Washington State Health Care Authority	**State Medicaid Agency Contract for** Covered Health Care Services to Dual Eligible Beneficiaries	HCA Contract Number:

THIS CONTRACT is made by and between the Washington State Health Care Authority, (HCA) and., (Contractor).

CONTRACTOR NAME		CONTRACTOR DOING BUSINESS AS (DBA)		
CONTRACTOR ADDRESS Street		City	State	Zip Code
CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS		
Is Contractor a Subrecipient under this Contract? ☐YES ☒NO				

HCA PROGRAM	HCA DIVISION/SECTION
Managed Care Program	Medicaid Programs Division
HCA CONTACT NAME AND TITLE	HCA CONTACT ADDRESS Health Care Authority 626 8th Avenue SE Olympia, WA 98504
HCA CONTACT TELEPHONE	HCA CONTACT E-MAIL ADDRESS

CONTRACT START DATE	CONTRACT END DATE	TOTAL MAXIMUM CONTRACT AMOUNT
January 1, 2025	December 31, 2025	N/A
PURPOSE OF CONTRACT: To provide, or arrange for the provision of, covered health care services to qualified Dual Eligible Beneficiaries.		

The parties signing below warrant that they have read and understand this Contract and have authority to execute this Contract. This Contract will only be binding upon signature by both parties. The parties may execute this contract in multiple counterparts, each of which is deemed an original and all of which constitute only one agreement. E-mail (electronic mail) transmission of a signed copy of this contract shall be the same as delivery of an original.

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

TABLE OF CONTENTS

Recitals

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

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

OR

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

WHEREAS, Contractor (or another organization under the same parent company and HCA have a current Apple Health Medicaid Integrated Managed Care (IMC) Contract (HCA Contract Number). Regions for which Contractor has an IMC contract for Behavioral Health (BH) Services are referenced in Attachment 3.

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

WHEREAS, Contractor holds an agreement with CMS to provide a Dual Special Needs Plan covered under this SMAC (or another organization under the same parent company) and receives direct capitation from HCA to provide coverage of the Medicaid benefits described in the Integrated Managed Care (IMC) Contract including BH Services listed in Attachment 6.

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

WHEREAS, the contractor will be designated as Highly Integrated (HIDE) Special Needs Plans defined in this SMAC and 42 CFR 422 in counties where the Contractor also holds a current Apple Health Medicaid Integrated Managed Care (IMC) Contract.

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

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

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

1. STATEMENT OF WORK (SOW)

The Contractor will provide the services and staff as described in Attachment 1, Statement of Work.

2. DEFINITIONS

2.1 **"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 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 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.

2.2 **"Care Coordination"** means the organization of a patient's care across multiple health care providers and the Member's healthcare needs are coordinated with the assistance of a Care Coordinator. The Care Coordinator provides information to the Member and the Member's caregivers and works with the Member to ensure that the Member receives the most appropriate treatment while ensuring that health care is not duplicated.

2.3 **"Care Management"** means a set of services, delivered by Care Coordinators, designed to improve the health of Members. Care Management includes a health assessment, development of a care plan and monitoring of Member status, Care Coordination, ongoing reassessment, consultation and crisis intervention, and case

conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the Member to a less intensive level of Care Management as warranted by Member improvement and stabilization.

2.4 **"Case Management"** means Care Management services delivered to Members to obtain access to care and services and coordination of their care.

2.5 **"Communications"** means activities and use of materials created or administered by the plans or any downstream entity to provide information to current and prospective enrollees. All activities and materials aimed at prospective and current enrollees, including their authorized representative, are "communications" within the scope of the regulations at 42 CFR Parts 417, 422, and 423.

2.6 **"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 comprises both Category 3 and Category 4 Data which includes, but is not limited to, Personal Information and Protected Health Information. For the purposes of this Contract, Confidential Information means the same as "Data".

2.7 **"Contract"** means this Contract document and all schedules, exhibits, attachments, incorporated documents and amendments.

2.8 **"Contract Administrator"** means the HCA individual designated to receive legal notices and to administer, amend, or terminate this Contract.

2.9 **"Contract Manager"** means the individual identified on the cover page of this Contract who will provide oversight of the activities conducted under this Contract.

