health Professionals and SUDPs

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

6.11.2.6 Outpatient Behavioral Health Agency Providers

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

6.11.3 Drive Time Standards

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

6.11.4 In Urban Areas, a thirty-minute drive from the Enrollee's primary residence to the service site or the service sites are accessible by public transportation with the total trip, including transfers, not to exceed ninety minutes each way;

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

6.11.6 In Large Rural Geographic Areas, a ninety-minute drive from the Enrollee's primary residence to the service site.

6.11.7 These travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or road

construction, public transportation shortages or delayed ferry service).

6.11.8 HCA may, at its sole discretion, grant exceptions to these standards. HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing, using the HCA approved exception request form and shall provide evidence to support the request.

6.12 **Assignment of Enrollees**

6.12.1 HCA has the sole and exclusive right to determine the methodology and procedures by which Enrollees are assigned to the Contractor or reassigned to any other Apple Health Expansion Contractors.

6.12.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or Enrollees.

6.12.3 HCA will count New Individuals, Family Connects, and Plan Reconnects as part of an AHEHP's enrollment in all service areas.

6.12.4 Reassignment of Enrollees

6.12.4.1 HCA may, at its sole discretion, reassign Enrollees to the Contractor and an individual may choose to voluntarily enroll with the Contractor if the Contractor is eligible to receive enrollment in the individual's service area, consistent with this Subsection.

6.12.5 Assignment of New Individuals

6.12.5.1 The number of New Individuals assigned to the Contractor and to all other AHEHPs depends on (a) the number of AHEHPs eligible to receive assignments in a service area; (b) the number of New Individuals eligible for assignment in a service area; and (c) the performance of the Contractor and all other AHEHPs on the Clinical Performance Measures and the Administrative Measures described in this Section.

6.12.5.2 HCA will assign New Individuals to an eligible AHEHP in the individual's service area. Once assigned, HCA will notify the Enrollee of his or her assignment and provide information on how the individual can change enrollment to another AHEHP available in the service area, if any. The effective date of enrollment will be consistent with the enrollment provisions of this Contract.

6.12.6 Service area assignment process:

6.12.6.1 HCA, in its sole discretion, shall determine whether the Contractor's Provider network meets the required capacity for the critical Provider types (hospital, mental health Providers, outpatient Behavioral Health agency Providers, primary care, pharmacy, obstetrical, and pediatricians).

6.12.6.2 To receive New Individual assignments and voluntary enrollments in a service area, the Contractor must maintain an adequate network as described in this contract.

6.12.6.2.1 If at any time during the term of this Contract the Contractor's provider network no longer meets the

minimum network adequacy standards in any service area, HCA may, in its sole discretion, reassign all Enrollees covered by the Contractor to another Apple Health Expansion Contractor in the service area.

6.12.6.2.1.1 Upon HCA's request, the Contractor shall provide a list of current Enrollees and their assigned PCP.

6.12.6.2.1.2 The Contractor shall assist HCA in the orderly transition of Enrollees to another AHEHP, consistent with the Care Coordination and Transitional Healthcare Services provisions of this Contract.

6.12.6.2.2 HCA recognizes certain provider types may not be available in a service area; therefore, HCA may, at its sole discretion, make exceptions to network adequacy standards to provide coverage for that service area.

6.12.6.2.3 The levels of service area participation are described in the following table:

Capacity Threshold	Assignment of New Individuals and/or Voluntary Enrollment	Family Connects or Plan Reconnects
80% or more in all seven Provider types	Assignment and voluntary enrollment	Yes
Between 60% to 80% in any Critical Provider types	No assignment, voluntary enrollment only	Yes
Below 60% in any of the Critical Provider types	No assignment or voluntary enrollment	None

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

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

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

6.12.6.4.1.1 Childhood Immunization Combo 10 Status.

6.12.6.4.1.2 Chlamydia Screening in Women (CHL) Total.

6.12.6.4.2 Administrative Measure (Initial Health Screen): The Contractor shall submit quarterly reports of its performance on completing Initial Health Screen on all New Individual, Family Connect, and Plan Reconnect Enrollees. Assignments will be based on the September and March submissions as described in Subsection 6.12.7.

6.12.7 Administrative Measure (Initial Health Screen) calculation:

6.12.7.1 The Contractor shall calculate and report its performance on completing the Initial Health Screen on all New Individual, Family Connect and Plan Reconnect Enrollees on a quarterly basis.

6.12.7.2 To calculate the quarterly screening performance:

6.12.7.2.1 The numerator is the total number of New Individuals, Family Connects, and Plan Reconnects that have received an Initial Health Screen.

6.12.7.2.1.1 Contact with the Enrollee must be completed in order to include in the total number of screenings.

6.12.7.2.2 The denominator is the total number of New Individuals, Family Connects, and Plan Reconnects.

6.12.7.2.3 The Contractor shall submit the Initial Health Screen Performance report via HCA MFT site and provide notification to hcamcprograms@hca.wa.gov with 'Initial Health Screen Performance' in the subject line of the email. The Contractor shall report its screening performance numerator, denominator and rate (expressed as a percentage) according to the following schedule:

6.12.7.2.3.1 January, February and March – Submitted June 15 of each contract year;

6.12.7.2.3.2 April, May and June – Submitted September 15 of each contract year;

6.12.7.2.3.3 July, August and September – Submitted December 15 of each contract year;

6.12.7.2.3.4 October, November and December – Submitted March 15 of each contract year.

6.13 Distance Standards for High Volume Specialty Care Providers

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

The Contractor shall analyze performance against standards at minimum, annually and provide a report to HCA upon request detailing the outcomes of this analysis along with the Contractor's analysis of Primary Care Providers.

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

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

6.15 Access to Specialty Care

6.15.1 The Contractor shall provide all medically necessary contracted specialty care for Enrollees in a service area, such as services an Enrollee may need to support Gender Affirming Care and Care Coordination to secure out-of-network services. If an Enrollee needs specialty care from a type of specialist who is not available within the Contractor's Provider network, or who is not available to provide the medically necessary services required by the Enrollee within the timeframe described in this Contract, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's Provider network, who is willing to see the Enrollee.

6.15.2 The Contractor shall maintain, and make readily available to Providers, up-to-date information on the Contractor's available network of specialty Providers and shall provide any required assistance in obtaining timely referral to specialty care for services necessary to assist Enrollees.

6.16 Enrollees Residing in Rural Areas

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

6.16.1 The Enrollee must have a choice of two (2) Primary Care Providers when there is a single plan in the area;

6.16.2 The Enrollee may seek care from a Non-Participating Provider when the service or type of Provider (in terms of training, experience and specialization) is not available within the Contractor's network or when the service or type of Provider is available in the Contractor's network, but an appointment with a Participating Provider cannot be scheduled to provide the service within the time frames listed in Subsection 6.9 of this Contract;

6.16.3 The Enrollee may seek a service from a Non-Participating Provider when Enrollee's Primary Care Provider or other Provider determines that the Enrollee needs related services that would subject the individual to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available from a Participating Provider; and

6.16.4 The Enrollee may seek a service from a Non-Participating Provider when the state determines that circumstances warrant out-of-network treatment.

6.17 Order of Acceptance

6.17.1 The Contractor shall provide care to all Enrollees who voluntarily choose the Contractor and all Enrollees assigned by HCA.

6.17.2 Enrollees will be accepted in the order in which they apply.

6.17.3 HCA shall enroll all eligible clients with the Contractor of their choice except as provided herein. Unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

6.17.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of Section 6.11 Provider Network – Distance and Drive Time Standards, and Section 6.12 Assignment of Enrollees. The Contractor shall submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.

6.17.5 The Contractor may request in writing that HCA suspend voluntary enrollment and/or assignments in any service area. HCA will approve the temporary suspension when, in the sole judgment of HCA, it is in the best interest of HCA and/or its clients. The Contractor shall submit any information HCA requires to make a final decision on this request.

6.17.6 The Contractor shall accept clients who are enrolled by HCA.

6.17.7 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or behavioral condition, including hospitalization, or the expectation of the need for frequent or high-cost care.

6.18 Provider Network Changes

6.18.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accordance with the Notices provisions of the General Terms and Conditions Section of this Contract, for the loss of a Material Provider. The Contractor shall also notify HCA of any other changes that result in the Contractor being unable to meet access, including a decrease in the number or frequency of a required service, employee strike or other work stoppage related to union activities, or any changes that results in the Contractor being unable to provide timely services.

6.18.1.1 If a Subcontract is terminated in less than ninety (90) days or a site closure occurs in less than ninety (90) days, the Contractor shall notify HCA as soon as possible and prior to a public announcement.

6.18.2 Any time a subcontract is terminated, a site closes, or changes occur that result in the inability to provide timely services, the Contractor shall submit a Notification of Site Closure/Service Reduction plan to HCA through MC-Track that includes at a minimum:

6.18.2.1 Name and NPI of terminating Provider:

6.18.2.2 Date termination notice was received;

6.18.2.3 Effective date of termination;

6.18.2.4 Notification to the Behavioral Health Advocate when the subcontractor is a Behavioral Health Provider agency;

6.18.2.5 Individual notification plan;

6.18.2.6 Plan for provision of uninterrupted services; and

6.18.2.7 Any information released to the media.

6.18.3 The Contractor shall make a good faith effort to provide written notification to Enrollees affected by any Provider termination within fifteen (15) calendar days after receiving or issuing a Provider termination notice. Enrollee notices shall have prior approval of HCA.

6.18.4 If the Contractor fails to notify affected Enrollees of a Provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected Enrollees to continue to receive services from the terminating Provider, at the Enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies Enrollees or the Enrollee's effective date of enrollment with another plan.

6.18.5 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material Subcontractor from a service area. This reimbursable expense shall be in addition to any other provisions of this Contract.

6.18.6 HCA reserves the right to impose Sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating Provider in a timely manner and does not comply with the notification requirements of this Section.

6.18.6.1 If the Contractor does not receive timely notification from the terminating Provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a Material Provider.

6.19 Network Submissions for Washington Healthplanfinder

The Contractor shall maintain provider network data. The Contractor shall submit provider AHEHP network data to the Health Benefit Exchange (HBE) in a format specified by HBE. The provider network data will support Enrollee plan selection and will include a provider directory. The data will be used by Enrollees to select a Managed Care Contractor. HBE will develop a detailed implementation schedule to include specific dates for Contractor submission of information. In addition, the Contractor may be required to participate in testing of provider network and directory functionality. The provider network and directory submissions required under this subsection are in addition to and do not supersede or replace any other provider network or provider directory submissions or reports due to HCA under this Contract.

6.20 Enrollee PCP Assignment Files

6.20.1 The Contractor shall submit its PCP assignment methodology in narrative form to HCA on an annual basis, no later than January 31, via MFT. The PCP assignment methodology will describe all of the logic and data elements that are used to make the assignment, and any manual processes or exceptions which may occur in the process.

6.20.2 The Contractor shall submit Enrollee PCP assignment files to HCA on a bi-annual basis, or within thirty (30) calendar days of a request by HCA. The Contractor shall submit the information to HCA via MFT, using the HCA Enrollee PCP Assignment report template.

6.20.3 Reporting for each calendar year shall follow the timeline below:

6.20.3.1 PCP assignment methodology due by January 31;

6.20.3.2 PCP assignments from January 1 – June 30, due by July 15;

6.20.3.3 PCP assignments for July 1 – December 31, due by January 15 of the following calendar year; and

6.20.3.4 PCP assignments for January 1 – December 31, due by August 15 of the following calendar year.

6.20.3.4.1 This report shall capture all potential retrospective PCP assignment changes.

6.21 SUD Access to Services

6.21.1 The Contractor shall ensure services are not denied to any eligible Enrollee regardless of:

6.21.1.1 The Enrollee's drug(s) of choice.

6.21.1.2 The fact an Enrollee is taking FDA approved medically prescribed medications.

6.21.1.3 The fact an Enrollee is using over-the-counter nicotine cessation medications or actively participating in a Nicotine Replacement Therapy regimen.

6.21.2 Enrollees cannot be required to relinquish custody of minor children in order to access residential SUD treatment services.

6.21.3 A pregnant woman who is unable to access residential treatment due to lack of capacity and is in need of withdrawal management, can be referred to a Chemical Using Pregnant (CUP) program for admission, typically within twenty-four (24) hours.

6.22 Pharmacy Network Management

6.22.1 The Contractor is ultimately responsible for any acts or omissions of the Contractor's PBM or subcontracted PBM that do not comply with this Contract. HCA may impose sanctions, liquidated damages, or both, against the Contractor for non-compliance, by the Contractor, the Contractor's PBM, or subcontracted PBM, with the requirements of this Contract or engaging in acts or omissions prohibited by this Contract.

6.22.1.1 Annually, no later than July 31, the Contractor shall submit via MC-Track a completed HCA PBM Subcontractor Attestation.

6.22.2 Annually by September 1, the Contractor shall provide HCA with non-redacted copies of all contracts, related to the administration of the Apple Health Expansion pharmacy benefits plan between the Contractor and its PBM and between the Contractor's PBM and its subcontracted PBM, as applicable. The

Contractor shall submit the contracts to HCA through MC-Track.

6.22.3 Annually by September 1, the Contractor shall provide HCA with non-redacted copies of all contract templates and compensation exhibits (and any applicable amendments) between the Contractor, PBM, or subcontracted PBM, with any retail pharmacy, mail pharmacy, specialty pharmacy, pharmacy services administrative organization (PSAO), or any other pharmacy related Subcontractor, that is participating as a network provider in the Contractor's, PBM's, or subcontracted PBM's pharmacy network. The Contractor shall submit the contracts to HCA through MC-Track.

6.22.3.1 The Contractor shall submit to HCA any changes, non-redacted, to any pharmacy network contract at least thirty (30) calendar days prior to their effective dates.

6.22.4 Annually by September 1, the Contractor shall submit pharmacy reimbursement rate methodologies (including reimbursement guarantees or other performance related incentives) to HCA. The Pharmacy Reimbursement Rate Methodology template is available from HCA through MC-Track.

6.22.4.1 The Contractor shall submit any changes to the reimbursement methodologies to HCA at least thirty (30) calendar days prior to the effective date. The Contractor shall include the reason for any changes to the methodologies and contracted rates. This notification must be separate from the PBM contract submission. The Contractor shall provide notification to hcamcprograms@hca.wa.gov with 'pharmacy reimbursement rate methodologies' in the subject line of the email.

6.22.4.2 The Contractor shall provide a quarterly report by the last business day of the month following the end of the quarter outlining the changes to the maximum allowable costs list.

6.22.5 The Contractor shall provide a quarterly report of claims paid to Non-Participating Provider pharmacies. The Contractor shall submit the report no more than forty-five (45) calendar days after the end of each quarter via MC-Track using the Claims Paid to Non-Participating Provider Pharmacies template. This report will include identifying details of all Non-Participating Provider pharmacy claims paid by the Contractor's PBM for the date of service submitted on each claim.

6.22.6 The Contractor shall ensure that all Subcontracts (i) include the requirements of this section and (ii) prohibit the PBM and subcontracted PBM's from engaging in conduct prohibited in this section.

6.22.7 The Contractor is responsible for any non-compliance with the requirements or prohibited conduct identified in this section, regardless of whether the non-compliance is by the Contractor, the PBM, or any Subcontractors of either the Contractor or their PBM.

6.22.8 With the exception of specialty pharmacies and mail order pharmacies, the Contractor is prohibited from preferring, steering, requiring, incentivizing, or otherwise encouraging a member to utilize the services of an Affiliate Pharmacy. The Contractor must also prohibit the PBM and the subcontracted PBM from engaging in this activity.

6.22.8.1 The Contractor shall not require a specific specialty or mail order

pharmacy when a Provider bills the Enrollee's MCO as the secondary payer.

6.22.8.2 Annually, no later than March 31, the Contractor must provide HCA with a list of Specialty Drugs limited to Specialty Pharmacies for HCA approval.

6.22.9 The Contractor is prohibited from paying Affiliate Pharmacies more than it pays a pharmacy that is not an Affiliate Pharmacy, or a pharmacy services administrative organization, for the same prescription drug product. The Contractor must also prohibit the PBM and subcontracted PBM from engaging in this activity.

6.22.10 The Contractor is prohibited from allowing or entering into a contract with the PBM or subcontracted PBM that allows the PBM or subcontracted PBM to charge the Contractor more than what was paid to the PSAO or network pharmacy or pharmacy services administrative organization for a prescription drug dispensed to an Enrollee. The purpose of this subsection is explicitly to prohibit the practice commonly known as "spread pricing."

6.22.11 The Contractor is prohibited, and must prohibit their PBM or subcontracted PBM, from retroactively denying or reducing a payment made to a Participating Provider pharmacy or PSAO for services after adjudication of the claim, including direct and indirect remuneration for a prescription drug dispensed to an enrollee, unless:

6.22.11.1 Approved by HCA based on the original claim having been submitted fraudulently; or

6.22.11.2 The denial or reduction is the result of a pharmacy audit conducted in accordance with RCW 19.340.040; or

6.22.11.3 Liability for payment of a claim shifted to another payer, including, but not limited to, coordination of benefits or subrogation.

6.22.12 The Contractor is prohibited and must prohibit their PBM or subcontracted PBM from entering into guaranteed effective rate contracts for brand and generic drugs with pharmacies or pharmacy services administrative organizations. Contractor is prohibited and must prohibit their PBM and subcontracted PBM for making retroactive adjustments to claims due to an effective rate guarantee for brand, generic and specialty drugs.

6.22.13 The Contractor shall require its PBM and subcontracted PBM to return to the Contractor all retroactive adjustments in payments made to PSAOs or participating pharmacies or pharmacy services administrative organizations.

6.22.13.1 The retroactive adjustment, including all forms of direct and indirect remuneration, must be returned to the Contractor within thirty (30) calendar days of the adjustment.

6.22.13.2 Any retroactive adjustment to remittance to a pharmacy or pharmacy services administrative organization must be attributed to an individual claim and submitted to HCA as an adjusted encounter within thirty (30) calendar days of the adjustment.

6.22.14 The Contractor is prohibited, and must prohibit their PBM or subcontracted

PBM, from causing or permitting the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

6.22.15 The Contractor is prohibited, and must prohibit their PBM, subcontracted PBM, and network pharmacies, from issuing Automatic Refills of prescriptions to their Enrollees.

6.22.16 The Contractor is prohibited, and must prohibit their PBM or subcontracted PBM, from charging a pharmacy or PSAO a fee related to:

6.22.16.1 The adjudication of a claim;

6.22.16.2 Credentialing, certification, accreditation, participation or enrollment in the Contractor's or PBM's network; or

6.22.16.3 Receiving and processing a claim.

6.22.17 The Contractor is prohibited, and must prohibit the PBM or subcontracted PBM, from requiring accreditation standards for Participating Provider pharmacies inconsistent with or more stringent than accreditation standards established by a national accreditation organization.

6.22.18 The Contractor shall have a process that meets the following requirements and shall require the PBM and subcontracted PBM to also follow these requirements with respect to network pharmacy provider appeals for pharmacy claims, for brand or generic drugs, that allegedly were underpaid, regardless of whether the claim was paid at the contracted reimbursement rate.

6.22.18.1 There shall be a process by which a network pharmacy may appeal its reimbursement for the drug ingredient portion of any prescription drug claim dispensed to an Enrollee. This requirement does not pertain to the dispensing fee portion of the pharmacy's payment.

6.22.18.2 A pharmacy may appeal the reimbursement amount for the drug if any pharmacy alleges that the reimbursement is less than the invoiced amount that the pharmacy paid to the supplier of the drug. The Contractor or its PBM may only require an invoice documenting actual acquisition cost relevant to the date the drug was dispensed.

6.22.18.3 The appeal of a Critical Access Pharmacy or a pharmacy that is licensed in Washington State, located in Washington State, and part of a corporate organization that has less than 15 retail outlets under its corporate umbrella within the state of Washington shall be upheld, if the pharmacy demonstrates it is unable to purchase the underpaid brand name drug or a therapeutically equivalent interchangeable product to the underpaid generic drug from the pharmacy's primary supplier and secondary supplier when available at the Contractor's or PBM's list price, even if the original claim was paid at the contracted reimbursement rate.

6.22.18.4 The appeals process shall include, but is not necessarily limited to, the following components:

6.22.18.4.1 There shall be a telephone number, posted on the website of the Contractor/PBM/subcontracted PBM,

at which the network pharmacy may contact and speak with an individual who is responsible for processing the appeals.

6.22.18.4.2 The Contractor/PBM/subcontracted PBM will notify the pharmacy, in writing, of the outcome of the appeal within thirty (30) calendar days after the pharmacy submits the appeal.

6.22.18.4.3 If the appeal is denied, the notice shall include the reason for the denial and the national drug code of a drug that was purchased by other network pharmacies located in Washington at a price that is equal to or less than the predetermined reimbursement cost for the prescription drug claim that is subject to appeal.

6.22.18.4.4 If the appeal is upheld the Contractor/PBM/subcontracted PBM shall make a reasonable adjustment to the payment to the pharmacy on a date no later than one (1) Business Day after the determination of the appeal. Adjustments to payments for underpaid claims to a single pharmacy are not applicable to the remaining network pharmacy providers, unless such providers have successfully pursued the appeals process outlined in this section.

6.22.18.5 The Contractor shall submit a quarterly report of all appeals submitted by network pharmacies for underpaid claims. The Underpaid Pharmacy Appeals report template is available in MC-Track.

6.22.18.5.1 The quarterly report shall be submitted within forty-five (45) calendar days after the end of each calendar quarter.

6.22.19 Critical Access Pharmacies

6.22.19.1 The Contractor must require its PBM or subcontracted PBM to provide fair and reasonable reimbursement to Critical Access Pharmacies as identified by HCA, that is not below the Critical Access Pharmacy's cost, including a fair and reasonable dispensing fee.

6.22.19.2 The Contractor must require their PBM or subcontracted PBM to include all Critical Access Pharmacies in their pharmacy networks.

6.22.19.3 The Contractor shall notify HCA of any changes to the reimbursement rate to a PASO or Critical Access Pharmacy, made by the Contractor, the Contractor's PBM, or subcontracted PBM, ninety (90) calendar days prior to the effective date of the change in reimbursement.

6.22.19.3.1 The Contractor is prohibited and must prohibit their PBM or subcontracted PBM from entering into

pharmacy reimbursement rate based on effective rate pricing with Critical Access Pharmacies and PSAOs that contract on behalf of Critical Access Pharmacies.

6.22.19.3.2 The Contractor shall ensure that their contracted PBM or subcontracted PBM reimburses Critical Access Pharmacies at the highest available reimbursement rate or rural reimbursement rate, even if the Critical Access Pharmacy is located in an urban setting.

6.22.19.3.3 The Contractor shall ensure that their PBM or subcontracted PBM has updated all impacted Critical Access Pharmacies and PSAOs contracts no later than January 1, 2025, with a retroactive effective date of July 1, 2024.

6.22.19.4 The Contractor shall notify HCA within thirty (30) calendar days if a Critical Access Pharmacy withdraws from the Network. Contractor shall provide notification to hcamcprograms@hca.wa.gov with 'Critical Access Pharmacy withdrawal' in the subject line of the email.

6.22.19.5 The Contractor shall submit any proposed termination of a Critical Access Pharmacy from the Network to HCA for review and approval at least sixty (60) calendar days prior to sending termination notice to the pharmacy. Contractor shall provide notification to hcamcprograms@hca.wa.gov with 'Critical Access Pharmacy termination' in the subject line of the email.

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Assessment and Performance Improvement (QAPI) Program

7.1.1 The Contractor shall have and maintain one quality assessment and performance improvement (QAPI) program for all services it furnishes to Apple Health eligible clients with an addendum focused on any differences in the Contractor's QAPI programs for Enrollees in this contract.

7.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.

7.1.1.2 The QAPI program structure shall include the following elements:

7.1.1.2.1 Assessment of the quality of care received by Enrollees, as measured by HEDIS® and other quality performance measures;

7.1.1.2.2 Goals and interventions to improve the quality of care received, including primary care and behavioral health bi-directional clinical integration and the recommendations of the Washington Integrated Care Assessment (WA-ICA) Initiative;

7.1.1.2.3 Assessment of health equity, including identification of health disparities;

7.1.1.2.4 Service to a culturally and linguistically diverse membership, including recommendations from the Contractor's Tribal Liaison;

7.1.1.2.5 Service to members with complex health issues and special health care needs;

7.1.1.2.6 Patient safety initiatives and tracking of the critical incident management system;

7.1.1.2.7 Inclusion of Enrollee voice and experience, which may include consumer surveys, grievances, and feedback from Ombuds process;

7.1.1.2.8 Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, provider appeals and surveys;

7.1.1.2.9 Utilization of active and continuous quality improvement principles and strategies (e.g., root cause analysis, Lean, rapid-cycle process improvement);

7.1.1.2.10 Involvement of designated physician in the QI program, including involvement of designated behavioral health care provider;

7.1.1.2.11 A quality improvement committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

7.1.1.2.11.1 Include practicing provider participation;

7.1.1.2.11.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement;

7.1.1.2.11.3 Institute actions to address performance deficiencies, including policy recommendations; and

7.1.1.2.11.4 Ensure appropriate follow-up.

7.1.1.2.12 A written QAPI program description shall include the following:

7.1.1.2.12.1 A listing of all quality-related committee(s);

7.1.1.2.12.2 Descriptions of committee responsibilities and oversight;

7.1.1.2.12.3 Contractor staff and practicing provider committee participant titles;

7.1.1.2.12.4 Meeting frequency;

7.1.1.2.12.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate;

7.1.1.2.12.6 All contractually required elements of the QAPI program structure as outlined above;

7.1.1.2.12.7 Proposed methods to meet the requirements under the Contract to evaluate and report performance measure results in a manner that distinguishes individuals who have indicators of need of mental health and/or SUD treatment;

7.1.1.2.12.8 Processes for monitoring, aggregating, and presenting information regarding physical and behavioral health providers or provider groups with at least 1,000 Enrollees, performance in a Provider Performance (PPP) format that encourages self-correction and includes, but is not limited to performance relative to:

7.1.1.2.12.8.1 Adherence to applicable EBPs and practice guidelines;

7.1.1.2.12.8.2 Appointment access standards; and

7.1.1.2.12.8.3 Utilization and quality metrics such as readmissions, average length of stay, and transitional health care services to ambulatory services.

7.1.1.2.13 A sufficient number of physical health and behavioral health staff members to completely implement all QAPI program requirements on a timely basis.

7.1.1.2.14 The Contractor shall participate in the single RSA Community Behavioral Health Advisory Board (CBHA).

7.1.1.2.15 The CBHA shall, at minimum, advise on the need for establishing a behavioral health Quality Management (QM) sub-committee. If the Community Advisory Board recommends a behavioral health QM subcommittee, the subcommittee shall:

7.1.1.2.15.1 Include, in an advisory capacity, Enrollees, family members, Certified Peer Counselors, and provider representatives.

7.1.1.2.15.2 Maintain records of meetings documenting attendance by Enrollees, family members, and providers, as well as committee's findings, recommendations, and actions.

7.1.1.2.15.3 Include mechanisms to solicit feedback and recommendations from a CBHA and key stakeholders to improve quality of care and Enrollee outcomes.

7.1.1.2.15.4 Provide quality improvement feedback to the CBHA, key stakeholders, and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request.

7.1.1.2.16 An annual quality work plan is due March 1 for all services it furnishes to the Apple Health Expansion eligible clients with an addendum focused on any differences in the Contractor's quality work plan for the Enrollees in this Contract. The work plan shall

contain:

7.1.1.2.16.1 Goals and objectives for the year, including objectives for patient safety, serving a geographically, culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization;

7.1.1.2.16.2 A plan to address the recommendations contained in the annual EQRO Technical Report which the Contractor has the ability to affect, e.g., HEDIS® measure performance;

7.1.1.2.16.3 Timeframe to complete each activity;

7.1.1.2.16.4 Identification of a responsible person for each activity;

7.1.1.2.16.5 Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs as defined in HCA's Quality Strategy; and

7.1.1.2.16.6 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.

7.1.1.2.17 An annual written QAPI Program Evaluation due July 15, of the overall reporting of the effectiveness of the Contractor's QAPI program for all services it furnishes to Apple Health eligible clients with an addendum focused on any differences in the Contractor's QAPI Program Evaluation for the Enrollees in this Contract. The report shall reflect on required QI program structure and activities in the Work Plan and shall include at minimum:

7.1.1.2.17.1 Analysis of and actions taken to improve health equity.

7.1.1.2.17.2 Inclusion of consumer voice.

7.1.1.2.17.3 Contractually required HEDIS® performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared AHE performance against the Medicaid NCQA 90th percentile and Washington State average. Both clinical and non-clinical performance measures must be trended and evaluated in the AHEHP report.

7.1.1.2.17.4 Accompanying written analysis of performance, including data comparisons to the Medicaid NCQA 90th percentile and Washington State average.

7.1.1.2.17.5 An analysis of actions taken to address the recommendations contained in the annual EQRO Technical Report and corresponding AHE Addendum which the Contractor has the ability to affect i.e., HEDIS® performance measure.

7.1.1.2.17.6 Findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health. The following minimum measure set shall be reported on in the annual QAPI program evaluation about over and under-utilization:

7.1.1.2.17.6.1 Preventable hospitalizations, including readmissions;

7.1.1.2.17.6.2 Avoidable emergency department visits;

7.1.1.2.17.6.3 Mental health treatment; and

7.1.1.2.17.6.4 Comprehensive Diabetes Care.

7.1.1.2.17.7 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.

7.1.1.2.17.8 A written assessment of the success of contractually required performance improvement projects.

7.1.1.3 The Contractor shall maintain a strategy to address public health emergencies as they emerge, supporting active and timely response in alignment with state agency initiatives. The strategy must include creation of targeted plans to address specific public health emergencies as needed, including provider and member education as appropriate.

7.1.1.3.1 A strategic plan must be established for a COVID-19 response and include a focus on increasing AHE Enrollee COVID-19 vaccination rates. The Contractor will participate in efforts to increase statewide efforts

to improve COVID-19 vaccination rates and make progress in higher COVID-19 vaccination rates for Enrollees.

7.1.2 Upon request, the Contractor shall make available to providers, Enrollees, or HCA, the QAPI program description with AHE Addendum, and information on the Contractor's progress towards meeting its quality plans and goals.

7.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

7.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.

7.1.3.2 Evaluation of the delegated organization prior to delegation.

7.1.3.3 An annual evaluation of the delegated entity.

7.1.3.4 Evaluation of regular delegated entity reports.

7.1.3.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

7.2 Performance Improvement Projects

7.2.1 The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on a clinical or non-clinical area. PIPs identified by the Contractor are subject to review and approval of HCA including, but not limited to area of focus, design and implementation, and evaluation methodologies. The Contractor shall conduct the following PIPs:

7.2.1.1 One PIP of the Contractor's choosing, one of which must be designed for Apple Health Expansion Enrollees;

7.2.2 The PIP shall be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction and shall include the following elements:

7.2.2.1 Measurement of performance using objective quality indicators.

7.2.2.2 Implementation of interventions to achieve improvement in the access to and quality of care.

7.2.2.3 Evaluation of the effectiveness of the interventions based on the performance measures.

7.2.2.4 Planning and initiation of activities for increasing or sustaining improvement.

7.2.2.5 The Contractor shall report the status and results of all required performance improvement projects to HCA.

7.2.2.6 The Contractor must submit current year PIP proposals to HCA annually upon request.

7.2.2.7 Each completed project shall be documented on a PIP Worksheet provided by HCA, in alignment with CMS protocol entitled "Conducting a Performance Improvement Project".

7.3 Integrated Patient Record/Clinical Data Repository

7.3.1 The Contractor shall collaborate with peer AH AHEHPs, HCA, and at the direction of HCA, the State HIE to design, establish and maintain a longitudinal integrated patient record for all Apple Health-Managed Care Enrollees assigned to Contractor.

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

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

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

7.3.5 The Contractor shall appoint a representative to provide input into the design and evaluation of the integrated patient record maintained in the CDR.

7.3.6 The Contractor shall pay the operational costs to maintain an integrated health record for each of its Enrollees as billed by the State HIE in two installments each year no later than January 31 and July 1.

7.3.6.1 The Contractor shall pay a percentage of the operational costs to maintain an integrated health record for current and past Enrollees. The cost shall not exceed $1.02 per year per covered life.

7.3.6.2 HCA will use the most current Managed Care Market Share report, or other agreed upon total population report, to report the Contractor's total percentage of Enrollees to the State HIE.

7.3.6.3 The State HIE will use the percentage of market share, multiplied by the total covered lives in the CDR, multiplied by a rate not to exceed $1.02 per covered life to determine the Contractor's invoice. The State HIE will bill the Contractor for the maintenance of integrated health records each year on or around January 31, and July 1.

7.3.6.4 The Contractor shall pay the State HIE in full by the due date indicated on the billings.

7.3.6.5 If the Contractor fails to pay the State HIE within thirty (30) calendar days of the due date on the billing, HCA will withhold the amount due from the next available scheduled monthly AH-IMC premium

payment to the Contractor.

7.3.6.6 Costs to the Contractor to connect to the HIE to access data are the responsibility of the Contractor.

7.3.6.7 Costs to the subcontractors to program EHR systems or connect to the HIE are the responsibility of individual entities.

7.3.7 The Contractor shall coordinate with HCA and the state HIE efforts to facilitate readiness activities intended to prepare for the secure exchange of high value health information among subcontractors identified by HCA through participation in communication and readiness activities organized by HCA and HIE.

7.3.8 The Contractor shall require subcontracted providers with certified EHR systems submit automated exports of standard CCD/CCDA, or subsequent ONC-specified standard healthcare transactions, as specified by HCA and consistent with the design of the integrated patient record, from their EHR to the CDR via the HIE each time an Enrollee is seen. The Contractor will include contract language reflecting these expectations during contract activities with subcontractors.

7.3.9 The Contractor shall participate in quality measurement activities related to the CDR.

7.3.9.1 When a subcontracted provider is required to participate in the CDR per subsection 7.3.8 above, the Contractor will require a clinical document to be submitted for a minimum of 80 percent of submitted claims and that a minimum of 85 percent of documents submitted by the subcontracted provider be error free.

7.3.9.2 The Contractor will provide a Provider Compliance report semi-annually to HCA by April 1 and October 1 detailing provider compliance with subsections 7.3.8 and 7.3.9.1 above for the prior six month period.

7.3.10 The Contractor shall participate in business process improvement activities related to the CDR.

7.3.10.1 The Contractor will review care coordination processes that require the use of clinical documentation (e.g., creation, use and/or transmission of discharge summaries, care plans, medication lists, chart notes) and determine the opportunities and challenges for subcontracted providers to submit this data to the CDR.

7.3.10.2 The Contractor will provide a CDR - Care Coordination and Recommendation report annually to HCA by July 1 detailing how CDR data is being used to support care coordination, and provide recommendations for improvements to CDR services to enhance usability, including recommendations for expanding CDR content.

7.3.11 The Contractor shall participate in workgroups related to enhancing the use of and participation in CDR activities.

7.4 Performance Measures

7.4.1 The Contractor shall include the AHE population in its annual calculation of HCA required HEDIS® measures following technical specifications for the Medicaid population according to directions provided by HCA's designated EQRO.

7.4.2 The Contractor shall report AHE required HEDIS® measures using the current year HEDIS® Technical Specifications and official corrections published by NCQA, to HCA annually, unless directed otherwise in writing by HCA. The Contractor shall use administrative, hybrid, stratified, and Electronic Data Systems (ECDS) data collection methods, as specified in the current HEDIS® Technical Specifications and required by HCA.

7.4.3 Attachment 1, Performance Measures is the list of HCA required HEDIS® performance measures to be submitted to NCQA and HCA. If "Hybrid", "ECDS" or 'Race and Ethnicity Stratification (RES)" is noted in the "Notes" column of Attachment 1, the Contractor is contractually required to report using the noted methodology. If the Contractor is unable to report using this methodology, the Contractor is required to notify HCA within five (5) Business Days with the reason and submit a plan and timeline for returning to contractual compliance.

7.4.4 No later than the date in June of each year as specified by the audit team, AHE required HEDIS® measures shall be submitted electronically to HCA's contracted EQRO according to instructions provided by HCA or HCA's designated EQRO.

7.4.5 State performance measures shall be produced by HCA, in partnership with the DSHS/Research and Data Analysis Division (RDA), and delivered to the Contractor in reporting year 2024; for the data collection period January 1, 2023 through December 31, 2023. Populations included are all eligible Apple Health enrolled populations. See Attachment 1, Performance Measures for performance measures applicable to this section in Table 2 under state measures.

7.4.6 The Contractor shall submit raw HEDIS® data to HCA electronically, no later than June 30 of each year. The Contractor shall submit the Raw AHE HEDIS®/Member Level Data according to specifications provided by HCA.

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

7.4.8 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's HEDIS® performance measures.

7.4.8.1 Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the CMS Validating Performance Measures protocol identified by HCA designated EQRO.

7.4.9 The Contractor shall create, maintain, and collect separate and unique data fields for Enrollee self-reported demographic data to the Contractor. At minimum, the following data fields shall be maintained by the Contractor: Enrollee name, address, email address, and ethnicity, race, and language

markers.

7.4.10 The Contractor shall rotate HEDIS® measures only when allowed by NCQA and with HCA's advance written approval. The Contractor may request approval to rotate measures by making a written request to HCAMCPrograms@hca.wa.gov. Any measures rotated by the Contractor without written permission from HCA shall be subject to the sanctions language described in this Contract.

7.5 NCQA Health Plan Accreditation

7.5.1 The Contractor shall have and maintain NCQA accreditation at a level of "accredited," receiving a health plan rating for the Medicaid product line of 2.5 stars or better. The Contractor shall apply NCQA accreditation standards to the Contractor's AHE population in the same manner and at the same level as required for the Medicaid population in Washington State. The Contractor must exclude AHE Enrollees from its Medicaid product line accreditation and report separately to HCA for the AHE population (i.e., AHE HEDIS measures must be reported separately to HCA from Medicaid HEDIS reporting).

7.5.2 The Contractor shall provide HCA with the results of the Contractor's NCQA accreditation reviews within thirty (30) calendar days of the finalized review, including accreditation status, survey type, level of accreditations, results of the review, HEDIS® summary level data, recommended actions or improvements, corrective action plans and summaries of findings and expiration date of the accreditation.

7.5.3 The Contractor shall notify HCA via HCAMCPrograms@hca.wa.gov of the date of its NCQA site visit within fifteen (15) calendar days of confirmation of the site visit by NCQA. The Contractor shall provide HCA with all written materials submitted to NCQA for purposes of the NCQA audit and allow HCA representative(s) to participate in the NCQA audit activities, including the site visit.

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

7.5.5 If the Contractor fails to obtain accreditation at a level of "accredited," receiving 2.5 stars or better within the timeframe described in this subsection or if the Contractor fails to maintain accreditation thereafter, the Contractor shall be considered in breach of this Contract. HCA shall terminate the Contract in accordance with the Termination by Default Subsection of this Contract.

7.5.6 The Contractor shall notify HCA via HCAMCPrograms@hca.wa.gov within thirty (30) calendar days of receiving any final accreditations, certifications or other recognitions (e.g., NCQA's Multicultural Health Care Distinction) for the Apple Health line of business earned through NCQA or any other private independent accreditation review entity. The Contractor shall provide the name of recognition, date of recognition, and any applicable expiration. The Contractor shall also provide a copy of accreditation, certification, and/or recognition awarded when requested by the HCA.

7.6 External Quality Review (EQR)

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

7.6.2 The following required activities will be validated:

7.6.2.1 Performance improvement projects.

7.6.2.2 Performance measures.

7.6.2.3 A monitoring review of standards established by HCA and included in this Contract and a comprehensive review conducted within the previous three (3) year period.

7.6.3 HCA reserves the right to include additional optional EQR activities if additional funding becomes available and as mutually negotiated between HCA and the Contractor.

7.6.4 The Contractor shall submit reports, findings, and other results obtained from a Medicare or private accreditation review (e.g., NCQA, eValue8, URAC, etc.) if requested by HCA. HCA may, at its sole discretion, use the accreditation review results in lieu of an assessment of compliance with any federal or state standards and the review conducted by HCA of those standards.

7.6.5 The Contractor shall submit to annual monitoring reviews by HCA and EQRO. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the EQR Apple Health Expansion Health Plan's Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by AHEHPs.

7.6.6 The Contractor shall, during an HCA annual monitoring review of the Contractor's compliance with contract standards or upon request by HCA or its EQRO Contractor(s), provide evidence of how external quality review findings, agency audits and contract monitoring activities, Enrollee Grievances and HEDIS® results are used to identify and correct problems and to improve care and services to Enrollees.

7.6.7 The Contractor will provide data requested by the EQRO for purposes of completing the AHE addendum to the External Quality Review Report Annual (EQRAR). The EQRAR is a detailed technical report that describes how the data from all activities described in the External Quality Review provisions of this Section. HCA will provide a copy of the EQRAR with AHE addendum to the Contractor, through print or electronic media were aggregated and analyzed and conclusions drawn as to the quality, timeliness, and access to care furnished by the Contractor.

7.6.8 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA and Washington State Department of Health (DOH) as needed to reduce duplicated work for both the Contractor and the State.

7.7 Provider Complaints and Appeals

7.7.1 The Contractor shall have a system in place to process, track, and record provider complaints and appeals. The Contractor shall accept, record, and process provider complaints forwarded by HCA. The Contractor's provider complaint and appeal process should include a quality improvement process. The Contractor shall provide a Provider Complaints and Appeals Report on provider complaint and appeal data to HCA quarterly. The report is due by the last Business Day of the month following the end of the quarter.

7.7.1.1 Contractor and Subcontractors will provide an alternative method for providers to submit complaints in addition to U.S. mail.

7.7.2 The Contractor shall provide to HCA upon request information regarding denials of payments to Providers.

7.8 Critical Incident Management System

7.8.1 The Contractor shall establish a Critical Incident Management System consistent with all applicable laws and shall include policies and procedures for identification of incidents, reporting protocols and oversight responsibilities. The Contractor shall designate a Critical Incident Manager responsible for administering the Incident Management System and ensuring compliance with the requirements of this Section.

7.8.2 Individual Critical Incident Reporting

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

7.8.2.1.1 To an Enrollee, and occurred within a contracted behavioral health facility (inpatient psychiatric, behavioral health agencies), FQHC, or by independent behavioral health provider.

7.8.2.1.1.1 Abuse, neglect, or sexual/financial exploitation perpetrated by staff;

7.8.2.1.1.2 Physical or sexual assault perpetrated by another individual;

7.8.2.1.1.3 Death; and

7.8.2.1.1.4 Severely adverse medical outcome or death occurring within 72 hours of transfer from a contracted behavioral facility to a medical treatment setting.

7.8.2.1.2 By an Enrollee, with a behavioral health diagnosis; or history of behavioral health treatment within the previous 365 days. Acts allegedly committed, to include:

7.8.2.1.2.1 Homicide or attempted homicide;

7.8.2.1.2.2 Arson;

7.8.2.1.2.3 Assault or action resulting in serious bodily harm which has the potential to cause prolonged disability or death;

7.8.2.1.2.4 Kidnapping; and

7.8.2.1.2.5 Sexual assault.

7.8.2.1.3 Unauthorized leave from a behavioral health facility during an involuntary detention.

7.8.2.1.4 Any event involving an Enrollee that has attracted, or is likely to attract media coverage. (Contractor shall include the link to the source of the media, as available).

7.8.2.2 The Contractor shall report critical incidents within one Business Day of becoming aware of the incident and shall report incidents that have occurred within the last thirty (30) calendar days, with the exception of incidents that have resulted in or are likely to attract media coverage. Media related incidents should be reported to HCA as soon as possible, not to exceed one Business Day.

7.8.2.2.1 The Contractor shall enter the initial report, follow-up, and actions taken into HCA Incident Reporting System https://fortress.wa.gov/hca/ics/, using the report template within the system.

7.8.2.2.2 If the system is unavailable the Contractor shall report Critical Incidents to HCAMCPrograms@hca.wa.gov.

7.8.2.2.2.1 HCA may ask for additional information as required for further research and reporting. The Contractor shall provide information within three (3) Business Days.

7.8.2.2.2.2 Reporting this information to HCA does not discharge the Contractor from completing mandatory reporting requirements, such as notifying the DOH, law enforcement, Residential Care Services, and other protective services.

7.9 Practice Guidelines

7.9.1 The Contractor shall adopt physical and behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements:

7.9.1.1 Are based upon the following:

7.9.1.1.1 Valid and reliable clinical scientific evidence;

7.9.1.1.2 In the absence of scientific evidence, on professional standards; or

7.9.1.1.3 In the absence of scientific evidence and professional standards, a consensus of Health Care Professionals in the particular field.

7.9.2 The Contractor shall develop practice guidelines based on recognized sources such as the United States Preventive Services Task Force (USPSTF) and the

current Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule published by the Centers for Disease Control (CDC) as primary guideline sources. The Contractor may also adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers, or the Substance Abuse and Mental Health Services Administration (SAMHSA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:

7.9.2.1 Be age appropriate to address the special needs or considerations that are driven by age.

7.9.2.2 Consider the needs of Enrollees and support client and family involvement in care plans.

7.9.2.3 Be adopted in consultation with contracting Health Care Professionals within the state of Washington, or, when applicable, are adopted in consultation with the behavioral health professionals in the Contractor's contracted network.

7.9.2.4 Be reviewed and updated at least every two (2) years and more often if national guidelines change during that time.

7.9.2.5 Be disseminated to all affected providers and, upon request, to HCA, Enrollees and Potential Enrollees (42 C.F.R. § 438.236(c)).

7.9.2.6 Be distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers.

7.9.2.7 Be the basis for and are consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply.

7.9.3 The Contractor shall develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor shall:

7.9.3.1 Conduct outreach to Enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.

7.9.3.2 Report on preventive care utilization through required performance measure reporting.

7.9.3.3 In collaboration with peer organizations, disaggregate data on at least one (1) preventive care measure and examine the data for racial/ethnic disparities.

7.9.3.4 In collaboration with peer organizations, target interventions with known disparities in preventive care utilization and measure the

impact of the interventions on utilization patterns.

7.9.3.5 Prepare and disseminate all such materials consistently with the requirements of Subsections 3.6 and 3.7.

7.9.4 The Contractor shall include the behavioral health medical director in the evaluation of medications and other emerging technologies for the treatment of behavioral health conditions and related decisions.

7.10 Health Information Systems

The Contractor shall maintain, and shall require subcontractors to maintain, a health information system consistent with requirements applying the same health information system standards verified in the Contractor's Medicaid HEDIS. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The Contractor shall:

7.10.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, Grievance and Appeals, and terminations of enrollment for other than loss of Apple Health eligibility.

7.10.2 Ensure data received from providers is accurate and complete by:

7.10.2.1 Verifying the accuracy and timeliness of reported data;

7.10.2.2 Screening the data for completeness, logic, and consistency; and

7.10.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.10.3 The Contractor shall make all collected data available to HCA upon request.

7.10.4 Establish and maintain protocols to support timely and accurate data exchange with any subcontractor that will perform any delegated behavioral health function under this Contract.

7.10.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims submission, and claims status updates for behavioral health services.

7.10.6 Have information systems that enable paperless submission, automated processing, and status updates for prior authorization and other UM related requests.

7.10.7 Establish and maintain data driven approaches to monitor requirements, by eligibility group when appropriate, including behavioral health network adequacy, crisis plans, mental health advance directives, and behavioral health specific reporting requirements for UM, QM, and financial management as well as administrative and clinical performance metrics.

7.10.8 Maintain behavioral health content on a website that meets the following minimum requirements:

7.10.8.1 Public and secure access via multi-level portals (such as providers and Enrollees) for providing web-based training, standard reporting, and data access as needed for the effective management and evaluation of the performance of the contract and the service delivery system as described under this Contract.

7.10.8.2 The Contractor shall organize the website to allow for easy access of information by Enrollees, family members, network providers, stakeholders, and the general public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:

7.10.8.2.1 Hours of operations for the Contractor.

7.10.8.2.2 How to access behavioral health services, including crisis contact information and toll-free crisis telephone numbers.

7.10.8.2.3 Telecommunications device for the deaf/text telephone numbers.

7.10.8.2.4 Information on the right to choose a qualified behavioral health service provider.

7.10.8.2.5 An overview of the range of behavioral health services being provided.

7.10.8.2.6 Access to behavioral health-medical integration tools and supports to support provider integration initiatives.

7.10.8.2.7 Access to information for Transitional Age Youth.

7.10.8.2.8 A library for providers and Enrollees that provides comprehensive information and practical recommendations related to mental illness, SUD and recovery, life events, and daily living skills.

7.10.8.2.9 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees receiving behavioral health services, family members, providers, and stakeholders to become involved.

7.10.8.2.10 Information regarding advocacy organizations, including how Enrollees and other family members may access advocacy services.

7.10.8.2.11 Opportunities, including surveys, for behavioral health Enrollees, family members, network providers, and other stakeholders to provide satisfaction/complaint feedback.

7.11 Clinical Data Repository

7.11.1 HCA shall develop and the Contractor shall publish guidelines for participation in the CDR, along with the contacts and resources to support provider organizations through the readiness activities.

7.11.2 The Contractor shall require that the subcontracted physical health provider organizations sends clinical information to the CDR after providing services to Apple Health Enrollees.

7.11.3 The Contractor shall support and encourage subcontracted behavioral health provider organizations send clinical information to the CDR after providing services to Apple Health Enrollees. Support may include, but is not limited to,

providing technical assistance resources to providers.

7.11.4 Clinical information submitted to the CDR should be provided as a care summary using the C-CDA standard or other applicable transaction as specified by HCA.

7.11.5 If a provider does not have an EHR certified to the 2014 or 2015 certification standards, these requirements do not apply.

7.11.6 If a provider holds itself out as a SUD treatment provider, these requirements do not apply.

7.12 Data Submission to Collective Medical Technologies (CMT)

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

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

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

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

7.13 Required Reporting for Admission, Discharge, and Transfer (ADT) Notifications

7.13.1 The Contractor will require the use of interoperable Health Information Technology (HIT) to create and send admission/discharge/transfer notifications (ADTs) to providers, facilities, or practitioners on behalf of Enrollees admitted to Inpatient Psychiatric Hospitals and Units that have access to HIT/EHRs.

7.13.2 The Contractor will require that it has access to or receive the ADTs for tracking and reporting of Enrollees who are placed, transferred, or discharged from Inpatient Psychiatric Hospitals and Units.

7.13.2.1 The network providers will create and exchange ADTs using the HL7 2.5.1 or later ADT message standard.

7.13.2.2 Annually, the Contractor will submit the Facility ADT Notification report to HCA by March 31 for the previous calendar year. The report will be submitted to HCA through MC Track. The first report is due March 31, 2023. The report will include:

7.13.2.2.1 Name of each contracted community-based psychiatric hospital and psychiatric hospital unit participating;

7.13.2.2.2 Name of community-based psychiatric hospital/unit without access to interoperable HIT/EHR;

7.13.2.2.2.1 Any current or future plans for each hospital/unit to acquire interoperable

HIT/EHR and date of proposed implementation.

7.13.2.2.3 Name of community-based psychiatric hospitals and psychiatric hospital units participating that report ADTs;

7.13.2.2.4 The interoperable HIT vendor and product name and version number used to create and send ADTs;

7.13.2.2.5 Total number of admissions, discharges, and transfers to each the Inpatient Psychiatric hospital or unit;

7.13.2.2.6 Total number of ADTs created and sent by each Inpatient Psychiatric hospital or unit; and

7.13.2.2.7 Total number of unique Enrollees for whom ADTs were created and sent by the Inpatient Psychiatric hospital or unit.

7.14 Required Reporting for Behavioral Health Supplemental Data

7.14.1 The Contractor is responsible for submitting and maintaining accurate, timely, and complete behavioral health supplemental data. The Contractor shall comply with the following:

7.14.1.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of behavioral health supplemental data submitted to HCA.

7.14.1.2 Reporting includes specific transactional data documenting behavioral health services collected by the Contractor and delivered to Enrollees during a specified reporting period.

7.14.1.3 Submit to HCA's BHDS complete, accurate, and timely supplemental data for behavioral health services for which the Contractor has collected for Enrollees, whether directly or through subcontracts or other arrangements.

7.14.1.3.1 The Contractor's disclosure of individually identifiable information is authorized by law.

7.14.1.3.2 The Contractor must respond to requests from HCA for behavioral health information not previously reported in a timeframe determined by HCA that will allow for a timely response to inquiries from the legislature, and other parties.

7.15 Resources for Reporting Behavioral Health Supplemental Data

7.15.1 The Contractor must comply with behavioral health supplemental data reporting requirements, including the requirements outlined in SERI and the Behavioral Health Data Guide (BHDG). The BHDG describes the content of the supplemental data for each transaction, requirements for frequency of reporting, required data fields, valid values for data fields, and timeliness reporting guidelines.

7.15.2 The Contractor must implement changes within 120 calendar days:

7.15.2.1 From the date of notification by HCA; changes will be documented in an updated version of the BHDG if applicable.

7.15.2.2 In the event that shorter timelines for implementation of changes under this Section are required or necessitated by either a court order, agreement resulting from a lawsuit, or legislative action, HCA will provide written notice of the impending changes and specification for the changes as soon as they are available. The Contractor will implement the changes required by the timeline established in the court order, legal agreement, or legislative action.

7.15.2.3 The Contractor shall, upon receipt of updates to the BHDG from HCA, provide notice of changes or updates to subcontractors.

7.15.3 The Contractor shall request technical assistance from HCA as needed. HCA will respond within two (2) to three (3) Business Days of a request for technical assistance by the Contractor. Submit request to mmishelp@hca.wa.gov.

7.15.3.1 The Contractor is responsible for providing technical assistance as needed to any subcontractors and providers.

7.15.3.2 On a quarterly basis, the Contractor shall submit via MC-Track the BHDS Behavioral Health Agency Quarterly Submission Report, which will contain a list of subcontracted Behavioral Health Agencies that are required to submit supplemental data to BHDS as outlined in the BHDG.

7.15.3.2.1 The BHDS Behavioral Health Agency Quarterly Submission Report shall be submitted no later than the 15th of the month for the months of January, April, July, and October.

7.16 Submission of Behavioral Health Supplemental Data

7.16.1 The Contractor must submit behavioral health supplemental data about Enrollees to the BHDS within thirty (30) calendar days of collection or receipt from subcontracted providers. Submissions must be in compliance with current submission guidelines as published by HCA. The Contractor shall submit supplemental data using the correct program and submitter identifiers as assigned by HCA.

7.16.1.1 Supplemental data includes all specific transactions as outlined in the BHDG.

7.16.2 All reporting must be done via a flat file in the format and with acceptable data values as outlined in the BHDG.

7.16.3 The Contractor must certify the accuracy and completeness of all supplemental data concurrently with each file submission. The certification must affirm that:

7.16.3.1 The Contractor has reported all collected supplemental data to HCA for the month being reported;

7.16.3.2 The Contractor has reviewed the supplemental data for the month of submission; and

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

7.16.3.3.1 The Contractor shall submit this certification using the Daily Batch File Submission of Behavioral Health Supplemental Data, a template of which is available through MC-Track. This certification is to be submitted to MC-Track whenever supplemental data files are sent to the BHDS.

7.16.3.4 The Contractor shall submit a signed Monthly Certification of the Behavioral Health Supplemental Data Batch Submissions, a template of which is available in MC-Track. This certification must include a list of all submitted supplemental data batch files and is due within five (5) Business Days from the end of each month. The purpose of this certification is to affirm that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful.

7.17 Data Quality Standards and Error Correction for Behavioral Health Supplemental Data

7.17.1 The submitted supplemental data shall adhere to the following data quality standards:

7.17.1.1 The data quality standards listed within this Contract and incorporated by reference into this Contract. The Contractor shall make changes or corrections to any systems, processes, or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended;

7.17.1.2 Submitted supplemental data shall include all transactions and shall have all fields required and outlined in the BHDG to support accurate data reporting and accurate matching with encounter data records submitted to the ProviderOne system;

7.17.1.3 Submitted supplemental data must pass all BHDS edits with a disposition of accept as listed in the BHDG or as sent out in communications from HCA to the Contractor; and

7.17.1.4 Submitted supplemental data must not contain transactions that are a duplicate of a previously submitted transaction unless submitted as a change or delete record to the existing record.

7.17.2 Upon receipt of data submitted, the BHDS generates error reports.

7.17.3 The Contractor must review each error report to assure that data submitted and rejected due to errors are corrected and resubmitted within thirty (30) calendar days from the date of rejection.

7.17.4 HCA shall perform supplemental transaction data quality reviews to ensure receipt of complete and accurate supplemental data for program administration and for matching supplemental transactions in the BHDS to encounters within the ProviderOne system.

7.17.4.1 Data quality shall be measured for each individual transaction as outlined in the BHDG. Error ratios that exceed 1 percent for each separate transaction may result in corrective actions up to and including sanctions.

7.17.4.2 Errors corrected as a result of error report review by the Contractor or as a result of an HCA data quality review must be submitted within thirty (30) calendar days from notification by HCA.

7.17.4.3 The Contractor shall, upon receipt of a data quality notice from HCA, inform subcontractors about any changes needed to ensure correct reporting of services.

7.17.4.4 If the Contractor requires more than thirty (30) calendar days to make corrections and resubmit identified supplemental transactions, then written notice must be submitted by the Contractor to HCA including reason for delay and date of completion. The Contractor shall notify HCA at mmishelp@hca.wa.gov or the specific email listed in the notification sent by HCA, and HCA will provide a final decision to the request in writing.

7.18 Technical Assistance

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

7.19 Annual Diabetes Report

7.19.1 The Contractor shall prepare an annual report on the prevalence of diabetes and utilization of diabetes education services among Contractor Enrollees. The report is due each year no later than the last Business Day of October and shall include data from the first Business Day of July of the previous calendar year through the last Business Day of June of the current calendar year.

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

7.19.2.1 The geographic distribution of Enrollees with Type 1 and Type 2 diabetes using the Enrollee's county of residence, rolled up into the *Healthier Washington* regional map found at: http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach.

7.19.2.2 A narrative description of how:

7.19.2.2.1 Enrollees are referred to diabetes education, and a description of any role that the plan plays in these referrals.

7.19.2.2.2 Diabetes education is promoted to Enrollees including links to Diabetes educational materials.

7.19.2.2.3 Diabetes education providers enroll with the Contractor if interested in joining the Contractor's network of providers.

7.19.2.2.4 The financial toll or impact diabetes and its complications places on the diabetes prevention and diabetes control program, and the financial toll or impact diabetes and its complications on these programs in comparison to other chronic diseases and conditions.

7.19.2.3 A list of:

7.19.2.3.1 Available Diabetes education providers including, name of diabetes educator, physical address, zip code, county and *Healthier Washington* region.

7.19.2.3.2 Any potential gaps in the network of diabetes educators, and measures the Contractor may take to address gaps in network providers.

7.19.2.4 Use the Diabetes Report template in MC-Track for reporting specific diabetes data.

8 POLICIES AND PROCEDURES

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

8.1 Contractor's Policies and Procedures

The Contractor's Policies and Procedures shall:

8.1.1 Direct and guide the Contractor's employees, Subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements;

8.1.2 Fully articulate the Contractor's understanding of the requirements;

8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training;

8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training; and

8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

8.2 Assessment of Policies and Procedures

8.2.1 The Contractor will provide a list of its policies and procedures related to this Contract to HCA through MC-Track using the Self-Assessment of Policy and Procedures template. The Contractor will complete and submit the list:

8.2.1.1 Annually no later than June 30 of each year;

8.2.1.2 In response to any corrective action issued by the HCA; and

8.2.1.3 Any time there is a new policy and procedure or a change to an existing policy and procedure.

8.2.2 The Contractor will also submit copies of policies and procedures to HCA upon request.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

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

9.1.1 The Contractor will submit to HCA for approval an HCA Self-Assessment form and any templates for an individual or entity to perform any duties or obligations that the Contractor is required to perform. Templates will also be submitted any time there is a substantive change to the template. The HCA Self-Assessment form and templates will be submitted to hcamcprograms@hca.wa.gov. This includes each of the following, as applicable:

9.1.1.1 Agreement;

9.1.1.2 Contract;

9.1.1.3 Statement of Work (SOW) or Memorandum of Understanding/Agreement (MOU/MOA) outlining contracted services;

9.1.1.4 Amendment(s) to previously approved subcontracts or delegated agreements;

9.1.1.5 Data sharing and security language, this language must be consistent with requirements found in Exhibit C; and

9.1.1.6 Exhibits.

9.1.2 Rates or payment amounts may be redacted from the contract template.

9.1.3 A subcontract will not take effect prior to HCA's review and written approval of the template. If HCA does not provide approval or denial within forty-five (45) Business Days, the Contractor may move forward with executing the subcontract.

9.1.4 Approval or denial shall be provided within forty-five (45) Business Days of the Contractor's submission to HCA. When denied, HCA will provide the deficiencies identified in the template in need of correction.

9.1.5 Value-added benefits that delegate or allow access or maintenance of records of client specific information consistent with Exhibit C must be submitted to HCA through the subcontract process for approval prior to implementation.

9.2 Solvency Requirements for Subcontractors

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

9.3 Provider Nondiscrimination

9.3.1 The Contractor shall not discriminate, with respect to participation,

reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold.

9.3.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision.

9.3.3 The Contractor's policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

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

9.3.4.1 Contract with providers beyond the number necessary to meet the needs of its Enrollees.

9.3.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

9.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs.

9.4 Required Provisions

All Subcontracts shall contain applicable provisions contained in Subsections 9.5 and 9.7 of this Contract and the following provisions:

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

9.4.2 A process for monitoring the Subcontractor's performance and a periodic schedule for formally evaluating performance, consistent with industry standards or state managed care laws and regulations.

9.4.3 Procedures and specific criteria for terminating the Subcontract and for any other remedies the Contractor provides if HCA or the Contractor determines that the Subcontractor has not performed satisfactorily.

9.4.4 Identification of the services to be performed and reports to be provided by the Subcontractor and which of those services may be subcontracted by the Subcontractor. If the Contractor allows the Subcontractor to further Subcontract, all Subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered Subcontracts.

9.4.5 Reimbursement rates and procedures for services provided under the Subcontract, including the use of the Contractor's own fee schedule for services provided by essential behavioral health providers.

9.4.6 Release to the Contractor any information necessary to perform any of its obligations under this Contract.

9.4.7 The requirement to permit the state of Washington, including HCA and state auditor, and their designees, to access, inspect, audit, and evaluate any records or documents of the Contractor or its Subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where AHE-related activities or work is conducted, at any time.

9.4.8 The Contractor and its Subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation identified in subsection 9.4.7. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its Subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law.

9.4.9 The requirement to completely and accurately report encounter data and behavioral health supplemental transactions, and to certify the accuracy and completeness of all data submitted to the Contractor. The Contractor shall ensure that all Subcontractors required to report encounter data and behavioral health supplemental transactions have the capacity to submit all HCA required data to enable the Contractor to meet the reporting requirements in the Encounter Data Guide and Behavioral Health Supplemental Transaction Data Guide published by HCA. Behavioral Health Supplemental transactions related to services provided to Enrollees must be submitted within thirty (30) calendar days from the date of service or event.

9.4.10 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.

9.4.11 No assignment of a Subcontract shall take effect without HCA's written agreement.

9.4.12 The Subcontractor shall comply with the applicable state and federal statutes, rules, and regulations including, but not limited to, the laws identified in Subsection 2.5 of this Contract.

9.4.13 Subcontracts shall set forth and require the Subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the Subcontract.

9.4.14 The Contractor shall provide the following information regarding the Grievance and Appeal System to all Subcontractors:

9.4.14.1 The toll-free numbers to file oral Grievances and Appeals.

9.4.14.2 The availability of assistance in filing a Grievance or Appeal, including informing the Enrollee about Ombuds services and how to access these services.

9.4.14.3 The Enrollee’s right to request continuation of services during an appeal or hearing and, if the Contractor’s Adverse Benefit Determination is upheld, that the Enrollee may be responsible to pay for the cost of the benefits received for the first sixty (60) calendar days after the appeal or hearing request was received.

9.4.14.4 The Enrollee’s right to file Grievances and Appeals and their requirements and timeframes for filing.

9.4.14.5 The Enrollee's right to a hearing, how to obtain a hearing, and representation rules at a hearing.

9.4.14.6 The Subcontractor may file a Grievance or request an adjudicative proceeding on behalf of an Enrollee in accordance with subsection 13.2.1.

9.4.15 The process for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

9.4.16 A process to identify deficiencies and take corrective action for both the Contractor and Subcontractor.

9.4.17 The process whereby the Subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the Enrollee's needs.

9.4.18 Prior to delegation, the Contractor shall evaluate any prospective Subcontractor's ability to perform the activities for which that Subcontractor is contracting, including the Subcontractor's ability to perform delegated activities described in the subcontracting document.

9.4.19 The requirement to refer potential allegations of fraud to HCA as described in the Fraud Referral Subsection of this Contract.

9.5 Health Care Provider Subcontracts

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

9.5.1 A quality improvement system consistent with the Contractor's obligations under Subsections 7.1, 7.2, and 7.4, tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Assessment and Performance Improvement (QAPI) activities required by Section 7 of this Contract.

9.5.3 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including QAPI, Utilization Management, Enrollee Rights and Responsibilities, Health Homes, and Credentialing and Re-credentialing.

9.5.4 A requirement that the Subcontractor shall comply with chapter 71.32 RCW (Mental Health Advance Directives).

9.5.5 Delegated activities are documented and agreed upon between Contractor and Subcontractor. The document must include:

9.5.5.1 Assigned responsibilities.

9.5.5.2 Delegated activities.

9.5.5.3 A mechanism for evaluation.

9.5.5.4 Corrective action policy and procedure.

9.5.6 Subcontractor will maintain and share, as appropriate, Enrollee health record(s) in accordance with professional standards.

9.5.7 Information about Enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

9.5.8 An agreement that applicable Subcontractors will receive payment for the supervision of behavioral health providers whose license or certification restricts them to working under supervision, effective with the next provider contracting period.

9.5.9 The Subcontractor accepts payment from the Contractor as payment in full. The Subcontractor shall not request payment from HCA or any Enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-1100 requirements applicable to providers.

9.5.10 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the Subcontractor, its agents, officers, employees or contractors.

9.5.11 If the subcontract includes physician or behavioral health services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.

9.5.12 If the subcontract includes physician services, provisions that inform the provider of any HCA determined appeal rights to challenge the failure of the Contractor to cover a service.

9.5.13 A ninety (90) day termination notice provision.

9.5.14 A specific termination provision for termination with short notice when a Subcontractor is excluded from participation in the AHE program.

9.5.15 The Subcontractor agrees to comply with all relevant provisions of this Contract, including, but not limited to, the appointment wait time standards and the obligation to report accurately the information required for the Contractor's provider directory and any changes thereto. The subcontract must provide for regular monitoring of timely access and corrective action if the Subcontractor fails to comply with the appointment wait time standards.

9.5.16 A provision that informs the provider of a reasonably accessible on-line location of the policies and procedures listed in Section 8 of this Contract.

9.5.17 A provision for ongoing monitoring and compliance review when the Contractor identifies deficiencies or areas requiring improvement and provide for corrective action.

9.5.17.1 The Contractor shall ensure that Subcontractors have complied with data submission requirements established by HCA for all services funded under the Contract.

9.5.17.2 The Contractor shall maintain written or electronic records of all Subcontractor monitoring activities and make them available to HCA upon request.

9.5.18 The Contractor shall document and confirm in writing all Single Case Agreements with providers. The agreement shall include:

9.5.18.1 The description of the services;

9.5.18.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.18.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and

9.5.18.4 Any other specifics of the negotiated rate.

9.5.19 The Contractor must supply documentation to the Subcontractor no later than five (5) Business Days following the signing of the agreement. Updates to the Single Case Agreement, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.20 The Contractor shall maintain a record of the Single Case Agreements for a period of ten (10) years.

9.5.21 The Contractor shall provide a copy of the Health Care Provider subcontract template and any contract samples upon request by HCA.

9.5.22 The Contractor shall include Exhibit E, Medicaid and CHIP Managed Care Addendum for IHCPs, in every subcontract with an IHCP.

9.5.23 The Contractor must ensure WISe Providers adhere to the WISe Manual and participate in all WISe-related quality activities.

9.5.23.1 The Contractor shall ensure WISe Providers participate in a review of WISe services using the WISe Quality Improvement Review Tool (QIRT) at least once annually. This review could be conducted by internal WISe Provider staff, a peer WISe Provider, or by an external partner. The review may be a rotating modular or full QIRT review, with the expectation that a full review would be completed over the course of three (3) years.

9.5.23.1.1 The state QIRT review, including reviews conducted by the state's EQRO, is in addition to this requirement. The state review does not meet the requirements of the Contract for providers to participate in a review.

9.5.23.2 WISe providers must include information regarding WISe services on the provider's website.

9.5.23.3 The Contractor shall ensure that WISe Provider staff conduct Child Adolescent Needs and Strengths (CANS) screenings for children and youth referred for WISe services.

9.6 Subcontracts with Indian Health Care Providers

9.6.1 The Contractor shall coordinate with and pay all IHCPs enrolled with the HCA who provide a service to Enrollees under this Contract regardless of the IHCP's

decision whether to subcontract.

9.6.2 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP. The Contractor will offer and negotiate contracts in good faith to all IHCPs, including any tribal care coordination, transportation, or related services. To be offered in good faith, a Contractor must offer contract terms comparable to terms that it offers to a similarly-situated non-IHCP provider, except for terms that would not be applicable to an IHCP, such as by virtue of the types of services that an IHCP provides. The Contractor will provide verification of such offers upon request from HCA, in order to verify compliance with this provision.

9.6.2.1 Any such subcontract must include the Special Terms and Conditions set forth in the Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail.

9.6.2.2 The subcontract must reference the IHCP's ability to submit complaints to the HCA for resolution and for the HCA to facilitate resolution directly with the Contractor.

9.6.3 Any subcontracts with IHCP must be consistent with the laws and regulations that are applicable to the IHCP.

9.6.4 The Contractor will include reference in any contract between the Contractor and the IHCP to the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

9.7 Health Care Provider Subcontracts Delegating Administrative Functions

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

9.7.1.1 For those Subcontractors at financial risk, that the Subcontractor shall maintain the Contractor's solvency requirements throughout the term of the Contract.

9.7.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to Enrollees and include, but are not limited to, utilization/medical management, claims processing, behavioral health supplemental transactions processing. Enrollee Grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

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

9.7.1.4 Provisions for revoking delegation or imposing sanctions if the Subcontractor's performance is inadequate.

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

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

9.7.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees assigned or serviced by the delegated entity to HCA by March 1 of each year applicable to this Contract and upon request by HCA.

9.8 Administrative Functions with Subcontractors and Subsidiaries

9.8.1 Essential Behavioral Health Administrative Functions may be subcontracted for a period of time as determined by HCA and the Contractor. The Contractor shall achieve full integration of Essential Behavioral Health Administrative Functions according to a timeline agreed upon with HCA. No Subcontractor shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

9.8.2 Behavioral Health Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Contract.

9.8.2.1 Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

9.8.3 GAIN-SS

9.8.3.1 Subcontracts for the provision of behavioral health services must require the use of the GAIN-SS and assessment process that includes use of the quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Disorder Screening and Assessment process is not implemented and maintained throughout the contract period of performance.

9.8.3.2 If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate referrals.

9.9 Subcontracts with Inpatient Behavioral Health Providers

9.9.1 The Contractor's subcontracts with inpatient behavioral health service provider shall require the facility to:

9.9.1.1 Inform the Contractor of the Enrollee's discharge on the following timelines:

9.9.1.1.1 For an anticipated discharge, no later than 24 hours

prior to the planned discharge date; or

9.9.1.1.2 For all the other discharges, including if the Enrollee leaves against medical advice, no later than the date of discharge.

9.9.1.2 Engage with the Contractor in discharge planning; and

9.9.1.3 Educate and connect inpatient Enrollees to Contractor care coordination to support maintenance of stability post-discharge.

9.10 Subcontracts with Substance Use Disorder Providers

9.10.1 Residential treatment facilities to offer MAT on-site or facilitate access off-site. The Contractor must require that residential and inpatient treatment agencies have policies and procedures to offer MAT on-site or facilitate access off-site.

9.10.1.1 The Contractor must only Subcontract with licensed SUD Behavioral Health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the FDA approved medications to treat all SUD will not be denied services.

9.10.1.2 The Contractor must assure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any level of ASAM SUD treatment.

9.10.1.3 The Contractor may not Subcontract with licensed SUD Behavioral Health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any SUD as a condition of Enrollees receiving treatment or continuing to receive Behavioral Health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing Provider.

9.10.1.4 The Contractor must Subcontract with licensed inpatient SUD Behavioral Health treatment agencies that have policies and procedures allowing Enrollees to seek FDA-approved medication for any SUD at any point in their course of treatment and ensuring the agency will provide or facilitate the induction of any prescribed FDA approved medications for any SUD.

9.10.1.4.1 This may be done by:

9.10.1.4.1.1 Having an appropriately credentialed prescriber on-site or available through telemedicine who can prescribe FDA approved medications for SUD; or

9.10.1.4.1.2 Facilitating off-site transportation of Enrollees to medical or Behavioral Health treatment agencies that offer medications for SUD.

9.10.1.5 The Contractor may only Subcontract with licensed inpatient SUD Behavioral Health treatment agencies that have policies and

procedures ensuring they will provide or facilitate the continuation of any prescribed FDA approved medications for any SUD. Decisions concerning medication adjustment must be based on medical necessity and in concert with the prescribing Provider.

9.10.1.5.1 This may be done by:

9.10.1.5.1.1 Facilitating off-site transportation of Enrollees to medical or Behavioral Health treatment agencies that offer medications for SUD; or

9.10.1.5.1.2 Allowing Enrollees currently on medications for SUD to continue to take their medications as prescribed and provide a safe storage space for said medication during their course of treatment.

9.10.2 Outpatient treatment facilities. The Contractor must require that outpatient treatment agencies have policies and procedures to facilitate treatment access to Enrollees who are prescribed any of the FDA-approved medications to treat all SUDs.

9.10.2.1 The Contractor must only Subcontract with licensed SUD Behavioral Health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the FDA approved medications to treat all SUDs will not be denied services.

9.10.2.2 The Contractor must ensure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any level of ASAM SUD treatment.

9.10.2.3 The Contractor may not Subcontract with licensed SUD Behavioral Health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any SUD as a condition of Enrollees receiving treatment and/or continuing to receive Behavioral Health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing Provider.

9.10.2.4 The Contractor shall begin development of policies and procedures related to contracting with SUD Peer Supports.

9.10.2.5 The Contractor shall provide information on how to access peer support services for Enrollees with SUDs transitioning from emergency departments, inpatient facilities, or receiving treatment as part of Hub and Spoke networks.

9.11 Physician Incentive Plans

Physician Incentive Plans, as defined herein, are subject to the conditions set forth in this Section. The Contractor shall provide written notification to HCA on an annual basis (due March 1) that its physician's incentive plans, if any, comply with this Contract.

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

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

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

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

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

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

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

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

9.11.3 If the Contractor, or any Subcontractor, places a physician or Physician Group at Substantial Financial Risk, the Contractor shall assure that all physicians and Physician Groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or Physician Group.

9.11.3.1 If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services that exceed 25 percent of maximum potential payments under the subcontract.

9.11.3.2 If stop-loss protection is based on a per-member limit, it must cover 90 percent of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

9.11.3.2.1 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional

services, or $6,000 for combined services.

9.11.3.2.2 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

9.11.3.2.3 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

9.11.3.2.4 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

9.11.3.2.5 10,001 - 25,000 members, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

9.11.3.2.6 25,001 members or more, there is no risk threshold.

9.11.3.3 The Contractor shall provide the following information regarding its Physician Incentive Plans to any Enrollee who requests it:

9.11.3.3.1 Whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;

9.11.3.3.2 The type of incentive arrangement; and

9.11.3.3.3 Whether stop-loss protection is provided.

9.12 Provider Education

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

9.12.1 The Contractor shall keep Participating Providers informed about and offer technical assistance on:

9.12.1.1 Covered Services for Enrollees served under this Contract.

9.12.1.2 Coordination of care requirements.

9.12.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.12.1.4 Health Homes.

9.12.1.5 HCA First Steps Program - Maternity Support Services (MSS). The Contractor shall notify providers about HCA's First Steps Program, MSS, using HCA's MSS informational letter template that includes HCA First Steps Program website and Provider Directory.

9.12.1.6 Interpretation of data from the Quality Improvement program.

9.12.1.7 Practice guidelines as described in the provisions of this Contract.

9.12.1.8 Behavioral Health services through the Contractor.

9.12.1.9 Behavioral Health resource line.

9.12.1.10 The information required for UM decision making, procedure coding and submitting claims.

9.12.1.10.1 The Contractor shall inform all network Providers in writing regarding these requirements.

9.12.1.11 Utilization Management protocols, including admissions, continued stay, and discharge criteria.

9.12.1.12 Contractor care management staff for assistance in care transitions and care management activity.

9.12.1.13 Program Integrity requirements.

9.12.1.14 DSHS long-term care services, including availability of home and community-based care (chapter 388-106 WAC).

9.12.1.15 DSHS developmental disability services including community-based care (WAC 388-823 to -850).

9.12.1.16 UW Psychiatry Consultation Line (PCL) offered by the University of Washington (UW).

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

9.12.1.18 Health IT and interoperable health information exchange at the state and federal levels.

9.12.1.19 Current and anticipated health information exchange and use via the CDR.

9.12.1.20 Information about Certified EHR Technology and ONC's Health IT Certification Program.

9.12.1.21 The Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

9.12.2 The Contractor shall develop and deliver ongoing training for network providers. The training objective is to strengthen the knowledge, skill and expertise of all parties to improve integrated care delivery as it relates to outreach and engagement, screening and assessment, appropriate referral and delivery of person-centered, recovery-oriented care. Training shall go beyond concepts to address how to incorporate guidelines and principles into daily practice. A schedule of training shall be available on the Contractor's website and updated as needed, but at least annually. This shall include, but is not limited to, offering technical assistance and support tools regarding coordinated care practices defined in Section 14 of this Contract. The training program shall meet the following minimum requirements:

9.12.2.1 Be accessible at alternate times and days of the week.

9.12.2.2 Training for Behavioral Health network providers shall address the following requirements:

9.12.2.2.1 The application of Evidence-Based, Research-Based and Promising Practices related to the assessment and treatment of Behavioral Health conditions, including those from the Bree Collaborative.

9.12.2.2.2 Incorporation of Recovery and Resilience principles in service provision as well as policies and procedures.

9.12.2.2.3 Screening, identification, and referral for treatment for medical conditions and risk factors commonly occurring in individuals with severe and persistent Behavioral Health. For individuals on medication, screening includes review of Enrollee medical and medication history, and for individuals on psychotropic medication, vital signs, weight, and BMI. Screening tools used with children and Youth shall be developmentally age-appropriate.

9.12.2.2.4 Ensure Contractor sponsored Certified Peer Counselor trainings are offered in accordance with DBHR policies. Policy requirements include the use of DBHR approved curriculum, trainers, testers and applicants.

9.12.2.2.5 Subcontracts must require Subcontractors to participate in training when requested by HCA. Requests for HCA to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted Subcontractor staff.

9.12.2.2.6 Annually, all community Behavioral Health employees who work directly with Enrollees must be provided with training on safety and violence prevention topics described in RCW 49.19.030.

9.12.2.2.7 Education and support regarding the requirement to submit HIPAA-compliant encounters.

9.12.3 The Contractor shall ensure all of its contracted Primary Care Providers are offered training related to all of the following:

9.12.3.1 Screening for Behavioral Health conditions using developmentally, age-appropriate screening tools.

9.12.3.2 Brief Intervention and Referral to Treatment for Enrollees aged 13 years and older.

9.12.3.3 The application of Evidence-Based, Research-Based and Promising Practices (including those from the Bree Collaborative) for Behavioral Health conditions commonly occurring in primary care.

9.12.3.4 Identification of individuals with First Episode Psychosis (FEP) and referral to appropriate FEP services.

9.12.4 Behavioral Health and medical Providers shall be offered training on effective approaches to managing individuals with co-occurring conditions including individuals with Behavioral Health and co-occurring medical conditions or co-occurring intellectual and developmental disabilities.

9.12.4.1 Training shall address the following requirements:

9.12.4.1.1 Care Coordination requirements as defined in Section 14, including, but not limited to creating and maintaining a shared care plan;

9.12.4.1.2 Collaborative care or similar Research-Based models for Care Coordination;

9.12.4.1.3 Discharge planning for Enrollees transitioning from the hospital to the community; and

9.12.4.1.4 Accurate diagnosis and appropriate treatment for individuals with I/DD.

9.12.4.2 Contractor shall ensure Enrollees, family members of Enrollees, and other caregivers have the option to be involved in the planning, development, and delivery of trainings specific to delivery of Behavioral Health services and behavioral health-medical integration initiatives.

9.12.4.3 Cultural competency shall be incorporated into provider training specific to delivery of Behavioral Health services and behavioral health-medical integration initiatives.

9.12.5 The Contractor shall provide training, support, and technical assistance to all contracted Providers (and non-contracted IHCPs) in order to:

9.12.5.1 Resolve encounters or claims denied, rejected, or pended in initial submission, including claims denied due to Medicare/D-SNP coordination of benefits;

9.12.5.2 Identify and resolve errors in encounter submissions and provider billing systems before they become significant and impact additional providers or delay payments for services for greater than ninety (90) calendar days; and

9.12.5.3 Address other billing or claim systems' issues discovered or brought to the attention of the Contractor. Contractor, at a minimum, shall ensure:

9.12.5.3.1 Complete root cause analysis and tracking of each respective billing issue.

9.12.5.3.2 Identification of a universe of claims that have been affected by the billing or claims systems' issue(s).

9.12.5.3.3 Implementation of necessary corrections to remedy the billing or claims systems' issue(s) so it does not

persist.

9.12.5.3.4 Proactive outreach attempts to provide technical assistance to address ongoing and persistent claims issue(s) with each provider affected.

9.12.6 Provider education that supports bi-directional integrated care shall be coordinated through the Washington Integrated Care Assessment (WA-ICA) Initiative's coordinating entities. Efforts to support advancing bidirectional integration shall be reported as per requirements set forth in the Bi-directional Behavioral and Physical Health Integration section of this Contract.

9.13 Claims Payment Standards

9.13.1 The Contractor shall meet the timeliness of payment standards specified below.

9.13.1.1 The Contractor shall pay or deny, and shall require Subcontractors to pay or deny, 90 percent of clean claims within thirty (30) calendar days of receipt, and 99 percent of clean claims within ninety (90) calendar days of receipt.

9.13.1.2 A claim is a bill for services, a line item of service or all services for one (1) Enrollee within a bill.

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

9.13.1.4 The date of receipt is the date the Contractor receives the claim from the Provider.

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

9.13.2 The Contractor shall support both hardcopy and electronic submission of claims and encounters for all claim types (hospital and professional services).

9.13.3 The Contractor must support hardcopy and electronic submission of claim inquiry forms, and adjustment claims and encounters.

9.13.4 The Contractor shall ensure timely payment to Behavioral Health Providers for services delivered to Enrollees when a mental health or SUD Provider cannot submit HIPAA-compliant encounters or electronic claims.

9.13.4.1 The Contractor shall produce and provide monthly reports to contracted Behavioral Health Providers to assist with claims management that includes numbers of accepted claims or encounters versus those that are not accepted on initial submission, and error rates by types of errors.

9.13.5 The Contractor shall update its claims and encounter system to support additional Behavioral Health services, Provider types and provider specialties for servicing Providers that will be added under the Apple Health - Integrated Managed Care program.

9.13.6 The Contractor shall require Providers to submit all claims no later than twelve (12) months from the date of service .

9.13.6.1 Claims that require resubmission, such as incorrectly denied or incorrectly paid claims, are excluded from this provision.

9.13.7 The Contractor shall produce and submit to HCA a monthly claims denial analysis report. The report is due within ten (10) Business Days following the end of the reporting month. The report submission shall follow specifications by HCA.

9.13.7.1 The monthly claims denial analysis report shall include a narrative that will be captured within the existing report template, and shall include actionable items to address how the Contractor will:

9.13.7.1.1 Establish a communication plan with Providers and respond to all inquiries within five (5) Business Days;

9.13.7.1.2 Explain the reason for any denial or rejection within thirty (30) calendar days;

9.13.7.1.3 Provide administrative guidance to help ensure that future claims are billed correctly; and

9.13.7.1.4 Provide education to the five network billing Providers with the highest number of total denied claims, address root causes of denied claims, and actions to address them. Provider education shall be conducted in a format agreed to by the parties (i.e., by in person, by phone, or by webinar) until the Provider's denial rate falls below 10 percent in the following month. Documentation of assistance offered and provided will be available to HCA upon request.

9.13.8 The Contractor shall produce and submit to HCA a monthly IHCP Claims Denial Analysis report. The report is due within ten (10) Business Days following the end of the reporting month. The report submission shall follow specifications by HCA.

9.13.8.1 The monthly IHCP Claims Denial Analysis Report shall include a narrative that will be captured within the existing report template, and shall include actionable items to address how the Contractor will:

9.13.8.1.1 Establish a communication plan with Providers and respond to all inquiries within five (5) Business Days;

9.13.8.1.2 Within thirty (30) calendar days, explain the reason for any denial and rejection;

9.13.8.1.3 Provide administrative guidance to help ensure that future claims are billed correctly; and

9.13.8.1.4 Provide education to the five IHCPs with the highest number of total denied claims, address root causes of denied claims and actions to address them. Provider education shall be conducted in a format agreed to by the parties (i.e., in person, by phone, or by webinar) until the IHCP's denial rate falls below 10 percent in the following month. Documentation of assistance offered and provided will be available to HCA upon

request.

9.13.9 HCA may impose sanctions and will require a corrective action plan to address a pattern of incorrectly denied or delayed Provider payments when HCA has determined a pattern of incorrectly denied or delayed Provider payments exists.

9.13.9.1 Incorrectly denied or incorrectly paid claims include but are not limited to:

9.13.9.1.1 Not following HCA reimbursement policies as required;

9.13.9.1.2 Payment amounts not consistent with contracted rates;

9.13.9.1.3 Failure to implement HCA guidelines in adjudication which result in payment errors;

9.13.9.1.4 Payment for services the Provider is not entitled to receive, or in an amount the Provider is not entitled to receive, under this Contract;

9.13.9.1.5 Failure to correctly configure claims systems and/or failure to manually process claims correctly.

9.13.9.2 Corrective action plans must include but are not limited to:

9.13.9.2.1 A contingency plan for paying Behavioral Health Providers when the identified pattern is the result of the Contractor's error;

9.13.9.2.2 Tools and reports the Contractor will share with Providers to help them with claims management; and

9.13.9.2.3 The Contractors process for accepting and paying claims within thirty (30) calendar days of receipt and what assistance will be given to Providers to ensure claims qualify for payment.

9.13.10 HCA may impose sanctions or require a corrective action plan when a Provider experiences ongoing claims issues as a result of incorrectly denied or incorrectly paid claims.

9.13.11 HCA has the sole and exclusive authority to determine a pattern of incorrect denials or if inappropriate delays of Provider payments exists.

9.13.12 If the Contractor fails to pay clean claims in accordance with standards of this Section:

9.13.12.1 Claims shall be reprocessed and paid within sixty (60) calendar days after identifying the error and without the need for the Provider to resubmit the claims;

9.13.12.2 The Contractor shall pay interest directly to the Provider on each clean claim paid more than sixty (60) calendar days from receipt;

9.13.12.3 Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month;

9.13.12.4 The Contractor shall add the interest payable to the amount of the unpaid claim without the necessity of the Provider or Facility submitting an additional claim;

9.13.12.5 Errors created by the Contractor's billing and payment system shall not be used in the determination of whether a claim is not considered clean;

9.13.12.6 Interest accrues until and including the day of late payment;

9.13.12.7 HCA may assess a maximum of $1,000 or commensurate to the harm caused per claim if the Contractor fails to pay interest timely. Interest is due and payable to the Provider once claims reprocessing is complete. Payment shall be made to the Provider directly;

9.13.12.8 The Contractor will maintain all records of interest calculation and provide to HCA within three (3) Business Days upon request;

9.13.12.9 Interest may not be included in the rate experience and must be paid from administrative funds; and

9.13.12.10 In lieu of interest or other penalties, the Contractor may choose or HCA may direct the Contractor to pay a contingency amount estimated to cover expected claims and interest. Payment shall be made to Provider directly.

9.13.13 The Contractor's failure to comply with the terms of any corrective action plan may result in the imposition of sanctions.

9.13.14 The Contractor's failure to comply with the terms of the Claims Payment Standards Section may result in the imposition of sanctions.

9.14 Claims Processing System Updates

9.14.1 The Contractor's claims processing systems must be updated and maintained to ensure claims are processed and paid in accordance with the Claims Payment Standards of this Contract, applicable laws and regulations, and HCA guidance. Updates to the Contractor's claims processing systems must be made within the following timeframes:

9.14.1.1 Changes to rates, codes, or covered services must be in effect on the effective date of the Contract, or be made within sixty (60) calendar days of receipt of written notification by HCA if not resulting from a Contract update.

9.14.1.1.1 Amending or repapering existing Subcontracts, or establishing new Subcontracts to implement required changes is not an exception to timeliness.

9.14.1.2 Any retroactive claims adjustments must be made within sixty (60) calendar days of the completion of a system update.

9.14.1.2.1 Contractor may request an extension in writing to HCA submitted to hcamcprograms@hca.wa.gov.

9.14.1.3 Changes to the claims processing system necessary to correct system errors, resolve outstanding systems issues, or resolve other issues as directed by HCA, must be fully implemented within sixty (60) calendar days of receipt of written notification by HCA.

9.14.1.3.1 Contractor may request an extension in writing to HCA submitted to hcamcprograms@hca.wa.gov. A maximum extension of sixty (60) calendar days may be granted by HCA and must be in writing.

9.14.2 Upon request from HCA, the Contractor shall supply all claims processing system changes being developed for the coming year that affect HCA, Providers, or vendors and what these changes are intended to address.

9.14.2.1 Coding changes will not be required for this report if in response to a change made by HCA.

9.14.2.2 Systems edit designs based on Contractor's internal policy changes must be submitted, including any communication plan to Providers.

9.14.2.3 HCA may assess sanctions under the Sanctions section of this Contract if (a) the Contractor's claims processing systems are not updated and maintained, thereby causing claims to not be paid timely or appropriately, or (b) the Contractor fails to timely comply with directives to correct system issues.

9.15 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor shall provide HCA with information related to subcontracted Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), as required by HCA Federally Qualified Health Center and Rural Health Center Billing Guides, published by HCA and incorporated by reference into this Contract.

9.16 Screening and Enrollment of Providers

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

9.16.2 HCA shall screen, enroll and periodically revalidate all network providers in the same manner as it would for Medicaid providers.

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

9.17 Provider Credentialing

The Contractor's policies and procedures shall be in writing and meet NCQA requirements related to the credentialing and re-credentialing of Health Care Professionals who have signed contracts or participation agreements with the Contractor. The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract.

9.17.1 The Contractor's policies and procedures related to the credentialing and recredentialing of Health Care Professionals shall ensure compliance with the

following requirements described in this Section.

9.17.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.

9.17.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

9.17.1.3 The Contractor is not responsible for credentialing Providers and facilities that are part of the Indian Health System.

9.17.2 The Contractor's credentialing and recredentialing program shall include:

9.17.2.1 Identification of the type of providers credentialed and recredentialed, including but not limited to, acute, primary, behavioral, SUD and LTSS providers, as appropriate .

9.17.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.

9.17.2.3 Use and dissemination of the Washington Provider Application (WPA).

9.17.2.4 Use and promotion of OHP's ProviderSource as the Contractor's single credentialing portal (chapter 48.165 RCW).

9.17.2.5 A process for provisional credentialing that affirms that:

9.17.2.5.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and

9.17.2.5.2 The provisional status will only be granted one (1) time and only for providers applying for credentialing the first time.

9.17.2.5.3 Provisional credentialing shall include an assessment of:

9.17.2.5.3.1 Primary source verification of a current, valid license to practice;

9.17.2.5.3.2 Primary source verification of the past five (5) years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and

9.17.2.5.3.3 A current signed application with attestation.

9.17.2.6 Prohibition against employment or contracting with providers excluded from participation in federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.

9.17.2.7 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.

9.17.2.8 Verification of provider compliance with all Program Integrity requirements in this Contract.

9.17.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:

9.17.3.1 Review materials.

9.17.3.2 Correct incorrect or erroneous information.

9.17.3.3 Be informed of their credentialing status.

9.17.4 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.

9.17.5 The Contractor's credentialing and recredentialing process for a decision within sixty (60) calendar days of the submission of the credentialing application when the provider application is complete upon submission.

9.17.6 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.

9.17.7 The Contractor's process to ensure confidentiality.

9.17.8 The Contractor's process to ensure listings in provider directories for Enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

9.17.9 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.

9.17.10 The Contractor's process to ensure that offices of all Health Care Professionals meet office site standards established by the Contractor.

9.17.11 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.

9.17.12 The Contractor's process and criteria for assessing and reassessing organizational providers.

9.17.13 The criteria used by the Contractor to credential and recredential practitioners shall include:

9.17.13.1 Evidence of a current valid license or certification to practice;

9.17.13.2 A valid DEA or CDS certificate if applicable;

9.17.13.3 Evidence of appropriate education and training;

9.17.13.4 Board certification if applicable;

9.17.13.5 Evaluation of work history;

9.17.13.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and

9.17.13.7 A signed, dated attestation statement from the provider that addresses:

9.17.13.7.1 The lack of present illegal drug use;

9.17.13.7.2 A history of loss of license and criminal or felony convictions;

9.17.13.7.3 A history of loss or limitation of privileges or disciplinary activity;

9.17.13.7.4 Current malpractice coverage;

9.17.13.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and

9.17.13.7.6 Accuracy and completeness of the application.

9.17.13.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.

9.17.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, Fraud; integrity; or quality.

9.17.15 The Contractor shall notify HCA in accord with the Notices section of this Contract, within three (3) Business Days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, Subcontractor or Subcontractor employee.

9.17.16 The Contractor shall require providers defined as "high categorical risk" for potential Fraud as defined in 42 C.F.R. § 424.518 (as that regulation exists as of July 1, 2024) to be enrolled and screened by Medicare.

9.17.17 The Contractor's policies and procedures shall ensure the Contractor does not discriminate against particular Health Care Professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

9.18 Behavioral Health Administrative Service Organization (BH-ASO)

9.18.1 The Contractor shall contract with HCA's selected Behavioral Health Administrative Services Organization (BH-ASO) for the administration of Crisis Services.

9.18.2 The Contractor shall reimburse the BH-ASO for behavioral health Crisis Services delivered to individuals enrolled in the Contractor's AHEHP. The Contractor shall reimburse for in-home stabilization services no later than January 1, 2025. The reimbursement shall be upon receipt of a valid claim per the requirements for timely accurate claims payment under this Contract or a monthly sub-capitation.

9.18.3 The Contractor shall submit complete and accurate encounter data related to

the provision of Crisis Services under this Contract in formats prescribed by HCA.

9.18.4 The Contractor shall enter into a Subcontract with the BH-ASO to evaluate and monitor the performance of the crisis system and develop corrective action where needed.

9.18.5 The Subcontract with the BH-ASO shall contain the following provisions.

9.18.5.1 Crisis Services shall be available 24 hours per day, seven (7) days per week, 365 days per year. This shall include availability of a 24/7 regional crisis hotline that provides screening and referral to a network of local providers, and availability of a 24/7 mobile crisis outreach team. Individuals will be able to access Crisis Services and in-home stabilization services without full completion of Intake Evaluations and/or other screening and assessment processes. AHEHPs shall make it a requirement for behavioral health providers to be the first contact for their assigned member to allow for an attempt at prevention or early intervention strategies to be implemented prior to Crisis Services being contacted. The Contractor shall ensure adherence to the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

9.18.5.2 The BH-ASO shall collaborate with the Contractor to develop and implement strategies to coordinate care with community behavioral health providers for individuals with a history of frequent crisis system utilization, or those enrolled in high intensity programs such as WISe and PACT. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and Mental Health Advance Directives in treatment planning consistent with requirements in Section 14 of this Contract.

9.18.5.3 The BH-ASO shall collaborate with the Contractor to support data exchange between the Contractor, the BH-ASO, and with community behavioral health providers, consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data, sharing of care plans, crisis plans, critical incidents, mental health Advance Directives, and other relevant information necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

9.18.5.4 The Contractor shall make provisions for the BH-ASO to access crisis plans and Individual Service Plans (ISP) on a 24/7 basis for Enrollees receiving Behavioral Health services.

9.18.6 The Contractor shall either cover Emergency Fills without authorization or guarantee authorization and payment after the fact for any Emergency Fill dispensed by a contracted pharmacy.

9.18.7 Contractor shall require mobile Crisis Services to coordinate with co-responders

within their region.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor shall comply with any applicable laws that pertain to Enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Enrollees (WAC 182-503-0100).

10.1.2 The Contractor shall have in place written policies that guarantee each Enrollee the following rights:

10.1.2.1 Receive information on Apple Health Expansion in general and the Contractor's Apple Health program in particular, including information about how to contact the person or entity designated as primarily responsible for coordinating the services accessed by the Enrollee.

10.1.2.2 To be treated with respect and with consideration for their dignity and privacy.

10.1.2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's ability to understand.

10.1.2.4 To participate in decisions regarding their health care, including the right to refuse treatment.

10.1.2.5 To receive information regarding UM protocols, including admission, continued stay, and discharge criteria.

10.1.2.6 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

10.1.2.7 To request and receive a copy of their medical records, and to request that they be amended or corrected.

10.1.2.8 Each Enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its Subcontractors treat the Enrollee.

10.1.2.9 To choose a behavioral Health Care Provider for services outlined in the Contract Services section of this contract.

10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees, volunteers, and Subcontractor staff of the Contractor who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults, as defined by RCW 43.43. 830(14), served under this Contract.

10.1.3.1 Such criminal history background check shall be consistent with RCW 43.43.832, RCW 43.43.834, RCW 43.20A.710, chapter 388-06 WAC, and any other applicable statute or regulation.

10.1.3.2 The Contractor shall not give employees, volunteers, and/or Subcontractor staff access to children and/or vulnerable adults until

a criminal history background check is performed and a positive result is reported.

10.2 Cultural Considerations

10.2.1 The Contractor shall promote access to and delivery of services that are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

10.2.2 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

10.2.3 The contractor shall support and provide resources to their Providers to comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to all Enrollees. At a minimum, the Contractor shall ensure providers:

10.2.3.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis (CLAS Standard 4);

10.2.3.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services (CLAS Standard 5);

10.2.3.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing (CLAS Standard 6);

10.2.3.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided (CLAS Standard 7);

10.2.3.5 Provide easy–to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area (CLAS 8);

10.2.3.6 Establish culturally and linguistically appropriate goals (CLAS Standard 9);

10.2.3.7 Conduct ongoing assessments of the organization’s CLAS, related activities and integrate CLAS, related measures into measurement and continuous quality improvement activities (CLAS Standard 10);

10.2.3.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery (CLAS 11); and

10.2.3.9 Create conflict and Grievance resolution processes that are

culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints (CLAS 14).

10.2.4 The Contractor shall make every effort to respect and promote awareness of and sensitivity to the needs of Lesbian/Gay/Bisexual/Transgender/Queer/Questioning/Intersex/Asexual (LGBTQIA+) Enrollees, including the increased potential for depression and suicidal thoughts in these Enrollees.

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

10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125 as described in this Section.

10.3.2 The Contractor's Advance Directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, Potential Enrollees.

10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing Advance Directives.

10.3.2.2 The Contractor's policies and procedures respecting the implementation of advance directives and POLST rights shall be included in the Enrollee handbook at a location designated in its template by HCA, and shall be featured on the Contractor's website in the member/enrollee section.

10.3.3 The Contractor's written policies respecting the implementation of Advance Directive POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an Advance Directive as a matter of conscience. At a minimum, this statement must do the following:

10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

10.3.3.2 Identify the state legal authority permitting such objection.

10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

10.3.4 If an Enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an Advance Directive or received a POLST, the Contractor may give Advance Directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accordance with state law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

10.3.5 The Contractor must require and ensure that the Enrollee's medical record documents, in a prominent part, whether or not the individual has executed an

Advance Directive or received a POLST.

10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an Advance Directive or received a POLST.

10.3.7 The Contractor shall ensure compliance with requirements of state and federal law (whether statutory or recognized by the courts of the State) regarding Advance Directives or POLSTs.

10.3.8 The Contractor shall provide education to staff concerning its policies and procedures on Advance Directives or POLSTs.

10.3.9 The Contractor shall provide community education regarding Advance Directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an Advance Directive, emphasizing that an Advance Directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state and federal law concerning Advance Directives. The Contractor shall document its community education efforts.

10.3.10 The Contractor is not required to provide care that conflicts with an Advance Directive; and is not required to implement an Advance Directive if, as a matter of conscience, the Contractor cannot implement an Advance Directive and state law allows the Contractor or any Subcontractor providing services under this Contract to conscientiously object.

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

10.4 Mental Health Advance Directive

10.4.1 The Contractor shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects individuals' Advance Directive for behavioral health care. Policy and procedures must comply with chapter 71.32 RCW.

10.4.2 The Contractor shall inform all Enrollees who present for mental health services of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

10.4.3 The Contractor shall maintain current copies of any Mental Health Advance Directive in the Enrollee's record.

10.4.4 The Contractor shall inform Enrollees that complaints concerning noncompliance with a MHAD should be referred to the Department of Health by calling 1-360-236-2620.

10.5 Enrollee Choice of PCP/Behavioral Health Provider

10.5.1 The Contractor must implement procedures to ensure each Enrollee has a source of primary care appropriate to their needs.

10.5.2 The Contractor shall allow, to the extent possible and appropriate, each new Enrollee to choose a participating PCP or behavioral health professional.

10.5.3 The Contractor shall offer each Enrollee a choice of providers for medically necessary behavioral health services.

10.5.4 In the case of AI/AN Enrollees, the Enrollee may choose any IHCP enrolled with the HCA for primary care, behavioral health care, or other services covered under this Contract. If the Enrollee chooses an IHCP as PCP, the Contractor shall treat the IHCP as PCP for all purposes under this Contract. At the election of the UIHP, the Contractor will not assign Enrollees to a UIHP; however, Enrollees may select assignment to a UIHP.

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

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

10.5.7 The Contractor shall allow an Enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the Enrollee's request for the change (WAC 182-525A-0200 and WAC 284-170-360).

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

10.6 **Prohibition on Enrollee Charges for Covered Services**

10.6.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including Non-Participating Providers, charge Enrollees for Covered Services (RCW 71.24.618 and WAC 182-525-1100).

10.6.2 Prior to authorizing services with Non-Participating Providers, the Contractor shall assure that Non-Participating Providers fully understand and accept the prohibition against balance billing Enrollees.

10.6.3 The Contractor shall require providers to report when an Enrollee is charged for services. The Contractor shall maintain a central record of the charged amount, Enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an Enrollee is charged for services, whether or not those charges are appropriate.

10.6.4 If an Enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee fail, the Contractor will repay the Enrollee the inappropriately charged amount.

10.6.4.1 Reimbursement to Enrollees who submit claims for Covered Services provided by Non-Participating Providers under the terms of this Contract shall be made consistent with subsection 5.20 of this Contract.

10.6.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees from being billed for contracted services.

10.6.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee for Covered Services including other insurer's copayments and coinsurance.

10.6.7 The Contractor is not required to reimburse Enrollees for the cost of services that are not covered under the terms of this Contract or if the Enrollee did not follow requirements for self-referral under the terms of this Contract.

10.7 Provider/Enrollee Communication

The Contractor may not prohibit, or otherwise restrict, a Health Care Professional acting within their lawful scope of practice from advising or advocating on behalf of an Enrollee who is their patient, for the following:

10.7.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

10.7.2 Any information the Enrollee needs in order to decide among all relevant treatment options.

10.7.3 The risks, benefits, and consequences of treatment or non-treatment.

10.7.4 The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

10.8 Enrollee Self-Determination

The Contractor shall ensure that all providers, obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (chapter 70.122 RCW) and state rules concerning Advance Directives (WAC 182-501-0125), and, when appropriate, inform Enrollees of their right to make anatomical gifts (chapter 68.64 RCW).

10.9 Women's Health Care Services

The Contractor must provide female Enrollees with direct access to a women's health practitioners within the Contractor's network for covered care necessary to provide women's routine and preventive health care services. This includes prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-170-350.

10.9.1 The Contractor will provide an annual report to HCA, which HCA will then share with the legislature concerning Post-partum Health via the Annual Post-partum Health report template submitted via MC-Track on December 31 each year.

10.10 Maternity Newborn Length of Stay

The Contractor shall ensure that hospital delivery maternity care is provided in accordance with RCW 48.43.115.

10.11 Enrollment Not Discriminatory

10.11.1 The Contractor will not discriminate against Enrollees due to an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable behavioral health condition.

10.11.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health

status, including the existence of a pre-existing physical or behavioral health condition, functional impairment, and/or hospitalization, or the expectation of the need for frequent or high cost care.

10.11.3 The Contractor will not exclude from participation in any health program or activity, deny benefits to, or discriminate against Enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, behavioral health or physical disability, or the use of a trained guide dog or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability.

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management General Requirements

The Contractor shall follow the Utilization Management (UM) requirements described in this Section and educate UM staff in the application of UM protocols, and communicate the criteria used in making UM decisions. UM protocols shall take into account the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care.

11.1.1 The Contractor shall demonstrate that all UM staff making service authorization decisions have been trained and are competent in working with the specific area of service for which they have authorization and management responsibility. This shall include, but not be limited to: (i) co-occurring MH and SUDs; (ii) co-occurring Behavioral Health and medical diagnoses; (iii) co-occurring Behavioral Health and I/DD; and (iv) the needs and clinical risk factors of diverse populations.

11.1.2 The Contractor shall ensure that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the Enrollee's medical, Behavioral Health, or long-term services and supports needs.

11.1.3 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of Subcontractors with, delegated authority for Utilization Management and the requirements described in this Section.

11.1.4 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and Behavioral Health services it furnishes its Enrollees (WAC 284-43-2000(3)). The UMP description shall include:

11.1.4.1 The definition of the Contractor's UMP structure and assignment of responsibility for UMP activities to appropriate individuals.

11.1.4.2 Identification of a designated physician responsible for program implementation, oversight and evaluation, and evidence of the physician and a Behavioral Health practitioner's involvement in program development and implementation.

11.1.4.3 Identification of the type of personnel responsible for each level of UM decision-making.

11.1.4.4 The use of board-certified consultants to assist in making medical necessity determinations.

11.1.4.5 Assurance that a physician, doctoral level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any Behavioral Health denial based on medical necessity.

11.1.4.6 A written description of all UM-related committee(s).

11.1.4.7 Descriptions of committee responsibilities.

11.1.4.8 Description of committee participant titles, including UM

Subcontractor, Sub-contractor representatives, and practicing Providers.

11.1.4.9 Meeting frequency.

11.1.4.10 Maintenance of signed meeting minutes reflecting decisions made by each committee, as appropriate.

11.1.4.11 Behavioral healthcare benefits to include at a minimum:

11.1.4.11.1 Benefit structure and description;

11.1.4.11.2 Triage and referral procedures and protocols, if any, (i.e., clearly describe how Enrollees access behavioral healthcare services);

11.1.4.11.3 UM activities and staff roles and responsibilities;

11.1.4.11.4 Coordination activities with the behavioral healthcare system, including behavioral health advocates;

11.1.4.11.5 Monitoring and oversight of the Behavioral Health program; and

11.1.4.11.6 Strategies to foster integration of physical health and Behavioral Health.

11.1.4.12 Annual evaluation and update of the UMP.

11.1.4.13 Annually upon request, the Contractor shall submit to HCA for approval a UMP description that incorporates and accommodates initiatives requested by HCA when there are changes to the UMP approved by the Contractor and HCA.

11.1.4.14 An explanation of how UM decision making takes into account the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care.

11.1.5 The Contractor shall monitor each Enrollee's needs and appropriately refer Enrollees for Care Coordination or Intensive Care Management (ICM) services consistent with Section 14 of this Contract.

11.1.6 The Contractor shall document use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-2000(3)). The criteria must be evaluated annually and updated as necessary.

11.1.7 The Contractor shall have written policies for applying UMP decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; the greater and particular needs of diverse populations, as reflected in Health Disparities, risk factors (such as ACEs for Enrollees of any age), Historical Trauma, and the need for Culturally Appropriate Care; and the availability of services in the local delivery system.

11.1.8 The Contractor shall have mechanisms for Providers and Enrollees on how they

can obtain the UM decision-making criteria upon request, including UM Adverse Benefit Determination letter template language reflecting the same (WAC 284-43-2000(3)).

11.1.9 The Contractor shall have mechanisms for at least annual assessment of interrater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions for both physical and Behavioral Health.

11.1.10 The Contractor shall maintain written job descriptions of all Contractor UM staff. Contractor staff that review denials of care based on medical necessity shall have job descriptions that describe required education, training or professional experience in medical or clinical practice and evidence of a current, non-restricted license, including HIPAA training compliance.

11.1.11 The Contractor shall have mechanisms to verify that claimed services were actually provided.

11.1.12 The Contractor shall require authorization decisions for Behavioral Health services be made by Washington licensed Behavioral Health professionals except when a Washington licensed Behavioral Health professional is temporarily unavailable. Contractor staff described in this subsection shall review any Behavioral Health Adverse Benefit Determination based on medical necessity, including any decision to authorize a service in an amount, duration or scope that is less than requested.

11.1.12.1 A physician board-certified or board-eligible in Psychiatry.

11.1.12.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM;

11.1.12.3 A licensed, doctoral level psychologist; or

11.1.12.4 A pharmacist, as appropriate.

11.1.13 The Contractor shall have Behavioral Health professionals with Utilization Management experience working in a Behavioral Health Managed Care setting or Washington State Behavioral Health clinical settings on staff. These staff must include individuals who are Certified SUDPs or have three (3) years of experience in an SUD setting.

11.1.14 The Contractor shall have Utilization Management staff who have experience and expertise in working with one (1) or more of the following populations:

11.1.14.1 Transitional Age Youth, adults and older adults with Behavioral Health needs;

11.1.14.2 High risk groups such as individuals with Behavioral Health conditions with or without co-occurring SUD;

11.1.14.3 Co-occurring Behavioral Health and chronic medical conditions or I/DD;

11.1.14.4 Individuals involved with multiple service systems;

11.1.14.5 Individuals with a SUD in need of medication-assisted treatment;

11.1.14.6 Individuals who are homeless.

11.1.15 The Contractor shall have a sufficient number of Behavioral Health clinical peer reviewers available to conduct denial and appeal reviews or to provide clinical consultation on psychological testing, complex case review and other treatment needs.

11.1.16 The Contractor shall ensure that any physical or Behavioral Health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.

11.1.17 The Contractor shall ensure that any Behavioral Health Adverse Benefit Determinations must be peer-to-peer — that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

11.1.17.1 A physician board-certified or board-eligible in Psychiatry must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations and reductions) for psychiatric treatment.

11.1.17.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM, must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations, and reductions) for SUD treatment.

11.1.18 Prior Authorization Administrative Simplification Workgroup. The Contractor shall participate in the statewide Prior Authorization Administrative Simplification Workgroup convened by the OIC (RCW 48.165.030). The Contractor will abide by best practice recommendations agreed to by the Prior Authorization Administrative Simplification Workgroup unless otherwise directed by HCA.

11.1.19 Opioid Crisis Engagement. The Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to collaborate on approaches to the opioid crisis. Contractor activities developed in collaboration with peer AHEHPs and HCA medical directors to address this health and safety concern may include, but are not limited to: Identification and management of Enrollees taking high-dose opioids for non-cancer pain; prescriber and Enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, use of naloxone, requesting second opinions from a pain management specialist, preauthorization of opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or SUD programs for assessment.

11.1.20 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

11.1.21 The Contractor shall not penalize or threaten a Provider or Facility with a reduction in future payment or termination of Participating Provider or participating facility status because the Provider or Facility disputes the Contractor's determination with respect to coverage or payment for health care

service.

11.1.22 The Contractor shall develop and implement UM protocols, including policies and procedures, consistent with HCA's medical necessity criteria and comply with federal and state parity requirements.

11.1.22.1 The Contractor shall use the six dimensions of the ASAM Criteria to make medical necessity decisions for SUD services.

11.1.23 The Contractor shall establish protocols to perform concurrent review which identify and actively refer Enrollees needing discharge planning who require assistance in transitioning from inpatient care, or administrative days to the next lower level of care, including home. Protocols must address response to discharge planning requests for Enrollee care in which UM review is not applicable, such as observation level of care or non-skilled nursing facility care. Protocols shall address the following:

11.1.23.1 Identify Enrollees who are eligible for Administrative Days and grant them as appropriate, as well as notify the hospital of the Enrollees who are granted Administrative Days.

11.1.23.1.1 The Contractor shall not require the hospital to submit requests for Administrative Days.

11.1.23.1.2 Administrative Days may be reversed based on outcomes of peer-to-peer reviews or hospital appeals.

11.1.23.2 Treatment availability and community supports necessary for recovery including, but not limited to: housing, financial support, medical care, transportation, employment and/or educational concerns, and social supports.

11.1.23.3 Barriers to access to and/or engagement with post-discharge ambulatory appointments, including Medication Management and other interventions.

11.1.23.4 Procedures for Concurrent Review, if applicable for Enrollees requiring extended inpatient care due to poor response to treatment and/or placement limitations.

11.1.23.5 Corrective action expectations for ambulatory Providers who do not follow-up on Enrollees discharged from inpatient settings as per the transitional health care services timeframes defined in Section 14 of this Contract.

11.1.23.6 The roles of Tribal governments and other IHCPs in providing diverse services, including Culturally Appropriate Care, for AI/AN Enrollees and their family members and the Protocols for Coordination with Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

11.1.24 The Contractor shall not impose additional authorization requirements on any IHCP that are not required of a network Provider.

11.2 Drug Utilization Review (DUR) Program

11.2.1 The Contractor must provide a DUR Program to assure that prescriptions are

appropriate, Medically Necessary and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists, and Enrollees.

11.2.2 Prospective Drug Utilization Review (Pro-DUR)

11.2.2.1 The Contractor must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, drug refill too soon and clinical abuse/misuse.

11.2.3 Retrospective Drug Utilization Review (Retro-DUR)

11.2.3.1 The Contractor must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, and abuse such as gross overuse, excessive filling or inappropriate or medically unnecessary care among physicians, pharmacists and Enrollees.

11.2.3.2 The Contractor shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

11.2.3.3 The Contractor shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

11.3 Medical Necessity Determination

The Contractor shall collect all information necessary to make medical necessity determinations. The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding Appeals, hearings and independent review.

11.4 Authorization of Services

11.4.1 The Contractor shall follow the authorization of services requirements described in this Section. The Contractor shall not have or implement authorization policies that inhibit Enrollees from obtaining medically necessary contracted services and supplies. For example, inpatient admissions for deliveries or home births should not require Prior Authorization because there is not a question of medical necessity associated with a delivery. It is reasonable to require notification of admissions for delivery or of a home delivery to support

Concurrent Review activities or Case Management.

11.4.2 Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for Chronic Conditions.

11.4.3 The Contractor's policies and procedures related to authorization and post-service review of services shall include compliance with WAC 284-43-2000(6)(b), chapters 182-525A and 182-550 WAC, WAC 182-501-0160 and -0169, and require compliance of Subcontractors with delegated authority for authorization of services with the requirements described in this Section, and shall include a definition of "service authorization" that includes an Enrollee's request for services.

11.4.4 The Contractor shall provide education and ongoing guidance and training to Enrollees and Providers about its UM protocols, including admission, continued stay, and discharge criteria.

11.4.5 The Contractor shall consult with the requesting Provider when appropriate.

11.4.6 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Health Care Professional who has appropriate clinical expertise in addressing the Enrollee's medical or behavioral health condition or long-term services and supports.

11.4.6.1 In denying services, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the Medicaid FFS program. For services that are Non-Contracted Services from this Contract, but are covered by HCA, the Contractor's denial will include directions to the Enrollee about how to obtain the services through HCA and will direct the Enrollee to those services and coordinate receipt of those services.

11.4.6.2 The Contractor will support Enrollee access to gender affirming treatment. The Contractor will not apply categorical or blanket exclusions to gender affirming treatment. The Contractor will not issue an adverse benefit determination for gender affirming treatment, unless a health care Provider with experience prescribing or delivering gender affirming treatment has reviewed and confirmed the appropriateness of the adverse benefit determination.

11.4.7 The Contractor may not impose utilization review requirements for SUD residential treatment facilities operated by the Indian Health Service or by Tribes or Tribal Organizations under a contract or compact with the Indian Health Service (25 U.S. Code § 1621e(c)).

11.4.8 The Contractor shall not implement Prior Authorization requirements for withdrawal management services as defined in RCW 71.24.618 or inpatient or residential SUD treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

11.4.8.1 The Contractor shall provide coverage for treatment in a behavioral health agency that provides inpatient or residential SUD treatment

for a minimum of two (2) Business Days, or a minimum of three (3) calendar days in the case of a behavioral health agency that provides withdrawal management services, prior to conducting a utilization review. The Contractor may then initiate UM review if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate Facility or lower level of care.

11.4.8.2 The Contractor must have policies and procedures in place allowing behavioral health agencies 24 hours from admission to provide notification of the admission, and two (2) Business Days from admission to provide records of the initial assessment and initial treatment plan, or three (3) calendar days in the case of a behavioral health agency that provides withdrawal management services. Following this time period and receipt of this information, the Contractor may perform utilization review. If the Contractor determines the admission is not medically necessary based on ASAM criteria:

11.4.8.2.1 Within one (1) Business Day from the start of the UM review period and receipt of the information, the Contractor is not required to pay the Facility for services delivered after the start of the UM review period, provided the Contractor has notified the behavioral health agency of the determination in writing.

11.4.8.2.2 If the Contractor's UM review is completed more than one (1) Business Day after the start of the UM review period and receipt of the information, the Contractor must pay for the services rendered from the time of admission until the time the UM review is completed and the behavioral health agency is notified of the determination in writing.

11.4.8.3 When the treatment plan approved by the Contractor involves transfer of the Enrollee to a different Facility or lower level of care, the Contractor shall continue to pay the behavioral health agency for Contracted Services provided at the current Facility until the seamless transfer to the different Facility or lower level of care is complete.

11.4.8.4 Denial of Payment that may result in Payment Liability: The authorization decision and notice is provided for the Enrollee, at the time of any Adverse Benefit Determination affecting the claim.

11.4.8.5 Termination, Suspension, or Reduction of Previously Authorized Services: The authorization decision and notice is provided ten (10) calendar days prior to such termination, suspension, or reduction, except in the following circumstances:

11.4.8.5.1 The Enrollee dies;

11.4.8.5.2 The Contractor has a signed written Enrollee statement requesting service termination or giving

information requiring termination or reduction of services (where the Enrollee understands that termination, reduction, or suspension of services is the result of supplying this information);

11.4.8.5.3 The Enrollee is admitted to an institution where he or she is ineligible for services.

11.4.8.5.4 The Enrollee's address is unknown and mail directed to him or her has no forwarding address;

11.4.8.5.5 The Enrollee has moved out of the Contractor's service area past the end of the month for which a premium was paid;

11.4.8.5.6 The Enrollee's PCP prescribes the change in the level of medical care;

11.4.8.5.7 An adverse determination regarding the preadmission screening for nursing facility was made;

11.4.8.5.8 The safety or health of individuals in the nursing facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to Adverse Benefit Determinations for nursing facility transfers); or

11.4.8.5.9 The Enrollee is accepted for Medicaid services in another local jurisdiction, state, territory, or commonwealth.

11.5 Prescription Drug Authorization Decisions and Timeframes

11.5.1 The Contractor must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, Prior Authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will, apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a "medical benefit" incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

11.5.2 The Contractor must respond to a Prior Authorization request for a covered outpatient drug or over-the-counter drug by telephone or other telecommunication device within 24 hours of the request.

11.5.2.1 For electronic standard Prior Authorizations, the Contractor must make a decision and notify the Provider or Facility within three (3) calendar days, excluding holidays, of the submission of an electronic standard Prior Authorization from of the original receipt of the request. If insufficient information has been provided, the Contractor shall request additional information from the Provider within one (1) calendar day of the original receipt of the request. If

additional information is required and requested, the Contractor must give the Provider five (5) calendar days to submit the information. Contractor must approve or deny the request within four (4) calendar days of the receipt of the additional information (WAC 284-43-2050).

11.5.2.1.1 A possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances

11.5.2.1.1.1 The Enrollee or if the Provider requests an extension; or

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

11.5.3 Does not respond to the Contractor's request for additional information within five (5) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.5.4 For non-electronic standard authorizations, the Contractor must make a decision and provide notification within five (5) calendar days from the original receipt of the request. If additional information is required and requested, the Contractor must give the Provider five (5) calendar days to submit the information and make a determination within four (4) calendar days of the receipt of the additional information (RCW 74.09). If the Provider does not respond to the Contractor's request for additional information within five (5) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.5.5 For electronic and non-electronic standard Prior Authorizations, a possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances:

11.5.5.1 The Enrollee or the Provider requests an extension; or

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

11.5.6 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

11.5.6.1 The Contractor shall provide the Enrollee written notice within three (3) Business Days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

11.5.6.2 The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires.

11.5.7 Expedited Authorization Decisions: For cases in which a Provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Enrollee's life or health or

ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires.

11.5.8 For electronic expedited authorizations, the Contractor will make the decision and provide notification within one (1) calendar day if the information provided is sufficient; or request additional information within one (1) calendar day if the information provided is not sufficient to complete the request. The Contractor must give the Provider two (2) calendar days to submit the requested information and then make a determination within two (2) calendar days of the receipt of the additional information. If the Provider does not respond to the Contractor's request for additional information within two (2) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.5.9 For non-electronic expedited authorization requests, the Contractor will make the decision and provide notification within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day if the information provided is not sufficient to complete the request. The Contractor must give the Provider two (2) calendar days to submit the requested information and then make a determination within two (2) calendar days of the receipt of the additional information. If the Provider does not respond to the Contractor's request for additional information within two (2) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.5.10 The Contractor may extend the expedited time period for both electronic and non-electronic expedited authorizations by up to ten (10) calendar days under the following circumstances:

11.5.10.1 Enrollee requests the extension; or

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

11.5.11 The Contractor shall have in place a mechanism to allow automated approval of Prior Authorization criteria based on situation specific codes or values submitted via point-of-sale by the dispensing pharmacy. Overrides of Prior Authorization criteria may be based on values submitted in either the Prior Authorization or diagnosis fields.

11.5.12 The Contractor shall have a process for providing an emergency drug supply to Enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the Enrollee's health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

11.5.13 The Contractor shall have a process for authorization after the fact of an emergency fill as defined in this Contract when an emergency fill of a medication is dispensed according to the professional judgment of the dispensing pharmacist not to exceed thirty (30) calendar days' supply. The authorization for the prescription must match the drug quantity and days supplied as dispensed by the pharmacist.

11.6 Service Authorization Decisions and Timeframes

11.6.1 The Contractor shall provide for the following timeframes for authorization

decisions and notices for all determinations regarding services:

11.6.1.1 For electronic standard authorizations, the Contractor must make a decision and provide notification within three (3) calendar days, excluding holidays, from the original receipt of the request. If additional information is required, the Contractor shall request additional information within one (1) calendar day of the original receipt of the request. The Contractor must give the Provider five (5) calendar days to submit the information and make a determination within four (4) calendar days of the receipt of the additional information (chapter 74.09 RCW). If the Provider does not respond to the Contractor's request for additional information within five (5) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.6.1.2 For non-electronic standard authorizations, the Contractor must make a decision and provide notification within five (5) calendar days from the original receipt of the request. If additional information is required the Contractor shall request additional information within five (5) calendar days of the original receipt of the request. The Contractor must give the Provider five (5) calendar days to submit the information and make a determination within four (4) calendar days of the receipt of the additional information (chapter 74.09 RCW). If the Provider does not respond to the Contractor's request for additional information within five (5) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.6.1.3 For electronic and non-electronic standard Prior Authorizations, a possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances.

11.6.1.3.1 The Enrollee or the Provider requests an extension; or

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

11.6.1.3.3 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

11.6.1.3.3.1 The Contractor shall provide the Enrollee written notice within three (3) Business Days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision.

11.6.1.3.3.2 The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires.

11.6.1.4 Expedited Authorization Decisions: For cases in which a Provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires.

11.6.1.5 For electronic expedited authorizations the Contractor will make the decision and provide notification within one (1) calendar day if the information provided is not sufficient to complete the request. The Contractor must give the Provider two (2) calendar days to submit the requested information and then make a determination within two (2) calendar days of the receipt of the additional information. If the Provider does not respond to the Contractor's request for additional information within two (2) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.6.1.6 For non-electronic expedited authorization requests, the Contractor will make the decision and provide notification within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day if the information provided is not sufficient to complete request. The Contractor must give the provider two (2) calendar days to submit the requested information and then make a determination within two (2) calendar days of the receipt of the additional information. If the Provider does not respond to the Contractor's request for additional information within two (2) calendar days of the request, the Contractor must make an appropriate authorization determination.

11.6.1.7 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances:

11.6.1.7.1 Enrollee requests the extension; or

11.6.1.7.2 Contractor justifies and documents a need for additional information and how the extension is in the Enrollee's interest.

11.6.1.8 Concurrent Review Authorizations: The Contractor must make its determination within one (1) Business Day of receipt of the request for authorization.

11.6.1.8.1 Concurrent review timeframes are applicable to authorization requests for Enrollees that are currently inpatient.

11.6.1.8.2 Requests to extend concurrent care review

authorization determinations may be extended to within three (3) Business Days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) Business Day after the request for authorization of additional days or services.

11.6.1.8.3 Notification of the Concurrent Review determination shall be made within one (1) Business Day of the Contractor's decision.

11.6.1.9 Post-service Authorizations: For post-service authorizations, including pharmacy post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.

11.6.1.9.1 The Contractor shall notify the Enrollee, the requesting provider, and facility in writing within three (3) Business Days of the Contractor's determination.

11.6.1.9.2 When post-service authorizations are approved, they become effective the date the service was first administered.

11.7 Notification of Coverage and Authorization Determinations

11.7.1 For all authorization determinations, the Contractor must notify the Enrollee, the attending/treating Provider, and requesting Facility in writing. The Contractor must notify the parties, other than the Enrollee, in advance whether it will provide notification by mail, fax or other means. The Contractor must use an HCA-developed template for skilled nursing-related Adverse Benefit Determinations.

11.7.1.1 If the Contractor is not able to obtain the name of the attending/treating Provider, the notification must be addressed "To the Attention of the Attending/Treating Practitioner." For urgent concurrent decisions, the Contractor may inform the hospital utilization review department staff without attempting to identify the attending/treating Provider.

11.7.2 For all authorization decisions, the notice shall be mailed as expeditiously as the Enrollee's health requires and within three (3) Business Days of the Contractor's decision, unless otherwise indicated in Section 11.

11.7.2.1 Authorization determinations involving an Expedited Authorization: The Contractor must notify the Enrollee in writing of the decision. The Contractor may initially provide notice orally to the Enrollee or the requesting Provider. The Contractor shall send the written notice within one (1) Business Day of the decision.

11.7.2.2 Adverse Authorization Decisions involving a WISe screening.

11.7.2.3 The Contractor shall notify the requesting provider and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice

shall meet the following requirements:

11.7.2.3.1 The notice to the Enrollee shall meet the requirements in the, Information Requirements for Enrollees and Potential Enrollees Section of this Contract to ensure ease of understanding.

11.7.2.3.2 The notice to the Enrollee and Provider shall explain the following; (WAC 182-525-A, 182-525-0800(5)):

11.7.2.3.2.1 The Adverse Benefit Determination the Contractor has taken or intends to take and the effective date, if applicable.

11.7.2.3.2.2 The evidence based Medical Necessity determination process that was utilized which.

11.7.2.3.2.3 The specific factual basis for the Adverse Benefit Determination, in easily understood language, including citations to the appropriate Washington Administrative Code and any Contractor guidelines, protocols, or other criteria that were the basis of the decision.

11.7.2.3.2.4 Sufficient detail to enable the Enrollee to learn the reasons for Contractor's determination, so the Enrollee can (i) prepare an appropriate response, and (ii) determine what additional or different information might be provided to Appeal the Contractor's determination.

11.7.2.3.2.5 If applicable, the notice must include information about alternative covered services/treatment which may be seen as a viable treatment option in lieu of denied services.

11.7.2.3.2.6 The Enrollee's and Provider's right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision, as well as reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination.

11.7.2.3.2.7 A statement whether or not an Enrollee has any liability for payment.

11.7.2.3.2.8 A toll-free telephone number to call if the Enrollee is billed for services.

11.7.2.3.2.9 The Enrollee's right to file an appeal and any deadlines applicable to the process.

11.7.2.3.2.10 If services are denied as non-covered, inform Enrollees how to access the Exception to Rule (ETR) process including, but not limited to, the fact that an Enrollee may Appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an ETR to obtain the services that are the subject of the Appeal, and that requesting an ETR does not affect any deadlines applicable to the Appeal process.

11.7.2.3.2.11 If services are denied or authorized in a more limited scope, amount or duration than requested because they would exceed the established limit on the scope, amount or duration of the requested service, inform Enrollees how to access the Limitation Extension (LE) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an LE to obtain the services that are the subject of the Appeal, and that requesting an LE does not affect any deadlines applicable to the appeal process.

11.7.2.3.2.12 The procedures for exercising the Enrollee’s rights.

11.7.2.3.2.13 The circumstances under which expedited resolution is available and how to request it.

11.7.2.3.2.14 The Enrollee's right to have benefits continue pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay for these services.

11.7.2.3.2.15 The Enrollee’s right to receive the Contractor’s or regional behavioral health advocates’ assistance with filing the Appeal.

11.7.2.3.2.16 The Enrollee’s right to equal access to services for Enrollees and potential

Enrollees with communications barriers and disabilities.

11.7.2.4 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either, standard or expedited service authorizations it is considered a denial and thus, an Adverse Benefit Determination. The Contractor shall issue a formal Notice of Adverse Benefit Determination to the Enrollee, including the Enrollee's right to an Appeal.

11.7.2.5 UM Authorization Turnaround Time Compliance Report: The Contractor will send quarterly a report to HCA by the last day of the month following the quarter that shall include:

11.7.2.5.1 Monthly UM authorization determination data that demonstrates timeliness compliance rates separated into Standard, Pharmacy, Expedited, Concurrent Review, and Post-service timelines, including:

11.7.2.5.1.1 Percentage compliance, including those in which the timeline is extended appropriately;

11.7.2.5.1.2 Specific numbers of authorization determinations meeting contractual timeframes and the numbers of those that did not; and

11.7.2.5.1.3 For those authorization determinations that did not meet contractual timeframes, the range of time to complete the authorization determinations.

11.7.2.5.2 If UM authorization turnaround time compliance is below 90 percent in any month during the quarter for any of the authorization categories specified in this Contract, the report shall also include a narrative description of the Contractor's efforts before and after notification to HCA to address the problem.

11.8 Experimental and Investigational Services for Managed Care Enrollees

11.8.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual Enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its FFS program, including the option to approve an investigational or experimental service when there is:

11.8.1.1 A humanitarian device exemption for the requested service or device from the Food and Drug Administration (FDA); or

11.8.1.2 A local Institutional Review Board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both HCA and the requesting Provider.

11.8.2 Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual Enrollee based on that Enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.

11.8.3 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid Enrollees than that applied to any other Enrollees.

11.8.4 An Adverse Benefit Determination made by the Contractor shall be subject to Appeal through the Contractor's Appeal, hearing, and independent review process in accordance with the Grievance and Appeal System Section of this Contract.

11.9 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with a governing federal statute or regulation. Where it is necessary to harmonize federal and state law, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents and Subcontractors to comply with the requirements of this Section.

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.

12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all statutes and regulations related to Program Integrity whether or not those provisions are listed below:

12.1.3.1 Chapter 182-502A WAC; and

12.1.3.2 Chapter 41.05A RCW.

12.1.4 The Contractor shall ensure compliance with the Program Integrity provisions of this Contract.

12.1.5 The Contractor shall have a staff person dedicated to working collaboratively with HCA on Program Integrity issues. This will include the following:

12.1.5.1 Participation in AHEHP-specific, quarterly Program Integrity meetings with HCA. Discussion at these meetings shall include but not be limited to case development and monitoring.

12.1.5.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.

12.1.5.3 Quality control and review of encounter data submitted to HCA.

12.1.5.4 The Contractor must have and sustain adequate staffing resources in the Contractor's Program Integrity and Special Investigation Units who are dedicated to identifying fraud, waste, and abuse. Staffing configuration should include all staff with appropriate education and expertise to conduct all required program integrity activities that:

12.1.5.4.1 Prevent, detect, investigate fraud, waste and abuse;

12.1.5.4.2 Refer potential fraud to HCA; and

12.1.5.4.3 Produce cost avoidance savings or post-payment recoveries of improper payments.

12.1.6 When the Contractor identifies an Overpayment, the Contractor will report the Overpayment to HCA and recover the Overpayment pursuant to this Contract, WAC 182-502A-1101, and other relevant laws and regulations.

12.1.6.1 HCA may impose sanctions, liquidated damages, or both on the Contractor for failure to report to HCA and collect Overpayments.

12.2 **Disclosure by Apple Health Expansion Health Plans: Information on Ownership and Control**

12.2.1 The Contractor must provide to HCA the following disclosures:

12.2.1.1 The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5 percent or more of the Contractor's equity (or, in the case of a Subcontractor's disclosure, 5 percent or more of the subcontractor's equity);

12.2.1.2 The identification of any person or corporation with an ownership interest of 5 percent or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the Contractor's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the Subcontractor equal to 5 percent of the Subcontractor's assets);

12.2.1.3 The name, address, date of birth, and Social Security Number of any managing employee of the Managed Care organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

12.2.2 The disclosures must include the following:

12.2.2.1 The name, address, and financial statement(s) of any person (individual or corporation) that has 5 percent or more ownership or control interest in the Contractor.

12.2.2.2 The name and address of any person (individual or corporation) that has 5 percent or more ownership or control interest in any of the Contractor's subcontractors.

12.2.2.3 Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor's employee such as a spouse, parent, child, or siblings; or is related to one of the Contractor's officers, directors or other owners.

12.2.2.4 Indicate whether the individual/entity with an ownership or control interest owns 5 percent or greater in any other organizations.

12.2.2.5 The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

12.2.2.6 Date of birth and Social Security Number (in the case of an individual).

12.2.2.7 Other tax identification number (in the case of a corporation) with an ownership or control interest in the AHEHP or its Subcontractor.

12.2.3 The Contractor must terminate or deny network participation if a provider, or any person with 5 percent or greater direct or indirect ownership interest fails to submit sets of fingerprints in a form and manner to be determined by HCA, within thirty (30) calendar days when requested by HCA.

12.2.4 Disclosures from the Contractor are due to HCA at any of the following times:

12.2.4.1 When the Contractor submits a proposal in accordance with an HCA procurement process.

12.2.4.2 When the Contractor executes the Contract with HCA.

12.2.4.3 Upon renewal or extension of the Contract.

12.2.4.4 Within thirty-five (35) calendar days after any change in ownership of the Contractor. The Contractor shall report the change on HCA Medicaid Provider Disclosure Statement Form HCA-09-048.

12.2.4.5 Upon request by HCA.

12.3 **Disclosure by Apple Health Expansion Health Plans: Information on Ownership and Control, Subcontractors**

12.3.1 The Contractor shall include the following provisions in its written agreements with all Subcontractors:

12.3.1.1 Requiring the Subcontractor to disclose to the AHEHP upon contract execution, upon request during the re-validation of enrollment process under, and within thirty-five (35) Business Days after any change in ownership of the Subcontractor.

12.3.1.2 The name and address of any person (individual or corporation) with an ownership or control interest in the Subcontractor.

12.3.1.3 If the Subcontractor is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address.

12.3.1.4 If the Subcontractor has corporate ownership, the tax identification number of the corporate owner(s).

12.3.1.5 If the Subcontractor is an individual, date of birth and Social Security Number.

12.3.1.6 If the Subcontractor has a 5 percent ownership interest in any of its Subcontractors, the tax identification number of the Subcontractor(s).

12.3.1.7 Whether any person with an ownership or control interest in the Subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the Subcontractor.

12.3.1.8 If the Subcontractor has a 5 percent ownership interest in any of its Subcontractors, whether any person with an ownership or control

interest in such Subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the Subcontractor.

12.3.1.9 Whether any person with an ownership or control interest in the Subcontractor also has an ownership or control interest in any Managed Care entity.

12.3.2 Upon request, the Contractor and the Contractor's Subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

12.3.2.1 The ownership of any Subcontractor with whom the Contractor or Subcontractor has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request.

12.3.2.2 Any significant business transactions between the Contractor or Subcontractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the five (5) year period ending on the date of the request.

12.3.3 Upon request, the Contractor and the Contractor's Subcontractors shall furnish to the Washington Secretary of State, the Washington State Auditor, and HCA a description of the transaction identified between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions:

12.3.3.1 A description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following:

12.3.3.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.

12.3.3.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.

12.3.3.1.3 Any lending of money or other extension of credit between the Contractor and such a party.

12.4 Information on Persons Convicted of Crimes

The Contractor shall include the following provisions in its written agreements with all Subcontractors and providers who are not individual practitioners or a group of practitioners:

12.4.1 Requiring the Subcontractor/provider to investigate and disclose to the AHEHP, at contract execution or renewal, and upon request by the AHEHP of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is:

12.4.1.1 A person who has an ownership or control interest in the

Subcontractor or provider.

12.4.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or provider.

12.4.1.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the subcontractor or provider.

12.5 **Fraud, Waste, and Abuse (FWA)**

12.5.1 The Contractor, or the Contractor's subcontractor delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between HCA and the Contractor, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. The arrangements or procedures must include the following:

12.5.1.1 A compliance program that includes, at a minimum, all of the following elements:

12.5.1.1.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.

12.5.1.1.2 Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the contract and who directly reports to the Chief Executive Officer (CEO) and the Board of Directors.

12.5.1.1.3 Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.

12.5.1.1.4 System for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under this Contract.

12.5.1.1.5 Effective lines of communication between the Compliance Officer and the Contractor's staff and subcontractors.

12.5.1.1.6 Enforcement of standards through well-publicized disciplinary guidelines.

12.5.1.1.7 Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt

response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract.

12.5.1.1.8 Ensure it maintains up-to-date program integrity policies and procedures relative to any contract modifications to ensure all program integrity functions are adequately addressed.

12.5.1.2 Provision for prompt reporting of all Overpayments identified or recovered, specifying the Overpayments due to potential fraud, to HCA.

12.5.1.3 Provision for notification to HCA when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

12.5.1.4 Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis.

12.5.1.4.1 The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, sexually transmitted diseases, and behavioral health services.

12.5.1.4.2 Results of the verification and any action(s) taken must be available upon HCA's request.

12.5.1.5 Written policies for all employees of the Contractor that provide detailed information about fraudulent activities, including protections for whistleblower. including information about rights of employees to be protected as whistleblowers chapter 74.09 RCW.

12.5.1.6 Provision for prompt referral of any potential fraud, waste, or abuse the Contractor identifies to HCA Program Integrity.

12.5.1.7 Provision for the Contractor's suspension of payments to a network provider for which HCA determines there is a credible allegation of fraud and pursuant to the Fraud Referral Subsection of this Contract.

12.5.1.8 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.5.1.9 Provision for notification of the Contractor's program integrity activities when requested by HCA to prevent duplication of activities.

12.5.2 The Contractor and its Subcontractors shall:

12.5.2.1 Provide written disclosure to HCA of any prohibited affiliation. Provide written disclosures of information on ownership and control as indicated under the Disclosure by Apple Health Expansion Health Plans: Information on Ownership and Control, Subcontractors Subsection of this Contract; and

12.5.2.2 Report to HCA within sixty (60) calendar days when it has identified capitation payments or other payment amounts received are in excess to the amounts specified in this Contract.

12.5.3 The Contractor must audit its providers and Subcontractors to detect and identify fraud, waste, and abuse.

12.5.3.1 Identified improper payments must be reported to HCA on the monthly Program Integrity Report.

12.5.3.2 Identified Overpayments must be recovered by the Contractor and reported to HCA in accordance with this Contract, WAC 182-502A-1101, and other reverent laws and regulations.

12.5.3.3 HCA will monitor the Contractor's activities through the Monthly Program Integrity Report.

12.5.4 Treatment of recoveries made by the Contractor of Overpayments to the providers.

12.5.4.1 The Contractor and its subcontractors shall:

12.5.4.1.1 Have internal policies and procedures for the documentation, retention, and recovery of all Overpayments, specifically for the recovery of Overpayments due to fraud, waste, or abuse.

12.5.4.1.2 Report the identification and recovery of all Overpayments as required in the Program Integrity Reporting Subsection of this Contract.

12.5.4.2 This subsection of the Contract does not apply to any amount of a recovery to be retained through investigations.

12.5.4.3 The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an Overpayment, to return the Overpayment within sixty (60) calendar days, and to notify the Contractor in writing of the reason for the Overpayment.

12.5.4.4 The Contractor shall report at least annually to HCA, or as required in the Contract, on their recoveries of Overpayments. See Program Integrity Reporting Subsection of this Contract.

12.5.5 When the Contractor conducts an audit of a Contractor's provider or

subcontractor, the Contractor must:

12.5.5.1 Provide a thirty (30) day notice to a provider or subcontractor prior to an onsite audit, unless there is evidence of danger to public health and safety or fraudulent activities.

12.5.5.2 Make reasonable efforts to avoid auditing a provider or subcontractor claim that is or has already undergone an audit, review or investigation by the Contractor without good cause.

12.5.5.3 Allow a provider or subcontractor, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the Contractor, or by facsimile transmission.

12.5.5.4 Extrapolate only when there is a sustained high level of payment error or when documented provider or subcontractor educational intervention has failed to correct the level of payment error.

12.5.5.5 Issue draft or preliminary findings within one-hundred twenty (120) calendar days from receipt of all provider or subcontractor information required to conduct the audit.

12.5.5.6 Provide a detailed explanation in writing to a provider or subcontractor for any adverse determination that would result in partial or full recoupment of a payment to the provider or subcontractor. The written notification shall, at a minimum, include the following:

12.5.5.6.1 The reason for the adverse determination;

12.5.5.6.2 The specific criteria on which the adverse determination was based;

12.5.5.6.3 An explanation of the provider's appeal rights; and

12.5.5.6.4 If applicable, the appropriate procedure to submit a claim adjustment.

12.5.5.7 Ensure any appeal process is completed before recouping Overpayments.

12.5.5.8 Offer a provider or subcontractor with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months.

12.5.5.9 In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board-certified, and experienced in the treatment, billing, and coding procedures used by the provider being audited to make findings and determinations.

12.5.5.10 Provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified

through audits and reviews, and opportunities for improvement.

12.5.5.11 In the event of an audit of a provider or subcontractor who is no longer in the Contractor's network, include a description of the claim with patient name, date of service and procedure.

12.5.5.12 Provide HCA with courtesy copies of all letters sent to the provider or subcontractor being audited through MC-Track.

12.5.5.13 HCA will utilize the information and documentation collected in the Fraud, Waste, and Abuse Subsection of this Contract for setting actuarially sound capitation rates for each Contractor.

12.5.6 The Contractor must provide HCA a detailed list of current and past program integrity activities initiated and completed by the Contractor upon HCA's request.

12.5.7 HCA may conduct independent or collaborative audits, investigations, and clinical reviews of the Contractors providers and subcontractors at any time.

12.5.8 In an effort to identify fraud, waste, and abuse, HCA will:

12.5.8.1 Conduct proactive data mining of the Contractor's data; and

12.5.8.2 Conduct audits of the Contractor's provider and subcontractor.

12.5.9 When HCA identifies an Overpayment by the Contractor to a Provider or Subcontractor that was not first identified and reported by the Contractor, HCA will assess liquidated damages in accordance with the Liquidated Damages Subsection of this Contract.

12.6 **Fraud Referral**

12.6.1 When the Contractor suspects that potential fraud exists, the Contractor shall make a Fraud referral to HCA within five (5) Business Days of the determination and stop any further action including: overpayment issuance, collection, or any other steps.

12.6.2 Using the Washington Fraud Referral Form, referrals must be submitted to HCA through MC-Track.

12.6.2.1 Fraud referrals will be reviewed and verified by HCA.

12.6.3 When HCA reviews and verifies the Contractor's referral of potential fraud is credible, HCA shall notify the Contractor's compliance officers in writing that the referral is credible and is being sent over to law enforcement for investigation.

12.6.4 HCA will inform the Contractor on the steps the Contractor must take regarding the referral.

12.7 **Investigations**

12.7.1 The Contractor must cooperate with HCA, any HCA-appointed investigator, and law enforcement agency that investigates Fraud, waste and abuse.

12.7.2 The Contractor must provide data in response to data requests from HCA within the timeframe provided and in the formats requested, or as negotiated with HCA.

12.7.3 The Contractor must suspend its own investigation and all program integrity activities if notified in writing to do so by HCA.

12.7.3.1 If HCA accepts a fraud referral, the Contractor must "stand-down." For the purpose of this Subsection, "stand-down" means the Contractor must not:

12.7.3.1.1 Proceed with any further investigation, audit, or other program integrity activity until notified otherwise by HCA.

12.7.3.1.2 Notify the provider or subcontractor in any way about the acceptance of the referral.

12.7.3.1.3 Seek to recover or identify any Overpayment identified in the Contractor's investigation, audit, or other program integrity activity.

12.7.3.1.4 Suspend payments until directed by HCA.

12.7.3.1.5 Deny any claims for a provider or subcontractor, who the Contractor referred for fraud, and HCA accepted the referral.

12.7.3.1.6 Terminate the provider due to any reason identified in the Contractor's investigation.

12.7.3.1.6.1 In circumstances where there are quality of care concerns, the Contractor will notify HCA. HCA will review the concern and HCA will notify the Contractor if it may proceed with a termination despite the stand-down order within sixty (60) calendar days of receiving the Contractors notice.

12.7.3.1.7 Invoke any other action that may tip off the provider or related parties to the existence of a possible investigation based on the Contractor's fraud referral.

12.7.4 The Contractor must maintain all records, documents and claim or encounter data for Enrollees, Providers and Subcontractors who are under investigation by HCA until the investigation is complete and the case is closed by HCA.

12.7.5 The Contractor must comply with directives resulting from the investigations.

12.7.6 The Contractor shall request a refund from a third-party payer, provider or subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to HCA as Overpayments in the monthly Program Integrity Report.

12.8 **Payment Suspension**

12.8.1 The Contractor will not implement a payment suspension without the notification and direction to implement a payment suspension from HCA.

12.8.2 Upon receipt of payment suspension notification from HCA, the Contractor shall send notice of the decision to suspend payments within five (5) calendar days of HCA's notification to suspend payment, unless HCA requests a temporary withhold of the notice.

12.8.3 The notice of payment suspension must include or address all of the following:

12.8.3.1 State that payments are being suspended in accordance with this provision;

12.8.3.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;

12.8.3.3 State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;

12.8.3.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

12.8.3.5 There are no appeal rights when a payment suspension is issued. The individual or entity subject to the payment suspension may submit written evidence for consideration and review. Neither the Contractor or HCA are obligated to reverse the payment suspension based on the evidence submitted.

12.8.4 All suspension of payment actions under this Section will be temporary and will not continue after either of the following:

12.8.4.1 The Contractor is notified by HCA that there is insufficient evidence of Fraud by the provider; or

12.8.4.2 The Contractor is notified by HCA that the legal proceedings related to the provider's alleged Fraud are completed.

12.8.5 The Contractor must document in writing the termination of a payment suspension and issue a notice of the termination to the provider and send a copy to HCA.

12.8.6 If the Contractor fails to suspend payments to an entity or individual that HCA directed the Contractor to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of this Contract.

12.8.7 The Contractor shall maintain for a minimum of ten (10) years from the date of issuance all materials documenting:

12.8.7.1 Details of payment suspensions that were imposed in whole or in part; and

12.8.7.2 Each instance when HCA directed the Contractor to not enforce a payment suspension.

12.8.8 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor and any involved subcontractor have no claim to any portion of such recovery.

12.8.9 Furthermore, the Contractor is fully subrogated, and shall require its

Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, Medical Equipment, or other health care related products or services.

12.8.10 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

12.8.11 For the purposes of this Section, “subrogation” means the right of any state of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party.

12.9 **Excluded Individuals and Entities**

The Contractor and its subcontractors are prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction, or on the prescription of an excluded person. The Contractor shall notify the suppliers of the excluded individual and allow the suppliers a fifteen (15) day grace period from the notification to stop all prescription fills.

12.9.1 The Contractor shall monitor for excluded individuals and entities by:

12.9.1.1 Screening Contractor and Subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes, and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.

12.9.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.

12.9.1.3 Screening, the LEIE and SAM lists monthly by the 15th of each month for all Contractor and Subcontractor individuals and entities with an ownership or control interest, and individuals defined as affiliates in the Federal Acquisition Regulation, of an individual that is debarred, suspended, or otherwise excluded from participating in procurement activities, and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities.

12.9.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

12.9.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its

provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within five (5) Business Days of discovery.

12.9.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees.

12.9.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations.

12.9.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).

12.9.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.10 **Program Integrity Reporting**

12.10.1 All Program Integrity notification and reporting to HCA shall be in accordance with the General Terms and Conditions of this Contract unless otherwise specified herein.

12.10.2 When the Contractor submits Program Integrity notification and reports to HCA, the Contractor is certifying that the notifications and reports are true and accurate.

12.10.3 All Program Integrity notification and reports shall be submitted through the MC-Track application unless otherwise instructed in this Section and/or within the notification form or report templates. Deliverables must be approved by the HCA via MC-Track to be considered on time. Any deliverable that has not been accepted and executed by the due date shown is considered past due. Failure to submit reports on time may be subject to sanctions or liquidated damages. See table below of the listing of notification forms and reports and their respective due dates:

DELIVERABLES	FREQUENCY	DUE DATE
Program Integrity Report	Monthly	Thirty (30) calendar days after the end of the reporting month
Provider Termination Report	Monthly	Thirty (30) calendar days after the end of the reporting month
Annual Program Integrity Plan for WA State	Annual	March 1 of each calendar year
Annual Program Integrity Report for WA State	Annual	March 1 of each calendar year
Audited Financial Report	Annual	June 5 of each calendar year
Audited Encounter Data Report*	Annual	June 5 of each calendar year *(first report due June 5, 2026)
Records	On Request, or while On-site	By the date specified in HCA's record request or while onsite
HCA Medicaid Provider Disclosure Statement Form HCA-09-048	Ad Hoc	Within thirty-five (35) calendar days of an owner change

DELIVERABLES	FREQUENCY	DUE DATE
WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) Business Days from the date of discovery
WA Fraud Referral Form	Ad Hoc	Within five (5) Business Days from the date of determining an allegation of potential fraud exists
FWA Correspondence	Ad Hoc	Within thirty (30) Business Days from date of correspondence

12.10.4 On a monthly basis, the Contractor shall use the Program Integrity Reporting Form to report the following:

12.10.4.1 Program Integrity Activities and all required notifications referenced in the Fraud, Waste, and Abuse Subsection of this Contract.

12.10.5 On a monthly basis, the Contractor shall use the Provider Termination Report to report the following:

12.10.5.1 Termination for convenience;

12.10.5.2 Provider self-termination;

12.10.5.3 Terminations due to:

12.10.5.3.1 Sanction;

12.10.5.3.2 Invalid Licenses;

12.10.5.3.3 Services or Billing Errors;

12.10.5.3.4 Re-credentialing Errors;

12.10.5.3.5 Data Mining;

12.10.5.3.6 Investigation; or

12.10.5.3.7 Any other related program integrity involuntary terminations.

12.10.6 On an annual basis, the Contractor shall use the HCA Annual Program Integrity Report to report the following:

12.10.6.1 Details of all the program integrity activities conducted by the Contractor for the prior year. This includes all program integrity activities such as, but not limited to, algorithms, data analytics, clinical reviews, audits, and investigations.

12.10.7 The Contractor is responsible for investigating Enrollee fraud, waste and abuse. If the Contractor suspects Client/member/Enrollee Fraud:

12.10.7.1 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of Enrollee fraud to HCA Division of Program Integrity by:

12.10.7.1.1 Sending an email to WAHeligibilityfraud@hca.wa.gov; or

12.10.7.1.2 Mailing a written referral to:

Health Care Authority
Attention: Program Integrity
P.O. Box 45503
Olympia, WA 98504-5503

Or

12.10.7.1.3 Faxing the written complaint to Attention Washington Apple Health Eligibility Fraud at 360-725-1158.

12.10.8 Any excluded individuals and entities discovered in the screening described in the Fraud, Waste and Abuse Subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) Business Days of discovery. The identified excluded individual/entities shall be reported using the WA Excluded Individual Reporting Form.

12.10.9 The Contractor shall investigate and disclose to HCA, within five (5) calendar days of Contractor's discovery or upon request from HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) services program since the inception of those programs and:

12.10.9.1 Who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor; or

12.10.9.2 Any person entering into a provider or subcontractor agreement with the Contractor, or

12.10.9.3 Any person who has ownership or control interest in a provider or subcontractor, or

12.10.9.4 Is an agent or managing employee of the provider or subcontractor.

12.10.10 The Contractor and any person entering into a provider or subcontractor agreement, or a person who has ownership or control interest in a Provider or subcontractor, or is an agent or managing employee of the provider or subcontractor shall, on a monthly basis, check the LEIE and SAM database to identify any excluded individuals/entities. Documentation shall be kept validating the review of the databases and provided to HCA upon request.

12.10.11 The Contractor shall submit to HCA via MC-Track using the Newborn Payment Assistance Request Form (NB PARF) for newborn retro-enrollment and the Payment Assistance Request Form (PARF) for all other payment and enrollment inquiries to include but not limited to Service Base Enhancements (DCR, WISe, etc.), regular premium payments and other demographic changes that may impact eligibility (DOD, out-of-state address, etc.). Please refer to MC-Track for current templates and instructions. Access to Records, and On-site Inspections and Periodic Audits.

12.10.12 The Contractor shall submit an Annual Program Integrity Plan of activities the Contractor plans for the upcoming year. The Plan shall include all program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, and investigations.

12.11 Access to Records, and On-site Inspections and Periodic Audits

12.11.1 The Contractor and its providers and subcontractors shall permit the state of Washington, including HCA, state auditor, and their designees, to access, inspect and audit any records or documents of the Contractor or its subcontractors, at any time and shall permit inspection of the premises, physical facilities, and equipment where AHE- activities or work is conducted, at any time.

12.11.2 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation identified in subsection 12.11.1. If the requesting agency requests copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. The right for the parties named above to audit, access, and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law.

12.11.3 A record, in this Section, includes, but is not limited to:

12.11.3.1 Medical records;

12.11.3.2 Billing records;

12.11.3.3 Financial records;

12.11.3.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;

12.11.3.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

12.11.3.6 Any record of a Contractor-paid claim or encounter, or a Contractor-denied claim or encounter.

12.11.4 Upon request, the Contractor, its provider or Subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate HCA or other HCA designees.

12.11.5 HCA will conduct, or contract for the conduct of, periodic audits of the Contractor no less frequently than once every three (3) years of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Contractor.

12.12 Affiliations with Debarred or Suspended Persons

12.12.1 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.12.2 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.12.3 The Contractor shall not knowingly have an employment, consulting, or any other contractual agreement with a person or entity for the provision of items or services that are significant and material to this Contract, when the person or entity has been debarred or suspended from participating in:

12.12.3.1 Procurement activities under the Federal Acquisition Regulation; or

12.12.3.2 Non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.12.4 The Contractor shall agree and certify it does not employ or contract, directly or indirectly, with any person or entity:

12.12.4.1 Debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.12.4.2 Excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

12.12.4.3 Discharged or suspended from doing business with HCA; or

12.12.4.4 Has a direct or indirect contractual relationship with an individual convicted of certain crimes.

12.13 **Transparency**

12.13.1 HCA shall post on its website the following documents and reports:

12.13.1.1 The Contract;

12.13.1.2 The documentation from which HCA certifies that the Contractor has complied with the contract requirements for availability and accessibility of services, including adequacy of the provider network;

12.13.1.3 The name and title of individuals deemed by HCA to be necessary to confirm ownership and control of the Contractor, and subcontractors as governed by the subcontractor section; and

12.13.1.4 The results of any audits, of the accuracy, truthfulness, and

completeness of the encounter and financial data submitted and certified by the Contractor.

12.14 **Liquidated Damages**

12.14.1 HCA may impose liquidated damages on the Contractor in any of the following circumstances:

12.14.1.1 Overpayments identified by HCA in its conduct of program integrity activities that are paid by the Contractor to its providers or subcontractors that were not found in any reports the Contractor provided;

12.14.1.2 If the Contractor fails to recover an Overpayment from a Subcontractor or Provider within the timeline stated in WAC 182-502A-1101;

12.14.1.3 If the Contractor fails to report or inaccurately reports Overpayments identified or recovered in its monthly Program Integrity Report;

12.14.1.4 If the Contractor fails to report or inaccurately reports encounter data; or

12.14.1.5 Any other circumstances specified elsewhere in this Contract.

12.14.2 If HCA determines that liquidated damages will be imposed in accordance with this Section, the Contractor shall be notified in writing, in a Notice of Damages.

12.14.3 HCA may assess liquidated damages against the Contractor regardless of whether the Contractor's failure to meet its obligation is the fault of the Contractor (including the subcontractor, network providers, agents, and/or consultants), provided that neither HCA nor any other state agency materially caused or contributed to the Contractor's failure to meet its obligation.

12.14.4 Nothing in this Section shall be construed to limit HCA's authority to investigate, audit, or otherwise obtain recoveries from a network provider, non-network provider, Contractor, subcontractor, or third party.

12.14.5 The liquidated damages specified in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HCA's projected financial loss and/or damage to the program resulting from the Contractor's nonperformance, including financial loss as a result of audit, investigation or review delays. Accordingly, if the Contractor fails to perform in accordance with this Contract, HCA may assess liquidated damages as provided in this Section.

12.14.6 HCA may assess liquidated damages in an amount equal to or up to five times the amount of the Overpayment.

12.14.7 Nothing in this Section shall be construed to limit HCA's authority to sanction the Contractor, without a cure period, for non-performance of conducting program integrity activities as required in this Contract under applicable law.

13 GRIEVANCE AND APPEAL SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance and Appeal System which complies with the requirements of chapters 182-525A, 182-526, and 284-43 WAC. The Grievance and Appeal System includes a Grievance Process, a single level of appeal, access to the state's administrative hearing process, and access to independent review through the Contractor. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to Enrollees regarding the Grievance and Appeal System.

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

13.1.3 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-4020(2)(h)).

13.1.4 The Contractor shall inform Enrollees about behavioral health advocate services including how to access these services, and provide Enrollees any reasonable assistance necessary in completing forms and other procedural steps for Grievances and Appeals (WAC 284-43-4020(2)(d)). Enrollees may also use the free and confidential regional behavioral health advocate services for assistance with Grievances and Appeals.

13.1.5 The Contractor shall cooperate with any representative authorized in writing by the Enrollee (WAC 284-43-4020(2)(e), and.

13.1.6 The Contractor shall consider all information submitted by the Enrollee or representative (WAC 284-43-4020(2)(f)).

13.1.7 The Contractor shall ensure that decision makers on Grievances and Appeals were not involved in previous levels of review or decision-making, nor were they a subordinate or direct report of any such individual and WAC 284-43-4040(4).

13.1.8 A physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral health Appeal of care based on medical necessity.

13.1.9 Decisions regarding Grievances and Appeals shall be made by individuals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply:

13.1.9.1 If the Enrollee is appealing an Adverse Benefit Determination concerning medical necessity, including any decision to not authorize the service in an amount, duration or scope less than requested.

13.1.9.2 If an Enrollee Grievance concerns a denial of expedited resolution of an Appeal.

13.1.9.3 If the Grievance or Appeal involves any clinical issues.

13.1.10 With respect to any decisions that involve Behavioral Health, the Contractor shall ensure that the individuals making such decisions:

13.1.10.1 Have clinical expertise in treating the Enrollee's condition or disease that is age appropriate when clinically indicated (e.g., a pediatric psychiatrist for a child Enrollee).

13.1.10.2 Are physician board-certified or board-eligible in Psychiatry or Child Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment.

13.1.10.3 Are physician board-certified or board-eligible in Addiction Medicine, a Sub-specialty in Addiction Psychiatry or by ASAM, if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment.

13.1.10.4 Are one (1) or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:

13.1.10.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry or by ASAM;

13.1.10.4.2 Licensed, doctoral level psychologists; or

13.1.10.4.3 Pharmacists.

13.2 **Grievance Process**

The following requirements are specific to the Grievance Process:

13.2.1 An Enrollee or the Enrollee's authorized representative may file a Grievance with the Contractor at any time. Only an Enrollee or the Enrollee's authorized representative may file a Grievance with the Contractor; a Provider may not file a Grievance on behalf of an Enrollee unless the Provider is acting on behalf of the Enrollee and with the Enrollee's written consent.

13.2.2 Enrollee Grievances must be filed with the Contractor, not with HCA. HCA will forward any Grievance received by HCA to the Contractor for resolution.

13.2.3 The Contractor shall accept, document, record, and process Grievances forwarded by HCA or DSHS.

13.2.4 The Contractor shall acknowledge receipt of each Grievance, either orally or in writing, within two (2) Business Days.

13.2.5 The Contractor shall provide a written response to HCA within three (3) Business Days to any constituent grievance, unless HCA requests an expedited response. For the purpose of this subsection, "constituent grievance" means a complaint or request for information from any state or federal elected official or any state or federal agency director or designee.

13.2.6 The Contractor shall investigate and resolve all Grievances whether received orally or in writing. The Contractor shall not require an Enrollee or his/her authorized representative to provide written follow-up for a Grievance the Contractor received orally (WAC 182-525A-800).

13.2.7 The Contractor shall complete the resolution of a Grievance and notice to the

affected parties as expeditiously as the Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if the Enrollee requests the extension. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee's best interest and give the Enrollee prompt oral notice of the delay.

13.2.7.1 If the Contractor extends the timeline for a Grievance not at the request of the Enrollee, it must give the Enrollee written notice, within two (2) calendar days of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

13.2.8 The Contractor must notify Enrollees of the resolution of Grievances within five (5) Business Days of determination. The notification may be orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing, must be easily understood and meet all Enrollee communications requirements in Subsection 3.2.

13.2.9 Enrollees do not have the right to a hearing in regard to the resolution of a Grievance, except to address the Contractor's failure to adhere to the notice and timing requirements for grievances (WAC 182-525A-0800(4)). If the AHEHP fails to adhere to the notice and timing requirements for grievances, the Enrollee is deemed to have completed the AHEHP's appeals process and may initiate an agency administrative hearing.

13.2.10 If the health plan fails to adhere to the notice and timing requirements for Grievances, the enrollee is considered to have completed the health plan's appeals process and may initiate an agency administrative hearing.

13.3 Appeal Process

The following requirements are specific to the Appeal process:

13.3.1 An Enrollee, the Enrollee's authorized representative, or a Provider acting on behalf of the Enrollee and with the Enrollee's written consent, may Appeal a Contractor Adverse Benefit Determination.

13.3.1.1 If a Provider has requested an Appeal on behalf of an Enrollee, but without the Enrollee's written consent, the Contractor shall not dismiss the Appeal without first contacting the Enrollee, informing the Enrollee within five (5) calendar days of receipt of the Provider's request, that an Appeal has been made on the Enrollee's behalf, and then asking if the Enrollee would like to continue the Appeal. The Contractor shall have made at least three (3) attempts to contact the Enrollee on three (3) different Business Days, at three (3) different times during the day, without success, prior to dismissing the provider-initiated appeal request.

13.3.1.2 If the Enrollee wants to continue the Appeal, the AHEHP shall obtain from the Enrollee a written consent for the Appeal. If the Enrollee does not wish to continue the Appeal, the AHEHP shall formally dismiss the Appeal, in writing, with appropriate Enrollee Appeal rights and by delivering a copy of the dismissal to the Provider as well as the Enrollee.

13.3.1.3 For expedited Appeals, the Contractor may bypass the requirement for Enrollee written consent and obtain Enrollee oral consent. The Enrollee's oral consent shall be documented in the Contractor's UMP records.

13.3.2 If HCA receives a request to Appeal an Adverse Benefit Determination of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Enrollee.

13.3.3 The Contractor shall acknowledge in writing the receipt of each Appeal. The Contractor shall provide the written notice to both the Enrollee and requesting Provider within five (5) calendar days of receipt of the Appeal (42 C.F.R. § 438.406(b)(1).

13.3.4 For standard and expedited Appeals of authorization decisions, an Enrollee, or a Provider acting on behalf of the Enrollee, must file an Appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Adverse Benefit Determination.

13.3.5 For Appeals for termination, suspension, or reduction of previously authorized services when the Enrollee requests continuation of such services, an Enrollee must file an Appeal within ten (10) calendar days of the date of the Contractor's mailing of the Notice of Adverse Benefit Determination. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for Appeals of standard resolution apply (WAC 182-525A-0800).

13.3.6 The Enrollee may request an Appeal either orally or in writing.

13.3.6.1 During the Appeal process, the Contractor shall proactively engage the Enrollee offering alternative treatment or pathway of care steps, Care Coordination, or explaining the continuation of benefits to support meeting medically necessary care.

13.3.7 The Appeal process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals in the case of expedited resolution.

13.3.8 The Appeal process shall provide the Enrollee and the Enrollee's representative copies of the Enrollee's case file, including medical records, other documents and records relied on, or generated by the Contractor (or at the direction of the Contractor) in connection with the Appeal of the Adverse Benefit Determination. This information must be provided upon request by either the Enrollee or the Enrollee's representative and free of charge and sufficiently in advance of the resolution timeframe for appeals.

13.3.9 The Appeal process shall include as parties to the Appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate.

13.3.10 In any Appeal of an Adverse Benefit Determination by a Subcontractor, the Contractor or its Subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.11 The Contractor shall resolve each Appeal and provide notice, as expeditiously

as the Enrollee's health condition requires, within the following timeframes:

13.3.11.1 For standard resolution of Appeals and for Appeals for termination, suspension, or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the Appeal, unless the Contractor notifies the Enrollee that an extension is necessary to complete the Appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for Appeal. For any extension not requested by an Enrollee, the Contractor shall resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

13.3.11.2 Standard Appeal timeframes apply to post-service denials.

13.3.11.3 The Enrollee may request an extension in the timeframe for processing an Appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay.

13.3.11.3.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

13.3.12 The Contractor shall provide notice of resolution of the Appeal in a language and format, which may be understood by the Enrollee. The notice of the resolution of the Appeal shall:

13.3.12.1 Be in writing and sent to the Enrollee and the requesting Provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

13.3.12.2 Include the date completed and reasons for the determination in easily understood language.

13.3.12.3 Include a written statement of the clinical rationale for the decision, including how the requesting Provider or Enrollee may obtain the UMP clinical review or decision-making criteria.

13.3.12.4 For Appeals not resolved wholly in favor of the Enrollee:

13.3.12.4.1 Include information on the Enrollee's right to request a hearing and an independent review and how to do so.

13.3.12.4.2 Include information on the Enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.12.4.3 Inform the Enrollee that the Enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending if the hearing decision upholds the Contractor's Adverse Benefit

Determination.

13.4 **Expedited Appeal Process**

13.4.1 The Contractor shall establish and maintain an expedited Appeal review process for Appeals when the Contractor determines or a Provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function.

13.4.2 The Enrollee may file an expedited Appeal either orally or in writing (WAC 182-525A-0800).

13.4.3 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes:

13.4.3.1 For expedited resolution of Appeals, Appeals of concurrent review authorizations, or Appeals of mental health drug authorization decisions, including notice to the affected parties, the Contractor shall make a decision within seventy-two (72) hours after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice of the decision.

13.4.3.2 The Enrollee may request an extension in the timeframe for processing an Appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay. If the Contractor extends the timeline for processing an expedited Appeal not at the request of the Enrollee, it must resolve the Appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

13.4.3.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance if he or she disagrees with that decision.

13.4.4 The Contractor shall ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports an Enrollee's Appeal.

13.4.5 If the Contractor denies a request for expedited resolution of an Appeal, it shall transfer the Appeal to the timeframe for standard resolution and make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial.

13.4.6 The Enrollee has a right to file a Grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor must inform the Enrollee of their right to file a Grievance in the notice of denial.

13.5 **Administrative Hearing**

13.5.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A Provider may not request a hearing on behalf of an Enrollee only with the Enrollee's written consent.

13.5.2 If an Enrollee does not agree with the Contractor's resolution of the Appeal, the

Enrollee may file a request for a hearing within the following time frames (See WAC 182-526-0200):

13.5.2.1 For hearings regarding a standard service, within one hundred twenty (120) calendar days of the date of the notice of the resolution of the Appeal (WAC 182-525A-0800).

13.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the Enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the Appeal. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply.

13.5.3 If the Enrollee requests a hearing, the Contractor shall provide to HCA and the Enrollee, upon request, and within three (3) Business Days, and for expedited Appeals, within one (1) Business Day, all Contractor-held documentation related to the Appeal, including but not limited to, any transcript(s), records, or written decision(s) from Participating Providers or delegated entities.

13.5.4 When medical necessity is an issue, the Contractor's medical director or designee shall review all cases where a hearing is requested and any related Appeals and the outcome of any independent review.

13.5.5 The Enrollee must exhaust Appeal rights prior to filing a request for a hearing with HCA. If the Contractor fails to adhere to the appeal notice and timing requirements, the Enrollee is deemed to have exhausted the Appeal process and may initiate a hearing.

13.5.6 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination of enrollment by the Contractor.

13.5.7 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.8 The hearings process shall include as parties to the hearing, the Contractor, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate and HCA.

13.6 **Independent Review**

13.6.1 After exhausting both the Contractor's Appeal process and the Administrative Hearing, the Enrollee has the right to request an independent review in accordance with RCW 48.43.535 and chapter 182-525A WAC.

13.6.2 The AHEHP will advise HCA Appeals Administrator at P.O. Box 45504, Olympia, WA 98504-5504 when an Enrollee requests an independent review as soon as the AHEHP becomes aware of the request. The AHEHP will forward a copy of the decision made by the Independent Review Organization to the Appeals Administrator as soon as the AHEHP receives the decision.

13.7 **Petition for Review**

13.7.1 Any party may Appeal the initial order from the Administrative Hearing to HCA Board of Appeals in accordance with chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the Administrative Hearing.

13.8 **Continuation of Services**

13.8.1 The Contractor shall continue the Enrollee's services if all of the following apply:

13.8.1.1 An Appeal, hearing, or independent review, is requested on or before the later of the following:

13.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of Adverse Benefit Determination.

13.8.1.1.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.

13.8.1.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

13.8.1.3 The services were ordered by an authorized Provider.

13.8.1.4 The original period covered by the original authorization has not expired.

13.8.1.5 The Enrollee requests an extension of services.

13.8.2 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's services while the Appeal, hearing, or independent review, is pending, the services shall be continued until one of the following occurs (WAC 182-526-0200 and WAC 182-538-110):

13.8.2.1 The Enrollee withdraws the Appeal, hearing, or independent review request.

13.8.2.2 The Enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days after the Contractor mailed the notice of resolution of the Appeal.

13.8.2.3 When the Office of Administrative Hearings issues a decision adverse to the Enrollee.

13.8.3 If the final resolution of the Appeal upholds the Contractor's Adverse Benefit Determination, the Contractor may recover from the Enrollee the amount paid for the services provided to the Enrollee for the first sixty (60) calendar days during which the Appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

13.9 **Effect of Reversed Resolutions of Appeals and Hearings**

13.9.1 If the Contractor, or an independent review (IR) decision by an independent review organization (IRO), or a final order from the Office of Administrative Hearings (OAH) or HCA Board of Appeals (BOA), reverses a decision to deny, limit, or delay services that were not provided while the Appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination.

13.9.2 If the final order of OAH or HCA Board of Appeals, or an IRO reverses a

decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

13.10 Recording and Reporting Adverse Benefit Determinations, Grievances, Appeals, Administrative Hearings, and Independent Reviews

The Contractor shall maintain accurate records of all Adverse Benefit Determinations, Grievances, Appeals, Administrative Hearings, and independent reviews.

13.10.1 The records shall include Adverse Benefit Determinations, Grievances and Appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such Adverse Benefit Determinations, Grievances, Appeals, Administrative Hearings, and independent reviews.

13.10.2 The Contractor shall provide a report of all Adverse Benefit Determinations, Grievances, Appeals, Administrative Hearings, and independent reviews to HCA.

13.10.2.1 The Contractor will separately track, trend and report Behavioral Health Adverse Benefit Determinations, Grievances, Appeals, Administrative Hearings, and independent reviews.

13.10.2.2 The Contractor will separately track, trend and report Grievances, Appeals, Administrative Hearings, and independent reviews for children/youth referred to WISe.

13.10.3 The Contractor is responsible for maintenance of records for and reporting of any Grievance, Adverse Benefit Determinations, and Appeals handled by delegated entities.

13.10.4 Delegated Adverse Benefit Determinations, Grievances, and Appeals are to be integrated into the Contractor's report.

13.10.5 Data shall be reported to HCA on the Grievance, Adverse Benefit Determinations, and Appeals (GAA) report template quarterly on the last Business Day of October, January, April, and July. Reports with missing data in required fields shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.

13.10.6 Reporting of Adverse Benefit Determinations shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to Providers unless the Enrollee is liable for payment in accordance with WAC 182-525-1100 and the provisions of this Contract.

13.10.7 Reporting of Grievances shall include all expressions of Enrollee dissatisfaction not related to an Adverse Benefit Determination. All Grievances are to be recorded and counted whether the Grievance is remedied by the Contractor immediately or through its Grievance and quality of care service procedures.

14 CARE COORDINATION

14.1 Continuity of Care

14.1.1 The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition, including Enrollees receiving WISe services and TAY who have a current care plan, and Enrollees who are being released from correctional facilities. The Contractor shall ensure continued access to services during a transition from one health plan AHEHP to another, in compliance with HCA's Transition of Care Policy. The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are supported with a continuity of care period that is no less than ninety (90) days for all new Enrollees. The Contractor shall honor service authorizations made by other systems such as FFS and peer AHEHPs.

14.1.2 Continuity of Care for opioid coverage, used for the treatment of chronic non-cancer pain or pain related to cancer, hospice, palliative, or end of life care, has specific provisions and has a one-month continuity of care period while the Contractor initiates the authorization process and requests the completed attestation from the provider. The Contractor shall collaborate with peer AHEHPs to promote patient safety when Enrollees transition from one AHEHP or AHEHP to another.

14.1.3 If the Enrollee's prescription expires during the continuity of care period, the Contractor shall facilitate a primary care visit and shall not deny the prescription. For the purposes of this subsection, a prescription expires when all refills are exhausted or one year from the written date for non-controlled substances or six (6) months from the written date for controlled substances.

14.1.3.1 If the Enrollee refuses an evaluation by a participating Provider the Contractor may apply current coverage rules to the pharmacy claim.

14.1.4 When changes occur in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions in this Contract.

14.1.5 The Contractor shall make a good faith effort to preserve Enrollee provider relationships, including relationships through transitions.

14.1.6 Where preservation of provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's physical and behavioral health condition requires.

14.1.7 The Contractor shall allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has a documented established relationship. The Contractor shall take the following steps:

14.1.7.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

14.1.7.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, clinically appropriate transition in care.

14.1.7.3 If the non-participating provider or the Enrollee will not cooperate with a necessary transition, the Contractor may transfer the Enrollee's care to a participating provider within ninety (90) calendar days of the Enrollee's enrollment effective date.

14.1.7.4 The Contractor shall pay the non-participating provider indefinitely if it chooses when the non-participating provider accepts payment rates the Contractor has established.

14.1.7.5 The Contractor shall apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.

14.1.8 Unless required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new Enrollees to fill prescriptions written prior to enrollment until the first of the following occurs:

14.1.8.1 The Enrollee's prescription expires. If the Enrollee's prescription expires before evaluation by a participating provider, the Contractor shall facilitate a primary care visit and shall not deny the prescription. For the purposes of this subsection, a prescription expires when the date by which a prescribed refill for the prescription passes or when the last fill on the prescription has been made by a pharmacy and the Enrollee has used the medications for that fill.

14.1.8.2 A participating provider examines the Enrollee to determine the continued need for the prescription, and if necessary, appropriate changes are made that do not threaten the health of the Enrollee.

14.1.8.2.1 If the Enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the Enrollee's safety and the safety of others is considered in the decision. The Contractor shall document in writing the information and factors it considered in refusing to fill the prescription.

14.1.8.3 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.

14.1.9 The Contractor shall provide for the smooth transition of care for Enrollees who lose eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.

14.1.10 The Contractor shall provide Care Coordination for Enrollees participating in WISe.

14.1.10.1 The Contractor must have policies and procedures consistent with the WISe Manual.

14.1.10.2 The Contractor shall:

14.1.10.2.1 Follow WISe policies and procedures to screen, identify, and engage Enrollees and caretakers who are eligible to receive the services under WISe.

14.1.10.2.2 Participate in the planning and implementation of a standardized screening and assessment process and uniform reporting of service level for Enrollees with intensive behavioral health needs with the Enrollee consent and according to the timelines and guidelines published by HCA to the extent they are not inconsistent with this Contract or federal regulations.

14.1.10.2.3 Report on actions taken in response to WISe Quality Plan reports and associated outcomes.

14.1.10.2.4 Support existing Enrollee relationships with behavioral health providers for specialty care situations including cultural connections even if such providers are not members of the WISe team.

14.1.11 Continuity and Care Coordination for TAY:

14.1.11.1 The Contractor must develop a comprehensive transition plan in collaboration with other systems and providers, including agencies contracted to provide services to Youth that identifies the Enrollee's goals, including but not limited to developmentally appropriate problem-solving conversations. The transition plan must take into account the following:

14.1.11.1.1 Individual behavioral and physical health needs, which may include continued services in the adult behavioral or physical health systems. The transition plan shall address the need for continuity and coordination of services and supports for the Enrollee and the Enrollee's family and identify developmentally and culturally appropriate adult services;

14.1.11.1.2 Connections with supportive housing and supported employment services, post-secondary education, technical training, housing community support, natural supports, and cross-system coordination as needed to attain the Enrollee's goals.

14.1.12 The Contractor must make at least three (3) reasonable attempts on different days and times of day to contact (by phone, email, or other methods) an Enrollee to provide Care Coordination and document these attempts.

14.1.12.1 If the Contractor is unable to reach Enrollee after minimum number of attempts have been made, then Contractor must send an unable to contact letter detailing attempts to contact and reason for the contact.

14.2 **Population Health Management Plan**

The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be submitted

to HCA annually no later than August 1 each year via MC Track. The AHE Addendum to the Apple Health Population Health Management plan shall incorporate or append the Care Management plan, and include at a minimum the following focus areas:

14.2.1 Keeping Enrollees healthy;

14.2.2 Managing Enrollees with emerging risk;

14.2.3 Enrollee safety and outcomes across settings;

14.2.4 Managing multiple chronic conditions;

14.2.5 Managing individuals with multiple service providers (e.g., physical health and behavioral health);

14.2.6 Serving geographically, culturally and linguistically diverse Enrollees, to address special health care needs and promote health equity; and

14.2.7 Ensuring transitional age youth and young adults who are exiting a publicly funded system of care have a plan designed to achieve and maintain safe and stable housing as well as any supportive services in place to support individual needs to align with RCW 43.330.720.

The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and include interventions that meet the requirements of NCQA and the subsections below. The Contractor's Population Health Management plan shall take into account available and needed: (i) data and analytic infrastructure, (ii) HIT and HIE infrastructure and tools, and (iii) other resources needed to support population health management activities.

14.3 **Population Health Management: Identification and Triage**

14.3.1 Initial Health Screen

14.3.1.1 The Contractor shall conduct a brief Initial Health Screen containing tobacco use, behavioral, developmental, physical, oral, and social determinants of health (SDOH) questions within sixty (60) calendar days of enrollment for all new Enrollees, including Family Connects and reconnects, beginning the first of the month after the month of enrollment.

14.3.1.1.1 The Contractor shall use evidence-based screening tools appropriate to the age of the Enrollee, and shall use screening questions selected by HCA in the following SDOH categories:

14.3.1.1.1.1 Housing and housing instability assessment.

14.3.1.1.1.2 Food insecurity; and

14.3.1.1.1.3 Transportation access.

14.3.1.2 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an Enrollee to complete the Initial Health Screen and document these attempts.

14.3.2 Initial Health Assessment (IHA): To assess identified Individuals who need Long Term Supports and Services (LTSS) or those with Special Health Care Needs, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or

Initial Health Screen that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.

14.3.2.1 The assessment shall include, at minimum, an evaluation of the Enrollee's physical, behavioral, and oral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.

14.3.2.2 The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or SUD providers or referral to community- based social services and LTSS.

14.3.2.3 The IHA shall be maintained in the Enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.

14.3.3 The Contractor will use other data sources to identify Enrollees who need care coordination and care management services, including but not limited to:

14.3.3.1 Enrollees that have had contact with crisis services;

14.3.3.2 Review of administrative data sets, such as PRISM;

14.3.3.3 Enrollees with unmet care needs (including Enrollee self-identification of unmet care needs or need for Care Coordination) or evidence of being underserved, including frequent utilization of inpatient or emergency department services;

14.3.3.4 Claims or encounter data;

14.3.3.5 Pharmacy data;

14.3.3.6 Laboratory data;

14.3.3.7 Electronic health records;

14.3.3.8 Data in the CDR; or

14.3.3.9 Results of Contractor-specific algorithms.

14.3.4 The Contractor will risk stratify the population to determine the level of intervention Enrollees require.

14.4 Population Health Management: Interventions

14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care.

14.4.1.1 The Contractor shall make clinical decision support tools available

to providers for use at the point of care that follow evidence based guidelines for:

14.4.1.1.1 Behavioral health conditions.

14.4.1.1.2 Chronic medical conditions.

14.4.1.1.3 Acute conditions.

14.4.1.1.4 Unhealthy behaviors.

14.4.1.1.5 Wellness.

14.4.1.1.6 Overuse/appropriateness issues; and.

14.4.1.1.7 Intellectual or Developmental Disabilities.

14.5 Multi-payer Primary Care Initiative

14.5.1 The Contractor shall actively engage in the Primary Care Initiative (PCI) multi-payer collaborative and will abide by recommendations agreed to by the collaborative unless otherwise directed by HCA.

14.6 Bi-Directional Behavioral and Physical Health Integration

14.6.1 The Contractor shall work in collaboration with peer AHEHPs, HCA and the ACHs in advancing bi-directional clinical integration in outpatient behavioral health (including both mental health and substance use disorders) and primary care practices across Washington State as defined by the Clinical Integration Assessment Workgroup (AHEHP, HCA, ACH collaboration).

14.6.2 The Contractor shall encourage outpatient behavioral health and primary care practices to complete the Washington Integrated Care Assessment (WA-ICA) as defined by the Clinical Integration Assessment Workgroup.

14.6.3 The Contractor shall encourage outpatient behavioral health and primary care practices to complete the WA-ICA in July of each year, consistent with the implementation schedule defined by the Clinical Integration Assessment Workgroup.

14.6.4 The Contractor shall support outpatient behavioral health and primary care practices to improve their level of clinical integration consistent with recommendations advanced by the Clinical Integration Assessment Workgroup.

14.7 Care Coordination Services (CCS) General Requirements

The Contractor shall implement the following activities:

14.7.1 The Contractor shall offer Wellness and Prevention services to all Enrollees according to the benefits outlined in this Contract.

14.7.1.1 Refer individuals identified in the Initial Health Screen as having a need for Care Coordination services to the Enrollee's PCP, Mental Health Professional or SUD provider or to DSHS/Home and Community Services (HCS) for follow-up care and needed services within thirty (30) calendar days of screening and identification.

14.7.1.2 Ensure the PCP has assessed and/or examined the Enrollee according to wellness assessment requirements and appointment scheduling standards.

14.7.1.3 Ensure the Enrollee has received appropriate follow-up health care

services, including preventive care, care for Chronic Conditions, and referrals to LTSS, social services and community-based organizations.

14.7.2 Care Coordination services are provided by the Contractor, clinic-based Care Coordinator staff, community-based organizations, or IHCPs, and delivered to Enrollees who have short-term, or intermittent needs for coordination of care, such as those identified as Enrollees with Emerging Risk. Care Coordination services may be provided by non-licensed staff and include but are not limited to:

14.7.2.1 Coordinating authorization of services such as Contractor timely approval of Medical Equipment, pharmacy, and medical supplies;

14.7.2.2 Ensuring access to medically necessary behavioral health, or physical health services and coordination with entities that provide mental health, SUD services, and oral health services; or

14.7.2.3 Ensuring access to community-based services, such as home care or long-term services and supports.

14.7.3 The Care Coordinator and affiliated staff shall work with Enrollees to promote the following:

14.7.3.1 Improved clinical outcomes;

14.7.3.2 Enrollee participation in care;

14.7.3.3 Continuity of Care;

14.7.3.4 Increased self-management skills;

14.7.3.5 Improved adherence to prescribed treatment; and

14.7.3.6 Improved access to care or to services that address social needs.

14.7.4 The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices.

14.7.5 The Care Coordinator shall deliver services in a culturally appropriate manner that addresses health disparities by interacting directly and in-person with the Enrollee and his or her family in the Enrollee's primary language, with appropriate consideration of literacy and cultural preference.

14.7.6 The Care Coordinator is responsible for:

14.7.6.1 Conducting Initial Health Screen or collecting Initial Health Screen data from providers, to assess Enrollees for unmet health care or social service needs;

14.7.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action;

14.7.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs;

14.7.6.4 Ensuring referrals are made and services are delivered, including any follow-up action, especially after ED visit or hospitalization for behavioral health conditions;

14.7.6.5 Ensuring the deployment of standardized screening tools outlined in this Contract; and

14.7.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing formal agreements with BH-ASOs to ensure an Enrollee is followed up with within seven (7) calendar days of when the Enrollee has received crisis services.

14.7.7 The Contractor shall develop policies and procedures for Care Coordination services that include:

14.7.7.1 Identification of gaps in care through Initial Health Screen or analysis of claims and encounter data for Enrollee patterns of under- or overutilization.

14.7.7.2 Referral of Enrollees identified through self-referral or the Initial Health Screen as having a gap in behavioral, developmental, physical or oral health services to the Enrollee's PCP and as appropriate, to a Mental Health Professional or SUD provider for services and follow-up care within thirty (30) calendar days of screening and identification.

14.7.7.3 Communication with the PCP and other providers regarding:

14.7.7.3.1 The Contractor's medical necessity decisions to authorize care and services.

14.7.7.3.2 Shared care plans and transitional services between the Care Coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service providers, and the PCP.

14.7.7.3.3 Enrollee over-use of emergency department, preventable hospitalizations and re-hospitalizations, crisis service, and opioid use.

14.7.8 If an Enrollee changes enrollment to another AHEHP or AH AHEHP, the Contractor shall coordinate transition of the Enrollee to the new plan's Care Coordination system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure Enrollee confidentiality and Enrollee rights are protected (

14.7.9 Care Coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.

14.7.10 The Contractor shall provide a toll-free line for PCPs and specialists who seek technical and referral assistance when any condition, including behavioral health conditions, requires treatment or developmental delays are suspected or identified.

14.7.10.1 Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals and referrals to LTSS when appropriate. Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to providers.

14.7.11 The Contractor shall implement policies and procedures to ensure the completion of Advance Directives (physical health and mental health).

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

14.7.13 The Contractor shall support practice change activities including the deployment of evidence-based and Promising Practices, preventive screening of Enrollees and models of service delivery that optimize health care service delivery, Enrollee social support and coordinated health care and social services. The Contractor may also support practices that are focused on groups for whom evidence-based or research-based criteria has not yet been developed.

14.7.14 The Contractor shall participate in a workgroup with HCA to explore the extent to which health IT infrastructure can be developed and used to support the tasks described above. The workgroup shall gather information on the technology currently used, and whether it supports interoperable information exchange and re-use. The workgroup shall gather information on other methods used by care coordination services, and the barriers to using interoperable health IT.

14.7.15 The Contractor will provide Care Coordination to Enrollees who are named on the HCA Referral List, also known as the "high utilizer list," in the Trueblood, et al., v. Department of Social and Health Services Settlement Agreement. HCA will provide the HCA Referral List to the Contractor monthly. The Contractor will support connecting Enrollees with behavioral health needs and current or prior criminal justice involvement to receive Care Coordination. The Contractor will report semi-annually, using the Semi-Annual Trueblood Misdemeanor Diversion Fund report template. Reports must be submitted to HCA through MC-Track by January 31, for the reporting period of July through December of the previous year, and by July 31, for the reporting period of January through June of the current year.

14.8 Care Management Services

The Contractor shall implement activities for Enrollees identified as requiring Complex Case Management (CCM), or those with multiple chronic conditions.

14.8.1 Support of a person-centered approach to care in which Enrollee's needs, strengths, and preferences play a central role in the development and implementation of the care plan by:

14.8.1.1 Ensuring the clinical appropriateness of care;

14.8.1.2 Addressing gaps in care, including appropriate use of Evidence- or Research-Based Practices, trauma-informed approaches, promising practices, and culturally appropriate care;

14.8.1.3 Promoting recovery using Certified Peer Counselors, Community Health Workers and community and natural supports;

14.8.1.4 Requesting modifications to treatment plans to address unmet service needs that limit progress;

14.8.1.5 Assisting Enrollees in relapse/crisis prevention planning that goes beyond crisis intervention and includes development and incorporation of recovery action plans and Advance Directives for individuals with a history of frequent mental health readmissions or crisis system utilization; and

14.8.1.6 Assuring coordination of assessments and evaluations with mental health, SUD and other providers.

14.8.1.7 Supporting to the maximum extent possible, the development and implementation of, and updates to interoperable electronic care plans, to include at a minimum information in subsections 14.8.3.1 through 14.8.3.3. The Contractor shall participate in a workgroup with HCA to assess the utilization of interoperable care plans and barriers to using electronic care plans.

14.8.2 Individuals identified by the Contractor as requiring CCM shall receive services in accordance with NCQA Standards and interventions as described elsewhere in Section 14.

14.8.3 Complete or verify the PCP completion of an Enrollee care plan. The care plan shall be developed in partnership with the Enrollee and in consultation with specialists and social service providers serving the Enrollee, updated at minimum annually and maintained in the Enrollee's health record). The care plan shall include all of the following:

14.8.3.1 Presenting diagnosis(es) and health problems;

14.8.3.2 An action plan, including agreed-upon health goals;

14.8.3.3 Documentation of behavioral health, social service, and community resource interventions that promote child development, healthy behaviors, and early referral and treatment for mental health and SUD conditions, including recovery-based programs; and

14.8.3.4 Documentation of Advance Directives (physical health and mental health).

14.8.4 For Enrollees with Special Health Care Needs, the Contractor will develop the Enrollee's care plan in accordance with the requirements described throughout Section 14 and will ensure the plan is reviewed and revised upon reassessment, at least every twelve (12) months or when the Enrollee's circumstances or needs change, or when the Enrollee requests an update.

14.8.4.1 For Enrollees determined to have LTSS needs, the Contractor shall coordinate with staff of Home and Community Services (HCS) to ensure the Enrollee has access to and appropriate evaluation and LTSS services.

14.9 Data Exchange Protocols

14.9.1 The Contractor shall develop data exchange protocols, including consent to

release before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including sharing of claims and pharmacy data, treatment plans or care plans, crisis plans, critical incidents and Advance Directives necessary to coordinate service delivery, and care management for each Enrollee in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

14.10 **Allied System Coordination**

14.10.1 Allied System Coordination Plan: For each RSA in which the Contractor participates, the Contractor shall develop a written Allied Systems Coordination Plan that describes how the Contractor will coordinate and collaborate with healthcare and other allied systems that serve Contractor Enrollees. The Contractor shall collaborate with ACH representatives and representatives of the entities listed in Subsection 14.12 to develop and update this plan as needed. The plan must describe how the Contractor will address the elements below and how the Contractor will interact with any Allied System that chooses not to participate in the jointly developed coordination plan and include the following elements:

14.10.1.1 Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system.

14.10.1.1.1 For individuals with behavioral health needs, who have current or prior criminal justice involvement, this includes processes for improving access to timely and appropriate treatment.

14.10.1.2 Identification of needed local resources, including initiatives to address those needs.

14.10.1.3 A process for facilitation of community reintegration from out-of-home placements (e.g., Facilities that provide care for individuals with 90 and 180-day civil commitments, Juvenile Rehabilitation facilities, foster care, nursing facilities, and acute inpatient settings) for Enrollees of all ages.

14.10.1.4 A process for working with ACH, the BH-ASO managing crisis services, and first responders, evaluate the need to develop procedures to engage and collaborate with first responders that address:

14.10.1.4.1 Education about Behavioral Health resources and crisis intervention to de-escalate volatile situations and prevent the use of lethal force.

14.10.1.4.2 Strengthening relationships between first responders and Behavioral Health providers to improve access to timely crisis response services or to improve engagement in Behavioral Health treatment.

14.10.1.4.3 Ensuring support to PCPs, emergency department, and local emergency management (fire, police) when Behavioral Health emergencies and urgent problems are encountered.

14.10.1.4.4 Jail diversion response for TAY and adults with

Serious and Persistent Mental Illness (SMI) or Co-Occurring Disorders (COD).

14.10.1.4.5 Transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

14.10.1.4.6 Prevention and treatment of overdose.

14.10.1.5 Facilitating linkages with social services and criminal justice/courts and providers under contract with the county or state.

14.10.1.6 A procedure for Contractor representatives attending relevant stakeholder, planning, and advocacy meetings and communicating/coordinating with other entities to ensure the Contractor is aligned with state and local Behavioral Health initiatives, including the Protocols for Coordination with Tribes and non-Tribal IHCPs once completed by the HCA.

14.10.2 The Contractor's Allied Coordination Plan shall include the following:

14.10.2.1 Processes for the sharing of information related to eligibility, access and authorization;

14.10.2.2 A process for sharing system issues;

14.10.2.3 Procedures to identify and address joint training needs; and

14.10.2.4 A process or format to address disputes related to service or payment responsibility, including attribution for hospital-related claims.

14.11 Health Information Technology (HIT) Tools for Integrated Care

14.11.1 The Contractor shall support the use by contracted providers, of Health Information Technology (HIT)/Health Information exchange (HIE) tools and services such as:

14.11.1.1 Certified EHR Technology (CEHRT);

14.11.1.2 Emergency Department Information Exchange (EDIE);

14.11.1.3 PreManage tools (including use by behavioral health providers);

14.11.1.4 Services offered by OneHealthPort (OHP), (such as the Clinical Data Repository); and

14.11.1.5 Other HIT/HIE tools and services to support the integration, coordination and continuity of care.

14.11.2 The Contractor shall consider how HIT/HIE can be used to support data exchange protocols and tools to support provider integration of behavioral health and medical services, transitional services, care coordination oversight and transitional planning for incarcerated individuals, and coordinate with the state to advance the use of statewide HIT/HIE tools/services and engage in the

implementation of the HIT Operational Plan.

14.11.3 The Contractor shall develop policies and procedures for Care Coordination and Care Management Services that encourage and support the use of HIT and HIE technologies (Certified EHRs, existing statewide HIE and HIT, and other technology solutions) to coordinate care across the care continuum, including physical health, behavioral health, social service, and other community-based organizations.

14.12 **Coordination Between the Contractor and External Entities**

14.12.1 The Contractor shall coordinate with, and refer Enrollees to, health care and social services/programs, including, but not limited to:

14.12.1.1 The Department of Social and Health Services:

14.12.1.1.1 Aging and Long-Term Support Administration (ALTSA) Home and Community Services including contracted Area Agencies on Aging;

14.12.1.1.2 Skilled nursing facilities and community-based residential programs;

14.12.1.1.3 Behavioral Health Administration; and

14.12.1.1.4 Developmental Disabilities Administration; and

14.12.1.1.5 Division of Vocational Rehabilitation.

14.12.1.2 Ombuds services;

14.12.1.3 Oral Health services, including the promotion of oral health screening and prevention;

14.12.1.4 Department of Health (DOH) and Local Health Jurisdiction (LHJ) services;

14.12.1.5 Department of Children, Youth and Families: Juvenile Rehabilitation, Early childhood and family support services including home visiting, ESIT, ECLIPSE, ECEAP/Head Start;

14.12.1.6 Department of Corrections;

14.12.1.7 Criminal Justice Systems (courts, jails, law enforcement, public defenders,);

14.12.1.8 State Hospitals;

14.12.1.9 Community hospitals/evaluation and treatment Facilities that provide care for individuals with 90 and 180-day civil commitments.

14.12.1.10 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and AHEHPs;

14.12.1.11 Educational Service Districts (ESDs);

14.12.1.12 Support Services for families and family/kinship caregivers;

14.12.1.13 HCA First Steps Program - Maternity Support Services (MSS);

14.12.1.14 Supported Housing and Employment programs;

14.12.1.15 State and/or federal agencies and local partners that manage access to housing;

14.12.1.16 Tribal entities and IHCPs;

14.12.1.17 Non-Emergency Medical Transportation brokers;

14.12.1.18 Interpreter Services;

14.12.1.19 Women, Infants, and Children (WIC) providers and programs;

14.12.1.19.1 The Contractor shall provide Care Coordination and referral for all WIC eligible Enrollees. The Contractor shall submit the WIC Eligible Referral report by the 10th Business Day of the month for the prior month's reporting period via MC-Track using the HCA provided template.

14.12.1.20 BH-ASOs outside of the RSA regarding state only, federal block grant, Ombuds, crisis services, and any other areas where information sharing would improve the services of either system; and

14.12.1.21 Any Re-entry Community Services Program (RCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.

14.12.2 The Contractor shall participate with, cooperate with, and coordinate with regional health alliances, such as the Southwest Washington Regional Health Alliance, Eastern Washington Regional Health Alliance, and CHOICE Regional Health Network.

14.12.3 The Contractor shall participate in the management or discussions held at the Bree Collaborative, or with the Foundation for Health Care Quality in their work on COAP, OB COAP, and SCOAP programs as well as coordinate with other organizations engaged in quality improvement in Washington State.

14.12.4 The Contractor shall participate in multi-payer and data-sharing initiatives as requested by HCA.

14.12.5 The Contractor will coordinate with HCA dental program to reduce emergency room visits for oral health services and ensure Enrollees with urgent or emergent oral health care needs are referred to a FFS dentist.

14.12.6 The Contractor shall join and pay a fee to be a member of the Washington Health Alliance (WHA) no later than February 15 of each calendar year.

14.12.6.1 The Contractor shall actively cooperate and participate with the WHA in efforts to improve the quality and efficiency of health care services.

14.12.6.2 The Contractor shall submit data to the WHA for the purpose of

producing results for the Community Checkup, the Washington State Common Measure Set on Health Care Quality and Cost, and all other health care measurement and reporting completed by WHA, according to the terms and schedule defined by the WHA.

14.12.6.2.1 As part of routine data submissions provided to the WHA as required under this subsection, the Contractor must include claim-line level financial information (e.g. Billed, Allowed, and Paid dollar amounts) as defined by the WHA.

14.12.7 The Contractor shall coordinate Enrollee information, including initial assessments, relevant reviews, and care plans, with other managed care entities as needed when an Enrollee changes from one AHEHP to another to reduce duplication of services and unnecessary delays in service provision for Enrollees.

14.12.8 For Enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC Enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the Enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.

14.12.9 The Contractor shall participate in the local Accountable Communities of Health (ACH) in each Regional Service Areas in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies, but must participate as follows:

14.12.9.1 Serve in a leadership or other supportive capacity;

14.12.9.2 Participate in the design and implementation of transformation projects;

14.12.9.3 Collaborate with provider networks to implement Value Based Purchasing Models; and

14.12.9.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

14.12.10 The Contractor shall have a dedicated phone line for use by Enrollees and providers seeking ABA services. This phone line shall be monitored and messages responded to within one (1) Business Day to ensure direct access to care coordination staff who can assist with connecting Enrollees to necessary ABA services.

14.13 Transitional Services

14.13.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another or one level of care to another.

14.13.2 The Contractor shall work with appropriate staff at any hospital, including HCA contracted long-term civil commitment facilities, to implement a safe, comprehensive discharge plan that assures continued access to medically

necessary covered services which will support the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Contractor's contracted state and community physical and Behavioral Health hospitals, residential treatment facilities and long-term care facilities, to ensure timely Enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

14.13.2.1 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

14.13.2.1.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal caregivers shall be included in this process when requested by the Enrollee;

14.13.2.1.2 A written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers;

14.13.2.1.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care;

14.13.2.1.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services;

14.13.2.1.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) Business Days following Enrollee discharge;

14.13.2.1.6 Information on what to do if a problem arises following discharge;

14.13.2.1.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition;

14.13.2.1.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals;

14.13.2.1.9 Scheduled outpatient Behavioral Health and/or

primary care visits within seven (7) calendar days of discharge;

14.13.2.1.10 Follow-up to ensure the Enrollee saw his/her provider; and

14.13.2.1.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.

14.13.2.2 When appropriate, the Contractor will obtain the Enrollee's permission to share information with clinical and non-clinical providers to facilitate care transitions.

14.13.2.3 The Contractor, in collaboration with all hospitals including state hospitals, HCA's contracted long-term civil commitment facilities, and other facilities that provide care for individuals with 90 and 180-day civil commitments, shall develop discharge planning policies and procedures to support successful placement back into the community.

14.13.2.3.1 The Contractor shall process hospital prior authorization requests for all clinic services required by the Enrollee within two (2) Business Days. Such services shall include authorizations for any therapies, home care services, equipment or pharmaceuticals.

14.13.2.3.2 The Contractor shall educate state hospitals, other facilities providing care for individuals with 90 and 180-day civil commitments, and discharge planning staff on clinical services requiring pre-authorization to facilitate timely discharge from these settings.

14.13.2.3.3 The Contractor shall not delay discharge from a hospital because of Contractor authorization procedures that unnecessarily delay such discharges. The Contractor shall utilize procedures, such as the 'honor authorization', to promote timely discharge and prevent unnecessary delays.

14.13.2.3.4 The Contractor must accept the 'honor authorization' for SUD residential admission when services are authorized by the Enrollee's previous AHEHP, in cases where an incarcerated Enrollee is authorized by one AHEHP but changes to another AHEHP upon release. This includes, but is not limited to:

14.13.2.3.4.1 Enrollee selects a different AHEHP upon release than they were enrolled in at incarceration;

14.13.2.3.4.2 The AHEHP that the Enrollee was enrolled in at incarceration is no longer being offered in the service area that the Enrollee was released in; or

14.13.2.3.4.3 The Enrollee becomes associated with a household that has selected a

different AHEHP than the Enrollee had prior to incarceration.

14.13.2.4 The Contractor shall prioritize Care Coordination and discharge planning for Enrollees who have been involuntarily detained, are in acute care settings, and are likely to experience significant challenges for a civil bed transfer or discharge. The Contractor shall:

14.13.2.4.1 Support discharge planning efforts with timely, streamlined communication across Enrollee's care teams to include case conferencing as needed to facilitate improved outcomes;

14.13.2.4.2 Explore viable options to create clinically appropriate discharge plans in tandem with the treating provider/entities and other agency supports;

14.13.2.4.3 Include Medical Director(s) early in discharge planning when medical or behavioral conditions present barriers to discharge, or when appropriate; and

14.13.2.4.4 Participate in case reviews with HCA, as requested.

14.13.2.5 Uniform Discharge Tool and Aggregate Reporting

14.13.2.5.1 The Contractor shall complete the Uniform Discharge Tool, within seven (7) calendar days of discharge, for every Enrollee discharging from Western or Eastern State Hospital, or from a community hospital or evaluation and treatment 90/180 civil commitment facility, to ensure all components of a successful discharge are utilized.

14.13.2.5.1.1 HCA may request a copy of the Uniform Discharge Tool for an Enrollee, and the Contractor must provide the completed tool within one Business Day of the request.

14.13.2.5.2 On a semi-annual basis, the Contractor must compile and submit through MC-Track a summary of aggregate scores derived from the Uniform Discharge Tools using the Uniform Aggregate Scoring Tool template in MC-Track. The report is due on July 15 for the reporting period of January 1 through June 30 and January 15 for the reporting period of July 1 through December 31. The report template has tabs for State Hospitals and Community-Based 90/180 civil beds.

14.13.3 Care coordination and transitions between levels of care – Inpatient Treatment Agencies.

14.13.3.1 The Contractor must require that behavioral health treatment agencies develop policies and procedures that enhance care coordination, including transitions between all levels of care.

14.13.3.2 The Contractor must work with behavioral health treatment agencies to ensure there is adequate coordination for Enrollees transitioning between various levels of treatment services to ensure continuity of care, including in accordance with RCW 71.24.618, when applicable. As used in this section, “continuity of care” means the situation under which an Enrollee who is receiving services from an individual provider is entitled to receive timely and applicable follow-up services from ancillary referral agencies with the goal of providing immediate follow-up to address the holistic needs of the Enrollee. This will include, at a minimum, the following:

14.13.3.2.1 The Contractor must work with the Subcontractor to ensure that discharge plans and facilitation to post-discharge services are documented in the Enrollee’s electronic health record. The following must occur when the Enrollee is discharged or transitioned to a lower or higher level of care:

14.13.3.2.1.1 Appropriate referrals are made to a behavioral health provider and coordination with the Enrollee’s AHEHP.

14.13.3.2.1.2 Follow up appointments must be scheduled to occur within seven calendar days of Enrollee discharge and documented as such in the Enrollee’s electronic health record. Documentation must include:

14.13.3.2.1.2.1 Release of Information between behavioral health treatment agencies for the Enrollee; date and time of appointment; any current medications; and

14.13.3.2.1.2.2 If applicable, sufficient supply and compliance plan for prescribed medications is documented as part of the discharge process.

14.13.3.2.2 Enrollee’s counselor or a designated outreach coordinator at the facility, will follow up via telephone, text message, or email with the Enrollee within 72

hours post-discharge.

14.13.3.3 The Contractor must ensure continuity of MAT services for an Enrollee who transfers out of their region if that Enrollee was inducted or continued on FDA approved medications for all substance use disorders during the course of their treatment. For those receiving FDA approved medications for substance use disorder, the following must occur:

14.13.3.3.1 The Contractor must ensure an intake appointment takes place within seven (7) calendar days of discharge from previous treatment facility.

14.13.3.3.2 Upon Enrollee discharge, the subcontractor must ensure medication management to include sufficient medication until the Enrollee's scheduled appointment with community provider or behavioral health treatment agency.

14.13.3.3.3 The Contractor must have enough subcontractors that provide MAT services to allow for potential referrals from Enrollees who transfer from other regions.

14.13.4 Transition from Inpatient SUD Behavioral Health Agency. The Contractor must coordinate with Subcontractors who provide inpatient treatment to ensure referrals of Enrollees to outpatient services post-discharge from their facility. This includes the following:

14.13.4.1 Inpatient Treatment Provider must have Policies in place for prompt exchange of Enrollee information between behavioral health treatment agencies to facilitate continuity of care.

14.13.4.2 Warm Hand-off: When an Enrollee completes or is discharged from an Inpatient Behavioral Health Agency, the subcontracting agency will have policies and practices in place to:

14.13.4.2.1 Provide scheduled immediate appointments with community health care providers, to include, but not be limited to the following:

14.13.4.2.1.1 Intensive Outpatient/Outpatient Services. Documentation of and appointment referral for next level of treatment upon completion of residential services.

14.13.4.2.1.2 MAT. If the Enrollee was inducted or continued on FDA approved medications for SUD during their stay in an Inpatient Behavioral Health facility, the agency will coordinate a same day appointment with an outpatient provider to coincide with the individual's discharge date.

14.13.4.2.1.3 Peer Support and Recovery Based Services. The Inpatient Behavioral Health facility will document and provide the Enrollee with addresses and phone numbers at discharge for community based Peer Support and Recovery Support resources.

14.13.4.2.1.4 Housing. Enrollee's housing status must be verified through the Enrollee or authorized representative and documented within the electronic health record system. When necessary, the Behavioral Health facility will refer Enrollee to housing and community support services; documentation of any referrals must be placed in the electronic health record. When the Enrollee is prescribed FDA approved medications for SUD, the provider must document efforts to obtain housing to fit the individual's needs.

14.13.4.2.1.5 Transportation- Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing.

14.13.4.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community.

14.13.4.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.3.3.2 and 14.13.5 of this Contract.

14.13.5 The Contractor shall use the following criteria and sources to identify Enrollees, at acute care hospitals, with complex discharge needs who are facing barriers to discharge. Acute care hospital means a licensed facility in which an Enrollee can receive emergency care, observation level of care, and inpatient services.

14.13.5.1 Enrollees with denied continued stay due to no longer meeting medical necessity, if:

14.13.5.1.1 Enrollee does not have a discharge plan in place;

14.13.5.1.2 Enrollee is facing barriers to discharge;

14.13.5.1.3 Enrollee receiving administrative days;

14.13.5.1.4 Referrals escalated through HCA for discharge planning and Care Coordination support;

14.13.5.1.5 Enrollee is on observation status greater than 72 hours;

14.13.5.1.6 Enrollee is participating in the complex discharge pilot

program; or

14.13.5.1.7 Enrollee does not meet the criteria outlined above, and if the Contractor believes that the Enrollee would benefit from being added to the Complex Discharge report, the Contractor may use their own judgment to add these Enrollees to the report.

14.13.5.2 The Contractor shall provide timely and appropriate Care Coordination and discharge planning support, which meet contractual expectations, for these Enrollees until they are discharged from the acute care hospital setting to a lower level of care. This includes collaboration with hospitals and other care team members to address barriers to discharge.

14.13.5.3 The Contractor shall add these Enrollees to a Complex Discharge report. Enrollees will remain on the report until they are discharged from the acute care setting. The Contractor shall update these reports on a weekly basis and email completed reports to HCA's Complex Discharge mailbox at HCAComplexDischarge@hca.wa.gov by close of business every Tuesday. If HCA has follow-up questions on Enrollees, the Contractor must respond in a timely manner.

14.14 Skilled Nursing Facility Coordination

14.14.1 Skilled Nursing Care is care provided by trained individuals (RN, PT, OT, ST, or RT) that typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (for example, rehab) or due to chronic medical conditions or disabilities. Skilled care is:

14.14.1.1 Rehabilitative: Care provided for or post an acute illness or injury with the intent of restoring or improving skills and/or function that was lost or impaired; or

14.14.1.2 Skilled Medical: Care provided daily and including, but not limited to, IV therapy, IM injections, indwelling and suprapubic catheters, tube feeding, TPN, respiratory therapy, or wound care.

14.14.2 The Contractor is responsible for medically necessary Skilled Nursing care in a SNF or NF when the Contractor determines Nursing Facility care is more appropriate than acute hospital care. The Contractor shall coordinate with the hospital or other acute care facility discharge planners and nursing facility Care Managers or social workers, as described in the Coordination between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the Enrollee to or from a SNF or NF.

14.14.3 The Contractor shall coordinate with the SNF or NF to provide Care Coordination and transitional care services and shall ensure coverage of all Medically Necessary Services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, Medical Equipment, therapies, intravenous medications, and any other medically necessary service or product.

14.14.3.1 If the Contractor, in coordination with the NF or SNF, anticipates the

Enrollee will be in the Facility for additional days after an Enrollee no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Contractor shall coordinate with the DSHS/ALTSA/HCS to:

14.14.3.1.1 Determine functional, financial, and institutional eligibility, if necessary; and

14.14.3.1.2 Assist the Enrollee to explore all options available for care, including whether the Enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for Long-Term Services and Supports (LTSS).

14.14.3.2 If the Enrollee is discharged home or a community residential setting, the Contractor shall coordinate with SNF/NF and HCS staff to ensure the Enrollee is discharged to a safe location and shall ensure Medically Necessary Services are available to the Enrollee including, but not limited to, home health services, Medical Equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the Enrollee's recovery. The Contractor shall also ensure follow-up care is provided consistent with the Transitional Care Coordination requirements of this Contract.

14.14.4 If the Enrollee remains in the SNF/NF, the Enrollee remains enrolled in AH-IMC and ALTSA is responsible for payment of SNF/NF room and board beginning on the date it is determined the Enrollee does not meet or no longer meets criteria for the rehabilitative or skilled benefit. The Contractor continues to be responsible for all Medically Necessary Services, prescriptions, and equipment not included in the ALTSA NF rate. The Contractor shall continue to monitor the Enrollee's status and assist in coordination of transitions back to the community.

14.14.5 Issuance of an award letter by ALTSA does not constitute a guarantee or promise of payment for nursing home care.

14.14.6 The Contractor must provide written notice to the Facility, including dates of service and the date coverage will end, if the Enrollee:

14.14.6.1 Is admitted under the rehabilitative or skilled benefit;

14.14.6.2 Does not meet rehabilitative or skilled nursing criteria; or

14.14.6.3 If a previously authorized stay is being reduced.

14.14.7 For purposes of this Section, "nursing facility level of care" means ongoing support services provided in a SNF/NF for Enrollees who do not meet the criteria for rehabilitative or skilled nursing services.

14.15 Care Coordination Oversight

14.15.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Care Coordination and ICM requirements and the quality and appropriateness of care furnished to Individuals with Special Health Care Needs

14.15.1.1 The Contractor shall have policies and procedures to route and

effectively address Care Coordination needs. Internal policies must include:

14.15.1.1.1 Criteria for when escalation is required;

14.15.1.1.2 Who is to be informed of the escalation;

14.15.1.1.3 Processes for escalation to external agencies and other departments within the Contractor's organization including utilization management (UM), leadership, medical director, and BH medical director; and

14.15.1.1.4 Actions to be taken in response to the escalation to ensure timely resolution.

14.15.2 Quality assurance reviews of documented Care Coordination and ICM activities shall include:

14.15.2.1 Case identification and assessment according to established risk stratification system;

14.15.2.2 Documented treatment plans and care plans with evidence of periodic revision as appropriate to the Enrollee emerging needs;

14.15.2.3 Effective Enrollee monitoring, including management of barriers;

14.15.2.4 Referral management;

14.15.2.5 Effective coordination of care, including coordination of services that the Enrollee receives through the FFS or AHEHP system; and

14.15.2.6 Identification of appropriate actions for the Care Coordinator to take in support of the Enrollee, and the Care Coordinator's follow-through in performing the identified tasks.

14.15.3 The Contractor shall have on-going training and development of resources that address specific cultural and ethnic needs to the Apple Health Expansion population. This includes:

14.15.3.1 Community based resources awareness and referral processes;

14.15.3.2 Performance development plans for supervision focusing on cultural awareness and humility. At a minimum, the performance development plans should address:

14.15.3.2.1 Developing of the supervisee's knowledge of cultural norms of behavior for individual clients, addressing how the supervisor's and supervisee's own cultures and privileges impact service delivery;

14.15.3.2.2 Developing the supervisee's ability to assess their own cultural competence and identifying when consultation or referral to another provider is needed;

14.15.3.2.3 Emphasizing the supervisee's commitment to maintaining cultural competence as an ongoing

process; and

14.15.3.2.4 Monitoring, evaluating, and documenting the supervisee's performance of assessment, treatment planning, and service delivery

14.15.4 The Contractor shall conduct quality assurance reviews, at a minimum, on a quarterly basis.

14.16 Direct Access to Specialists for Individuals with Special Health Care Needs

When the required treatment plan of Individuals with Special Health Care Needs, indicates the need for frequent utilization of a course of treatment with or regular monitoring by a specialist, the Contractor shall allow these Individuals to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care.

14.17 Transitional Planning for Incarcerated Enrollees

For the purposes of this subsection, “correctional facility” includes city and county jails, Department of Corrections (DOC) facilities, Youth correctional facilities, and Juvenile Rehabilitation facilities.

14.17.1 The Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee’s release, including honoring another AHEHPs prior authorization for admission to SUD residential facility.

14.17.2 The Contractor shall:

14.17.2.1 Provide transitional Care Coordination services to Enrollees when they enter a correctional facility, including:

14.17.2.1.1 Working with the facility to define the responsible party at the facility who will provide Care Coordination activities in the facility;

14.17.2.1.2 Ensuring the facility is aware of the Enrollee’s special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions, and is aware of medications and supplies the Enrollee needs; and

14.17.2.1.3 Providing information to enable the facility to maintain the Enrollee’s medication regimen while the Enrollee is incarcerated.

14.17.2.2 Provide services and Care Coordination for Enrollees upon release from a correctional facility, or other facilities that provide care for individuals with 90 and 180-day civil commitments, including:

14.17.2.2.1 Coordinating with the facility to get copies of the Enrollee’s medical records at the time of discharge;

14.17.2.2.2 Requesting the Enrollee sign a Release of Information to allow exchange of health care

information between systems;

14.17.2.2.3 Using an evidence based approach to care coordination as the Enrollee transitions from incarceration to the community;

14.17.2.2.4 Ensuring expedited prior authorization for medications or supplies prescribed while the Enrollee was incarcerated, and for admissions to SUD residential treatment facilities when previously authorized by another AHEHP during the client's incarceration period;

14.17.2.2.5 Prioritize Care Coordination for Enrollees with special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions;

14.17.2.2.6 Providing the Enrollee with an overview of benefits for which the Enrollee is eligible through the Contractor;

14.17.2.2.7 Discuss with the Enrollee how to access a PCP, notify the Enrollee who their PCP is or help the Enrollee to find a PCP; and

14.17.2.2.8 Assist the Enrollee to access the following services:

14.17.2.2.8.1 Transportation to healthcare appointments;

14.17.2.2.8.2 Follow-up appointments for Behavioral Health or medical services;

14.17.2.2.8.3 Housing and employment assistance; and

14.17.2.2.8.4 Other support services the Enrollee may need.

14.17.3 HCA shall provide:

14.17.3.1 Information to the Contractor about the Enrollee's incarceration status when the information is available to HCA.

14.17.4 When possible, HCA shall coordinate with the Contractor to re-enroll the Enrollee with the AHEHP he or she was enrolled in prior to incarceration, even when the incarceration was longer than six (6) months.

14.18 **Mental Health Parity**

14.18.1 Notwithstanding anything in this Contract to the contrary, Washington State statutes and OIC regulations regarding mental health parity do not apply to the provision of services to Enrollees under this Contract.

14.18.2 The Contractor shall not impose Non-Quantitative Treatment Limits (NQTL) for mental health or SUD benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the Contractor's policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the

classification.

14.18.3 The Contractor shall monitor the Non-Quantitative Treatment Limits (NQTL) used in providing mental health or SUD benefits to Enrollees, to assure they are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors the Contractor uses to apply limitations for medical/surgical benefits in the appropriate classifications. The Contractor shall complete the Parity Review Report annually and submit through MC-Track no later than November 1 of the calendar year in review.

14.18.3.1 The Contractor shall also report disparate applications and parity concerns to hcamcprograms@hca.wa.gov within fourteen (14) calendar days of discovery.

14.18.4 The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or SUD benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

14.18.5 The Contractor may cover, in addition to services covered under the Medicaid State Plan, any services necessary for compliance with the requirements for parity in mental health and SUD benefits in, and the contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the state or the Contractor.

14.18.6 If Enrollees are provided mental health or SUD benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or SUD benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided.

14.18.7 The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and SUD benefits in.

14.18.8 The Contractor must provide all necessary documentation and reporting to HCA to establish and demonstrate compliance with regarding parity in mental health and SUD benefits.

14.18.9 The Contractor shall make the criteria for medical necessity determinations made by the Contractor for mental health or substance abuse disorder benefits available to any Enrollee, potential Enrollee, or contracting provider upon request.

14.18.10 The Contractor shall not impose aggregate lifetime, annual dollar limits or any other financial limitations on Enrollees for mental health, SUD benefits regardless of whether the services are covered by the Contractor.

14.19 Outreach to Enrollees for Hepatitis C Virus Screening, Connection to Care, Treatment and Cure of Positively Diagnosed Enrollees

14.19.1 The Contractor shall provide outreach to network providers to assure screening, connection to care, and treatment of Hepatitis C Virus (HCV) in conformance with Directive of the Governor 18-13 and CDC guidelines. The Contractor's provider outreach efforts shall include education, assistance in Enrollee connection to care, and medication adherence.

14.19.2 The Contractor shall provide HCA with a verbal progress report at the quarterly AHEHP meeting on their progress of related treatment initiatives. HCA will

provide information on the number of Enrollees treated for HCV and the number of newly identified Enrollees prior to the quarterly meetings.

14.19.2.1 The Contractor shall submit a quarterly report with list of HCV network Providers who treat HCV and if they are accepting new Enrollees. The HCV Network Provider List report will be submitted quarterly each year to MC-Track. The report is due thirty (30) calendar days after the end of the quarter: May 1, quarter one; August 1, quarter two; November 1, quarter three; and February 1, quarter four.

15 SPECIAL PROVISIONS

15.1 Special Provisions Regarding Coordination with IHCPs

15.1.1 Tribal Liaison

15.1.1.1 The Contractor shall designate an employee(s) to fulfill the role of Tribal Liaison.

15.1.1.2 The dedicated Tribal Liaison(s) shall be the primary contact for all tribal related billing and claims issues. Expectations for handling all IHCP escalations shall be as follows:

15.1.1.2.1 Tribal Liaison's response to the initial escalation shall be no later than three (3) Business Days upon receipt of the complaint. The response should include (i) details of the root cause analysis performed, (ii) an estimated completion date for ultimate resolution, and (iii) an ongoing cadence for future communications.

15.1.1.3 The Contractor will designate a staff person who is competent in understanding the cultural and legal aspects of Medicaid and IHCPs and AI/AN Enrollees.

15.1.1.3.1 The Contractor must provide for training of its Tribal Liaison, conducted by one or more IHCPs, the American Indian Health Commission for Washington State, or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs. No later than September 30 of each year, the Contractor will provide written documentation of efforts to obtain this training.

15.1.1.4 The Contractor's Tribal Liaison will also serve the role of Indian Health Care Compliance Manager.

15.1.1.5 This position will be responsible for monitoring the Contractor's compliance with the requirements in this Contract that apply expressly to IHCPs and should report to executive leadership with authority over such compliance.

15.1.1.6 The Contractor's Tribal Liaison will participate in HCA's meetings with Tribes and non-Tribal IHCPs to develop the Protocols for Coordination with Tribes and non-Tribal IHCPs.

15.1.1.7 The Contractor's Tribal Liaison may seek technical assistance from HCA Tribal Affairs Office to understand the legal protections applicable to IHCPs.

15.1.2 Protocols for Coordination with Tribes and non-Tribal IHCPs.

15.1.2.1 HCA in partnership with the Contractor through the convened meetings will develop and revise protocols for the coordination of crisis services (including involuntary commitment assessment), care coordination, and discharge and transition planning as part of HCA's government-to-government relationship with each of the Tribes under chapter 43.376 RCW and various federal requirements and as part of HCA's meet-and-confer relationship with each non-Tribal IHCP under HCA policy. These protocols will include a procedure and timeframe for evaluating the protocols' efficacy and reviewing or modifying the protocols to the satisfaction of all parties. These protocols may be jointly developed with more than one Tribe and/or non-Tribal IHCPs in a Regional Service Area. With respect to crisis and involuntary commitment assessment services, these protocols will include at a minimum a description of the procedures or processes for:

15.1.2.1.1 Designated Crisis Responders to access Tribal lands to provide services, including crisis response and involuntary commitment assessment;

15.1.2.1.2 Providing services on Tribal lands in the evening, holidays, or weekends if different than during Business Hours;

15.1.2.1.3 Notifying Tribal authorities when crisis services are provided on Tribal land, especially on weekends or holidays or after Business Hours, including who is notified and timeframes for the notification;

15.1.2.1.4 How Designated Crisis Responders will coordinate with Tribal mental health and/or substance use disorder providers and others identified in the protocols, including coordination and debriefing with any Tribal mental health or substance use disorder providers after a crisis service has been provided;

15.1.2.1.5 When a Designated Crisis Responder determines whether to detain or not for involuntary commitment; and

15.1.2.1.6 If ITA evaluations cannot be conducted on Tribal land, how and by whom individuals will be transported to non-Tribal lands for involuntary commitment assessment and detention and/or to a licensed Evaluation and Treatment Facility.

15.1.2.2 Until these protocols are completed and agreed upon for each Tribe or non-Tribal IHCP, the Contractor shall use the most recent annual plan for providing crisis and ITA evaluation on Tribal Lands that was agreed upon by the Contractor and the Tribe.

15.1.3 The Contractor's staff, including Tribal Liaison, shall receive annual training applicable to the AI/AN communities in the RSAs contracted, including cultural humility, IHCPs and services available, and the Protocols for Coordination with

Tribes and Non-Tribal IHCPs applicable to the Contractor's Regional Service Area(s).

15.1.4 If the Contractor and the IHCP fail to enter into a Subcontract within ninety (90) calendar days from the date of the IHCP's written request, the IHCP may request HCA assistance in facilitating resolution. Executive leadership of the Contractor must attend this meeting in person and are permitted to have legal counsel present.

15.2 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of behavioral health benefits also shall comply with the following provisions:

15.2.1 Unless otherwise agreed upon, Essential Behavioral Health Functions and required behavioral health personnel shall be located in Washington State and available during Business Hours.

15.2.2 Outside of Business Hours, information, crisis triage, referral services and prior authorization may be conducted out-of-state. Any Contractor staff that work outside of Washington State must be trained and have knowledge of Washington State-specific behavioral health Covered Services, Managed Care rules, UM protocols and Level of Care Guidelines.

15.2.3 The Contractor must maintain an adequate complement of qualified and trained staff located in Washington State to accomplish AHE program goals and to meet the needs of individuals with serious emotional disturbance, serious mental illness and SUDs. The Contractor shall have behavioral health resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the required education, experience, credentials, orientation and training to perform assigned job duties.

15.2.4 The Contractor shall designate employees who fulfil the following behavioral health functions:

15.2.4.1 A Behavioral Health Medical Director.

15.2.4.2 A Behavioral Health Clinical Director.

15.2.5 The Contractor shall designate managerial positions with the following behavioral health responsibilities:

15.2.5.1 An Addictions Administrator.

15.2.5.2 A Behavioral Health Utilization/Care Management Administrator.

15.2.5.3 A Behavioral Health network development manager.

15.2.5.4 A Behavioral Health provider relations manager.

15.2.6 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under this Contract.

15.2.6.1 The Contractor shall locate a sufficient number of Provider Relations staff within the state to meet requirements under this Contract for provider education and training, provider profiling, and provider performance improvement or problem resolution.

15.2.6.2 The Contractor shall ensure that one (1) or more Data Management and Reporting Specialists shall have experience and expertise in Medicaid data analytics and behavioral health data systems to oversee all data interfaces and support the behavioral health specific reporting requirements under this Contract. This position can be located outside of Washington State.

15.2.6.3 The Contractor shall designate one (1) or more Community Liaisons to work within Washington State, county behavioral health leadership, and ACHs within its service area. Contractor shall participate and coordinate with the designated regional ACH and actively participate in at least one (1) health improvement strategy identified by the ACH.

15.2.6.4 The Contractor shall ensure a sufficient number of qualified staff to meet both new contract requirements and increased volume including the following functions: administrative and support, member services, Grievance and Appeal, claims, encounter processing, behavioral health supplemental transactions processing, data analysts, and financial reporting analysts.

15.2.6.5 The Contractor may administer claims out of state. If claims are administered in another location, physical and behavioral health provider relations staff shall have access to the claims payment and reporting platform during Business Hours.

15.2.7 The Contractor shall develop and maintain a human resources and staffing plan that describes how the Contractor will maintain adequate staffing:

15.2.7.1 The Contractor shall hire employees for the key and required behavioral health functions specified in the Contract. Consultants must be prior approved by the state.

15.2.7.2 The Contractor may propose a staffing plan, with prior approval by the State, which combines positions and functions with other positions.

15.2.7.3 The Contractor shall develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.

15.2.8 The Contractor must ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee Behavioral Health services to Enrollees. The individual(s) responsible for Behavioral Health training must have at least two (2) years' experience and expertise in developing training programs related to behavioral health systems comparable to those under the Contract.

16 BENEFITS

16.1 Scope of Services

16.1.1 Exhibit F, Scope of Benefits, includes a table that provides a general description of the scope of services available under AHE. The Contractor also must comply with any statutes or HCA regulations regarding the amount, duration, and scope of services.

16.1.2 Medically Necessary Services. The Contractor is responsible for covering medically necessary medical and behavioral health services to Enrollees sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor shall cover services that address the following (WAC 182-501-0060):

16.1.2.1 The prevention, diagnosis, and treatment of an Enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

16.1.2.2 The ability for an Enrollee to achieve age-appropriate growth and development.

16.1.2.3 The ability for an Enrollee to attain, maintain, or regain functional capacity.

16.1.2.4 Integrated behavioral health services that support a bi-directional delivery of care model. The Contractor shall implement coverage of designated services collaboratively with HCA to support an integrated model of care that has no barriers by provider type or place of service, except as driven by scope of licensure, CPT or correct coding initiatives. This will include coverage of selected codes, including those classified as collaborative care codes, behavioral health integration codes and primary care codes.

16.1.2.5 Except as otherwise specifically provided in this Contract, the Contractor must provide Contracted Services in the same amount, duration, and scope as described in WAC 182-500 through 182-560, as applicable. For specific Contracted Services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by HCA under its FFS program, but shall rather be construed to require the Contractor to provide the same scope of services. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional without being limited by such guidelines.

16.1.2.6 The Contractor makes the decision whether or not a Contracted Service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a health care professional with expertise appropriate to the Enrollee's condition. The Contractor may not make global medical necessity decisions since that is a coverage decision.

16.1.2.7 The amount and duration of contracted services that are medically necessary depends on the Enrollee's condition.

16.1.2.8 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the Enrollee's diagnosis, type of illness or condition.

16.1.2.9 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to Enrollees nor unduly burden providers or Enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid FFS program.

16.1.2.10 If the Contractor objects on moral or religious grounds to providing a counseling or referral service that it would otherwise be required to provide, reimburse for, or provide coverage for, the Contractor is not required to do so. The Contractor must document the grounds on which it objects to providing this service.

16.1.3 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the Enrollee's right to choose the method of family planning to be used is protected.

16.1.3.1 For services that HCA determines are non-covered, the Contractor shall have policies and procedures consistent with WAC 182-501-0160, Exception to Rule (ETR). The Contractor shall cover a service when the criteria in this WAC are met. The ETR process is not to be applied to Excluded Services.

16.1.3.2 For services that are covered, but with limits in scope, amount or duration, the Contractor will have policies and procedures consistent with WAC 182-501-0169, Limitation Extension (LE), to determine medical necessity of services outside or more than the limit. The Contractor is responsible for covering a service when the criteria in this WAC are met and results in an approval of services outside or more than the limitation.

16.1.3.3 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of Contracted Services. Services provided outside the scope of Contracted Services shall be reported separately to HCA and shall not be included in the rates development process.

16.1.4 The Contractor may limit the provision of Contracted Services to Participating Providers except for the following:

16.1.4.1 Emergency Services;

16.1.4.2 Services provided outside the Service Areas as necessary to provide Medically Necessary Services;

16.1.4.3 Coordination of Benefits, when an Enrollee has other primary comparable physical and/or behavioral health coverage as necessary to coordinate benefits; and

16.1.4.4 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor shall cover Enrollees for all physical and/or behavioral health necessary services.

16.1.5 Outside the Service Areas:

16.1.5.1 For Enrollees who are temporarily outside the service areas or who have moved to a service area not served by the Contractor and have not been enrolled with another AHEHP, the Contractor shall cover the following services:

16.1.5.1.1 Emergency and Post-Stabilization Services.

16.1.5.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the Appointment Standards provisions of the Access to Care and Provider Network Section of this Contract, are not exceeded.

16.1.5.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access to Care and Provider Network Section of this Contract are not exceeded.

16.2 **Second Opinions**

16.2.1 The Contractor must authorize a second opinion regarding the Enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the Enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for an independent and impartial qualified health care professional. The appointment for a second opinion must occur within thirty (30) calendar days of the request unless the Enrollee requests a delay for the second opinion to a date later than thirty (30) calendar days.

16.2.2 If the Contractor refuses to authorize a second opinion, or a second opinion from a provider of the Enrollee's choice, the refusal is an Adverse Benefit Determination, which shall be subject to Appeal under the provisions of the Grievance and Appeal System section of this Contract.

16.2.3 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

16.3 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are equivalent to the standards required for Medicaid in 42 C.F.R. § 441 Subpart F, and that a Consent for Sterilization form (HHS-687) is used. A hysterectomy requires the Hysterectomy Consent and Patient Information form (HCA 13-365). These forms can be accessed using the link provided in HCA Sterilization Supplemental Billing Guide.

16.4 Enrollee in Facility at Enrollment: Medical and Acute Behavioral Health Conditions

16.4.1 If an Enrollee was admitted to a hospital the same month that enrollment occurs, the Contractor is responsible for the admission and all related services.

16.4.2 HCA is responsible for payment of all hospital and professional services provided from the date of admission until the date the Enrollee is discharged from the acute hospital inpatient stay when the client was on FFS before the admission and is enrolled in AHE during the admission.

16.4.3 If an Enrollee was admitted to a skilled nursing or nursing facility, the same month that enrollment occurs, the Contractor is responsible for the admission and all related services, until the Enrollee no longer meets rehabilitation or skilled level of care criteria.

16.4.4 Within available resources appropriated for the purposes of this service, DSHS is responsible for payment of nursing facility admissions including when the Enrollee meets rehabilitation or skilled level of care criteria, provided from the date of admission until the date the Enrollee is discharged from the nursing facility when funded for the service and when:

16.4.4.1 The client was admitted to the nursing facility in the same month eligibility is established but enrollment is not completed until the following month; or

16.4.4.2 The client was on FFS before the admission and is enrolled in AHE during the admission.

16.4.5 If the Enrollee's admission to a nursing facility is the responsibility of DSHS, under the provisions of subsection 16.4.4, the Contractor is responsible for all other services as described in this Contract, except for the room and board for the nursing facility, that are medically necessary and required to meet the client's needs, including professional services, specialty beds, specialty wheelchairs, etc. The Contractor is responsible for management of the authorization requirements for these services.

16.4.6 The Contractor is responsible for actively planning from either a hospital or a nursing facility when that admission is the responsibility of HCA or DSHS, respectively. The Contractor is also responsible for the delivery of care pursuant to this Contract once discharge has occurred, including any subsequent care: hospital inpatient, rehabilitation, outpatient, outpatient observation, any professional services, and any subsequent nursing facility placements that meet rehabilitative or skilled stay nursing level of care criteria.

16.4.6.1 If the Enrollee is admitted to a hospital or a nursing facility after the first of the month in which enrollment occurred, the Contractor may conduct retrospective review to establish medical necessity of the admission.

16.4.7 If an Enrollee changes AHE Plans and the change becomes effective during an inpatient admission, including an admission to a behavioral health acute inpatient facility, the AHE Plan that the Enrollee was enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services. The AHE Plan that is receiving the Enrollee is responsible for completing the responsibilities described in subsection 16.4.6.

16.4.7.1 This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for the rehabilitative or skilled benefit, or is discharged from a Facility to home or a community residential setting or readmitted to an inpatient or observation hospital stay, consistent with the Skilled Nursing Facility Coordination subsection of this Contract. The party responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

16.5 **Enrollee in Hospice at Enrollment**

16.5.1 If an Enrollee changes AHE Plans and the change becomes effective while the Enrollee is receiving hospice services, the AHE Plan that the Enrollee was enrolled with on the date of hospice admission is responsible for payment of all covered hospice services regardless of place of service. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for hospice or is discharged from hospice. The AHE Plan that is receiving the Enrollee is responsible for coordinating discharge and ensuring continuity of services for the Enrollee.

16.6 **Enrollee in Facility at Termination of Enrollment**

If an Enrollee is in a facility at the time of termination of enrollment and the Enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

16.6.1 The Enrollee is discharged from a Facility to home or a community residential setting, including behavioral health residential treatment facilities or a lower level of care.

16.6.2 The Enrollee's eligibility to receive AHE services ends. The Contractor's obligation for payment ends at the end of the month the Enrollee's AHE eligibility ends.

16.6.3 The Enrollee no longer meets the Contractor's rehabilitative or skilled criteria applicable to the skilled nursing facility setting.

16.7 **In Lieu of Services (ILOS)**

16.7.1 The Contractor may provide ILOS services to an Enrollee who chooses to accept them in accordance with In Lieu of Services listed in this Contract.

16.7.2 The Contractor may provide services or settings that are ILOS or as follows:

16.7.3 HCA shall determine whether the alternative service or setting is a Medically Appropriate and cost-effective substitute for the Covered Service or setting

16.7.4 The Enrollee is not required to use the alternative service or setting.

16.7.5 The approved ILOS are authorized and identified in this Contract.

16.7.6 The utilization of and actual cost of the ILOS is reported in the Contractor's

encounter data submission.

16.7.7 Approved ILOS for this Contract are the following:

16.7.7.1 IMD services, for the provision of inpatient psychiatric treatment.

16.7.8 No later than December 1, 2024, and annually thereafter, the Contractor shall submit an annual narrative report titled ILOS Annual Attestation via MC-Track with the ILOS they will offer to their Enrollees who qualify for the next calendar year. These services must be offered equally across the population who qualify, and the Contractor may not remove these ILOS offerings prior to the end of the calendar year.

16.7.9 ILOS must be delivered in compliance with all applicable federal and state requirements to be included in rate setting.

16.7.10 The offer or coverage of ILOS(s) by an AHE Plan in no way alters or diminishes an Enrollee's rights to Grievance and Appeal processes. The Contractor shall ensure that all Grievance and Appeal Systems requirements are applied to ILOS(s) consistent with this Contract.

16.7.11 The Contractor shall ensure that all Prior Authorization and utilization management requirements are applied to ILOS consistent with this Contract.

16.7.12 The Contractor shall not deny an Enrollee a Covered Service on the basis that they have been offered an ILOS, are currently receiving an ILOS, or has received an ILOS in the past.

16.7.13 If an Enrollee changes enrollment to another AHE Plan and the new AHE Plan offers the same ILOS as the service the Enrollee received under their previous AHE Plan, then the new AHE Plan must honor the service authorization for that Enrollee according to the Continuity of Care Section of this Contract.

16.7.14 The Contractor shall submit the Health-Related Social Needs (HRSN) Services Utilization report template via MC-Track quarterly no later than the last business day of April, July, October, and January. The deliverable shall include the following:

16.7.14.1 Quarterly data reflecting utilization and payment.

16.7.14.2 Annual HRSN Narrative report of each HRSN and ILOS service offered by the Contractor. Due the last business day of April to include the work of the previous calendar year submitted via MC-Track and shall include the following:

16.7.14.2.1 Strengths and opportunities identified with recommendations to the state and action taken by the Contractor;

16.7.14.2.2 The Contractor's evaluation of medically appropriateness of each ILOS service; and

16.7.14.2.3 Data for each service, including annual cost (total and average by service), utilization (total and average by membership), and summary of Adverse Benefit Determinations, Appeals, and Grievances.

16.8 **Deliveries and Newborn Coverage**

16.8.1 For newborns born while their mother is hospitalized:

16.8.1.1 The party responsible for the payment of Covered Services for the mother's hospitalization shall be responsible for payment of all Covered Services provided to the mother from the date of admission until the date discharged from the acute care hospital.

16.8.2 For covered deliveries in a birthing center, the Contractor shall pay for all Covered Services, including Facility costs and professional services provided to the mother and the newborn until the date the enrolled mother and newborn are discharged from the birthing center.

16.8.3 For home deliveries, the Contractor shall pay for all costs associated with the home delivery, including professional services provided to the mother and newborn.

16.8.4 Donor Human Milk

16.8.4.1 The Contractor is responsible for covering medically necessary donor human milk for any inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board-certified lactation consultant certified by the International Board of Lactation Consultant Examiners (IBCLE) for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the criteria in accordance with RCW 48.43.815(1)(a) – (o):

16.9 **Qualifying Clinical Trials**

16.9.1 The Contractor is responsible for covering routine patient costs (as defined below) associated with Qualifying Clinical Trials. For purposes of this Section, the term "Qualifying Clinical Trials" means a clinical trial meeting all the following criteria within this subsection:

16.9.1.1 Any clinical phase of development.

16.9.1.2 A clinical trial being conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition.

16.9.1.3 A clinical trial that meets one of the following requirements:

16.9.1.3.1 A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:

16.9.1.3.1.1 National Institutes of Health (NIH);

16.9.1.3.1.2 CDC;

16.9.1.3.1.3 Agency for Health Care Research and Quality (AHRQ);

16.9.1.3.1.4 CMS;

16.9.1.3.1.5 A cooperative group or center of any of the previously listed entities or the

Department of Defense or the Department of Veterans Affairs; or

16.9.1.3.1.6 A qualified non-governmental research entity identified in the guidelines issued by NIH for center support grants.

16.9.1.3.2 A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the secretary of DHHS determines comparable to the system of peer review of studies and investigations used by NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

16.9.1.3.2.1 Department of Energy;

16.9.1.3.2.2 Department of Veterans Affairs; or

16.9.1.3.2.3 Department of Defense.

16.9.1.3.3 A clinical trial that is one conducted pursuant to an investigational new drug exemption under Section 505(i) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(i)), or an exemption for a biological product undergoing investigation under Section 351(a)(3) of the federal Public Health Service Act (42 U.S.C. 262).

16.9.1.3.4 A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the previous bullet.

16.9.2 For purposes of the Qualifying Clinic Trials Section of this Contract, the term “routine patient costs” includes the following:

16.9.3 Any item or service that would otherwise be covered by the State Plan outside the course of participation and that is a Covered Service provided by the state, which is not considered a Contracted Service; or

16.9.4 Any item or service provided to an Enrollee enrolled in a Qualifying Clinical Trial that is provided to prevent, diagnose, monitor, or treat complications resulting from the participation in the Qualifying Clinical Trial.

16.9.5 “Routine patient costs” do not include any of the following:

16.9.5.1 Any item or service provided to an Enrollee enrolled in a Qualifying Clinical Trial that is required solely for the provision of the investigational drug, item, device, or service;

16.9.5.2 The investigational item or service itself;

16.9.5.3 Items and services for the purpose of determining eligibility for the study that are not related to medically necessary clinical care;

16.9.5.4 Items and services customarily provided by the research sponsors free-of charge for any Enrollee in the trial, and items provided by the research sponsors free-of-charge for any Enrollee in the trial;

16.9.5.5 Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Enrollee. Examples include, but are not limited to, laboratory tests and imaging studies done at a frequency dictated by the study protocol and not consistent with signs and symptoms and other standards of care for that diagnosis or treatment type; or

16.9.5.6 Items and services not covered under the Enrollee's benefit service package, not allowed per Washington statutes or regulations, or not included in the Contracted Services.

16.9.6 A Qualifying Clinical Trial Attestation Form is required to be completed by the Contractor's provider and submitted to the Contractor prior to the start of all Qualifying Clinical Trials. For the AHE Contract, the Contractor may use the CMS attestation form that can be found on the CMS website, and HCA's Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial (HCA 13-0103) that can be found on HCA's Forms and Publications website.

16.9.7 When the Contractor requires prior authorization for any Qualifying Clinical Trial or any service within the clinical trial, the Contractor must make the determination within 72 hours after receiving the request. The requesting provider must indicate within the prior authorization request whether it is related to a Qualifying Clinical Trial.

16.9.8 The Contractor shall maintain Enrollee records of Qualifying Clinical Trial Attestation Forms, including tracking by National Clinical Trial Number.

17 General Description of Contracted Services

17.1 Contracted Services

The Contractor shall provide the following services, as medically necessary, to Enrollees:

17.1.1 The Contractor shall provide a wellness exam to each Enrollee that documents the Enrollee's baseline health status and allows the Enrollee's PCP to monitor health improvements and outcome measures.

17.1.2 The Contractor is responsible for providing integrated medical and Behavioral Health services as directed by Section 14.

17.1.3 Inpatient Services:

17.1.3.1 Provided by acute care hospitals, including and behavioral health inpatient facilities.

17.1.3.2 Provided by a Nursing Facility, Skilled Nursing Facility or other acute care setting, when services are determined medically necessary and are covered by this Contract.

17.1.3.3 Consultations with specialty providers, including psychiatric or psychology consultations, are covered during hospital stays.

17.1.3.4 Inpatient professional mental health services associated with an ITA or voluntary inpatient psychiatric admission, for an AHE Enrollee. This includes those professional services provided during admissions where the facility charges are covered by HCA in the Long-Term Inpatient Mental Health Program. Facility charges in these facilities are stated in the Excluded and Non-Contracted Services section of this Contract.

17.1.3.5 Inpatient psychiatric mental health services except when the Enrollee is approved for placement in a state hospital, as stated in the Excluded and Non-Contracted Services section of this Contract.

17.1.3.6 Covered services provided during an inpatient admission for medical detoxification services.

17.1.3.7 Any and all covered facility charges provided during an inpatient admission for the care and treatment of dental conditions.

17.1.4 Outpatient Hospital Services: Provided by acute care hospitals, including surgeries, labs, diagnostics and emergency room, including facility charges for the care and treatment of dental conditions.

17.1.5 Emergency Services:

17.1.5.1 The Contractor will provide all inpatient and outpatient Emergency Services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider is a participating provider, including dental and oral health services as follows:

17.1.5.1.1 An Enrollee had an emergency medical or Behavioral Health condition, including cases in which the

absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.

17.1.5.1.2 A participating provider or other Contractor representative instructs the Enrollee to seek emergency services.

17.1.5.2 The Contractor shall ensure that an Enrollee who has an Emergency Medical Condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

17.1.5.3 The Contractor shall not refuse to cover emergency or Crisis Services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within ten (10) calendar days of presentation for Emergency Services.

17.1.5.4 Emergency Services shall be provided without requiring prior authorization.

17.1.5.5 What constitutes an Emergency Medical Condition may not be limited on the basis of lists of diagnoses or symptoms.

17.1.5.6 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating Facility prevails and is binding on the Contractor.

17.1.6 Post-Stabilization Services:

17.1.6.1 The Contractor will provide all inpatient and outpatient Post-Stabilization Services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating provider.

17.1.6.2 The Contractor shall cover Post-Stabilization Services under the following circumstances:

17.1.6.2.1 The services are pre-approved by a Participating Provider or other Contractor representative.

17.1.6.2.2 The services are not pre-approved by a Participating Provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one (1) hour of a request to the Contractor for pre-approval of further post-stabilization care services.

17.1.6.2.3 The services are not pre-approved by a Participating Provider or other Contractor representative, but are administered to maintain, improve, or resolve the Enrollee's stabilized condition and the Contractor

does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(1)(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the Enrollee until a Contractor physician is reached.

17.1.6.2.3.1 The Contractor's responsibility for Post-Stabilization Services it has not pre-approved ends when:

17.1.6.2.3.1.1 A Participating Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

17.1.6.2.3.1.2 A Participating Provider assumes responsibility for the Enrollee's care through transfer;

17.1.6.2.3.1.3 A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or

17.1.6.2.3.1.4 The Enrollee is discharged.

17.1.7 Ambulatory Surgery Center: Services provided at ambulatory surgery centers including services for care and treatment of dental conditions.

17.1.8 Intensive Behavioral Intervention for Autism Spectrum Disorder and other related disorders (WAC 182-531A-0100 to -1200).

17.1.8.1 Initial Clinical Evaluation by a Center of Excellence (COE) for Enrollees, with a diagnosis, or suspected diagnosis, of autism spectrum disorder, or other developmental delay conditions, for evaluation of the appropriateness of Applied Behavioral Analysis (ABA) as part of the plan of care.

17.1.8.2 ABA treatment services.

17.1.8.3 Care Coordination activities for Enrollees with a diagnosis or

suspected diagnosis of autism spectrum disorder when the Contractor becomes aware of a need for services.

17.1.9 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, Mental Health Professionals, substance use disorder specialists, certified dietitians, and interns and residents under the supervision of a teaching physician.

17.1.9.1 Medical examinations and mental health evaluations, including wellness exams for adults, and referrals for further behavioral health assessment and other services, as needed, to include:

17.1.9.1.1 Fluoride varnish for Enrollees of all ages, by a medical provider regardless of provider ABCD certification.

17.1.9.2 Immunizations in accordance with the practice guidelines in subsection 7.9.2.

17.1.9.3 Family planning services provided or by referral from a Participating Provider or practitioner.

17.1.9.4 Performing and/or reading diagnostic tests.

17.1.9.5 Surgical services.

17.1.9.6 Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction.

17.1.9.7 Anesthesia.

17.1.9.8 Administering pharmaceutical products.

17.1.9.9 Fitting prosthetic and orthotic devices.

17.1.9.10 Physical Medicine Rehabilitation services.

17.1.9.11 Enrollee health education.

17.1.9.12 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia.

17.1.9.13 Bio-feedback training when determined medically necessary.

17.1.9.14 Genetic testing for all Enrollees. Genetic counseling non-pregnant adults.

17.1.9.15 Palliative care for adults.

17.1.9.16 Hormone therapy for any transgender Enrollees consistent with HCA's gender dysphoria treatment benefit.

17.1.9.17 Medication Assisted Treatment, including assessment, counseling, medical management, and prescribing to assist Enrollees in treatment for SUD in a medical office setting.

17.1.9.18 MAT including medications prescribed or administered as part of a MAT protocol, except for methadone, when treatment is provided in a SUD clinic setting.

17.1.9.19 Eyeglass and contact lens fitting fees.

17.1.10 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell. The AHEHP shall use the same standards respecting coverage and delivery of the services as the state uses.

17.1.11 Laboratory, Radiology, and Other Medical Imaging Services: Screening, diagnostic services and radiation therapy.

17.1.12 Vision Care: Eye examinations once every twenty-four (24) months for adults and once every twelve (12) months for children under age 21 (WAC 182-531-1000). These limitations do not apply to additional services needed for medical conditions.

17.1.13 Rehabilitative Behavioral Health Services. The Contractor shall provide the following Behavioral Health Services:

17.1.13.1 Behavioral Health Care Coordination and Community Integration;

17.1.13.2 Crisis Intervention;

17.1.13.3 Crisis Stabilization;

17.1.13.4 Intake evaluation, assessment, and screenings (mental health);

17.1.13.5 Intake evaluation, assessment, and screenings (Substance Use or Problem Gambling Disorder);

17.1.13.6 Medication Management;

17.1.13.7 Medication Monitoring;

17.1.13.8 Mental Health Treatment Interventions;

17.1.13.9 Peer Support;

17.1.13.10 Substance Use Disorder Brief Intervention;

17.1.13.11 Substance Use Disorder Case Management;

17.1.13.12 Substance Use or Problem Gambling Disorder Treatment Interventions; and

17.1.13.13 Substance Use Disorder Withdrawal Management.

17.1.14 Opiate Treatment Programs.

17.1.15 Wraparound with Intensive Services (WISe) and Monitoring:

17.1.15.1 The Contractor shall provide intensive in-home and community-based services to help children receive Behavioral Health treatment and connect with natural supports in their homes, schools, and communities consistent with the requirements of the WISe program. The WISe service delivery model shall be based on medical necessity criteria.

17.1.15.2 The Contractor shall ensure that the Enrollee has access to medically necessary mental health services, including supports that are sufficient in intensity and scope, based on available evidence of effectiveness, and are individualized to each Enrollee's needs consistent with the WISe service delivery model and state and federal Medicaid laws and regulations.

17.1.15.3 Provision of WISe services must include, at a minimum, access to:

17.1.15.3.1 Intake Evaluation;

17.1.15.3.2 Intensive Care Coordination;

17.1.15.3.3 Intensive Services;

17.1.15.3.4 24/7 Crisis Intervention and Stabilization Services; and

17.1.15.3.5 Peer Support.

17.1.15.4 Provision of WISe services must also include any rehabilitative Behavioral Health service as determined medically necessary. The delivery of services must be focused on needs and strengths of the Enrollee and driven by youth and family voice and choice.

17.1.15.5 Evaluation of WISe service includes:

17.1.15.5.1 Semi-annual review of Service Encounters.

17.1.15.5.2 Individual chart review – quarterly by supervisors, annually by state.

17.1.15.5.3 Feedback on service effectiveness to meet desired goals from youth/families through annual interviews.

17.1.15.5.4 Quarterly review of Notices of Adverse Benefit Determinations that reflect an adverse decision.

17.1.15.5.5 Quarterly review of Grievances and Appeals related to WISe.

17.1.15.5.6 Annual Quality Improvement Review findings, based on outcomes from the Quality Improvement Review tool.

17.1.15.5.7 Additional elements as detailed in the AIM of the WISe Quality Management Plan.

17.1.16 Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee's illness, disability, condition or injury, or for the amelioration of the effects of a

developmental disability.

17.1.16.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational, or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.

17.1.17 Non-pharmaceutical birth control products, including:

17.1.17.1 ParaGard® (T 380A);

17.1.17.2 Fertility awareness-based methods, such as cycle beads, basal body temperature thermometers, and charts; and

17.1.18 Enteral nutrition products, including the following:

17.1.18.1 Parenteral nutritional supplements and supplies for all Enrollees.

17.1.18.2 Enteral nutrition products and supplies for tube-feeding are covered for all Enrollees.

17.1.19 Medical Equipment and Supplies and any applicable sales tax including, but not limited to: Medical Equipment; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for Enrollees over 3 years of age; medical supplies; and bed and pillow covers for Enrollees under age 21 diagnosed with asthma and dust mite sensitivity. Incontinence supplies shall not include non-disposable diapers unless the Enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax.

17.1.20 Respiratory Care: Equipment, services and supplies.

17.1.21 Services rendered under the Collaborative Care model (CoCM) by an HCA approved CoCM provider.

17.1.22 Palliative Care and Care Coordination: Provision of skilled care services and care coordination to Enrollees with a life-limiting medical condition under a palliative care model. Services can be provided in the following settings, but not limited to, hospice care centers, hospitals, clinics, and the Enrollee's home.

17.1.23 Hospice Services: Includes services for adults and children and provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the Enrollee's home. Hospice services include:

17.1.23.1 Pediatric Concurrent Care- Treatment, including diagnostics, that is related to an Enrollee's terminal condition for an Enrollee aged 20 and younger who voluntarily elects hospice care. Pediatric concurrent care preserves the Enrollee's rights to hospice care without waiving any rights to services that the Enrollee is entitled to

(WAC 182-551-1860).

17.1.24 Treatment for Renal Failure: Hemodialysis, peritoneal dialysis, and other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

17.1.25 Smoking Cessation Services with or without Primary Care Provider referral or Contractor prior authorization. The Contractor shall submit a quarterly report to HCA. The report shall include the number of Enrollees that have accessed the Contractor's Quit Line in the previous quarter. The quarterly reports are due to HCA no later than the fifteenth of the month of January, April, July and October.

17.1.26 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair.

17.1.27 Bilateral Cochlear Implants, including implants, parts, accessories, batteries, chargers, and repairs.

17.1.28 Bone-Anchored Hearing Aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries: For Enrollees age 20 and younger.

17.1.29 Services to Inmates of City and County Jail Facilities: The Contractor shall provide inpatient hospital services to Enrollees who are inmates of a city or county jail facility when an inpatient admission occurs during the first month of the incarceration period and HCA has paid a premium for that month to the Contractor. The Contractor's existing policies about establishing medical necessity for the inpatient admission and procedure(s) may be applied, even retrospectively, to determine payment. The Contractor shall provide transitional care coordination services to inmates upon release from jail in accordance with Subsection 14.17 of this Contract.

17.1.29.1 HCA may recoup a premium payment and retroactively terminate enrollment for an inmate if the inpatient hospital services occur after the first (1st) month of incarceration period and HCA has paid a premium for the full month of enrollment.

17.1.30 Screening, Brief Intervention and Referral to Treatment (SBIRT) services (services are provided by SBIRT certified providers) for adults who are at who are at high risk for Substance Use Disorder, to include substances with or without anxiety or depression. Screening conducted without Brief Intervention and referral to treatment is not reimbursable. SBIRT activities for identifying and reducing risk in individuals with substance use concerns shall be one (1) of the screening tools/interventions selected. Included as part of this effort are screens for depression and anxiety.

17.1.31 Comprehensive Medication Therapy Management Services.

17.1.32 Bariatric surgery consistent with WAC 182-531-1600 and WAC 182-550-2301.

17.1.33 Early, elective inductions (before 39 weeks) that meet medically necessary indicators set by the Joint Commission. Because the Joint Commission's criteria do not capture all situations in which an early delivery is medically indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet that criteria, but which the hospital and delivering provider believe were medically necessary.

17.1.34 Services identified in this Section that are medically necessary to treat

complications resulting from a Non-Covered or an Excluded Service (e.g. antibiotics to treat infection that occurs post operatively of a non-covered surgery or a Non-Contracted Service such as a voluntary termination of pregnancy procedure).

17.1.35 For services that HCA determines are non-covered for Enrollees ages 20 and younger, the Contractor shall apply Exception to Rule (ETR) according to Section 16.

17.2 Enrollee Self-Referral

17.2.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments paid through separate arrangements with the state of Washington.

17.2.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

17.2.3 The Enrollees also may choose to receive such services from the Contractor.

17.2.4 The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the local health department for services provided to Enrollees up to the limits described herein.

17.2.5 The Contractor shall make a reasonable effort to subcontract with all local health departments contracted with HCA, and IHCP Providers.

17.2.6 If the Contractor subcontracts with local health departments, or IHCP Providers as Participating Providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.

17.2.7 The services to which an Enrollee may self-refer are:

17.2.7.1 Sexually transmitted disease screening and treatment services provided at participating or non-Participating Providers, including but not limited to family planning agencies, such as Planned Parenthood.

17.2.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up if provided by a local health department.

17.2.7.3 Immunizations, sexually transmitted disease screening and behavioral health services through and if provided by a school-based health center.

17.2.7.4 Crisis Response Services, including crisis intervention; crisis respite; investigation and detention services; and, evaluation and treatment. Self-referrals can also be made for assessment and intake for behavioral health services.

17.3 Pharmacy Benefits and Services

17.3.1 General Requirements:

17.3.1.1 The Contractor shall cover all covered outpatient drugs when determined to be Medically Necessary, unless otherwise excluded from coverage. This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

17.3.1.2 The Contractor shall provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature, unless otherwise directed by HCA.

17.3.1.3 The Contractor must cover all over the counter and prescription drugs produced by rebate eligible manufacturers listed on the Apple Health Expansion Preferred Drug List (AHE PDL), with the exception of those indicated as non-covered on the AHEHPDL or those Non-Contracted Drugs listed in Exhibit G and Exhibit H, or drugs which HCA has specifically instructed the Contractor not to cover.

17.3.1.4 The Contractor shall ensure that drugs produced by non-rebate eligible manufacturers are not covered, unless otherwise instructed by HCA to cover these products as defined on the AHEHPDL.

17.3.1.5 The Contractor shall have in place a mechanism to deny prescriptions:

17.3.1.5.1 Written by excluded providers; and

17.3.1.5.2 Prescribed for non-medically accepted indications.

17.3.1.6 The Contractor shall allow up to a ninety (90) day supply as an early prescription refill for prescriptions that are lost, stolen, or destroyed once per prescription per 6-month period. The period replacement prescription shall be for the same quantity and number of days of supply as the lost, stolen, or destroyed prescription. Exceptions to the 6-month period may be granted for extreme circumstances (e.g. fire, flood, natural disaster, etc.) at the AHEHPs discretion.

17.3.1.7 The Contractor shall allow, once every 6 months, up to a ninety (90) day supply as an early prescription refill for a vacation for each prescription due during the vacation period.

17.3.2 The Contractor shall have a refill threshold in place that is no higher than an 80 percent refill allowance.

17.3.2.1 Any proposed changes to the refill threshold must be submitted to HCA for review and approval prior to implementation, at least ninety (90) calendar days prior to implementing any changes.

17.3.3 Apple Health Expansion Preferred Drug List

17.3.3.1 The Contractor must use the AHEHPDL as its primary preferred drug list. HCA has final authority on the status of products included on the AHPDL. HCA will provide the Contractor with opportunities to offer feedback on the preferred status of products on the AHEHPDL.

17.3.3.1.1 The Contractor must use the AHEHPDL Specialty Drug List as its primary Specialty Drug List and only require members to obtain medications through specialty pharmacies when designated by HCA.

17.3.3.2 The Contractor will follow the preferred status, authorization criteria, quantity limits, step therapy protocols, specialty drug designation, 90-day supply designation and other restrictions as directed by HCA. In the absence of an HCA approved authorization criteria or clinical policy the Contractor shall use its own drug specific policy if available, when HCA requires prior authorization for medical necessity.

17.3.3.3 HCA will notify the Contractor of major changes to the preferred status, authorization criteria, quantity limits, step therapy protocol, specifically drug designation, 90-day supply designation or other restrictions for products on the AHEHPDL at least ninety (90) calendar days prior to implementation of the changes, unless it is an urgent request, see subsection 17.3.3.4.3. The Contractor has ten (10) Business Days to review the file and submit questions or requests for changes to HCA. HCA will respond and provide final determination no later than sixty (60) calendar days prior to implementation.

17.3.3.3.1 HCA may request urgent implementation of new criteria when an existing product receives a new indication or when a new drug comes to market. Contractor must implement those policies within thirty (30) calendar days of receipt.

17.3.3.4 HCA shall provide the Contractor with comprehensive files detailing the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions for products included in the AHEHPDL. The file will also contain product specific information such as product identification number and specific National Drug Code (NDC).

17.3.3.4.1 HCA will provide the AHEHPDL file through MFT protocol posted on HCA website. The file will be submitted in a format and at a frequency mutually agreed upon by all participating Apple Health Managed Care Contractors and HCA.

17.3.3.4.2 The Contractor will adjudicate claims using the AHEHPDL file within ten (10) Business Days of notification the file is available.

17.3.3.4.3 The Contractor has three (3) Business Days to review the file and request an extension if the Contractor

determines any change is too complex to implement within the required timeframe. HCA will review the request and notify Contractor whether an extension is granted on the next Business Day.

17.3.3.5 The Contractor shall place new drugs to market on prior authorization until otherwise directed by HCA.

17.3.3.6 The Contractor must achieve a threshold of at least 90 percent of the number of prescriptions written for preferred versus non-preferred products on the AHPDL per calendar quarter, excluding drugs that were given on-going continuation status. Contractor shall provide data to HCA forty-five (45) calendar days after the end of each calendar quarter in a format determined by HCA. The first quarter AHEHPDL Compliance report is due May 15.

17.3.3.7 The HCA may require a corrective action for any AHEHPDL non-compliance. HCA may impose sanctions if corrective actions fail to improve AHEHPDL compliance.

17.3.4 Wrap-around Drug Formulary Requirements for drugs not on the AHEHPDL

17.3.4.1 The Contractor must develop and maintain a wraparound formulary for drugs not included within a class on the AHEHPDL.

17.3.4.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AHEHPDL:

17.3.4.2.1 Antigens and allergens;

17.3.4.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

17.3.4.2.3 Antihemophiliac Blood Product – Blood factors VII, VIII, and IX and the anti-inhibitor provided to Enrollees with a diagnosis of hemophilia or von Willebrand disease when the Enrollee is receiving services in an inpatient setting.

17.3.4.2.4 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:

17.3.4.2.4.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over-the-counter. There are no limits to these

OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

17.3.4.2.4.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.

17.3.4.2.4.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months.

17.3.4.2.4.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the Enrollee requests a smaller supply.

17.3.4.2.4.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs.

17.3.4.2.5 All drugs FDA labeled or prescribed as MOUD or maintenance therapy for substance use disorders, with the exception of methadone dispensed directly by opiate substitution treatment programs. The Contractor will cover all MOUD according to detailed guidelines and requirements determined by HCA.

17.3.4.2.6 The term “Formulary” as used in this subsection includes lists of products and their formulary status, preferred status, authorization requirements and coverage limitations available through retail specialty, and mail order pharmacies, and drugs paid by the Contractor under the medical benefits.

17.3.4.2.7 HCA may require changes to the formulary at any time, upon sixty (60) calendar days’ written notice of the change. Required formulary changes may include any aspect of drug coverage, including, but not limited to: formulary status, limitations, prior authorization requirements, approval criteria, use of automated overrides, or determination of the benefit under which a product will be available. Failure to make requested changes by the date specified in HCA’s notice may result in sanctions as described in

the Sanctions subsection of this Contract.

17.3.4.2.8 If HCA determines the Contractor's online formulary does not accurately reflect coverage requirements, or the Contractor is not providing coverage as previously required by HCA, the Contractor shall make the necessary changes in coverage and update its online formulary and related materials as required by HCA within five (5) Business Days of the request.

17.3.4.2.9 The Contractor shall have a process in place to allow access to all non-formulary drugs, other than those that are Non-Contracted, when determined to be Medically Necessary.

17.3.4.2.10 The Contractor shall produce their wrap-around drug formulary and related materials to HCA, upon request. The submission shall be in an electronic format according to HCA specifications.

17.3.4.2.10.1 Any change to the formulary must be approved in writing by HCA before publication. Any proposed changes to the formulary and utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc., must be submitted to HCA for review and approval prior to implementation, at least ninety (90) calendar days prior to implementing any changes.

17.3.4.2.11 The Contractor shall provide prominent public online access to the AHEHPDL, the plan formulary and coverage criteria shall include information on how to request authorization for covered drugs, non-preferred drugs, and non-formulary drugs. The online formulary shall be easy to access and the website in which it is situated will be designed to use easily understandable language.

17.3.5 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act).

17.3.5.1 The Contractor will apply the drug status, authorization criteria, quantity limits, and other restrictions established by HCA policy 65.10.00 Analgesics Opioid Agonists found at: https://www.hca.wa.gov/assets/billers-and-providers/opioid-policy.pdf

17.3.5.1.1 The Contractor will apply the exception criteria established by HCA policy 65.10.00 Analgesics Opioid Agonists as an expedited authorization (EA) using the EA codes published on the Apple Health EA list.

17.3.5.1.2 The Contractor will use the attestation forms provided

by HCA in relation to HCA policy 65.10.00 Analgesics Opioid Agonists. Contractor may modify the forms to include branding and Contractor specific contact information.

17.3.5.1.2.1 The Contractor and its Subcontractors shall maintain the member specific attestation form(s) as part of the member's medical record and follow the record requirements in Section 2 of this Contract.

17.3.5.1.3 Contractor will use the approval and denial language provided by HCA when reviewing requests in relation to HCA policy 65.10.00 Analgesics Opioid Agonists. For situations not accounted for in the provided approval or denial language the Contractor may use their own language for notifications and send a copy to the Applehealthpharmacypolicy@hca.wa.gov mailbox.

17.3.6 Provider and Enrollee Notification

17.3.6.1 The Contractor shall have policies and procedures for notifying Providers and Enrollees of changes to the Contractor's Formulary or AHEHPDL, and any changes to Prior Authorization requirements.

17.3.6.1.1 The Contractor shall provide:

17.3.6.1.1.1 Written notification for changes to the Formulary or AHEHPDL and Prior Authorization requirements to all affected Providers and Enrollees at least thirty (30) days prior to the effective date of the change.

17.3.6.1.1.2 Written information about changes to the Formulary or AHEHPDL and Prior Authorization requirements upon request by Providers or Enrollees.

17.3.6.1.1.3 Provide information about Formulary, AHEHPDL, and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

17.3.7 Medication Therapy Management

17.3.7.1 The Contractor shall ensure its provider contracts include provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington State to provide chronic care management including comprehensive medication management services to individuals, consistent with the goals established in RCW 74.09.522.

17.3.8 Rebates

17.3.8.1 The Contractor or the Contractor's PBM is prohibited from negotiating and collecting rebates for utilization by Apple Health Expansion Enrollees with drug companies for preferred or non-preferred pharmaceutical products included on the AHEHPDL that are dispensed by a retail, mail, or specialty pharmacy. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer for a product on the AHEHPDL, all drug claims for Apple Health Expansion enrollees, must be exempt from such rebate agreements, unless the claim is for prescription drug that is not dispensed by a retail, mail, or specialty pharmacy.

17.3.8.2 The Contractor or the Contractor's PBM, is authorized to negotiate and collect rebates with drug manufacturers for any product that is not included in a class on the AHEHPDL.

17.3.8.3 The Contractor shall ensure that:

17.3.8.3.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer as defined in this Contract and show as rebate eligible on the weekly AHPDL file. A list of eligible manufacturers can be found at: https://www.hca.wa.gov/assets/billers-and-providers/rebate-customer-list.xlsx.

17.3.8.3.2 Drug rebate records are kept in accordance with the Records section of this Contact and are made available to HCA upon request.

17.3.8.4 HCA retains all funds collected from pharmaceutical manufacturers from rebates under the Apple Health Expansion Drug Rebate Program based on drug utilization by the Contractor's Enrollees.

17.3.8.5 HCA retains all funds collected from pharmaceutical manufacturers from rebates negotiated by HCA for its Apple Health Expansion program for utilization of drugs, by the Contractor's Enrollees, that are listed on the AHEHPDL.

17.3.8.6 The Contractor retains all funds from rebates or discounts negotiated by the contractor with pharmaceutical manufacturers for drugs not included in the AHEHPDL, and must report those to HCA as an offset to the costs of providing healthcare.

17.3.9 Reports

17.3.9.1 Prior Authorization

17.3.9.1.1 The Contractor shall submit a report of all prescription drug authorizations forty-five (45) calendar days after the end of the calendar quarter in a format determined by HCA. Detail must be provided by drug label name, number of requests, number denied, and number approved. The first quarter Prescription Drug

Authorization report is due May 15. The Contractor shall provide a quarterly Drug Rebate report no later than forty-five (45) calendar days following the end of the calendar quarter estimating the amounts of rebates or discounts negotiated with drug manufacturers that will be invoiced to manufacturers for drug utilization by managed care Enrollees in the preceding calendar quarter. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected. The first quarter Drug Rebate report is due May 15.

17.3.9.2 Rebates and Pharmacy Reimbursement

17.3.9.2.1 The Contractor shall provide a Network Pharmacy Reimbursement Reconciliation report detailing the actual ingredient cost and dispensing fee paid to network pharmacies by the Contractor or by the Contractor's PBM for all paid claims as well as total amount paid to the PBM for the same claims that the Contractor reported to HCA through submission of encounter data. The Network Pharmacy Reimbursement Reconciliation report is due on an ad hoc basis.

17.3.9.2.2 The Contractor shall provide a quarterly Drug Rebate report no later than forty-five (45) calendar days following the end of the calendar quarter estimating the amounts of rebates or discounts negotiated with drug manufacturers that will be invoiced to manufacturers for drug utilization by managed care Enrollees in the preceding calendar quarter. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected. The first quarter Drug Rebate report is due May 15.

17.3.9.2.3 The Contractor shall provide an annual Drug Rebate report, no later than June 30, of any actual savings collected from manufacturers for rebates or discounts negotiated by the Contractor with drug manufacturers for utilization in the previous calendar year. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected.

17.3.9.3 Confidentiality of Proprietary Rebate Information

17.3.9.3.1 The Contractor shall identify any confidential or proprietary information contained within reports. Failure to label such materials or failure to respond

timely after notice of request for public disclosure has been given shall be deemed a waiver by the Contractor of any claim that information contained in the submitted reports is confidential, proprietary or trade secrets.

17.4 **Excluded and Non-Contracted Services**

17.4.1 The following services and supplies are excluded from coverage under this Contract.

17.4.1.1 Unless otherwise required by this Contract, Ancillary Services resulting solely from or ordered in the course of receiving Non-Contracted or Excluded Services are also Non-Contracted or an Excluded Service (e.g. dressing supplies as a medical supply to care for an incision related to a cosmetic abdominoplasty).

17.4.1.2 The Contractor shall adopt the requirements applicable to Medicaid prohibiting payment for services that violate the Assisted Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).

17.4.1.3 The Contractor is not responsible for coverage of any services when an Enrollee is outside the United States of America and its territories and possessions.

17.4.1.4 Early, elective inductions (before thirty-nine (39) weeks) that do not meet medically necessary indicators set by the Joint Commission.

17.4.1.5 Long-term private duty nursing for Enrollees 18 and over;

17.4.1.6 Habilitative Services

17.4.1.7 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients; and

17.4.1.8 Intensive Behavioral Supportive Supervision (IBSS).

17.4.2 Services listed as covered services in the HCA Integrated Managed Care Wraparound Contract, and all other non-Medicaid expenditures related to state-specific programs or SAMHSA-specific Federal Block Grant services and supports are excluded in this contract unless otherwise strictly restated.

17.4.3 Services listed as covered services and services listed as not contracted services in the HCA Apple Health Integrated Managed Care Contract, where the service is allowable as a Medicaid expenditure within the Alien-Emergency Medical (AEM) service under the Medicaid State Plan, are excluded from this Contract. The following Covered Services are provided by the state and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication, or Contractor publications:

17.4.3.1 Hospital services relating to the implantation of Allogeneic Processed Thymus Tissue (Rethymic) for the treatment of congenital athymia;

17.4.3.2 Eyeglass frames, lenses, and fabrication services covered under HCA's selective contract for these services for children under age 21, and associated dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult Enrollees age 21 and over if not offered by the Contractor as a value-added benefit;

17.4.3.3 Voluntary Termination of Pregnancy;

17.4.3.4 Court-ordered transportation services, including ambulance services;

17.4.3.5 Long Term Inpatient Psych Program covered by HCA: Per diem bed rate for court-ordered mental health Involuntary Treatment Act (ITA) commitment starting the date the ninety (90) to one hundred eighty (180) day court order is issued, where the individual is approved for placement in a state hospital or HCA-contracted long-term mental health community hospital bed or E&T;

17.4.3.6 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation, and common carriers;

17.4.3.7 Ambulance services, including air and ground ambulance transportation services;

17.4.3.8 Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a dental condition, including anesthesia for dental care;

17.4.3.9 Orthodontics;

17.4.3.10 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;

17.4.3.11 Sterilizations for Enrollees under age 21, or those that do not meet requirements of Subsection 16.3 of this Contract;

17.4.3.12 Services provided by a health department when an Enrollee self-refers for care if the health department is not contracted with the Contractor;

17.4.3.13 HIV Case Management;

17.4.3.14 Prenatal Genetic Counseling;

17.4.3.15 HCA AHE Non-Contracted Drugs;

17.4.3.15.1 HCA will review and determine which new drugs are to be Non-Contracted Drugs. A drug may be Non-

Contracted if it is indicated for treatment of patients with rare diseases that are not likely to be equally distributed across the Apple Health Expansion Health Plans or if it has a price such that the Contractor's premium is no longer actuarially sound. Apple Health Expansion Non-Contracted Drugs are listed in Exhibit G, HCA Non-Contracted Drugs and Exhibit H, ASO Non-Contracted Drugs of the Washington Apple Health Integrated Managed Care Contract. AHE Non-Contracted drugs are fully carved out and covered by HCA.

17.4.3.15.2 AHE Non-Contracted Drugs are not included in the calculation of the premium payment described in subsection 5.2.1 this Contract for the Apple Health Expansion program.

17.4.3.15.3 AHE Non-Contracted Drugs are not the Contractor's responsibility regardless of claim reimbursement type other than inpatient, except when indicated on Exhibit G, HCA Non-Contracted Drugs and Exhibit H, of the Washington Apple Health Integrated Managed Care Contract.

17.4.3.15.4 Non-Contracted Drugs listed in Exhibit G, HCA Non-Contracted Drugs and Exhibit H, of the Washington Apple Health Integrated Managed Care Contract will be published on HCA's website and a link to the published list will reside in HCA's professional billing guide(s).

17.4.3.16 Sexual reassignment surgery as described in WAC 182-531-1675(6)(d) and (e) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures; and

17.4.3.17 "Treat and Refer", or treatment with no transport when provided by eligible providers defined as fire departments pursuant to a community assistance referral and education services program (CARES) as described in RCW 35.21.930.

17.4.4 The following services may be covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or Contractor publications.

17.4.4.1 Nursing facility stays that do not meet rehabilitative or skilled criteria may be covered through the Aging and Long-Term Support Administration (ALTSA); and

17.4.4.2 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;

17.4.4.3 Any service provided to an Enrollee while incarcerated with the Washington State Department of Corrections (DOC).

17.5 Patient Review and Coordination (PRC)

17.5.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135.

17.5.2 Clinical oversight of the PRC review process must be provided by a qualified professional who is legally licensed and authorized by law or rule to determine if Enrollees have used health care services at a frequency or amount that is not medically necessary. Licensed professionals that may provide this clinical oversight include Physician, ARNP, Physician's Assistant, and Registered Nurse.

17.5.3 If either the Contractor or HCA places an Enrollee into the PRC program, both parties will honor that placement.

17.5.4 The Contractor's placement of an Enrollee into the PRC program shall be considered an Adverse Benefit Determination, which shall be subject to Appeal under the provisions of the Grievance and Appeal System section of this Contract. If the Enrollee Appeals the PRC placement, the Contractor will notify HCA of the Appeal and the outcome. Contractor shall send HCA a copy of Enrollee appeal letter(s) in accordance with the timeframe provided in the Patient Review and Coordination Managed Care Program Guide published by HCA.

17.5.5 When an Enrollee is placed in the Contractor's PRC program, the Contractor shall send the Enrollee a written notice of the Enrollee's PRC placement, or any change of status, in accordance with the requirements of WAC 182-501-0135.

17.5.6 The Contractor shall send HCA a written notice of the Enrollee's PRC placement, or any change of status, in accordance with the required format provided in the Patient Review and Coordination Managed Care Program Guide published by HCA.

17.5.7 The Contractor shall ensure PRC Enrollees and providers have direct access to the Contractor's PRC-trained program staff during the Business Day, including access to make needed changes to assigned providers. The Contractor may also subcontract to provide this service.

17.5.8 The Contractor shall have policies to ensure PRC Enrollees do not experience a lapse in access to program staff that can assist with the Enrollee's ability to obtain needed prescriptions from the narcotics prescriber or Primary Care Provider.

17.5.9 For an Enrollee admitted to a licensed facility for health, treatment or behavioral health services, the Contractor shall allow a representative of the facility to make changes to assigned providers, including pharmacies, on the Enrollee's behalf without the Enrollee's written or oral consent.

17.5.10 In accord with WAC 182-501-0135, HCA will limit the ability of an Enrollee placed in the PRC program to change their enrolled Contractor for twelve (12) months after the Enrollee is placed in the PRC program by HCA or the Contractor unless the PRC Enrollee moves to a residence outside the Contractor's service areas, the Enrollee's assigned PCP no longer participates with the Contractor and is available in another AHEHP, or if the Enrollee is admitted to a subacute mental health Facility. The Contractor shall allow for a temporary change in PCP or pharmacy for the Enrollee. The Contractor shall accept notification from the Facility of the change in Enrollee status and the need for a newly assigned PCP and pharmacy. The temporary change in

providers is effective until the date of discharge from the Facility.

17.5.11 Family members of an Enrollee whose ability to change their enrolled AHEHP is limited because of placement in the PRC program may still change enrollment as provided in this Contract.

18 Third Party Liability

18.1 Definitions. For the purposes of this Section:

18.1.1 "Coordination of Benefits Agreement" or "COBA" means the national model contract which standardized the way the eligibility and Medicare Claims payment information within a claims crossover context is exchanged to allow plans that provide health or prescription coverage for a person with Medicare to determine their respective payment responsibilities when an individual is covered by more than one plan.

18.1.2 "Cost Avoidance" means a method used by HCA to avoid payment when other primary insurance resources are available to the Enrollee. When claims are submitted on behalf of Enrollees who have other primary insurance on file, payment will be denied and claims returned to the providers, who are then required to bill and collect payment from any liable third parties.

18.1.3 "Cost Recovery" (also known as "pay and chase") means that the payer pays providers for submitted claims and then attempts to recover payments from liable third parties. Payers pay and chase claims for two primary reasons: post-payment identification of primary third party resources and Social Security Act exceptions to cost avoidance that require States to pay and chase claims instead of using cost avoidance. This is required when coverage is through a parent whose obligation to pay support is enforced by the states' child enforcement agency.

18.1.4 "Post Payment Recovery" means seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). "Cost Recovery", "Post Payment Recovery" may be referred to as "pay and chase".

18.1.5 "Third Party Liability" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for services provided to Enrollees.

18.2 General Provisions

18.2.1 HCA authorizes the Contractor to obtain TPL reimbursement by any lawful means, and to coordinate benefits for Enrollees. The Contractor shall take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the Apple Health Expansion Health Plan.

18.2.2 The Contractor shall assume full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the liability of third parties to pay for services provided to Enrollees under this Contract. The Contractor also shall be responsible for identifying existing TPL resources, undertaking cost avoidance, and recovering any liability from the third party. The Contractor shall develop and implement policies and procedures to meet its obligations regarding TPL including but not limited to:

18.2.2.1 Implementation of Coordination of Benefits Agreement (COBA) with CMS and the Federal Benefits Coordination and Recovery Center (BCRC) for automated crossover claims processing for dual-eligible clients.

18.2.3 For Enrollees who have primary health insurance, the Contractor shall coordinate benefits in accordance with RCW 41.05A.005. Coordination of Benefits includes paying any applicable cost-sharing on behalf of an Enrollee,

up to the Medicaid allowed amount.

18.2.4 Nothing in this Section negates any of the Contractor's responsibilities under this Contract, including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections section of this Contract. The Contractor shall:

18.2.4.1 Identify third party resources consistent with the Contractor's policies and procedures;

18.2.4.2 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts;

18.2.4.3 Attempt to recover any third-party resources available to Enrollees and shall make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under Subsection 12.10 of this Contract;

18.2.4.4 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed;

18.2.4.5 Coordinate with out-of-network providers with respect to payment to ensure the cost to Enrollees is no greater than it would be if the services were furnished within the network;

18.2.4.6 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them;

18.2.4.7 Deny claims the primary payer denied because the provider or the Enrollee did not follow the payer's payment or adjudication rules; (e.g., claims submission without required prior authorization or untimely claims filing); and

18.2.4.8 Make its own independent decisions about approving claims for payment that have been denied by the primary payer if either (a) the primary payer does not cover the service and the Contractor does, or (b) the service was denied as not medically necessary and the provider followed the dispute resolution and/or appeal process of the primary carrier and the denial was upheld.

18.2.5 If the Contractor's allowed amount for a service exceeds the primary insurer's paid amount, the Contractor shall pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount paid by the primary insurer.

18.2.6 The Contractor shall have policies and procedures in place to investigate potential TPL resources related to trauma or accident and pursue recoveries.

18.3 Provider Agreements

All provider agreements executed by the Contractor and all provider agreements executed by subcontracting entities or organizations shall define the provider's responsibilities regarding TPL, including the provider's obligation to identify TPL coverage and, except as otherwise provided in this Contract, to seek such third party payment before submitting claims to the Contractor.

18.4 Cost Avoidance

18.4.1 The Contractor shall ensure coverage by all potential third-party payers is exhausted before the Contractor makes a payment for covered services, by directing subcontracted providers to submit a claim and receive final determination from the identified Third Party payer before billing the Contractor for services.

18.4.2 The Contractor shall use a Cost Avoidance procedure for all claims or services subject to third-party payment to the extent permitted by state and federal law. If the Contractor has established the probable existence of TPL at the time the provider submits a claim, the Contractor shall deny the claim and provide information about the Third Party payer to the billing provider.

18.4.3 The Contractor shall not require an EOB from a provider when an Enrollee has Medicare primary coverage and the service being billed is known to not be covered by Medicare. In these situations, the Contractor will become primary payer and disregard the Medicare coverage.

18.4.4 The Contractor shall not require an EOB from provider types that are unable to enroll as a Medicare provider when the Enrollee has primary Medicare coverage. In these situations, the Contractor shall pay claims from these provider types as primary payer and disregard the Medicare coverage.

18.4.5 The Contractor shall not require Prior Authorization when a Provider bills the Enrollee's AHEHP as the secondary payer. If the billing is for a service determined to be a Non-Covered Service through the Enrollee's primary payer, the Provider must then follow the Apple Health AHEHP Prior Authorization requirements.

18.4.5.1 For pharmacy claims, Prior Authorization will be required if the drug is listed on the Coordination of Benefits Exceptions provided to the Contractor by the HCA pharmacy program.

18.5 Post-Payment Recoveries

18.5.1 The Contractor shall recover funds post payment in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or the Contractor was not able to use a Cost Avoidance procedure. The Contractor shall identify and pursue all potential TPL payments. Potentially liable third party coverage sources include, but are not limited to:

18.5.1.1 Third party liability insurance (for example, group health plans including medical, pharmacy);

18.5.1.2 Self-insured plans;

18.5.1.3 Managed care organizations;

18.5.1.4 Pharmacy benefit managers;

18.5.1.5 Union and other fraternal organizations; and

18.5.1.6 Certain other state or federal programs.

18.5.2 Cost Benefit. (1) The Contractor's Post Payment Recovery processes shall not require the Contractor to spend more on an individual claim basis than the threshold limits established by the Medicaid State Plan. (2) The Contractor shall use Cost Avoidance procedures to avoid payment on any claim where TPL is on file, other than those in Subsection 18.10 below.

18.5.3 Contractor must attempt to recover any third party resources available to Enrollees and will make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under subsection 12.10 of this Contract.

18.5.3.1 Contractor must pay and chase if the claim is for a service provided to an Enrollee on whose behalf child support enforcement is being carried out if, 1) the third party coverage is through an absent parent; and 2) the Provider certifies that, if the Provider has billed a third party the provider has waited one hundred (100) calendar days from the date of billing without receiving payment before billing Medicaid.

18.5.4 Retention of Recoveries. The Contractor is entitled to retain any amounts recovered through its efforts. Distributions of recoveries will be made to the Contractor, in an amount equal to the Contractor's expenditures for the individual on whose behalf the collection was based, and to the beneficiary, any remaining amount.

18.5.5 Unsuccessful Effort. If the Contractor is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after a period of sixty (60) calendar days of such efforts the Contractor must inform HCA in a format to be determined by HCA that its efforts have been unsuccessful.

18.6 **Data**

18.6.1 HCA shall include information about known TPL resources on the daily 834 enrollment files. Any new TPL resources learned of by HCA through its contractor(s) are added to the next available enrollment file.

18.6.2 The Contractor shall:

18.6.2.1 Proactively identify those Enrollees with other primary health insurance including their enrollment and disenrollment dates, and provide this information to HCA on the Enrollees with Other Health Insurance (OHI) report;

18.6.2.2 Cooperate with HCA in any manner necessary to ensure collection of this information;

18.6.2.3 Include all third party payments by Enrollee in its regular encounter data submissions; and

18.6.2.4 Provide TPL data to any contracted provider having a claim denied by the Contractor based on the third party coverage.

18.7 **Reports**

18.7.1 The Contractor shall submit a quarterly *Recovery and Cost Avoidance Report* that includes any recoveries for third party resources as well as claims that the Contractor denies due to TPL coverage. The report shall include recoveries or denied claim payments for any covered service. The Contractor shall calculate cost savings in categories described by HCA. The Contractor shall treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data submitted to HCA. The report is due by the sixtieth (60th) calendar day following the end of the quarter. This report shall be submitted on the template provided in MC-Track.

18.7.2 The Contractor shall submit to HCA on the 15th of the month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care insurance coverage with any carrier, including the Contractor. This report should only include newly discovered third-party records and any existing records to which changes have been made during the reporting period. This report shall be submitted on the template provided in MC-Track.

18.7.3 The Contractor shall submit to HCA on the 20th of the following month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the Contractor newly becomes aware of a cause of action to recover health care costs for which the Contractor has paid under this Contract. This report shall be submitted on the template provided in MC-Track.

18.7.4 HCA will continue to terminate enrollment for clients who become eligible for Medicare.

18.8 **Compliance**

18.8.1 HCA may determine whether the Contractor is in compliance with the requirements in this Section by inspecting source documents for:

18.8.1.1 Appropriateness of recovery attempt;

18.8.1.2 Timeliness of billing;

18.8.1.3 Accounting for third party payments;

18.8.1.4 Settlement of claims; and

18.8.1.5 Other monitoring deemed necessary by HCA.

18.8.2 The Contractor shall demonstrate, upon request, to HCA that reasonable efforts have been made to seek, collect and/or report third party recoveries. HCA shall have the sole responsibility for determining whether reasonable efforts have been demonstrated. In making its determination, HCA shall (a) take into account reasonable industry standards and practices and (b) have the right to inspect the Contractor's books and records in accordance with Subsection 12.10.

18.9 **Subrogation of Rights and Third Party Liability**

18.9.1 For the purposes of this subsection:

18.9.1.1 "Injured person" means an Enrollee who sustains bodily injury.

18.9.1.2 “Contractor's health care expense” means the expense incurred by the Contractor for the care or treatment of the injury sustained, computed in accord with the Contractor's FFS schedule.

18.9.2 If an Enrollee requires health care services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

18.9.3 HCA specifically assigns to the Contractor HCA’s rights to such third party payments for health care provided to an Enrollee on behalf of HCA, which the Enrollee assigned to HCA as provided in WAC 182-503-0540.

18.9.4 HCA also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor shall be subrogated to HCA’s rights and remedies under RCW 74.09.180(2) and 41.05A.050 through 41.05A.080 with respect to covered services provided to Enrollees on behalf of HCA under chapter 74.09 RCW.

18.9.5 The Contractor may obtain a signed agreement from the Enrollee in which the Enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

18.9.6 The Contractor shall notify HCA of the name, address, and other identifying information of any Enrollee and the Enrollee's attorney:

18.9.6.1 Who settles a claim without protecting the Contractor's interest in contravention of RCW 41.05A.060; or

18.9.6.2 When a claim has been identified as having potential TPL.

18.10 **Good Cause Exemption from Billing Third Party Insurance**

18.10.1 The Contractor must have a policy to allow Enrollees the right to be exempt from billing third party insurance due to good cause. This includes a procedure that allows for the good cause process to apply on an individual claim basis and a means to flag the Enrollee’s account so that the need for additional privacy and precaution can be easily seen. “Good cause” means that the use of the third-party coverage would violate an Enrollee's confidentiality because the third party:

18.10.1.1 Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;

18.10.1.2 The Enrollee has a reasonable belief that cooperating with the Contractor in identifying TPL coverage could result in serious physical or emotional harm to the Enrollee, a child in his or her care, or a child related to him or her; or

18.10.1.3 The Enrollee is incapacitated without the ability to cooperate with the Contractor.

18.10.2 A description of this process, including any steps the Enrollee must take to seek exemption based on good cause, must be included in every notice the Contractor provides to Enrollees regarding Third Party billing or seeking cooperation with such billing. The notices must include that reasons such as

fear of domestic violence or other harm are included in good cause. The Contractor's policy must include a procedure that allows for the good cause process to apply on an individual claim basis. Any denial of good cause is an adverse benefit determination. Any communications or billing must be suspended pending a good cause request or appeal of a request denial.

19 BUSINESS CONTINUITY AND DISASTER RECOVERY

19.1 Primary and Back-up Systems

19.1.1 The Contractor shall have in place a primary and back-up system for electronic submission of data requested by HCA. This must include the use of the Inter-Governmental Network (IGN); state of Washington, Washington Technology Solutions (WaTech) approved secured Virtual Private Network (VPN) or other WaTech approved dial-up.

19.1.1.1 In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HCA Enterprise Technology Service's (ETS) review and approval.

19.2 Business Continuity and Disaster Recovery Plan

19.2.1 The Contractor shall develop and maintain a business continuity and disaster recovery plan that ensures timely reestablishment of the Enrollee information system following total loss of the primary system or a substantial loss of functionality.

19.2.1.1 The Contractor shall submit through MC-Track an annual statement by January 1 of each Contract year, certifying that there is an up-to-date business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must indicate that the system, data backup and recovery procedures have been tested, and that copies of the Contractor and Subcontractor plans are available for HCA to review and audit. The disaster plan must include the following:

19.2.1.1.1 A mission or scope statement.

19.2.1.1.2 Identification of the information services disaster recovery staff.

19.2.1.1.3 Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers.

19.2.1.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority and hardware and software vendor list.

19.2.1.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.

19.2.1.1.6 Description and location of off -site storage of system and data back-ups and ability to recover data and systems from back up files.

19.2.1.1.7 Designated recovery options which may include use of a hot or cold site.

19.2.1.1.8 Documentation that disaster recovery tests or drills have been performed.

20 HEALTH EQUITY

20.1 Staffing

20.1.1 By January 1, 2025, the Contractor shall retain a full-time health equity director who is part of the executive team. The health equity director responsibilities must include leadership in the design and implementation of the Contractor's strategies and programs to ensure Health Equity is prioritized and addressed.

20.1.2 Under the direction of the health equity director, the Contractor's policies and procedures must consider health inequities and be designed to promote Health Equity where possible, including but not limited to:

20.1.2.1 Communication strategies;

20.1.2.2 Medical and other health services policies;

20.1.2.3 Member and Provider outreach;

20.1.2.4 Quality Improvement activities, including delivery system reforms;

20.1.2.5 Grievances and Appeals;

20.1.2.6 Utilization Management;

20.1.2.7 Training of staff and managing ongoing integration efforts; and

20.1.2.8 AI/AN policies and services.

20.2 Trauma-Informed Care Education and Training

20.2.1 The Contractor shall offer education and training about Trauma-Informed Care to all Providers and other Subcontractors with direct Enrollee contact at no charge.

20.2.2 The education program shall be designed to make Providers and Subcontractors aware of the importance of providing services in a manner that is based on an understanding of the vulnerabilities and triggers of trauma, so that services can be more supportive and avoid re-traumatization.

20.2.3 The Contractor shall make Providers and Subcontractors aware of training and educational opportunities (via website announcements, provider portals, welcome booklets, etc.).

20.3 NCQA Health Equity Accreditation

20.3.1 The Contractor must earn NCQA's Health Equity Accreditation at the level of "accredited" by January 1, 2025, and maintain Health Equity Accreditation throughout the term of this Contract.

20.3.1.1 If the Contractor fails to obtain accreditation as described in this Subsection HCA may pursue enforcement activity (including but not limited to sanctions and requiring a Correction Action Plan).

20.3.2 The Contractor shall provide HCA information regarding the Contractor's progress in achieving Health Equity Accreditation upon HCA's request.

20.3.3 The Contractor shall provide HCA with evidence of the Contractor's Health

Equity Accreditation, including the results of the Contractor's most recent NCQA review.

20.3.3.1 The Contractor may authorize NCQA to provide HCA a copy of the most recent Health Equity Accreditation review for the Contractor.

EXHIBIT A – RATES

The rate exhibits are not included in this online version of the contract.

Exhibit B
Washington State Health Care Authority
Instructions for MLR Reporting
Apple Health Expansion

Table of Contents

Introduction

These instructions are for the Excel-based MLR Reporting Template. The Excel workbook is designed to collect all information needed for MLR reporting as required by this Contract.

The MLR Reporting Template for all enrollees under this Contract is to be completed and submitted to the Health Care Authority (HCA) via MC-Track by May 31st of the year following the MLR reporting year.

If the state were to make a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit new MLR reports to the state for all impacted reporting years.

General Requirements

The Contractor will aggregate data for all eligibility groups covered under this contract unless the state requires separate reporting and a separate MLR calculation for specific populations. If the data is aggregated, a description of the aggregation method used to calculate total incurred claims for each reporting year. Beginning July 1, 2024, HCA will include the Apple Health Expansion (AHE) (state only) population in the MLR calculation. The initial calculation for the AHE population will cover an eighteen-month period (July 1, 2024 through December 31, 2025) and will be included in the CY2025 MLR reporting to HCA. MCOs will not include AHE population in the CY2024 reporting period. Effective January 1, 2026, the AHE calculation will cover a twelve month period in alignment with other included populations. The AHE population will be reported separately from the IMC/AHE-EMC populations for MLR purposes.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

Plan Information

Please fill out the contact information of your MCO.

Numerator

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

The expenditures reported by the Contractor shall include non-claims costs and expenditures related to activities compliant with program integrity requirements.

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

NUMERATOR: INCURRED CLAIMS

Line 1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system.

(A) Direct claims that the MCO paid to providers for services or supplies covered under the contract and provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

Line 1.2 Incurred but not reported (IBNR) for claims incurred in the period expected to be paid in months after the known runout. This requires the MCO to estimate the cost of claims owed but not yet received.

Line 1.3 Withholds from payments made to network providers.

Line 1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers.

Line 1.5 Changes in other claims-related reserves.

Line 1.6 Reserves for contingent benefits and the medical claim portion of lawsuits.

Line 1.7 Net payment or receipts related to state-mandated solvency funds.

Line 1.8a Amount spent on fraud reduction.

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities.

Line 1.8b Amount of claims payments recovered through fraud reduction: See also Line 1.8a.

Items Deducted from Incurred Claims

Line 1.9 Claims that are recoverable for anticipated coordination of benefits (payments from third party payors).

Line 1.10 Claims payments recoveries received as a result of subrogation.

Line 1.11 Overpayment recoveries received from network providers: The State expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system.

Line 1.12 Prescription drug rebates received and accrued.

NUMERATOR: ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY

Line 2.1

Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(2) The activity must be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example,

face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

(1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model

(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.

(3) Quality reporting and documentation of care in non-electronic format.

(4) Health information technology to support these activities.

(5) Accreditation fees directly related to quality of care activities.

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(B) Patient-centered education and counseling.

(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(1) The appropriate identification and use of best clinical practices to avoid harm.

(2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.

(3) Activities to lower the risk of facility-acquired infections.

(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.

(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

(6) Health information technology to support these activities.

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include

(1) Wellness assessments;

(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

(4) Public health education campaigns that are performed in conjunction with State or local health departments;

(ii) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims,

(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(8) Health information technology to support these activities.

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

Expenditures and activities that must not be included in quality improving activities are:

1. Those that are designed primarily to control or contain costs;
2. The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;
3. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;
4. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;
5. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD–10 code sets;
6. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;
7. All retrospective and concurrent utilization review;
8. Fraud prevention activities;
9. The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;
10. Provider credentialing;
11. Marketing expenses;

12. Costs associated with calculating and administering individual enrollee or employee incentives;
13. That portion of prospective utilization that does not meet the definition of activities that improve health quality.

Line 2.2 MCO activity related to any EQR-related activity performed by the State, its agent, or EQRO:

1. Validation of performance improvement projects that were underway during the preceding 12 months.

2. Validation of MCO performance measures calculated by the State during the preceding 12 months.

3. A review, conducted within the previous 3-year period, to determine the MCO's compliance with the availability of services standards, the disenrollment requirements and limitations described, the enrollee rights requirements, the emergency and post-stabilization services requirements, and the quality assessment and performance improvement requirements. This will not apply to the first 18 months of the program.
4. Validation of MCO network adequacy during the preceding 12 months.
5. Validation of encounter data reported by an MCO.
6. Administration or validation of consumer or provider surveys of quality of care.
7. Calculation of performance measures in addition to those reported by an MCO and validated by an EQRO.
8. Conduct of performance improvement projects in addition to those conducted by an MCO and validated by an EQRO.
9. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

Assist with the quality rating of MCOs.

Line 2.3 MCO expenditure that is related to Health Information Technology and meaningful use and is not considered incurred claims.

Excluded Non-Claim Costs

This worksheet collects information for items excluded from the numerator, but is required to be reported. Note that incurred claims by one MCO that are later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 3.1 Amounts paid to third party vendors for secondary network savings.

Payments made by one managed care plan to another vendor to purchase their network for use as a secondary network. In practice, the managed care plan purchases another managed care plan's network to serve as contracted, out-of-network providers so as to avoid single-case agreements with those providers, resulting in savings on out-of- network service costs.

Line 3.2 Amounts paid to third party vendors for network development, admin fees, claims: processing, and utilization management.

Line 3.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees.

Line 3.4 Fines and penalties assessed by regulatory authorities.

Line 3.5 Amounts paid to the State as remittance for prior MLR experience.
Remittance to the State if specific MLR is not met.

Line 3.6 Amounts for pass-through payments under.

Third Party Vendor/Subcontractor Requirements

If a managed care plan delegates any of its activities or obligations under its contract with the State to a subcontractor, then:

(1) The delegated activities or obligations, and related reporting responsibilities, must be specified in a contract or written agreement;

(2) The subcontractor must agree to perform the delegated activities and reporting responsibilities specified in compliance with the managed care plan's contract obligations; and

(3) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the managed care plan determine that the subcontractor has not performed satisfactorily.

The MCO must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR calculation and reporting. Consequently, all subcontractors that administer claims for the MCO must report the incurred claims, expenditures for activities that improve health care quality, information about mandatory deductions or exclusions from incurred claims (overpayment recoveries, rebates, other non-claims costs, etc.) to the MCO. The reporting must be in sufficient detail to allow the MCO to accurately incorporate the expenditures associated with the subcontractor's activities into the Contractor's overall MLR calculation. The level of detail must be no less than the reporting requirements outlined in this document, but may need to be more if necessary to accurately calculate an overall MLR or to comply with any additional reporting requirements imposed by the state in its contract with the managed care plan.

The MCO may only include in incurred claims for services covered under this contract the amount that the subcontractor actually pays the medical provider or supplier for providing

services covered under this contract to enrollees. Where the subcontractor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense and should not be counted as an incurred claim for the purposes of MLR calculations.

Denominator

DENOMINATOR: PREMIUM REVENUE

This worksheet collects information for the denominator. Note that the total amount of the denominator for a MCO, which is later assumed by another entity, must be reported by the assuming MCO for the entire MLR reporting year, and no amount for that year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 4.1 State capitation payments, including adjustments, excluding pass-through payments.

Line 4.2 State developed one time payments for specific life events of enrollees.

Line 4.3 Earned premium withholds – this will not apply to the first 18 months of the program.

Line 4.4 Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract:

> Unpaid cost-sharing amounts that the MCO could have collected from enrollees under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect.
>
> **Does not apply**.

Line 4.6 Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms risk corridors, reinsurance, and stop loss limits.

DENOMINATOR: FEDERAL, STATE, AND LOCAL TAXES

Taxes paid by the MCO if applicable.

Line 5.3 Federal taxes and assessments allocated to MCOs: Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

Line 5.4 State and local taxes and assessments:

(iv) State and local taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific

claims) paid to the State or locality directly.

(B) Guaranty fund assessments.

(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures.

Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:

(1) Are available broadly to the public and serve low-income consumers;

(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;

(4) Leverage or enhance public health department activities such as childhood immunization efforts; and

(5) Otherwise would become the responsibility of government or another tax-exempt organization.

MLR Calculation

This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. There are also inputs for member months and credibility adjustments if applicable. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible but the Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

The MCO should enter the number of member months in the appropriate cell.

The State has elected a minimum MLR of 85%

Expense Allocation

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document.

Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results and shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

Remittance Calculation

Remittance of amounts owed to the State will be calculated as described in Risk Corridor Program section of this contract.

Exhibit C

DATA USE, SECURITY, AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit:

1.1. **"Authorized User"** means an individual or individuals with an authorized business need to access HCA's Confidential Information under this Contract.

1.2. **"Breach"** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract that compromises the security, confidentiality or integrity of the Data.

1.3. **"Data"** means the information that is collected, accessed, disclosed, or exchanged as described by this Contract. For purposes of this Exhibit, Data means the same as "Confidential Information."

1.4. **"Disclosure"** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

1.5. **"Electronic Protected Health Information (ePHI)"** means Protected Health Information that is transmitted by electronic media or maintained as described in the definition of electronic media at 45 C.F.R. § 160.103.

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

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

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

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

1.7. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, as amended, together with its implementing regulations, including the Privacy Rule, Breach Notification Rule, and Security Rule. The Privacy Rule is located at 45 C.F.R. Part 160 and Subparts A and E of 45 C.F.R. Part 164. The Breach Notification Rule is located in Subpart D of 45 C.F.R. Part 164. The Security Rule is located in 45 C.F.R. Part 160 and Subparts A and C of 45 C.F.R. Part 164.

1.8. **"HIPAA Rules"** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.

1.9. "**Medicare Data Use Requirements**" refers to the documents attached and incorporated into this Exhibit as Schedules 1, and 2 that set out the terms and conditions Contractor must agree to for the access to and use of Medicare Data for the Enrollees who are dually eligible in the Medicare and Medicaid programs.

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

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

1.12. **"PRISM"** means the DSHS secure, web-based clinical decision support tool that shows administrative data for each Medicaid Enrollee and is organized to identify care coordination opportunities.

1.13. **"Protected Health Information"** or **"PHI"** has the same meaning as in HIPAA, excpet in this Contract the term includes information only relating to Clients.

1.14. "**ProviderOne**" means the Medicaid Management Information System, which is the State's Medicaid payment system managed by HCA.

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

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

1.17. **"Transport"** means the movement of Confidential Information from one entity to another, or within an entity, that: places the Confidential Information outside of a Secured Area or system (such as a local area network); and is accomplished other than via a Trusted System.

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

1.19. **"U.S.C."** means the United States Code. All references in this Exhibit to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at http://uscode.house.gov/

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

1.21. **"Use"** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2. Data Classification

2.1. The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4, *Data Security*, of *Securing IT Assets Standards* No. 141.10 in the *State Technology Manual* at https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets. Section 4 is hereby incorporated by reference.)

The Data that is the subject of this Contract is classified as Category 4 – Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:

2.1.1. Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;

2.1.2. Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

3. Purpose

3.1. This Exhibit G covers all data sharing, collection, maintenance, and Use of Data by Contractor for work performed under the Contract.

4. PRISM Access

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

4.2. Justification. The Data being accessed is necessary for Contractor to provide care coordination, quality improvement, and case management services for Enrollees.

4.3. PRISM Data Constraints.

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

4.3.2. The Data shared may only be used for care coordination and quality improvement purposes, and no other purposes. The Data in PRISM cannot be used for research.

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

4.4.1. Contractor 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 Contractor Contract Manager or their designee.

4.4.2. 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 Contractor's Authorized User(s) until the two forms are completed and accepted by DSHS.

4.4.3. Contractor must access these systems through SecureAccessWashington (SAW) or through another method of secure access approved by the HCA and DSHS.

4.4.4. DSHS will grant the appropriate access permissions to Contractor employees or Subcontractor employees.

4.4.5. HCA and DSHS **do not** allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. Contractor 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.

4.4.6. Contractor will notify the prism.admin@dshs.wa.gov within five (5) business days whenever an Authorized User who has access to the Data is no longer employed or contracted by the Contractor, or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

4.4.7. Contractor'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.

5. Constraints on Use of Data

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

5.2. Data shared under this Contract 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. Party 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.

5.2.1. The information received under subsection 7.18.3 of the Contract is also protected by federal law, including 42 C.F.R. Part 2, Subpart D, § 2.53, which requires HCA and their Subcontractors to:

5.2.1.1. Maintain and destroy the patient identifying information in a manner consistent with the policies and procedures established under 42 C.F.R. § 2.16;

5.2.1.2. Retain records in compliance with applicable federal, state, and local record retention laws; and

5.2.1.3. Comply with the limitations on disclosure and Use in 42 C.F.R. Part 2, Subpart D, § 2.53(d).

5.3. Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.

5.4. The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.

5.4.1. Contractor must identify:

5.4.1.1. Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and

5.4.1.2. For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.

5.4.2. Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Contract.

5.5. For all Data, including claims data, that is individually identifiable, shared outside of Contractor's system for research or data analytics not conducted on behalf of the Contractor, Contractor must provide HCA with thirty (30) calendar days' advance notice and opportunity for review and advisement to ensure alignment and coordination between Contractor and HCA data governance initiatives. Contractor will provide notice to HCAData@hca.wa.gov and hcamcprograms@hca.wa.gov. Notice will include:

5.5.1. The party/ies the Data will be shared with;

5.5.2. The purpose of the sharing; and

5.5.3. A description of the types of Data involved, including specific data elements to be shared.

5.6. Contractor must provide a report by the 15th of each month of all Data, individually identifiable and de-identified, regarding Enrollees, including claims data, shared with external entities, including but not limited to Subcontractors and researchers, to HCA on the supplied template, Data Shared with External Entities Report via MC-Track.

6. Security of Data

6.1. Data Protection

6.1.1. The Contractor must protect and maintain all Confidential Information gained by reason of this Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

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

6.1.1.2. Physically securing any computers, documents, or other media containing the Confidential Information.

6.2. Data Security Standards

6.2.1. Contractor must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.) The Security Standard 141.10 is hereby incorporated by reference into this Contract.

6.2.2. Data Transmitting

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

6.2.2.2. When transmitting Data via paper documents, the Contractor must use a Trusted System.

6.2.3. Protection of Data. The Contractor agrees to store and protect Data as described.

6.2.3.1. Data at Rest:

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

6.2.3.2. Data stored on Portable/Removable Media or Devices

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

6.2.3.2.2. HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor must protect the Data by:

6.2.3.2.2.1. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;

6.2.3.2.2.2. Controlling access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;

6.2.3.2.2.3. Keeping devices in locked storage when not in use;

6.2.3.2.2.4. Using check-in/check-out procedures when devices are shared;

6.2.3.2.2.5. Maintaining an inventory of devices; and

6.2.3.2.2.6. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

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

6.2.4. Data Segregation

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

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

6.2.4.1.1. On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

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

6.2.4.1.3. In a database that contains only HCA Data;

6.2.4.1.4. Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;

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

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

6.3. Data Disposition

6.3.1. Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

Media are to be destoryed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

6.3.2. For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 4.2.b, above. Destruction of the Data as outlined in this section of this Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

7. Data Confidentiality and Non-Disclosure

7.1. Data Confidentiality.

7.1.1. The Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:

7.1.1.1. as provided by law; or

7.1.1.2. with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

7.2. Non-Disclosure of Data

7.2.1. The Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Exhibit before gaining access to the Data identified herein. The Contractor will ensure that any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.

7.2.2. The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and non-disclosure requirements of Data under this Contract. The Contractor must retain the signed copy of employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Contractor will make this documentation available to HCA upon request.

7.3. Penalties for Unauthorized Disclosure of Data

7.3.1. The Contractor must comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.

7.3.2. The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

8. Data Shared with Subcontractors

8.1. If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor. Contractor must provide an attestation by January 31, each year that all Subcontractor(s) meet, or continue to meet, the terms, conditions, and requirements in this Exhibit.

9. Data Breach Notification

9.1. The Breach or potential compromise of Data must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov and to the Managed Care Contract Manager at hcamcprograms@hca.wa.gov within five (5) business days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within 15 business days of discovery. To the extent possible, these reports must include the following:

9.1.1. The identification of each individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;

9.1.2. The nature of the unauthorized use or disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;

9.1.3. A description of the types of PHI involved;

9.1.4. The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects, and protect against recurrence;

9.1.5. Any details necessary for a determination of the potential harm to Enrollees whose PHI is believed to have been used or disclosed and the steps those Enrollees should take to protect themselves; and

9.1.6. Any other information HCA reasonably requests.

9.2. The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.

9.3. The Contractor must notify HCA in writing, as described in Section 8.1 above, within two (2) business days of determining notification must be sent to enrollees.

9.4. At HCA's request, the Contractor will provide draft Enrollee notification to HCA at least five (5) business days prior to notification, and allow HCA an opportunity to review and comment on the notifications.

9.5. At HCA's request, the Contractor will coordinate its investigation and notifications with HCA and the Office of the State of Washington Chief Information Officer (OCIO), as applicable.

10. HIPAA Compliance

10.1. The Contractor must perform all of its duties, activities, and tasks under this Contract in compliance with HIPAA, the HIPAA Rules, and all applicable regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable. The Contractor and Contractor's subcontracts must fully cooperate with HCA efforts to implement HIPAA requirements.

10.2. Within ten business days, Contractor must notify the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov, with a copy to the Managed Care Contract Manager at hcamcprograms@hca.wa.gov, of any complaint, enforcement, or compliance action initated by the Office for Civil Rights based on an allegation of violation of HIPAA or the HIPAA Rules and must inform HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines, or sanctions imposed against Contractor for violations of HIPAA or the HIPAA Rules and for any sanction imposed against its Subcontractors or agents for which it is found liable.

11. Inspection

11.1. HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

12. Indemnification

12.1. The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.

Medicare Data Use Requirements Documents

Schedule 1: Medicare Part D – Conflict of Interest Attestation

Schedule 2: PRISM Access Request Form

Exhibit C-1

Schedule 1, Medicare Part D - Conflict of Interest Attestation

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]

Exhibit C-1

Schedule 2, PRISM Access Request Form

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

EXHIBIT D
APPLE HEALTH EXPANSION
REGIONAL SERVICE AREA
Effective July 1, 2024

Region/County	Community Health Plan	Coordinated Care	Molina Healthcare	United Healthcare
GREATER COLUMBIA	**X**	**X**	**X**	
ASOTIN, BENTON, COLUMBIA, FRANKLIN, GARFIELD, KITTITAS, WALLA WALLA, WHITMAN, YAKIMA				
GREAT RIVERS	**X**	**X**	**X**	**X**
COWLITZ, GRAYS HARBOR, LEWIS, PACIFIC, WAHKIAKUM				
KING	**X**	**X**	**X**	**X**
King				
NORTH CENTRAL	**X**	**X**	**X**	
CHELAN, DOUGLAS, GRANT, OKANOGAN				
NORTH SOUND	**X**	**X**	**X**	**X**
ISLAND, SAN JUAN, SKAGIT, SNOHOMISH, WHATCOM				
PIERCE	**X**	**X**	**X**	**X**
Pierce				
SALISH	**X**	**X**	**X**	**X**
CLALLAM, JEFFERSON, KITSAP				
SOUTHWEST	**X**	**X**	**X**	
CLARK, KLICKITAT, SKAMANIA				
SPOKANE	**X**	**X**	**X**	
ADAMS, FERRY, LINCOLN, PEND OREILLE, SPOKANE, STEVENS				
THURSTON-MASON	**X**	**X**	**X**	**X**
MASON, THURSTON				

Exhibit E

Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (IHCPs)

1. Purpose of Addendum; Supersession.

The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network provider agreement by and between _____ (herein "Managed Care Plan") and _____ (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network provider agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. Definitions.

For purposes of this Addendum, the following terms and definitions shall apply:

a. "American Indian/Alaska Native (AI/AN)" means any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

   i. Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member;
   ii. Is an Eskimo or Aleut or other Alaska Native;
   iii. Is considered by the Secretary of the Interior to be an Indian for any purpose; or
   iv. Is determined to be an Indian under regulations issued by the Secretary.

   The term "AI/AN" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

b. "Indian Health Care Provider (IHCP)" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 USC 1603).

c. "Managed Care Plan" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Manager (PCCM) or Primary Care Case Managed Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. § 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

d. "Indian Health Service or IHS" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 USC 1661.

e. "Indian tribe" has the meaning given in the IHCIA Section 4(14), 25 USC 1603(14).

f. "Tribal health program" has the meaning given in the IHCIA Section 4(25), 25 USC 1603(25).

g. "Tribal organization" has the meaning given in the IHCIA Section 4(26), 25 USC 1603(26).

h. "Urban Indian organization" has the meaning given in the IHCIA Section 4(29), 25 USC 1603(29).

3. Description of IHCP.

The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

☐ IHS.

☐ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450 et seq.

☐ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450 et seq.

☐ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 USC 47 (commonly known as the Buy Indian Act).

☐ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. Cost-Sharing Exemption for AI/ANs; No Reduction in Payments.

The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an AI/AN who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an AI/AN who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, (42 USC 1396o-(j)), 42 C.F.R. § 447.56 and 457.535.

5. Enrollee Option to Select the IHCP as Primary Health Care IHCP.

The Managed Care Plan shall allow any AI/AN otherwise eligible to receive services from an IHCP to choose the IHCP as the AI/AN's primary health care provider if the IHCP has the capacity to provide primary care services to such AI/AN, and any referral

from such IHCP to a network provider shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, (42 USC 1396u-2(h)), 42 C.F.R § 438.14((b)(3), and § 457.1209.

6. Agreement to Pay IHCP.

The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in section 1932(h) of the Social Security Act, (42 USC 1396u-2(h)), 42 C.F.R. § 438.14 and § 457.1209.

7. Persons Eligible for Items and Services from IHCP.

a. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 USC 1601 et seq. and/or 42 C.F.R. Part 136.

b. No term or condition of the Managed Care Plan's network provider agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. Applicability of Federal Laws not Generally Applicable to other Providers.

Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in Appendix A.

9. Non-Taxable Entity.

To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. Insurance and Indemnification.

a. Indian Health Service. The Indian Health Service (IHS) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

b. Indian Tribes and Tribal Organizations. A provider which is an Indian tribe or a tribal organization operating under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 USC 450, or employee of a tribe or tribal organization (including

contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability. This is because Indian tribes and tribal organizations operating under a contract or compact to carry out programs, services, functions, and activities, (or programs thereof) of the IHS pursuant to the ISDEAA, 25 USC 450, are covered by the FTCA, which means the United States consents to be sued in place of employees of a tribe or tribal organization (including contractors) for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of employees acting within the scope of their employment. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such provider, any employee of such provider, or any personal services contractor to perform any act outside the scope of his/her employment.

c. Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider attests that it is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such provider or any employee of such provider to perform any act outside the scope of his/her employment.

11. Licensure and Accreditation.

Pursuant to 25 USC 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity attests that it meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

12. Dispute Resolution.

In the event of any dispute arising under the Managed Care Plan's network provider agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. Governing Law.

The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. Medical Quality Assurance Requirements.

To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA (25 USC 1675).

15. Claims Format.

The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA (25 USC 1621e(h)), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. Payment of Claims.

The Managed Care Plan shall pay claims from the IHCP in accordance section 1932(h)(2) of the Act, (42 USC 1396u-2(h)), 42 C.F.R. § 438.14(c)(2), and § 457.1209 (the "Federal Payment Amount Requirements"), and shall pay at either the rate provided under the state plan in a Fee-For-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the IHS (the "IHS Encounter Rate"), whichever is higher; provided that, if the Managed Care Plan does not pay the IHS Encounter Rate, the state shall pay the difference between the IHS Encounter Rate and the amount paid by the Managed Care Plan such that the IHCP receives the amount to which it is entitled under the Federal Payment Amount Requirements.

17. Hours and Days of Service.

The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. Coordination of Care/Referral Requirements.

The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan.

19. Sovereign Immunity.

Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. Endorsement.

IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan: **For the IHCP**:

By: _____ By: _____

Name: _____ Name: _____

Date: _____ Date: _____

APPENDIX A

The following laws apply to each type of IHCP as follows:

(a) Indian Health Service:
(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:
(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.; (3) FTCA, 28 U.S.C. §§ 2671-2680;
(3) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(4) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(5) HIPAA, 45 C.F.R. Parts 160 and 164.

(c) An urban Indian organization that is an IHCP:
(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(3) HIPAA, 45 C.F.R. Parts 160 and 164.

EXHIBIT F
SCOPE OF BENEFITS
APPLE HEALTH EXPANSION (AHE)

The table below provides a general description of the scope of services included by the Apple Health Expansion Contract

For more information regarding the health care coverage, see WAC 182-501-0050, for health care coverage-program benefit packages by Enrollee eligibility category, see WAC 182-501-0060, and for a description of the category of covered services, see WAC 182-501-0065.

The limitations of amount, scope, or duration noted in the regulations referenced below set the minimum standard the Contractor must apply. The Contractor may set limits on amount, scope, or duration more generous than the State's fee-for-service program (FFS) but cannot be more restrictive. The WACs in this table are informational and are not incorporated by reference in this Contract.

Service	Summary of Scope/Limitations

Applied Behavior Analysis (ABA)	• Available to all Enrollees regardless of age when medically necessary.
	
	<u>WAC references</u>
	• Applied behavior analysis (ABA)—Client eligibility.
	  ○ WAC 182-531A-0400
	• Applied behavior analysis (ABA)—Stage one: Center of Excellence (COE) evaluation and order.
	  ○ WAC 182-531A-0500
	• Applied behavior analysis (ABA)—Stage two: Functional assessment and treatment plan development.
	  ○ WAC 182-531A-0600
	• Applied behavior analysis (ABA)—Stage three: Delivery of ABA services.
	  ○ WAC 182-531A-0700
	• Applied behavior analysis (ABA)—Covered services.
	  ○ WAC 182-531A-0900
	• Applied behavior analysis (ABA)—Noncovered services.
	  ○ WAC 182-531A-1000
	• Applied behavior analysis (ABA)—Prior authorization and recertification of ABA services.
	  ○ WAC 182-531A-1100

Behavioral Health services	Services include, but are not limited to: • Behavioral Health Care Coordination and

Service	Summary of Scope/Limitations
	Community Integration; • Crisis Intervention; • Crisis Stabilzation; • Intake evaluation, assessment, and screenings (mental health); • Intake evaluation, assessment, and screenings (Substance Use or Problem Gambling Disorder); • Medication Management; • Medication Monitoring; • Peer Support Services; • Substance Use Disorder Brief Intervention; • Substance Use Disorder Case Management; • Substance Use Disorder Withdrawal Management; • Substance Use or Problem Gambling Disorder Treatment Interventions; **WAC references:** • Psychiatric physician-related services and other professional mental health services. o WAC 182-531-1400 • Substance abuse detoxification physician-related services. o WAC 182-531-1650 • Alcohol and substance misuse counseling (SBIRT) o WAC 182-531-1710
Dental Services	• Contracted services include: o Prescriptions written by a dentist. o Medical/surgical services provided by a dentist. o Hospital/Ambulatory Surgery Center facility charges. • All other dental services are covered FFS by WA State HCA. **WAC References** o • Physician-Related Services: o Chapter 182-531 WAC • Prescription drug coverage: o WAC 182-530-2000 o WAC 182-530-2100

Service	Summary of Scope/Limitations

Diagnostic Services (Laboratory and Radiology)	• "Pathology services" are the same as "laboratory services" and are covered under the inpatient hospital benefit.
	• Limitations shown below are for outpatient diagnostic services only:
	  ○ Drug screens only when medically necessary and when:
	  ▪ Ordered by a physician as part of a medical evaluation; or
	  ▪ As drug and alcohol screens required to assess suitability for medical tests or treatment.
	• Portable x-ray services furnished in the Enrollee's home or a nursing facility are limited to films that do not involve the use of contrast media.
	
	<u>WAC References</u>
	• Anesthesia providers and covered physician-related services.
	  ○ WAC 182-531-0300
	• Laboratory and pathology physician-related services.
	  ○ WAC 182-531-0800
	• Radiology physician-related services.
	  ○ WAC 182-531-1450

Donor Human Milk	• Medically necessary donor human milk for any inpatient use when ordered by a licensed health care provider with prescriptive authority or an international board-certified lactation consultant certified by the International Board of Lactation Consultant Examiners (IBCLE) for an infant who is medically or physically unable to receive maternal human milk or participate in chest feeding or whose parent is medically or physically unable to produce maternal human milk in sufficient quantities or caloric density or participate in chest feeding, if the infant meets at least one of the criteria listed in accordance with RCW 48.43.518(1)(a) – (o). • WAC 110-300-0281

Service	Summary of Scope/Limitations
Enteral Nutrition	• Enteral nutrition products and supplies for tube-feeding are covered for all Enrollees. • Medically necessary oral enteral nutrition products for Enrollees 20 years of age and under. **<u>WAC References</u>** • For Eligibility Criteria: o WAC 182-554-300 • Covered Orally Administered Enteral Nutrition Products, Equipment, and Related Supplies, age 20 and younger: o WAC 182-554-500 • Covered Orally Administered Enteral Nutrition Products, Equipment, and Related Supplies: Thickeners: o WAC 182-554-525 • Covered orally administered enteral nutrition products, equipment and related supplies—Enrollees with amino acid, fatty acid, and carbohydrate metabolic disorders, and phenylketonuria. o WAC 182-554-550 • Covered enteral nutrition products, equipment and related supplies—Tube-delivered. o WAC 182-554-600 • Noncovered—Enteral nutrition products, equipment, and related supplies. o WAC 182-554-800
Freestanding Kidney Centers	• Covered as an outpatient service when provided by a freestanding renal dialysis center or a freestanding community hemodialysis unit. **<u>WAC References</u>** • Eligibility o WAC 182-540-110 • Covered services o WAC 182-540-130 • Noncovered services o WAC 182-540-140 • Reimbursement – General o WAC 182-540-150 • Epoetin alpha (EPO) therapy o WAC 182-540-200
Health Care Professional Services	Services include, but are not limited to: • Alcohol and substance misuse counseling • Allergen immunotherapy services; • Anesthesia services;

Service	Summary of Scope/Limitations

	• Dialysis and end stage renal disease services
	• Emergency physician services;
	• ENT (ear, nose, and throat) related services;
	• Reproductive health services;
	• Hospital inpatient services;
	• Maternity care, delivery, and newborn care services;
	  ○ Licensed non-nurse midwives must be an agency approved provider to participate in homebirths and in birthing centers.
	• Office visits;
	• Vision-related services
	• Osteopathic treatment services;
	• Pathology and laboratory services;
	• Physiatry and other rehabilitation services
	• Foot care and podiatry services;
	• Primary care services;
	• Collaborative Care services;
	• Psychiatric services;
	• Psychotherapy services;
	• Pulmonary and respiratory services;
	• Radiology services;
	• Surgical services;
	• Cosmetic, reconstructive, or plastic surgery, and related services and supplies to correct physiological defects (e.g., congenital or as a result of illness or physical trauma), or for mastectomy reconstruction for post cancer treatment;
	• Medication Assisted Treatment (MAT)
	• Tobacco/nicotine cessation counseling;
	• Vaccines for adults, adolescents, and children;
	• Physical Examinations only when the examination is for one of the following:
	  ○ A screening exam for Enrollees 19-20 years of age; or
	  ○ A screening pap smear, mammogram, or prostate exam.
	
	<u>WAC References</u>
	• Scope of coverage for physician-related and health care professional services—General and administrative.
	  ○ WAC 182-531-0100
	• Noncovered physician-related and health care professional services—General and administrative.
	  ○ WAC 182-531-0150

Service	Summary of Scope/Limitations
	• Anesthesia providers and covered physician-related services. o WAC 182-531-0300 • HIV/AIDS counseling and testing as physician-related services. o WAC 182-531-0600 • Inpatient chronic pain management physician-related services. o WAC 182-531-0700 • Inpatient hospital physician-related services. o WAC 182-531-0750 • Laboratory and pathology physician-related services. o WAC 182-531-0800 • Office and other outpatient physician-related services. o WAC 182-531-0950 • Manipulative therapy. o WAC 182-531-1050 • Foot care services for Enrollees twenty-one years of age and older. o WAC 182-531-1300 • Sleep studies. o WAC 182-531-1500 • Sterilization physician-related services. o WAC 182-531-1550 • Tobacco/nicotine cessation counseling. o WAC 182-531-1720 • Bariatric surgery. o WAC 182-531-1600 • Washington apple health—Gender dysphoria treatment program. o WAC 182-531-1675
Hearing Aids	• Monaural hearing aids including: o Fitting o Follow up o Batteries • Cochlear implants • Bone Anchored Hearing Aids o Covered for ages 19-20 years of age **<u>WAC References</u>** • General. o WAC 182-547-0100 • Eligibility. o WAC 182-547-0700

Service	Summary of Scope/Limitations

	• Coverage—Clients age twenty years and younger.
	  ○ WAC 182-547-0800
	• Coverage—Clients age twenty-one and older.
	  ○ WAC 182-547-0850
	• Noncovered services—Clients age twenty-one and older.
	  ○ WAC 182-547-0900

Hearing Evaluations	• Assessments of Enrollees 19-20 years of age with hearing loss, determination of the range, nature and degree of hearing loss, including the referral to medical or other professional services for restoration and rehabilitation due to hearing disorders. **WAC References** • Audiology services. ○ WAC 182-531-0375

Home Health Services	• Nursing care services are limited to:
	  ○ Services that are medically necessary;
	  ○ Services that can be safely provided in the home setting;
	  ○ Two visits per day (except for the services listed below);
	  ○ Three high risk obstetrical visits per pregnancy; and
	  ○ Infant home phototherapy that was not initiated in the hospital setting.
	• Home health aide services must be:
	  ○ Intermittent or part time;
	  ○ Ordered by a physician on a plan of care established by the nurse or therapist;
	  ○ Provided by a Medicare-certified home health agency;
	  ○ Limited to one medically necessary visit per day;
	  ○ Supervised by the nurse or therapist biweekly in the Enrollee's home.
	  ○ Social services providing care management to home health clients based on assessment of needs.
	
	WAC References
	• General.
	  ○ WAC 182-551-2000
	• Skilled services – requirements.
	  ○ WAC 182-551-2030

Service	Summary of Scope/Limitations

	• Face-to-face requirements.
	  o WAC 182-551-2040
	• Covered skilled nursing services.
	  o WAC 182-551-2100
	• Covered specialized therapy.
	  o WAC 182-551-2100
	• Covered aide services.
	  o WAC 182-551-2120
	• Delivered through telemedicine.
	  o WAC 182-551-2125
	• Noncovered services.
	  o WAC 182-551-2130
	• Exceptions.
	  o WAC 182-551-2140

Home infusion/Parenteral Nutrition Program	Covered when Enrollee:
	• Has a written physician order for all solutions and medications to be administered.
	• Is clinically stable and has a condition that does not warrant hospitalization,
	• Is able to manage their infusion in one of the following ways:
	  • Independently
	  • With a volunteer caregiver who can manage the infusion
	  • By choosing to self-direct the infusion with a paid caregiver.
	
	<u>WAC References</u>
	• Home infusion therapy/parenteral nutrition program –Enrollee eligibility and assignment.
	  o WAC 182-553-300
	• Home infusion therapy/parenteral nutrition program – coverage, services, limitation, prior authorization, and reimbursement.
	  o WAC 182-553-500

Hospice Services	• Includes services provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the Enrollee's home.
	• Concurrent Care for children on hospice in accordance with section 2302 of the Affordable Care Act.
	  o Hospice Enrollees 19-20 years of age and under are eligible.
	  o The hospice benefit may be elected without foregoing curative services to which the Enrollee is entitled for treatment of the terminal condition.

Service	Summary of Scope/Limitations

	WAC References
	• Applicability.
	  ○ WAC 182-550-1000
	• Hospital care—General.
	  ○ WAC 182-550-1100
	• Specific items/services not covered.
	  ○ WAC 182-550-1600

Hospital Services-Inpatient	• Chronic pain management is limited to inpatient services provided by an agency-approved pain center in a hospital.
	• Long-term acute care services are provided in agency approved hospitals. This is not sub-acute care; rather this is intensive acute inpatient care provided to patients who would otherwise remain in intensive care or a similar level of care outside of a hospital's intensive care unit.
	• Treatment in an Institution for Mental Diseases (IMD) is provided for up to sixty days of inpatient psychiatric treatment as an in-lieu-of service.
	• Inpatient administrative days for birthing parent of newborns with Neonatal Abstinence Syndrome or Neonatal Opioid Withdrawal Syndrome.
	• Inpatient administrative days for those days of a hospital stay in which the Enrollee does not meet criteria for acute inpatient level of care, as determined by the MCO, but is not discharged because appropriate placement outside the hospital is not available.
	
	WAC References
	• Covered and noncovered revenue codes categories and subcategories for inpatient hospital services.
	  ○ WAC 182-550-1400
	• Specific items/services not covered.
	  ○ WAC 182-550-1600
	• Transplant coverage.
	  ○ WAC 182-550-1900
	• Inpatient chronic pain management services.
	  ○ WAC 182-550-2400
	• Acute physical medicine and rehabilitation (acute PM&R) program—General.
	  ○ WAC 182-550-2501
	• Client eligibility requirements for acute PM&R services.
	  ○ WAC 182-550-2521

Service	Summary of Scope/Limitations
	• Inpatient psychiatric services ○ WAC 182-550-2600 • Admin day rate • WAC 182-550-4550

Hospital Services - Outpatient	• Hospital-owned institutional facilities that are hospital-based may provide outpatient hospital services to eligible Enrollees.
	• Freestanding hospital-owned institutional facilities that are nonhospital-based may provide outpatient services to eligible Enrollees.
	• Freestanding Ambulatory Surgery Centers
	• Rural Health Clinics
	• Federally Qualified Health Center services
	<u>WAC References</u>
	• Applicability.
	  ○ WAC 182-550-1000
	• Hospital care – general.
	  ○ WAC 182-550-1100
	• Restrictions on coverage.
	  ○ WAC 182-550-1200
	• Covered and noncovered revenue code categories and subcategories for outpatient hospital services.
	  ○ WAC 182-550-1500
	• Specific items/services not covered.
	  ○ WAC 182-550-1600
	• Outpatient hospital diabetes education
	  ○ WAC 182-550-6400
	• Federally qualified health center – services.
	  ○ WAC 182-548-1300
	• Rural health clinics – services
	  ○ WAC 182-549-1300

Medical Nutrition Therapy	• Includes medical nutrition therapy, nutrition assessment, and counseling for conditions that are within the scope of practice for a registered dietitian (RD) to evaluate and treat.
	<u>WAC References</u>
	• Eligibility
	  ○ WAC 182-555-0300
	• Covered services.
	  ○ WAC 182-555-0500

Medical supplies	• Medical supplies, equipment, and appliances suitable for use in the home.

Service	Summary of Scope/Limitations
	• Medical supplies, equipment and appliances must be: o Medically necessary; o In the Enrollee's plan of care; and o Ordered by the treating physician and renewed annually. **<u>WAC References</u>** • Hospital beds, mattresses, and related equipment. o WAC 182-543-3000 • Patient lifts/traction, equipment/fracture, and frames/transfer boards. o WAC 182-543-3100 • Osteogenesis electrical stimulator (bone growth stimulator). o WAC 182-543-3300 • Communication devices/speech generating devices (SGD). o WAC 182-543-3400 • Ambulatory aids (canes, crutches, walkers, related supplies). o WAC 182-543-3500 • Wheelchairs—General. o WAC 182-543-4000 • Wheelchairs—Manual. o WAC 182-543-4100 • Wheelchairs—Power-drive. o WAC 182-543-4200 • Prosthetics/orthotics. o WAC 182-543-5000 • Medical supplies and related services. o WAC 182-543-5500 • Medical equipment for Enrollees in skilled nursing facilities. o WAC 182-543-5700
Nursing Facility Services	• Rehabilitative or Skilled services only. **<u>WAC References</u>** • Outpatient hospital services – conditions of payment and payment methods. o WAC 182-550-6000 • Nursing Facility Services o WAC 388-97-0020 • Outpatient hospital physical therapy. o WAC 182-550-6100

Service	Summary of Scope/Limitations

	• Outpatient hospital occupational therapy.
	  o WAC 182-550-6150
	• Outpatient hospital speech therapy services.
	  o WAC 182-550-6200

Physical Rehabilitative Services	• Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders are provided when medically necessary.
	• Includes Neurodevelopmental Centers (NDC) for Enrollees age 19 -20 years of age.
	• May be provided by a home health agency or medical rehabilitation facility.
	WAC References
	• Outpatient rehabilitation (occupational therapy, physical therapy, and speech therapy).
	  o WAC 182-545-200
	• Neurodevelopmental centers.
	  o WAC 182-545-900

Prescription Drugs	• The State's preferred drug list will be used by all contracted Medicaid managed care organizations Medicaid managed care organizations cover all drugs approved by the Food and Drug Administration with a manufacturer signed drug rebate agreement. Specific drug coverage can be found on:
	  o The State's preferred drug list used by all contracted Medicaid managed care organizations.
	  o The Medicaid managed care organization's wrap-around formulary.
	WAC References
	• Outpatient drug program—General.
	  o WAC 182-530-1000
	• Requirements—Use of tamper-resistant prescription pads.
	  o WAC 182-530-1075
	• Covered—Outpatient drugs, devices, and drug-related supplies.
	  o WAC 182-530-2000
	• Noncovered—Outpatient drugs and pharmaceutical supplies.
	  o WAC 182-530-2100
	• Medicaid preferred drug list (Medicaid PDL).
	  o WAC 182-530-4100
	• Generics first for a client's first course of

Service	Summary of Scope/Limitations
	treatment. o WAC 182-530-4125 • Therapeutic interchange program (TIP). o WAC 182-530-4150
Reproductive services: Family planning	**WAC References** • Reproductive health services—Eligibility. o WAC 182-532-100 • Reproductive health services—Covered services. o WAC 182-532-120 • Reproductive health services—Noncovered services. o WAC 182-532-130
Respiratory care services	• Medically necessary oxygen and/or respiratory therapy equipment, supplies, and services to eligible Enrollees. **WAC References** • Respiratory care—General. o WAC 182-552-0001 • Respiratory care—Client eligibility. o WAC 182-552-0100 • Respiratory care—Clients residing in skilled nursing facilities, boarding homes, and adult family homes. o WAC 182-552-0150 • Respiratory care—Provider requirements. o WAC 182-552-0200 • Respiratory care—Proof of delivery. o WAC 182-552-0250 • Respiratory care—Covered—Apnea monitors and supplies. o WAC 182-552-0300 • Respiratory care—Continuous positive airway pressure (CPAP) device and supplies. o WAC 182-552-0400 • Mandibular advancement device. o WAC 182-552-0450 • Respiratory care—Covered—Bi-level respiratory assist devices and supplies. o WAC 182-552-0500 • Respiratory care—Covered—Airway clearance devices. o WAC 182-552-0600 • Respiratory care—Covered—Nebulizers, humidifiers, and accessories. o WAC 182-552-0650

Service	Summary of Scope/Limitations
	• Respiratory care—Covered—Inhalation drugs and solutions. o WAC 182-552-0700 • Respiratory care—Covered—Oxygen and oxygen equipment. o WAC 182-552-0800 • Respiratory care—Covered—Oximeters. o WAC 182-552-0900 • Covered—Respiratory and ventilator equipment and supplies. o WAC 182-552-1000 • Respiratory care—Covered—Suction pumps and supplies. o WAC 182-552-1100 • Respiratory care—Noncovered services. o WAC 182-552-1200
Tobacco Cessation Services	Tobacco/nicotine cessation counseling is covered when: • Delivered by qualified providers through an approved tobacco/nicotine cessation telephone counseling service; • Provided through screening, brief intervention, and referral to treatment (SBIRT). • For pregnant or post-partum Enrollees: o Face-to-face office visits with the following limits: ▪ Counseling must be provided by qualified physicians, advanced registered nurse practitioners (ARNPs), physician assistants-certified (PA-Cs), naturopathic physicians, pharmacists, certified nurse-midwives (CNM), licensed midwives (LM), psychologists, or dentists; ▪ Two tobacco/nicotine cessation counseling attempts are allowed every twelve months. An attempt is defined as up to four tobacco/nicotine cessation counseling sessions; and ▪ Not more than one face-to-face tobacco/nicotine cessation counseling session per Enrollee, per day. **<u>WAC References</u>** • Tobacco/nicotine cessation counseling o WAC 182-531-1720

Service	Summary of Scope/Limitations
Vision Exams/Optometrists/ Ophthalmic Services	• Medically necessary eye examinations, refractions and eyeglass/contact lens fitting fees. • For Enrollees age 19 -20 years of age , services will be provided subject to determination of medical necessity. **<u>WAC References</u>** • Vision care—General. o WAC 182-544-0010 • Vision care—Eligible persons—Twenty years of age and younger. o WAC 182-544-0100 • Vision care—Covered eyeglasses (frames and lenses)— Enrollees age twenty and younger. o WAC 182-544-0300 • Vision care—Covered eyeglass frames and repairs— Enrollees age twenty and younger. o WAC 182-544-0325 • Vision care—Covered eyeglass lenses— Enrollees age twenty and younger. o WAC 182-544-0350 • Vision care—Covered contact lenses— Enrollees age twenty and younger. o WAC 182-544-0400 • Ophthalmic services. o WAC 182-531-1000 • Vision care—Noncovered eyeglasses and contact lenses. o WAC 182-544-0575

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ANTICONVULSANTS : NEUROACTIVE STEROID- GABA MODULATOR	GANAXOLONE	ZTALMY	N/A	7/1/2024
ANTIDEMENTIA AGENTS : ANTI-AMYLOID ANTIBODIES	ADUCANUMAB-AVWA	ADUHELM	J0172	7/1/2024
ANTIDEMENTIA AGENTS : ANTI-AMYLOID ANTIBODIES	LECANEMAB-IRMB	LEQEMBI	J0174	7/1/2024
ANTIDIABETICS : ANTI-CD3 ANTIBODIES	TEPLIZUMAB-MZWV	TZIELD	J9381	7/1/2024
ANTIDIABETICS : CELLULAR THERAPY	DONISLECEL-JUJN	LANTIDRA	J3590	7/1/2024
ANTIHEMOPHILIC PRODUCTS : GENE THERAPY AGENTS	ETRANACOGENE DEZAPARVOVEC	HEMGENIX	J3490	7/1/2024
ANTIHEMOPHILIC PRODUCTS : GENE THERAPY AGENTS	FIDANACOGENE ELAPARVOVEC-DZKT	BEQVEZ	J3490	7/1/2024
ANTIHEMOPHILIC PRODUCTS : GENE THERAPY AGENTS	VALOCTOCOGENE ROXAPARVOVEC-RVOX	ROCTAVIAN	J3590	7/1/2024
ANTIHYPERLIPIDEMICS : ANGIOPOIETIN-LIKE PROTEIN INHIBITORS	EVINACUMAB-DGNB	EVKEEZA	J1305	7/1/2024
ANTIPARASITICS : FOLIC ACID ANTAGONISTS	PYRIMETHAMINE	DARAPRIM	N/A	7/1/2024
ANTIPARASITICS : FOLIC ACID ANTAGONISTS	PYRIMETHAMINE	PYRIMETHAMINE	N/A	7/1/2024
ANTIVIRALS : COVID-19 - ORAL	MOLNUPIRAVIR	LAGEVRIO	N/A	7/1/2024
ANTIVIRALS : COVID-19 - ORAL	NIRMATRELVIR-RITONAVIR	PAXLOVID	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	ELBASVIR-GRAZOPREVIR	ZEPATIER	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	GLECAPREVIR-PIBRENTASVIR	MAVYRET	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	LEDIPASVIR-SOFOSBUVIR	HARVONI	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	LEDIPASVIR-SOFOSBUVIR	LEDIPASVIR/SOFOSBUVIR	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	OMBITASVIR-PARITAPREVIR-RITONAVIR-DASABUVIR	VIEKIRA PAK	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	SOFOSBUVIR	SOVALDI	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	SOFOSBUVIR-VELPATASVIR	EPCLUSA	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	SOFOSBUVIR-VELPATASVIR	SOFOSBUVIR/VELPATASVIR	N/A	7/1/2024
ANTIVIRALS : HEPATITIS C AGENTS - DIRECT ACTING ANTIVIRALS	SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR	VOSEVI	N/A	7/1/2024
CARDIOVASCULAR AGENTS : TRANSTHYRETIN STABILIZERS	TAFAMIDIS	VYNDAMAX	N/A	7/1/2024
CARDIOVASCULAR AGENTS : TRANSTHYRETIN STABILIZERS	TAFAMIDIS MEGLUMINE (CARDIAC)	VYNDAQEL	N/A	7/1/2024
DERMATOLOGICS : GENE THERAPY	BEREMAGENE GEPERPAVEC	VYJUVEK	J3490	7/1/2024
DERMATOLOGICS : MELANOCORTIN RECEPTOR AGONISTS (UV PROTECTIVE)	AFAMELANOTIDE ACETATE	SCENESSE	J7352	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : ACID SPHINGOMYELINASE DEFICIENCY AGENTS	OLIPUDASE ALFA-RPCP	XENPOZYME	J3490	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : ADENOSINE DEAMINASE SCID TREATMENT AGENTS - INJECTABLE	ELAPEGADEMASE-LVLR	REVCOVI	J3590	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : ADRENAL STEROID INHIBITORS	LEVOKETOCONAZOLE	RECORLEV	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : ALPHA MANNOSIDOSIS AGENTS	VELMANASE ALFA-TYCV	LAMZEDE	J3590	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : CORTISOL SYNTHESIS INHIBITORS	OSILODROSTAT PHOSPHATE	ISTURISA	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : FABRY DISEASE AGENTS - INJECTABLE	AGALSIDASE BETA	FABRAZYME	J1080	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ENDOCRINE AND METABOLIC AGENTS : FABRY DISEASE AGENTS - INJECTABLE	PEGUNIGALSIDASE ALFA-IWXJ	ELFABRIO	J3590	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : FABRY DISEASE AGENTS - ORAL	MIGALASTAT HCL	GALAFOLD	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : GAA DEFICIENCY AGENTS	ALGLUCOSIDASE ALFA	LUMIZYME	J0221	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : GAA DEFICIENCY AGENTS	AVALGLUCOSIDASE ALFA-NGPT	NEXVIAZYME	J0219	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : GAA DEFICIENCY AGENTS	CIPAGLUCOSIDASE ALFA-ATGA	POMBILITI	J3490	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : GAA DEFICIENCY AGENTS	MIGLUSTAT (GAA DEFICIENCY)	OPFOLDA	J3490	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HEREDITARY TYROSINEMIA TYPE 1 (HT-1) AGENTS - ORAL	NITISINONE	NITISINONE	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HEREDITARY TYROSINEMIA TYPE 1 (HT-1) AGENTS - ORAL	NITISINONE	NITYR	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HEREDITARY TYROSINEMIA TYPE 1 (HT-1) AGENTS - ORAL	NITISINONE	ORFADIN	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HYPERAMMONEMIA AGENTS - ORAL	CARGLUMIC ACID	CARBAGLU	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HYPERAMMONEMIA AGENTS - ORAL	CARGLUMIC ACID	CARGLUMIC ACID	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : HYPOPHOSPHATASIA AGENTS - INJECTABLE	ASFOTASE ALFA	STRENSIQ	J3590	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ENDOCRINE AND METABOLIC AGENTS : INSULIN-LIKE GROWTH FACTOR-1 RECEPTOR INHIBITORS(IGF-1R)	TEPROTUMUMAB-TRBW	TEPEZZA	J3241	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : LEPTIN ANALOGUES	METRELEPTIN	MYALEPT	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : LYSOSMAL ACID LIPASE DEFICIENCY AGENTS	SEBELIPASE ALFA	KANUMA	J2840	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MOLYBDENUM COFACTOR DEFICIENCY (MOCD) AGENTS	FOSDENOPTERIN HYDROBROMIDE	NULIBRY	J3490	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS	ELOSULFASE ALFA	VIMIZIM	J1322	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS	GALSULFASE	NAGLAZYME	J1458	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS	IDURSULFASE	ELAPRASE	J1743	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS	LARONIDASE	ALDURAZYME	J1931	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : MUCOPOLYSACCHARIDOSIS AGENTS	VESTRONIDASE ALFA-VJBK	MEPSEVII	J3397	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : NATRIURETIC PEPTIDES	VOSORITIDE	VOXZOGO	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - INJECTABLE	PEGVALIASE-PQPZ	PALYNZIQ	J3590	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - ORAL	SAPROPTERIN DIHYDROCHLORIDE	JAVYGTOR	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - ORAL	SAPROPTERIN DIHYDROCHLORIDE	KUVAN	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : PHENYLKETONURIA (PKU) AGENTS - ORAL	SAPROPTERIN DIHYDROCHLORIDE	SAPROPTERIN DIHYDROCHLORIDE	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : TRIPEPTIDYL PEPTIDASE 1 DEFICIENCY AGENTS	CERLIPONASE ALFA	BRINEURA	J0567	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	CITRULLINE (UREA CYCLE)	CITRULLINE EASY	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	GLYCEROL PHENYLBUTYRATE	RAVICTI	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	SODIUM PHENYLBUTYRATE	BUPHENYL	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	SODIUM PHENYLBUTYRATE	OLPRUVA	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	SODIUM PHENYLBUTYRATE	PHEBURANE	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : UREA CYCLE DISORDER AGENTS - ORAL	SODIUM PHENYLBUTYRATE	SODIUM PHENYLBUTYRATE	N/A	7/1/2024
ENDOCRINE AND METABOLIC AGENTS : X-LINKED HYPOPHOSPHATEMIA (XLH) AGENTS	BUROSUMAB-TWZA	CRYSVITA	J0584	7/1/2024
GASTROINTESTINAL AGENTS : ILEAL BILE ACID TRANSPORTER INHIBITORS	MARALIXIBAT CHLORIDE	LIVMARLI	N/A	7/1/2024
GASTROINTESTINAL AGENTS : ILEAL BILE ACID TRANSPORTER INHIBITORS	ODEVIXIBAT	BYLVAY	N/A	7/1/2024
GASTROINTESTINAL AGENTS : ILEAL BILE ACID TRANSPORTER INHIBITORS	ODEVIXIBAT	BYLVAY (PELLETS)	N/A	7/1/2024
GASTROINTESTINAL AGENTS : SHORT BOWEL SYNDROME	TEDUGLUTIDE (RDNA)	GATTEX	J3490	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
GENITOURINARY AGENTS : HYPEROXALURIA AGENTS	LUMASIRAN SODIUM	OXLUMO	J0224	7/1/2024
GENITOURINARY AGENTS : HYPEROXALURIA AGENTS	NEDOSIRAN SODIUM	RIVFLOZA	J3490	7/1/2024
GENITOURINARY AGENTS : CYSTINOSIS AGENTS	CYSTEAMINE BITARTRATE	CYSTAGON	N/A	7/1/2024
GENITOURINARY AGENTS : CYSTINOSIS AGENTS	CYSTEAMINE BITARTRATE	PROCYSBI	N/A	7/1/2024
GENITOURINARY AGENTS : IGA NEPHROPATHY AGENTS	SPARSENTAN	FILSPARI	N/A	7/1/2024
GOUT AGENTS : PEGYLATED URIC ACID ENZYMES	PEGLOTICASE	KRYSTEXXA	J2507	7/1/2024
HEMATOLOGICAL AGENTS : ANTI-VON WILLEBRAND FACTOR AGENTS	CAPLACIZUMAB-YHDP	CABLIVI	J3590, C9047	7/1/2024
HEMATOLOGICAL AGENTS : AMINOLEVULINATE SYNTHASE 1-DIRECTED SIRNA	GIVOSIRAN SODIUM	GIVLAARI	J0223	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHIL FACT(RCMB) PEGYLATED-AUCL (BDD-RFVIII PEG-AUCL	JIVI	J7208	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (HUMAN)	HEMOFIL M	J7190	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (HUMAN)	KOATE	J7190	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (HUMAN)	KOATE-DVI	J7190	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) BD TRUNCATED (BD TRUNC-RFVIII)	NOVOEIGHT	J7182	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) FC FUSION PROTEIN(BDD-RFVIIIFC	ELOCTATE	J7205	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) FC-VWF-XTEN FUSION PROTEIN-EHT	ALTUVIIIO	J7214	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) MOROCTOCOG ALFA(BDD-RFVIII,MOR	XYNTHA	J7185	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) MOROCTOCOG ALFA(BDD-RFVIII,MOR	XYNTHA SOLOFUSE	J7185	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) PLASMA/ALBUMIN FREE (RAHF-PFM)	ADVATE	J7192	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) PLASMA/ALBUMIN FREE (RAHF-PFM)	KOVALTRY	J7211	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RCMB) SIMOCTOCOG ALFA(BDD-RFVIII,SIM	NUWIQ	J7209	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT PORCINE) (RPFVIII)	OBIZUR	J7188	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) (RFVIII)	KOGENATE FS	J7192	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) (RFVIII)	RECOMBINATE	J7192	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) GLYCOPEGYLATED-EXEI	ESPEROCT	J7204	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) PEGYLATED	ADYNOVATE	J7207	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR (RECOMBINANT) SINGLE CHAIN	AFSTYLA	J7210	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	ALPHANATE	J7186	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	HUMATE-P	J7187	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIHEMOPHILIC FACTOR/VON WILLEBRAND FACTOR COMPLEX (HUMAN)	WILATE	J7183	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	ANTIINHIBITOR COAGULANT COMPLEX	FEIBA	J7198	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX	ALPHANINE SD	J7193	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX (RECOMB) FC FUSION PROTEIN (RFIXFC)	ALPROLIX	J7201	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX (RECOMBINANT)	BENEFIX	J7195	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX (RECOMBINANT)	IXINITY	J7195	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX (RECOMBINANT)	RIXUBIS	J7200	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX (RECOMBINANT) GLYCOPEGYLATED	REBINYN	J7203	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR IX RECOMB ALBUMIN FUSION PROTEIN (RIX-FP	IDELVION	J7202	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR VIIA (RECOMBINANT)	NOVOSEVEN	J7189	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR VIIA (RECOMBINANT)	NOVOSEVEN RT	J7189	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR VIIA (RECOMBINANT)-JNCW	SEVENFACT	J7212	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR X (HUMAN)	COAGADEX	J7175	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	COAGULATION FACTOR XIII A-SUBUNIT (RECOMBINANT)	TRETTEN	J7181	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	EMICIZUMAB-KXWH	HEMLIBRA	J7170	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	FACTOR IX COMPLEX	PROFILNINE	J7194	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	FACTOR XIII CONCENTRATE (HUMAN)	CORIFACT	J7180	7/1/2024
HEMATOLOGICAL AGENTS : ANTIHEMOPHILIC PRODUCTS	VON WILLEBRAND FACTOR (RECOMBINANT)	VONVENDI	J7179	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - ORAL	AVACOPAN	TAVNEOS	N/A	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - ORAL	DANICOPAN	VOYDEYA	N/A	7/2/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - ORAL	IPTACOPAN	FABHALTA	J3490	7/3/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	ECULIZUMAB	SOLIRIS	J1300	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	PEGCETACOPLAN	EMPAVELI	J3490	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	POZELIMAB-BBFG	VEOPOZ	J3590	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	RAVULIZUMAB-CWVZ	ULTOMIRIS	J1303	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	SUTIMLIMAB-JOME	ENJAYMO	C9094	7/1/2024
HEMATOLOGICAL AGENTS : COMPLIMENT INHIBITORS - INJECTABLE	ZILUCOPLAN SODIUM	ZILBRYSQ	J3490	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	BEROTRALSTAT HCL	ORLADEYO	N/A	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	C1 ESTERASE INHIBITOR (HUMAN)	BERINERT	J0597	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	C1 ESTERASE INHIBITOR (HUMAN)	CINRYZE	J0598	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	C1 ESTERASE INHIBITOR (HUMAN)	HAEGARDA	J0599	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	C1 ESTERASE INHIBITOR (RECOMBINANT)	RUCONEST	J0596	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	ECALLANTIDE	KALBITOR	J1290	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	ICATIBANT ACETATE	FIRAZYR	J1744	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	ICATIBANT ACETATE	ICATIBANT ACETATE	J1744	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	ICATIBANT ACETATE	SAJAZIR	J1744	7/1/2024
HEMATOLOGICAL AGENTS : HEREDITARY ANGIOEDEMA AGENTS	LANADELUMAB-FLYO	TAKHZYRO	J0593	7/1/2024
HEMATOLOGICAL AGENTS : PLASMA PROTEINS - PLASMINOGEN	PLASMINOGEN, HUMAN-TVMH	RYPLAZIM	J2998	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
HEMATOLOGICAL AGENTS : PYRUVATE KINASE ACTIVATORS	MITAPIVAT SULFATE	PYRUKYND	N/A	7/1/2024
HEMATOLOGICAL AGENTS : PYRUVATE KINASE ACTIVATORS	MITAPIVAT SULFATE	PYRUKYND TAPER PACK	N/A	7/1/2024
HEMATOPOEITIC AGENTS : AUTOLOGOUS CELLULAR GENE THERAPY	BETIBEGLOGENE AUTOTEMCEL IV SUSP	ZYNTEGLO	J3490	7/1/2024
HEMATOPOIETIC AGENTS : CXCR4 RECEPTOR ANTAGONISTS	MAVORIXAFOR	XOLREMDI	J3490	7/1/2024
HEMATOPOIETIC AGENTS : ERYTHROID MATURATION AGENTS	LUSPATERCEPT-AAMT	REBLOZYL	J0896	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	ELIGLUSTAT TARTRATE	CERDELGA	N/A	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	IMIGLUCERASE	CEREZYME	J1786	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	MIGLUSTAT	MIGLUSTAT	N/A	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	MIGLUSTAT	YARGESA	N/A	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	MIGLUSTAT	ZAVESCA	N/A	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	TALIGLUCERASE ALFA	ELELYSO	J3060	7/1/2024
HEMATOPOIETIC AGENTS : GAUCHER DISEASE	VELAGLUCERASE ALFA	VPRIV	J3385	7/1/2024
HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA AGENTS - INJECTABLE	EXAGAMGLOGENE AUTOTEMCEL	CASGEVY	J3590	7/1/2024
HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA AGENTS - INJECTABLE	LOVOTIBEGLOGENE AUTOTEMCEL	LYFGENIA	J3590	7/1/2024
HEMATOPOIETIC AGENTS : SICKLE CELL ANEMIA - SELECTIN BLOCKERS	CRIZANLIZUMAB-TMCA	ADAKVEO	J0791	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	CABOTEGRAVIR	APRETUDE	J0739	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	CABOTEGRAVIR & RILPIVIRINE	CABENUVA	J0741	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	CABOTEGRAVIR	CABOTEGRAVIR ER	J0739	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	ENFUVIRTIDE	FUZEON	J1324	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	LENACAPAVIR SODIUM	SUNLENCA	J1961	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	RILPIVIRINE	RILPIVIRINE ER	J3490	7/1/2024
ANTIVIRALS : HIV – INJECTABLE	ZIDOVUDINE	RETROVIR IV INFUSION	J3485	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ANTIVIRALS : HIV - MONOCOLONAL ANTIBODIES	IBALIZUMAB-UIYK	TROGARZO	J1746	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : CYCLOSPORINE ANALOGS - ORAL	CYCLOSPORINE	CYCLOSPORINE	J7502, J7515	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : CYCLOSPORINE ANALOGS - ORAL	CYCLOSPORINE	SANDIMMUNE	J7502, J7515	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : CYCLOSPORINE ANALOGS - ORAL	CYCLOSPORINE MODIFIED (FOR MICROEMULSION)	CYCLOSPORINE MODIFIED	J7502, J7515	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : CYCLOSPORINE ANALOGS - ORAL	CYCLOSPORINE MODIFIED (FOR MICROEMULSION)	GENGRAF	J7502, J7515	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : CYCLOSPORINE ANALOGS - ORAL	CYCLOSPORINE MODIFIED (FOR MICROEMULSION)	NEORAL	J7502, J7515	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS - ORAL	MYCOPHENOLATE MOFETIL	CELLCEPT	J7517	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS - ORAL	MYCOPHENOLATE MOFETIL	MYCOPHENOLATE MOFETIL	J7517	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS - ORAL	MYCOPHENOLATE SODIUM	MYCOPHENOLIC ACID DR	N/A	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS - ORAL	MYCOPHENOLATE SODIUM	MYFORTIC	N/A	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	EVEROLIMUS (IMMUNOSUPPRESSANT)	EVEROLIMUS	J7527	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	EVEROLIMUS (IMMUNOSUPPRESSANT)	ZORTRESS	J7527	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	SIROLIMUS	RAPAMUNE	J7520	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	SIROLIMUS	SIROLIMUS	J7520	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	TACROLIMUS	ASTAGRAF XL	J7508	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	TACROLIMUS	ENVARSUS XR	J7503	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	TACROLIMUS	PROGRAF	J7507	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	TACROLIMUS	PROGRAF	J7525	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MACROLIDE IMMUNOSUPPRESSANTS	TACROLIMUS	TACROLIMUS	J7507	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES	BASILIXIMAB	SIMULECT	J0480	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES	EMAPALUMAB-LZSG	GAMIFANT	J9210	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES	INEBILIZUMAB-CDON	UPLIZNA	J1823	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : MONOCLONAL ANTIBODIES	SATRALIZUMAB-MWGE	ENSPRYNG	N/A	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : ROCK INHIBITORS	BELUMOSUDIL MESYLATE	REZUROCK	N/A	7/1/2024
IMMUNOSUPPRESSIVE AGENTS : SELECTIVE T-CELL COSTIMULATION BLOCKERS	BELATACEPT	NULOJIX	J0485	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : ALLOGENEIC THYMUS TISSUE*	ALLOGENEIC PROCESSED THYMUS TISSUE-AGDC*	RETHYMIC*	J3590	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : NEONATAL FC RECEPTOR ANTAGONIST	EFGARTIGIMOD ALFA-FCAB	VYVGART	J9332	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : NEONATAL FC RECEPTOR ANTAGONIST	EFGARTIGIMOD ALF-HYALURONIDASE-QVFC	VYVGART HYTRULO	J3590	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : NEONATAL FC RECEPTOR ANTAGONIST	ROZANOLIXIZUMAB-NOLI	RYSTIGGO	J3590	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : PHOSPHOINOSITIDE 3-KINASE AGENTS	LENIOLISIB	JOENJA	N/A	7/1/2024
MISCELLANEOUS THERAPEUTIC CLASSES : PIK3CA-RELATED AGENTS	ALPELISIB (PROS AGENTS)	VIJOICE	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
MISCELLANEOUS THERAPEUTIC CLASSES : PROGERIA TREATMENT AGENTS	LONAFARNIB	ZOKINVY	N/A	7/1/2024
MUSCULOSKELETAL THERAPY AGENTS : FIBRODYSPLASIA AGENTS	PALOVAROTENE	SOHONOS	N/A	7/1/2024
N/A	ACORAMIDIS	AG10	N/A	Date to market
N/A	AFAMITRESGENE AUTOLEUCEL	MAGE-A4 TCR	N/A	Date to market
N/A	APADAMTASE ALFA-CINAXADAMTASE ALFA	TAK-755	N/A	Date to market
N/A	ARIMOCLOMOL	MIPLYFFA	N/A	Date to market
N/A	BULEVIRTIDE	MYRCLUDEX B	N/A	Date to market
N/A	CONCIZUMAB	NN7415	N/A	Date to market
N/A	COPPER HISTIDINATE	CUTX-101	N/A	Date to market
N/A	CROVALIMAB	RG6107	N/A	Date to market
N/A	DEBAMESTROCEL	NUROWN	N/A	Date to market
N/A	DONANEMAB	DONANEMAB	N/A	Date to market
N/A	EB-101	EB-101	N/A	Date to market
N/A	ECULIZUMAB	ABP 959	J1300	Date to market
N/A	EFANESOCTOCOG ALFA	BIVV001	N/A	Date to market
N/A	ELADOCAGENE EXUPARVOVEC	UPSTAZA	N/A	Date to market
N/A	ELAMIPRETIDE	MTP-131	N/A	Date to market
N/A	FILSUVEZ	FILSUVEZ	N/A	Date to market
N/A	GARADACIMAB	GARADACIMAB	N/A	Date to market
N/A	GIVINOSTAT	GIVINOSTAT	N/A	Date to market
N/A	NARSOPLIMAB	OMS721	N/A	Date to market
N/A	PEGZILARGINASE	AEB1102	N/A	Date to market
N/A	TABELECLEUCEL	ATA-129	N/A	Date to market
N/A	TRORILUZOLE	BHV-4157	N/A	Date to market
NEUROLOGICAL AGENTS : ANOREXIANTS / ANTI-OBESITY – GLP-1 RECEPTOR AGONISTS	SEMAGLUTIDE	WEGOVY	N/A	7/1/2024
AUTOLOGOUS CELLULAR GENE	ELIVALDOGENE AUTOTEMCEL	SKYSONA	J3490	7/1/2024
METACHROMATIC	ATIDARSAGENE AUTOTEMCEL	LENMELDY	J3590	7/1/2024
NEUROLOGICAL AGENTS : TRANSTHYRETIN AMYLOIDOSIS AGENTS	EPLONTERSEN SODIUM	WAINUA	J3490	7/1/2024
NEUROLOGICAL AGENTS : TRANSTHYRETIN AMYLOIDOSIS AGENTS	INOTERSEN SODIUM	TEGSEDI	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
NEUROLOGICAL AGENTS : TRANSTHYRETIN AMYLOIDOSIS AGENTS	PATISIRAN SODIUM	ONPATTRO	J0222	7/1/2024
NEUROLOGICAL AGENTS : TRANSTHYRETIN AMYLOIDOSIS AGENTS	VUTRISIRAN SODIUM	AMVUTTRA	J0225	7/1/2024
NEUROMUSCULAR AGENTS : ALS AGENTS - MISC	EDARAVONE	RADICAVA	J1301	7/1/2024
NEUROMUSCULAR AGENTS : ALS AGENTS - MISC	EDARAVONE	RADICAVA ORS	J1301	7/1/2024
NEUROMUSCULAR AGENTS : ALS AGENTS - MISC	EDARAVONE	RADICAVA ORS STARTER KIT	N/A	7/1/2024
NEUROMUSCULAR AGENTS : ALS AGENTS - MISC	SODIUM PHENYLBUTYRATE-TAURURSODIOL	RELYVRIO	N/A	7/1/2024
NEUROMUSCULAR AGENTS : ALS AGENTS - MISC	TOFERSEN	QALSODY	J1304	7/1/2024
NEUROMUSCULAR AGENTS : FREIDRICHS ATAXIA AGENTS	OMAVELOXOLONE	SKYCLARYS	N/A	7/1/2024
NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS	CASIMERSEN	AMONDYS 45	J1426	7/1/2024
NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS	DELANDISTROGENE MOXEPARVOVEC	ELEVIDYS	J3590	7/1/2024
NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS	ETEPLIRSEN	EXONDYS 51	J1428	7/1/2024
NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS	GOLODIRSEN	VYONDYS 53	J1429	7/1/2024
NEUROMUSCULAR AGENTS : MUSCULAR DYSTROPHY AGENTS	VILTOLARSEN	VILTEPSO	J1427	7/1/2024
NEUROMUSCULAR AGENTS : POTASSIUM CHANNEL BLOCKERS	AMIFAMPRIDINE PHOSPHATE	FIRDAPSE	N/A	7/1/2024
NEUROMUSCULAR AGENTS : RETT SYNDROME AGENTS	TROFINETIDE	DAYBUE	N/A	7/1/2024
NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY - GENE THERAPY AGENTS	ONASEMNOGENE ABEPARVOVEC-XIOI	ZOLGENSMA	J3399	7/1/2024
NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY AGENTS - ANTISENSE OLIGONUCLEOTIDES	NUSINERSEN	SPINRAZA	J2326	7/1/2024
NEUROMUSCULAR AGENTS : SPINAL MUSCULAR ATROPHY AGENTS - ANTISENSE OLIGONUCLEOTIDES	RISDIPLAM	EVRYSDI	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PDUFA Name	HCPCS	Non-Contracted Effective Date
ENDOCRINE AND METABOLIC AGENTS : FATTY ACID METABOLISM AGENTS	TRIHEPTANOIN	DOJOLVI	N/A	7/1/2024
ONCOLOGY AGENTS : ALLOGENIC CELLULAR IMMUNOTHERAPY	OMIDUBICEL-ONLV	OMISIRGE	J3590, C9399	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY	SIPULEUCEL-T	PROVENGE	Q2043	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	AXICABTAGENE CILOLEUCEL	YESCARTA	Q2041	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	BREXUCABTAGENE AUTOLEUCEL	TECARTUS	Q2053	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	CILTACABTAGENE AUTOLEUCEL	CARVYKTI	C9399	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	IDECABTAGENE VICLEUCEL	ABECMA	Q2055	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	LISOCABTAGENE MARALEUCEL	BREYANZI	Q2054	7/1/2024
ONCOLOGY AGENTS : AUTOLOGOUS CELLULAR IMMUNOTHERAPY (CAR-T)	TISAGENLECLEUCEL	KYMRIAH	Q2042	7/1/2024
ONCOLOGY AGENTS : GENE THERAPIES	NADOFARAGENE FIRADENOV-VNCG	ADSTILADRIN	J9029	7/1/2024
ONCOLOGY AGENTS : INTERFERONS	INTERFERON GAMMA-1B	ACTIMMUNE	J9216	7/1/2024
ONCOLOGY AGENTS : LUTETIUM AGENTS	LUTETIUM LU 177 DOTATATE	LUTATHERA	A9699	7/1/2024
ONCOLOGY AGENTS : LUTETIUM AGENTS	LUTETIUM LU 177 VIPIVOTIDE TETRAXETAN	PLUVICTO	A9607	7/1/2024
OPHTHALMIC AGENTS : GENE THERAPY	VORETIGENE NEPARVOVEC-RZYL	LUXTURNA	J3398	7/1/2024
OPHTHALMIC AGENTS : NERVE GROWTH FACTORS	CENEGERMIN-BKBJ	OXERVATE	N/A	7/1/2024

*Non-Contracted Inpatient. Entire inpatient claim is non-contracted (carved out)

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE	ABACAVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE	ABACAVIR SULFATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE	ZIAGEN	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE-LAMIVUDINE	ABACAVIR SULFATE/LAMIVUDINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE-LAMIVUDINE	EPZICOM	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR SULFATE-LAMIVUDINE-ZIDOVUDINE	TRIZIVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE	TRIUMEQ	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ABACAVIR-DOLUTEGRAVIR-LAMIVUDINE	TRIUMEQ PD	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ATAZANAVIR SULFATE	ATAZANAVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ATAZANAVIR SULFATE	ATAZANAVIR SULFATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ATAZANAVIR SULFATE	REYATAZ	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ATAZANAVIR SULFATE-COBICISTAT	EVOTAZ	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	BICTEGRAVIR-EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE	BIKTARVY	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	CABOTEGRAVIR SODIUM	VOCABRIA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	COBICISTAT	TYBOST	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DARUNAVIR	DARUNAVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DARUNAVIR	PREZISTA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DARUNAVIR-COBICISTAT	PREZCOBIX	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DARUNAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	SYMTUZA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DIDANOSINE	DIDANOSINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DOLUTEGRAVIR SODIUM	TIVICAY	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DOLUTEGRAVIR SODIUM	TIVICAY PD	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DOLUTEGRAVIR SODIUM-LAMIVUDINE	DOVATO	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DOLUTEGRAVIR SODIUM-RILPIVIRINE HCL	JULUCA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DORAVIRINE	PIFELTRO	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	DORAVIRINE-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE	DELSTRIGO	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ	EFAVIRENZ	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ	SUSTIVA	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ANTIVIRALS : HIV - ORAL	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	ATRIPLA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ-EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE	EFAVIRENZ/LAMIVUDINE/TENOFOVIR DISOPROXIL FUMARATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE	SYMFI	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EFAVIRENZ-LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE	SYMFI LO	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR ALAFENAMIDE	GENVOYA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ELVITEGRAVIR-COBICISTAT-EMTRICITABINE-TENOFOVIR DF	STRIBILD	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE	EMTRICITABINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE	EMTRIVA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-RILPIVIRINE-TENOFOVIR ALAFENAMIDE FUMARATE	ODEFSEY	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-RILPIVIRINE-TENOFOVIR DISOPROXIL FUMARATE	COMPLERA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-TENOFOVIR ALAFENAMIDE FUMARATE	DESCOVY	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	EMTRICITABINE/TENOFOVIR DISOPROXIL	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE	TRUVADA	N/A	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ANTIVIRALS : HIV - ORAL	ETRAVIRINE	ETRAVIRINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ETRAVIRINE	INTELENCE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	FOSAMPRENAVIR CALCIUM	FOSAMPRENAVIR CALCIUM	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	FOSAMPRENAVIR CALCIUM	LEXIVA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	FOSTEMSAVIR TROMETHAMINE	RUKOBIA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LAMIVUDINE	EPIVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LAMIVUDINE	LAMIVUDINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LAMIVUDINE-TENOFOVIR DISOPROXIL FUMARATE	CIMDUO	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LAMIVUDINE-ZIDOVUDINE	COMBIVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LAMIVUDINE-ZIDOVUDINE	LAMIVUDINE/ZIDOVUDINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LOPINAVIR-RITONAVIR	KALETRA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LOPINAVIR-RITONAVIR	LOPINAVIR/RITONAVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	MARAVIROC	MARAVIROC	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	MARAVIROC	SELZENTRY	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	NELFINAVIR MESYLATE	VIRACEPT	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	NEVIRAPINE	NEVIRAPINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	NEVIRAPINE	NEVIRAPINE ER	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	RALTEGRAVIR POTASSIUM	ISENTRESS	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	RALTEGRAVIR POTASSIUM	ISENTRESS HD	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	RILPIVIRINE HCL	EDURANT	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	RITONAVIR	NORVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	RITONAVIR	RITONAVIR	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	STAVUDINE	STAVUDINE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	LENACAPAVIR SODIUM	SUNLENCA	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	TENOFOVIR DISOPROXIL FUMARATE	TENOFOVIR DISOPROXIL FUMARATE	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	TENOFOVIR DISOPROXIL FUMARATE	VIREAD	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	TIPRANAVIR	APTIVUS	N/A	7/1/2024
ANTIVIRALS : HIV - ORAL	ZIDOVUDINE	RETROVIR	S0104, J3490	7/1/2024
ANTIVIRALS : HIV - ORAL	ZIDOVUDINE	ZIDOVUDINE	S0104, J3490	7/1/2024
N/A	RIVOCERANIB	RIVOCERANIB	N/A	Date to market
ONCOLOGY AGENTS : ANDROGEN BIOSYNTHESIS INHIBITORS - ORAL	ABIRATERONE ACETATE	ABIRATERONE ACETATE	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : ANDROGEN BIOSYNTHESIS INHIBITORS - ORAL	ABIRATERONE ACETATE	YONSA	J8999	7/1/2024
ONCOLOGY AGENTS : ANDROGEN BIOSYNTHESIS INHIBITORS - ORAL	ABIRATERONE ACETATE	ZYTIGA	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIADRENALS - ORAL	MITOTANE	LYSODREN	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	APALUTAMIDE	ERLEADA	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	BICALUTAMIDE	BICALUTAMIDE	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	BICALUTAMIDE	CASODEX	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	DAROLUTAMIDE	NUBEQA	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	ENZALUTAMIDE	XTANDI	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	FLUTAMIDE	EULEXIN	S0175	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	FLUTAMIDE	FLUTAMIDE	S0175	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	NILUTAMIDE	NILANDRON	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIANDROGENS - ORAL	NILUTAMIDE	NILUTAMIDE	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIESTROGENS - ORAL	TAMOXIFEN CITRATE	TAMOXIFEN CITRATE	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIESTROGENS - ORAL	TOREMIFENE CITRATE	FARESTON	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIESTROGENS - ORAL	TAMOXIFEN CITRATE	SOLTAMOX	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIESTROGENS - ORAL	TOREMIFENE CITRATE	TOREMIFENE CITRATE	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIESTROGENS - ORAL	ELACESTRANT HYDROCHLORIDE	ORSERDU	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	AZACITIDINE	ONUREG	J8999	7/1/2024
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	CAPECITABINE	CAPECITABINE	J8520	7/1/2024
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	CAPECITABINE	XELODA	J8521	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	MERCAPTOPURINE	MERCAPTOPURINE	S0108	7/1/2024
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	MERCAPTOPURINE	PURIXAN	S0108	7/1/2024
ONCOLOGY AGENTS : ANTIMETABOLITES - ORAL	THIOGUANINE	TABLOID	J8999	7/1/2024
ONCOLOGY AGENTS : ANTINEOPLASTICS COMBINATIONS - ORAL	DECITABINE-CEDAZURIDINE	INQOVI	J8999	7/1/2024
ONCOLOGY AGENTS : ANTINEOPLASTICS COMBINATIONS - ORAL	RIBOCICLIB SUCCINATE-LETROZOLE	KISQALI FEMARA	J8999	7/1/2024
ONCOLOGY AGENTS : ANTINEOPLASTICS COMBINATIONS - ORAL	TRIFLURIDINE-TIPIRACIL	LONSURF	J8999	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	ANASTROZOLE	ANASTROZOLE	S0170	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	ANASTROZOLE	ARIMIDEX	S0170	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	EXEMESTANE	AROMASIN	S0156	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	EXEMESTANE	EXEMESTANE	S0156	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	LETROZOLE	FEMARA	J8999	7/1/2024
ONCOLOGY AGENTS : AROMATASE INHIBITORS - ORAL	LETROZOLE	LETROZOLE	J8999	7/1/2024
ONCOLOGY AGENTS : BCL-2 INHIBITORS - ORAL	VENETOCLAX	VENCLEXTA	J8999	7/1/2024
ONCOLOGY AGENTS : BRAF KINASE INHIBITORS - ORAL	DABRAFENIB MESYLATE	TAFINLAR	J8999	7/1/2024
ONCOLOGY AGENTS : BRAF KINASE INHIBITORS - ORAL	ENCORAFENIB	BRAFTOVI	J8999	7/1/2024
ONCOLOGY AGENTS : BRAF KINASE INHIBITORS - ORAL	TOVORAFENIB	OJEMDA	J8999	7/1/2024
ONCOLOGY AGENTS : BRAF KINASE INHIBITORS - ORAL	VEMURAFENIB	ZELBORAF	J8999	7/1/2024
ONCOLOGY AGENTS : CYCLIN DEPENDENT KINASES (CDK) INHIBITORS - ORAL	ABEMACICLIB	VERZENIO	J8999	7/1/2024
ONCOLOGY AGENTS : CYCLIN DEPENDENT KINASES (CDK) INHIBITORS - ORAL	PALBOCICLIB	IBRANCE	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : CYCLIN DEPENDENT KINASES (CDK) INHIBITORS - ORAL	RIBOCICLIB SUCCINATE	KISQALI	J8999	7/1/2024
ONCOLOGY AGENTS : ANTINEOPLASTIC ESTROGENS - ORAL	ESTRAMUSTINE PHOSPHATE SODIUM	EMCYT	J8999	7/1/2024
ONCOLOGY AGENTS : FGFR KINASE INHIBITORS - ORAL	ERDAFITINIB	BALVERSA	J8999	7/1/2024
ONCOLOGY AGENTS : FGFR KINASE INHIBITORS - ORAL	INFIGRATINIB PHOSPHATE	TRUSELTIQ	J8999	7/1/2024
ONCOLOGY AGENTS : FGFR KINASE INHIBITORS - ORAL	FUTIBATINIB	LYTGOBI	J8999	7/1/2024
ONCOLOGY AGENTS : FGFR KINASE INHIBITORS - ORAL	PEMIGATINIB	PEMAZYRE	J8999	7/1/2024
ONCOLOGY AGENTS : GAMMA SECRETASE INHIBITORS	NIROGACESTAT HYDROBROMIDE	OGSIVEO	J8999	7/1/2024
ONCOLOGY AGENTS : GONADOTROPIN-RELEASING HORMONE (GNRH) RECEPTOR ANTAGONISTS - ORAL	RELUGOLIX	ORGOVYX	J8999	7/1/2024
ONCOLOGY AGENTS : HEDGEHOG PATHWAY INHIBITORS - ORAL	GLASDEGIB MALEATE	DAURISMO	J8999	7/1/2024
ONCOLOGY AGENTS : HEDGEHOG PATHWAY INHIBITORS - ORAL	SONIDEGIB PHOSPHATE	ODOMZO	J8999	7/1/2024
ONCOLOGY AGENTS : HEDGEHOG PATHWAY INHIBITORS - ORAL	VISMODEGIB	ERIVEDGE	J8999	7/1/2024
ONCOLOGY AGENTS : HIF-2-ALPHA INHIBITORS	BELZUTIFAN	WELIREG	J8999	7/1/2024
ONCOLOGY AGENTS : HISTONE DEACETYLASE INHIBITORS - ORAL	PANOBINOSTAT LACTATE	FARYDAK	J8999	7/1/2024
ONCOLOGY AGENTS : HISTONE DEACETYLASE INHIBITORS - ORAL	VORINOSTAT	ZOLINZA	J8999	7/1/2024
ONCOLOGY AGENTS : IMMUNE MODULATORS	POMALIDOMIDE	POMALYST	N/A	7/1/2024
ONCOLOGY AGENTS : ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS - ORAL	IVOSIDENIB	TIBSOVO	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : ISOCITRATE DEHYDROGENASE-1 (IDH1) INHIBITORS - ORAL	OLUTASIDENIB	REZLIDHIA	J8999	7/1/2024
ONCOLOGY AGENTS : ISOCITRATE DEHYDROGENASE-2 (IDH2) INHIBITORS - ORAL	ENASIDENIB MESYLATE	IDHIFA	J8999	7/1/2024
ONCOLOGY AGENTS : JANUS ASSOCIATED KINASE (JAK) INHIBITORS - ORAL	FEDRATINIB HCL	INREBIC	J8999	7/1/2024
ONCOLOGY AGENTS : JANUS ASSOCIATED KINASE (JAK) INHIBITORS - ORAL	MOMELOTINIB DIHYDROCHLORIDE	OJJAARA	J8999	7/1/2024
ONCOLOGY AGENTS : JANUS ASSOCIATED KINASE (JAK) INHIBITORS - ORAL	PACRITINIB CITRATE	VONJO	J8999	7/1/2024
ONCOLOGY AGENTS : JANUS ASSOCIATED KINASE (JAK) INHIBITORS - ORAL	RUXOLITINIB PHOSPHATE	JAKAFI	J8999	7/1/2024
ONCOLOGY AGENTS : KRAS INHIBITORS	ADAGRASIB	KRAZATI	J8999	7/1/2024
ONCOLOGY AGENTS : KRAS INHIBITORS	SOTORASIB	LUMAKRAS	J8999	7/1/2024
ONCOLOGY AGENTS : MEK INHIBITORS - ORAL	BINIMETINIB	MEKTOVI	J8999	7/1/2024
ONCOLOGY AGENTS : MEK INHIBITORS - ORAL	COBIMETINIB FUMARATE	COTELLIC	J8999	7/1/2024
ONCOLOGY AGENTS : MEK INHIBITORS - ORAL	SELUMETINIB SULFATE	KOSELUGO	J8999	7/1/2024
ONCOLOGY AGENTS : MEK INHIBITORS - ORAL	TRAMETINIB DIMETHYL SULFOXIDE	MEKINIST	J8999	7/1/2024
ONCOLOGY AGENTS : METHYLTRANSFERASE INHIBITORS	TAZEMETOSTAT HBR	TAZVERIK	J8999	7/1/2024
ONCOLOGY AGENTS : MITOTIC INHIBITORS - ORAL	ETOPOSIDE	ETOPOSIDE	J8560	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	MIDOSTAURIN	RYDAPT	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	REGORAFENIB	STIVARGA	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	SORAFENIB TOSYLATE	NEXAVAR	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	SORAFENIB TOSYLATE	SORAFENIB	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	SORAFENIB TOSYLATE	SORAFENIB TOSYLATE	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	SUNITINIB MALATE	SUNITINIB MALATE	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	SUNITINIB MALATE	SUTENT	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	TEPOTINIB HCL	TEPMETKO	J8999	7/1/2024
ONCOLOGY AGENTS : MULTIKINASE INHIBITORS - ORAL	TIVOZANIB HCL	FOTIVDA	J8999	7/1/2024
ONCOLOGY AGENTS : NITROSOUREAS - ORAL	LOMUSTINE	GLEOSTINE	S0178	7/1/2024
ONCOLOGY AGENTS : ORNITHINE DECARBOXYLASE INHIBITORS	EFLORNITHINE	IWILFIN	J8999	7/1/2024
ONCOLOGY AGENTS : PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS - ORAL	ALPELISIB	PIQRAY	J8999	7/1/2024
ONCOLOGY AGENTS : PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS - ORAL	DUVELISIB	COPIKTRA	J8999	7/1/2024
ONCOLOGY AGENTS : PHOSPHATIDYLINOSITOL 3-KINASE (PI3K) INHIBITORS - ORAL	IDELALISIB	ZYDELIG	J8999	7/1/2024
ONCOLOGY AGENTS : POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL	NIRAPARIB TOSYLATE	ZEJULA	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL	NIRAPARIB TOSYLATE-ABIRATERONE ACETATE	AKEEGA	J8999	7/1/2024
ONCOLOGY AGENTS : POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL	OLAPARIB	LYNPARZA	J8999	7/1/2024
ONCOLOGY AGENTS : POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL	RUCAPARIB CAMSYLATE	RUBRACA	J8999	7/1/2024
ONCOLOGY AGENTS : POLY (ADP-RIBOSE) POLYMERASE (PARP) INHIBITORS - ORAL	TALAZOPARIB TOSYLATE	TALZENNA	J8999	7/1/2024
ONCOLOGY AGENTS : PROTEASOME INHIBITORS - ORAL	IXAZOMIB CITRATE	NINLARO	J8999	7/1/2024
ONCOLOGY AGENTS : RETINOIDS - ORAL	TRETINOIN (CHEMOTHERAPY)	TRETINOIN	J8999	7/1/2024
ONCOLOGY AGENTS : SELECTIVE RETINOID X RECEPTOR AGONISTS - ORAL	BEXAROTENE	BEXAROTENE	J8999	7/1/2024
ONCOLOGY AGENTS : SELECTIVE RETINOID X RECEPTOR AGONISTS - ORAL	BEXAROTENE	TARGRETIN	J8999	7/1/2024
ONCOLOGY AGENTS : TOPOISOMERASE INHIBITORS - ORAL	TOPOTECAN HCL	HYCAMTIN	J8705	7/1/2024
ONCOLOGY AGENTS : TROPOMYOSIN RECEPTOR KINASE INHIBITORS - ORAL	ENTRECTINIB	ROZLYTREK	J8999	7/1/2024
ONCOLOGY AGENTS : TROPOMYOSIN RECEPTOR KINASE INHIBITORS - ORAL	LAROTRECTINIB SULFATE	VITRAKVI	J8999	7/1/2024
ONCOLOGY AGENTS : TROPOMYOSIN RECEPTOR KINASE INHIBITORS - ORAL	REPOTRECTINIB	AUGTYRO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ACALABRUTINIB	CALQUENCE	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	AFATINIB DIMALEATE	GILOTRIF	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ALECTINIB HCL	ALECENSA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ASCIMINIB HCL	SCEMBLIX	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	AVAPRITINIB	AYVAKIT	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	AXITINIB	INLYTA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	BOSUTINIB	BOSULIF	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	BRIGATINIB	ALUNBRIG	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CABOZANTINIB S-MALATE	CABOMETYX	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CABOZANTINIB S-MALATE	COMETRIQ	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CAPIVASERTIB	TRUQAP	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CAPMATINIB HCL	TABRECTA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CERITINIB	ZYKADIA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	CRIZOTINIB	XALKORI	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	DACOMITINIB	VIZIMPRO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	DASATINIB	SPRYCEL	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ERLOTINIB HCL	ERLOTINIB HYDROCHLORIDE	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ERLOTINIB HCL	TARCEVA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	FRUQUINTINIB	FRUZAQLA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	GEFITINIB	GEFITINIB	J8565	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	GEFITINIB	IRESSA	J8565	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	GILTERITINIB FUMARATE	XOSPATA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	IBRUTINIB	IMBRUVICA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	IMATINIB MESYLATE	GLEEVEC	S0088	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	IMATINIB MESYLATE	IMATINIB MESYLATE	S0088	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PIRTOBRUTINIB	JAYPIRCA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	LAPATINIB DITOSYLATE	LAPATINIB DITOSYLATE	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	LAPATINIB DITOSYLATE	TYKERB	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	LENVATINIB MESYLATE	LENVIMA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	LORLATINIB	LORBRENA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	MOBOCERTINIB SUCCINATE	EXKIVITY	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	NERATINIB MALEATE	NERLYNX	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	NILOTINIB HCL	TASIGNA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	OSIMERTINIB MESYLATE	TAGRISSO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PAZOPANIB HCL	PAZOPANIB HCL	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PAZOPANIB HCL	VOTRIENT	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PEXIDARTINIB HCL	TURALIO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PONATINIB HCL	ICLUSIG	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	PRALSETINIB	GAVRETO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	QUIZARTINIB DIHYDROCHLORIDE	VANFLYTA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	RIPRETINIB	QINLOCK	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	SELPERCATINIB	RETEVMO	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	TUCATINIB	TUKYSA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	VANDETANIB	CAPRELSA	J8999	7/1/2024
ONCOLOGY AGENTS : TYROSINE KINASE INHIBITORS - ORAL	ZANUBRUTINIB	BRUKINSA	J8999	7/1/2024
ONCOLOGY AGENTS : XPO1 INHIBITORS - ORAL	SELINEXOR	XPOVIO	J8999	7/1/2024

Apple Health Preferred Drug List Theraputic Class	Generic Ingredient	Label/PUDFA Name	HCPCS	ASO non-contracted effective date
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS	DORNASE ALFA	PULMOZYME	J7639	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS	MANNITOL (CYSTIC FIBROSIS)	BRONCHITOL	J7665	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS	MANNITOL (CYSTIC FIBROSIS)	BRONCHITOL TOLERANCE TEST	J7665	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS - CFTR POTENTIATORS	ELEXACAFTOR-TEZACAFTOR-IVACAFTOR	TRIKAFTA	N/A	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS - CFTR POTENTIATORS	IVACAFTOR	KALYDECO	N/A	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS - CFTR POTENTIATORS	LUMACAFTOR-IVACAFTOR	ORKAMBI	N/A	7/1/2024
RESPIRATORY AGENTS : CYSTIC FIBROSIS AGENTS - CFTR POTENTIATORS	TEZACAFTOR-IVACAFTOR	SYMDEKO	N/A	7/1/2024

Exhibit I
Apple Health Expansion (AHE)
Behavioral Health vs Physical Health Capitation Rate Components

HCA's designated actuary develops the Behavioral Health and physical heath capitation rate components separately. The Behavioral Health component is based on services provided by Department of Health (DOH) licensed Behavioral Health Agencies (BHAs). HCA relies on the current DOH BHA directory to identify BHA providers: https://doh.wa.gov/sites/default/files/2022-02/606019-BHADirectory.pdf.

There are a limited number of instances in which a BHA's experience is not used to inform the Behavioral Health component of the capitation rates, including Providers who are licensed as BHAs but are only providing physical health services. This set of Providers includes acute care hospitals, office-based opioid treatment Providers and some integrated Providers, including but not limited to the following BHAs:

- Astria Toppenish Hospital
- Cowlitz Indian Health Services Health Clinic – Longview
- Harborview Medical Center – Inpatient, Addition Programs and Mental Health Services
- Ideal Balance – Kennewick
- MultiCare Good Samaritan
- PeaceHealth Southwest Medical Center
- PeaceHealth St. John Medical Center Evaluation and Treatment (E&T)
- Peninsula Community Health Services – Multiple Locations
- Providence Holy Family Hospital RISE Program
- Providence Sacred Heart Medical Center – Outpatient
- Sea Mar Behavioral Health – Seattle and Bellingham
- Seattle Indian Health Board
- Sound Integrated Health LLC
- Swedish Edmonds Evaluation and Treatment (E&T)
- Tri-Cities Community Health – Pasco
- UCNW Interfaith Community Health Center
- University of Washington Medical Center – Northwest

To be considered part of the Behavioral Health benefit, encounters must be part of the following universe:

Institutional (837i) - Have an HCA claim type on the following list:

3	Outpatient Claim
26	OPPS Claim
28	Part B XO Claim
31	Inpatient Claim
33	Part A XO Inpatient Claim
34	Part A XO Outpatient Claim

AND, satisfy one of the following:

Contain a Revenue code listed in the 'Standalone Procedure and Revenue Code' list below; or, Contain HCPCS code H2036

Professional (837p) – Have the following HCA claim type:

1	Professional Claim

And satisfy one of the following:

Contain a HCPCS code listed in the 'Standalone Procedure and Revenue Code' list below; or,
Contain a HCPCS code listed in the 'Codes w Requirements' list below and satisfy the additional listed requirements

Standalone Procedure and Revenue Code List:
UB-04 Manual. OFFICIAL UB-04 DATA SPECIFICATIONS MANUAL, 2023, is copyrighted by American Hospital Association (AHA), Chicago, Illinois.

Revenue Codes

RevCode	Description
0114	Private (One Bed)-Psychiatric
0116	Private (One Bed)-Detoxification
0124	Semi-Private Two Beds-Psychiatric
0126	Semi-Private Two Beds-Detoxification
0134	Semi-Private-Three And Four Beds-Psychiatric
0136	Semi-Private-Three And Four Beds-Detoxification
0144	Deluxe Private-Psychiatric
0146	Deluxe Private-Detoxification
0154	Room & Board-Ward-Psychiatric
0156	Room & Board-Ward-Detoxification
0204	Intensive Care Unit-Psychiatric
0902	Behavioral Health Treatment/Services-Milieu Therapy
0903	Behavioral Health Treatment/Services-Play Therapy
0904	Behavioral Health Treatment/Services-Activity Therapy
0905	Behavioral Health Treatment/Services-Intensive Outpatient Services-Psychiatric
0906	Behavioral Health Treatment/Services-Intensive Outpatient Services-Chemical Dependency

Revenue Codes

RevCode	Description
0907	Behavioral Health Treatment/Services-Community Behavioral Health Program (Day Treatment)
0909	Behavior Health Treatments/Services: Other
0910	Behavioral Health Treatment/Services-Extension of 090X-general classification
0911	Behavioral Health Treatment/Services-Extension of 090X-Rehabilitation
0912	Behavioral Health Treatment/Services-Extension of 090X-Partial Hospitalization-Less Intensive
0913	Behavioral Health Treatment/Services-Extension of 090X-Partial Hospitalization-Intensive
0914	Behavioral Health Treatment/Services-Extension of 090X-Individual Therapy
0915	Behavioral Health Treatment/Services-Extension of 090X-Group Therapy
0916	Behavioral Health Treatment/Services-Extension of 090X-Family Therapy
0917	Behavioral Health Treatment/Services-Extension of 090X-Bio Feedback
1000	Behavioral Health Accommodations-General Classification
1001	Behavioral Health Accommodations-Residential-Psychiatric
1001	Behavioral Health Accommodations-Residential-Psychiatric
1002	Behavioral Health Accommodations-Residential-Chemical Dependency
1003	Behavioral Health Accommodations-Supervised Living
1004	Behavioral Health Accommodations-Halfway House
1005	Behavioral Health Accommodations-Group Home
1006	Behavioral Health Accommodations-Outdoor/Wilderness Behavioral Health

Procedure Codes

HCPCS	Description
99075	Medical testimony
G2067	Med assist tx meth wk
G2068	Med assist tx bupre oral
G2069	Med assist tx inject
G2070	Med assist tx implant
G2071	Med tx remove implant
G2072	Med tx insert/remove imp
G2073	Med tx naltrexone
G2074	Med assist tx no drug
G2075	Med tx meds nos
G2076	Intake act w/med exam
G2077	Periodic assessment

Procedure Codes

HCPCS	Description
G2078	Take-home meth
G2079	Take-hom buprenorphine
G2080	Add 30 mins counsel
G2215	Home supply nasal naloxone
G2216	Home supply inject naloxon
H0001	Alcohol and/or drug assess
H0002	Behavioral health screening to determine eligibility for admission to treatment program
H0003	Alcohol and/or drug screening; laboratory analysis of specimens for presence of alcohol and/or drugs
H0004	Behavioral health counseling and therapy, per 15 minutes
H0010	Alcohol and/or drug services; subacute detoxification (residential addiction program inpatient)
H0011	Alcohol and/or drug services; acute detoxification (residential addiction program inpatient)
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)
H0017	Behavioral health; residential (hospital residential treatment program), without room and board, per diem
H0018	Behavioral health; short-term residential (nonhospital residential treatment program), without room and board, per diem
H0019	Behavioral health; long-term residential (nonmedical, nonacute care in a residential treatment program where stay is typically longer than 30 days), without room and board, per diem
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)
H0023	Behavioral health outreach service (planned approach to reach a targeted population)
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior)
H0026	Alcohol andlor drug prevention process service, community-based (delivery of services to develop skills of impactors)
H0030	Alcohol and/or drug hotline
H0031	Mh health assess by non-md
H0032	Mh svc plan dev by non-md
H0033	Oral med adm direct observe
H0034	Med trng & support per 15min
H0035	Mh partial hosp tx under 24h
H0036	Comm psy face-face per 15min
H0038	Self-help/peer svc per 15min
H0040	Assert comm tx pgm per diem

Procedure Codes

HCPCS	Description
H0043	Supported housing, per diem
H0045	Respite not-in-home per diem
H0046	Mental health service, nos
H0047	Alcohol/drug abuse svc nos
H0050	Alcohol and/or drug services, brief intervention, per 15 minutes
H2011	Crisis interven svc, 15 min
H2012	Behav hlth day treat, per hr
H2013	Psych hlth fac svc, per diem
H2014	Skills train and dev, 15 min
H2015	Comp comm supp svc, 15 min
H2017	Psysoc rehab svc, per 15 min
H2021	Com wrap-around sv, 15 min
H2022	Com wrap-around sv, per diem
H2023	Supported employ, per 15 min
H2025	Supp maint employ, 15 min
H2027	Psychoed svc, per 15 min
H2028	Sex offend tx svc, 15 min
H2031	Mh clubhouse svc, per diem
H2033	Multisys ther/juvenile 15min
H2036	A/d tx program, per diem
S0109	Methadone oral 5mg
S9125	Respite care, in the home, p
S9446	PT education noc group
S9480	Intensive outpatient psychia
S9484	Crisis intervention per hour
S9485	Crisis intervention mental h
S9976	Lodging per diem
T1005	Respite care service 15 min
T1009	Child Sitting Services
T1013	Sign Lang/Oral Interpreter
T1016	Case management
T1017	Targeted case management
T1041	Comm bh clinic svc per month
T2003	N-et; encounter/trip

Procedure Codes

HCPCS	Description
T2033	Res, nos waiver per diem
T2038	Comm trans waiver/service
T2048	Bh ltc res r&b, per diem

Procedure and Revenue Codes with Additional Requirements List:

HCPCS	Description	BH-Only BHA	Other
80305	Drug test prsmv dir opt obs	Y	
80306	Drug test prsmv instrmnt	Y	
80307	Drug test prsmv chem anlyzr	Y	
90785	Psytx complex interactive	Y	MH or SUD primary diagnosis
90791	Psych diagnostic evaluation	Y	MH or SUD primary diagnosis
90792	Psych diag eval w/med srvcs	Y	MH or SUD primary diagnosis
90832	Psytx w pt 30 minutes	Y	MH or SUD primary diagnosis
90833	Psytx w pt w e/m 30 min	Y	MH or SUD primary diagnosis
90834	Psytx w pt 45 minutes	Y	MH or SUD primary diagnosis
90836	Psytx w pt w e/m 45 min	Y	MH or SUD primary diagnosis
90837	Psytx w pt 60 minutes	Y	MH or SUD primary diagnosis
90838	Psytx w pt w e/m 60 min	Y	MH or SUD primary diagnosis
90846	Family psytx w/o pt 50 min	Y	MH or SUD primary diagnosis
90847	Family psytx w/pt 50 min	Y	MH or SUD primary diagnosis
90849	Multiple family group psytx	Y	MH or SUD primary diagnosis
90853	Group psychotherapy	Y	MH or SUD primary diagnosis
96110	Developmental screen w/score	Y	
96116	Nubhvl xm phys/qhp 1st hr	Y	
96121	Nubhvl Xm Phy/Qhp Ea Addl Hr	Y	
96130	Psycl Tst Eval Phys/Qhp 1St	Y	

HCPCS	Description	BH-Only BHA	Other
96131	Psycl Tst Eval Phys/Qhp Ea	Y	
96132	Nrpsyc Tst Eval Phys/Qhp 1St	Y	
96133	Nrpsyc Tst Eval Phys/Qhp Ea	Y	
96136	Psycl/Nrpsyc Tst Phy/Qhp 1St	Y	
96137	Psycl/Nrpsyc Tst Phy/Qhp Ea	Y	
96138	Psycl/Nrpsyc Tech 1St	Y	
96139	Psycl/Nrpsyc Tst Tech Ea	Y	
96164	Hlth bhv ivntj grp 1st 30	Y	MH or SUD primary diag, or U6 modifier
96165	Hlth bhv ivntj grp ea addl	Y	MH or SUD primary diag, or U6 modifier
96167	Hlth bhv ivntj fam 1st 30	Y	MH or SUD primary diag, or U6 modifier
96168	Hlth bhv ivntj fam ea addl	Y	MH or SUD primary diag, or U6 modifier
96170	Hlth bhv ivntj fam wo pt 1st	Y	MH or SUD primary diag, or U6 modifier
96171	Hlth bhv ivntj fam w/o pt ea	Y	MH or SUD primary diag, or U6 modifier
96372	Ther/proph/diag inj sc/im	Y	MH or SUD primary diag, or OTP provider
99050	Medical services after hrs	Y	MH or SUD primary diag, or OTP provider
99051	Med serv eve/wkend/holiday	Y	MH or SUD primary diag, or OTP provider
99201	Office/outpatient visit new	Y	
99202	Office O/P New Sf 15-29 Min	Y	
99203	Office O/P New Low 30-44 Min	Y	
99204	Office O/P New Mod 45-59 Min	Y	
99205	Office O/P New Hi 60-74 Min	Y	
99211	Office O/P Est Minimal Prob	Y	MH or SUD primary diag, or OTP provider
99212	Office O/P Est Sf 10-19 Min	Y	MH or SUD primary diag, or OTP provider
99213	Office O/P Est Low 20-29 Min	Y	MH or SUD primary diag, or OTP provider
99214	Office O/P Est Mod 30-39 Min	Y	MH or SUD primary diag, or OTP provider
99215	Office O/P Est Hi 40-54 Min	Y	MH or SUD primary diag, or OTP provider
99304	Nursing facility care init	Y	MH or SUD primary diagnosis

HCPCS	Description	BH-Only BHA	Other
99305	Nursing facility care init	Y	MH or SUD primary diagnosis
99306	Nursing facility care init	Y	MH or SUD primary diagnosis
99307	Nursing fac care subseq	Y	MH or SUD primary diag, or OTP provider
99308	Nursing fac care subseq	Y	MH or SUD primary diag, or OTP provider
99309	Nursing fac care subseq	Y	MH or SUD primary diag, or OTP provider
99310	Nursing fac care subseq	Y	MH or SUD primary diag, or OTP provider
99324	Domicil/r-home visit new pat	Y	MH or SUD primary diagnosis
99325	Domicil/r-home visit new pat	Y	MH or SUD primary diagnosis
99326	Domicil/r-home visit new pat	Y	MH or SUD primary diagnosis
99327	Domicil/r-home visit new pat	Y	MH or SUD primary diagnosis
99328	Domicil/r-home visit new pat	Y	MH or SUD primary diagnosis
99334	Domicil/r-home visit est pat	Y	MH or SUD primary diag, or OTP provider
99335	Domicil/r-home visit est pat	Y	MH or SUD primary diag, or OTP provider
99336	Domicil/r-home visit est pat	Y	MH or SUD primary diag, or OTP provider
99337	Domicil/r-home visit est pat	Y	MH or SUD primary diag, or OTP provider
99341	Home visit new patient	Y	
99342	Home visit new patient	Y	
99343	Home visit new patient	Y	
99344	Home visit new patient	Y	
99345	Home visit new patient	Y	
99347	Home visit est patient	Y	MH or SUD primary diag, or OTP provider
99348	Home visit est patient	Y	MH or SUD primary diag, or OTP provider
99349	Home visit est patient	Y	MH or SUD primary diag, or OTP provider
99350	Home visit est patient	Y	MH or SUD primary diag, or OTP provider
99354	Prolng Svc O/P 1St Hour	Y	
99355	Prolng Svc O/P Ea Addl 30	Y	

HCPCS	Description	BH-Only BHA	Other
99356	Prolng Svc I/P/Obs 1St Hour	Y	
99357	Prolng svc i/p/obs ea addl	Y	
99421	Ol dig e/m svc 5-10 min	Y	MH or SUD primary diag, or OTP provider
99422	Ol dig e/m svc 11-20 min	Y	MH or SUD primary diag, or OTP provider
99423	Ol dig e/m svc 21+ min	Y	MH or SUD primary diag, or OTP provider
99441	Phone e/m phys/qhp 5-10 min	Y	MH or SUD primary diag, or OTP provider
99442	Phone e/m phys/qhp 11-20 min	Y	MH or SUD primary diag, or OTP provider
99443	Phone e/m phys/qhp 21-30 min	Y	MH or SUD primary diag, or OTP provider
G0317	Prolong nursin fac eval 15m	Y	
G0318	Prolong home eval add 15m	Y	
G0480	Drug test def 1-7 classes	Y	
G0481	Drug test def 8-14 classes	Y	
G0482	Drug test def 15-21 classes	Y	
G0483	Drug test def 22+ classes	Y	
G2212	Prolong outpt/office vis	Y	
T1001	Nursing assessment/evaluatn	Y	MH or SUD primary diag, or OTP provider
T1015	Clinic service	Y	
T1023	Program intake assessment	Y	MH primary diagnosis

Attachment 1
Performance Measures

Refer to Notes columns within the applicable tables in this Attachment for additional requirements or information:

- "Hybrid", "Race and Ethnicity Stratification (RES)", or Electronic Clinical Data systems (ECDS) denotes a measure for which the Contractor is required to report using the noted methodology; the Contractor must notify HCA within five (5) Business Days with the reason the Contractor is unable to report and what are the barriers to reporting, as well as a plan and timeline for returning to contractual compliance.

- "Assignment" denotes performance measures included in the Assignment Measures Methodology

Table 1 - Reporting of performance measures: Selected measures for data reporting within current contracted year, including HEDIS® and state measures. The Contractor shall collect and report the listed HEDIS® measures statewide for all eligible Enrollees enrolled through AHE contracts during the performance year via HEDIS® IDSS file "special project" submission. The listed state measures shall be collected and reported statewide as available for the AHE population. as indicated in the "Notes" column.

Table 1: Reporting of performance measures (MY2024) Selected measures for data collection and reporting within current contracted year		
NCQA Abbreviation	**Measure**	**Notes**
Prevention and Screening		
CCS	Cervical Cancer Screening	Hybrid
COL	Colorectal Cancer Screening	Hybrid;
CHL	Chlamydia Screening in Women	
OED	Oral Evaluation, Dental Services	No Benefit
Respiratory Conditions		
CWP	Appropriate Testing for Pharyngitis	
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
PCE	Pharmacotherapy Management of COPD Exacerbation	
AMR	Asthma Medication Ratio	RES
Cardiovascular Conditions		
CBP	Controlling High Blood Pressure	Hybrid; RES
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	
SPC	Statin Therapy for Patients With Cardiovascular Disease	
CRE	Cardiac Rehabilitation	
Diabetes		
HBD	Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)	Hybrid; RES
HBD	Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8.0%)	Hybrid; RES
BPD	Blood Pressure Control or Patients with Diabetes (<140/90 mmHg)	Hybrid

EED	Eye Exam for Patients with Diabetes	Hybrid
KED	Kidney Health Evaluation for Patients With Diabetes	
SPD	Statin Therapy for Patients With Diabetes	
Behavioral Healthcare		
DMH	Diagnosed Mental Health Disorders (formerly **MPT** measure)	
AMM	Antidepressant Medication Management	
FUH	Follow-Up After Hospitalization for Mental Illness	Assignment
FUM	Follow-Up After Emergency Department Visit for Mental Illness	
DSU	Diagnosed Substance Use Disorders (formerly IAD measure)	
FUI	Follow-Up After High Intensity Care for Substance Use Disorder	
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	
POD	Pharmacotherapy for Opioid Use Disorder	RES
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Overuse/Appropriateness		
URI	Appropriate Treatment for Upper Respiratory Infection	
AAB	Avoidance of Antibiotic Therapy for Acute Bronchitis	
LBP	Use of Imaging Studies for Low Back Pain	
HDO	Use of Opioids at High Dosage	
UOP	Use of Opioids from Multiple Providers	
COU	Risk of Chronic Opioid Use	
Access/Availability of Care		
AAP	Adults' Access to Preventive/Ambulatory Health Services	
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	RES
PPC	Prenatal and Postpartum Care – Timeliness of Prenatal Care and Postpartum Care	Hybrid; RES
Utilization		
AMB	Ambulatory Care	
IPU	Inpatient Utilization–General Hospital/Acute Care	
AXR	Antibiotic Utilization for Acute Respiratory Conditions	
Risk Adjusted Utilization		
PCR	Plan All-Cause Readmission	
NCQA Abbreviation	**Health Plan Descriptive Information**	**Notes**
ENP	Enrollment by Product Line - Total	

LDM	Language Diversity of Membership	
RDM	Race/Ethnicity Diversity of Membership	
Measures Reported Using Electronic Clinical Data Systems (ECDS)		
BCS-E	Breast Cancer Screening	ECDS; RES
CCS-E	Cervical Cancer Screening	ECDS
COL-E	Colorectal Cancer Screening	ECDS; RES
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	ECDS
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	ECDS
DRR-E	Depression Remission or Response for Adolescents and Adults	ECDS
ASF-E	Unhealthy Alcohol Use Screening and Follow-Up	ECDS
AIS-E	Adult Immunization Status	ECDS; RES
PRS-E	Prenatal Immunization Status	ECDS
PND-E	Prenatal Depression Screening and Follow-Up	ECDS
PDS-E	Postpartum Depression Screening and Follow-Up	ECDS
SNS-E	Social Needs Screening and Intervention	ECDS; Public reporting not required; Reporting to HCA required
State (RDA)	**State Measures: Reported by the state as available within Current Contracted Year**	**Notes**
SUD	Substance Use Disorder Treatment Rate	AHE
MH-B	Mental Health Treatment Rate – Broad Definition	AHE
PCR-P	Thirty (30) day psychiatric inpatient readmissions	AHE
NTSV	Number of Nulliparous Transverse Singleton Vertex (NTSV) C-sections (cesarean births)	AHE
HCBS	Home- and community-based long-term services and supports use	AHE
Home-B; Home-N	Homelessness – broad and narrow definitions	AHE
SA-SUD	Percent Arrested - Members with SUD Treatment Need	AHE
SA-MH	Percent Arrested - Members with Mental Health Treatment Need	AHE
DI-FUA-7D	Receipt of SUD Tx within 7 Days - DOC Facility Releases	AHE
DI-FUA-30D	Receipt of SUD Tx within 30 Days - DOC Facility Releases	AHE
DV-FUA-7D	Receipt of SUD Tx within 7 Days - Local Jail Release from DOC Custody	AHE
DV-FUA-30D	Receipt of SUD Tx within 30 Days - Local Jail Release from DOC Custody	AHE
DI-FUM-7D	Receipt of MH Tx within 7 Days - DOC Facility Releases	AHE
DI-FUM-30D	Receipt of MH Tx within 30 Days - DOC Facility Releases	AHE
DV-FUM-7D	Receipt of MH Tx within 7 Days - Local Jail Release from DOC	AHE

	Custody	
DV-FUM-30D	Receipt of MH Tx within 30 Days - Local Jail Release from DOC Custody	AHE

Table 2 - Collecting of performance measures: Selected performance measures for data collection within the contracted year, including HEDIS® and state measures. The Contractor shall collect and report the following HEDIS® measures statewide for all eligible Enrollees enrolled through AH-IMC and AH-IFC contracts during the performance year. The listed state measures shall be collected and reported statewide for the populations indicated in the Notes column: IMC, IFC, or BHSO.

Table 2: Collecting of performance measures (MY2025) Selected HEDIS® measures for data collection within current contracted year		
NCQA Abbreviation	**Measure**	**Notes**
Prevention and Screening		
CCS	Cervical Cancer Screening	Hybrid
CHL	Chlamydia Screening in Women	Assignment
OED	Oral Evaluation, Dental Services	No Benefit
Respiratory Conditions		
CWP	Appropriate Testing for Pharyngitis	
PCE	Pharmacotherapy Management of COPD Exacerbation	
AMR	Asthma Medication Ratio	RES
Cardiovascular Conditions		
CBP	Controlling High Blood Pressure	Hybrid; RES
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	
SPC	Statin Therapy for Patients With Cardiovascular Disease	
CRE	Cardiac Rehabilitation	
Diabetes		
GSD	Glycemic Status Assessment for Patients with Diabetes: HbA1c Poor Control (>9.0%)	Hybrid; RES
GSD	Glycemic Status Assessment for Patients with Diabetes: HbA1c Control (<8.0%)	Hybrid; RES
BPD	Blood Pressure Control or Patients with Diabetes (<140/90 mm Hg)	Hybrid
EED	Eye Exam for Patients with Diabetes	Hybrid; RES
KED	Kidney Health Evaluation for Patients With Diabetes	RES
SPD	Statin Therapy for Patients With Diabetes	

Behavioral Healthcare		
DMH	Diagnosed Mental Health Disorders (formerly **MPT** measure)	
AMM	Antidepressant Medication Management	
FUH	Follow-Up After Hospitalization for Mental Illness	RES
FUM	Follow-Up After Emergency Department Visit for Mental Illness	RES
DSU	Diagnosed Substance Use Disorders (formerly **IAD** measure)	
FUI	Follow-Up After High Intensity Care for Substance Use Disorder	
FUA	Follow-Up After Emergency Department Visit for Substance Use	RES
POD	Pharmacotherapy for Opioid Use Disorder	RES
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Overuse/Appropriateness		
URI	Appropriate Treatment for Upper Respiratory Infection	
AAB	Avoidance of Antibiotic Therapy for Acute Bronchitis	
LBP	Use of Imaging Studies for Low Back Pain	
HDO	Use of Opioids at High Dosage	
UOP	Use of Opioids from Multiple Providers	
COU	Risk of Chronic Opioid Use	
Access/Availability of Care		
AAP	Adults' Access to Preventive/Ambulatory Health Services	
IET	Initiation and Engagement of Substance use Disorder Treatment	RES
PPC	Prenatal and Postpartum Care – Timeliness of Prenatal Care and Postpartum Care	Hybrid; RES
Utilization		
AXR	Antibiotic Utilization for Acute Respiratory Condition	
Risk Adjusted Utilization		
PCR	Plan All-Cause Readmission	
NCQA Abbreviation	**Health Plan Descriptive Information**	**Notes**
ENP	Enrollment by Product Line - Total	
LDM	Language Diversity of Membership	
RDM	Race/Ethnicity Diversity of Membership	
Measures Reported Using Electronic Clinical Data Systems (ECDS)		
BCS-E	Breast Cancer Screening	ECDS; RES
CCS-E	Cervical Cancer Screening	ECDS; RES
COL-E	Colorectal Cancer Screening	ECDS; RES
DSF-E	Depression Screening and Follow-Up for Adolescents and Adults	ECDS

DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	ECDS
DRR-E	Depression Remission or Response for Adolescents and Adults	ECDS
ASF-E	Unhealthy Alcohol Use Screening and Follow-Up	ECDS
AIS-E	Adult Immunization Status	ECDS; RES
PRS-E	Prenatal Immunization Status	ECDS; RES
PND-E	Prenatal Depression Screening and Follow-Up	ECDS; RES
PDS-E	Postpartum Depression Screening and Follow-Up	ECDS; RES
SNS-E	Social Needs Screening and Intervention	ECDS
State (RDA) Abbreviation	**State Measures: Reported by the State as available within Current Contracted Year**	**Notes**
SUD	Substance Use Disorder Treatment Rate	AHE
MH-B	Mental Health Treatment Rate – Broad Definition	AHE
PCR-P	Thirty (30) day psychiatric inpatient readmissions	AHE
NTSV	Number of Nulliparous Transverse Singleton Vertex (NTSV) C-sections (cesarean births)	AHE
HCBS	Home- and community-based long-term services and supports use	AHE
Home-B; Home-N	Homelessness – broad and narrow definitions	AHE
SA-SUD	Percent Arrested - Members with SUD Treatment Need	AHE
SA-MH	Percent Arrested - Members with Mental Health Treatment Need	AHE
DI-FUA-7D	Receipt of SUD Tx within 7 Days - DOC Facility Releases	AHE
DI-FUA-30D	Receipt of SUD Tx within 30 Days - DOC Facility Releases	AHE
DV-FUA-7D	Receipt of SUD Tx within 7 Days - Local Jail Release from DOC Custody	AHE
DV-FUA-30D	Receipt of SUD Tx within 30 Days - Local Jail Release from DOC Custody	AHE
DI-FUM-7D	Receipt of MH Tx within 7 Days - DOC Facility Releases	AHE
DI-FUM-30D	Receipt of MH Tx within 30 Days - DOC Facility Releases	AHE
DV-FUM-7D	Receipt of MH Tx within 7 Days - Local Jail Release from DOC Custody	AHE
DV-FUM-30D	Receipt of MH Tx within 30 Days - Local Jail Release from DOC Custody	AHE

HCA reserves the right to issue changes to this attachment or measure requirements, such as due to changes in HEDIS® technical specifications.