2.10 **"Contractor"** means, its employees and agents. Contractor includes any firm, provider, organization, individual or other entity performing services under this Contract. It also includes any Subcontractor retained by Contractor as permitted under the terms of this Contract.

2.11 **"Coordination Only"** means that as of January 1, 2023, CO D-SNPs are D-SNPs that meet minimum CMS requirements but do not qualify as a HIDE SNP or FIDE SNP. CO D-SNPs must: (1) hold a contract with the state Medicaid agency in each state of operation that meets the requirements described at 42 CFR 422.107; (2) coordinate the delivery of Medicare and Medicaid services for its enrollees; and (3) meet the information-sharing requirements described at 42 CFR 422.107(d) (see Box 2 for more information).

2.12 **"Cost Sharing Obligations"** means those financial payment obligations incurred by HCA in satisfaction of the deductibles, coinsurance, and co-payments for the Medicare Part A and Part B programs with respect to Dual Eligible Members. For purposes of this SMAC, Cost Sharing Obligations do not include (1) Medicare premiums that HCA

is required to pay under the Washington State Plan on behalf of qualified Dual Eligible Beneficiaries, or (2) wrap-around services that are covered by Medicaid.

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

2.14 **"Data"** means information produced, furnished, acquired, or used by Contractor in meeting requirements under this Contract. Confidential Information, Personal Information, and Protected Health Information are all considered Data for the purposes of this Contract.

2.15 **"Default Enrollment"** means a process approved by the State and CMS that allows the Contractor to offer enrollment to a Member of an affiliated Medicaid Managed Care Organization (MCO) to its Medicare Dual Eligible Special Needs Plan (D-SNP) when that member becomes newly eligible for Medicare. (42 CFR 422.66).

2.16 **"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:

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

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

iii. Development Disabilities Administration (DDA) 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.

2.17 **"Dual Eligible Special Needs Plan (D-SNP)"** means a specialized MA plan for special needs individuals who are entitled to medical assistance under a State plan under title XIX of the Act that—

i. Coordinates the delivery of Medicare and Medicaid services for individuals who are eligible for such services;

ii. May provide coverage of Medicaid services, including long-term services and supports and behavioral health services for individuals eligible for such services;

iii. Has a contract with the State Medicaid agency consistent with § 422.107 that meets the minimum requirements in paragraph (c) of such section; and

iv. Beginning January 1, 2021, satisfies one or more of the following criteria for the integration of Medicare and Medicaid benefits:

v. Meets the additional requirement specified in § 422.107(d) in its contract with the State Medicaid agency.

vi. Is a highly integrated dual eligible special needs plan.

vii. Is a fully integrated dual eligible special needs plan.

2.18 **"Dual Eligible Beneficiary"** means a Medicare managed care recipient who is also eligible for Medicaid, and for whom HCA has a responsibility for payment of Cost Sharing Obligations under the Washington State Plan. For purposes of this SMAC, Dual Eligibles are limited to the categories of recipients identified in Attachment 2.

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

ii. Qualified Medicare Beneficiary without other Medicaid (QMB only): An individual entitled to Medicare Part A, with an income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for Supplemental Social Security (SSI) eligibility, and who is not otherwise eligible for full Medicaid benefits through HCA. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers to the extent consistent with the Medicaid State Plan. Medicaid does not pay towards out-of-pocket (OOP) costs for deductibles, premiums, coinsurance, or copayments for Medicare Part D prescription drug coverage.

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

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

v. Specified Low-Income Medicare Beneficiary with Comprehensive Medicaid Benefits (SLMB+): An individual who meets the standards for SLMB eligibility, and who also meets the criteria for full HCA Medicaid benefits. The individuals are entitled to payment of the Medicare Part B premium, in addition to HCA Medicaid benefits covered under the program for which they become eligible, e.g., the Medically Needy (MN) for those who meet spenddown requirements. These individuals often qualify for Medicaid by meeting Medically Needy standards or by spending down excess income to the Medically Needy level. See also Full Benefit Dual Eligible #7. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

vi. Qualifying Individual (QI): An individual entitled to Medicare Part A, with an income at least 120% FPL but less than 135% FPL, and resources that do not exceed twice the SSI limit, and who is not otherwise eligible for Medicaid benefits. This individual is eligible for Medicaid payment of the Medicare Part B premium only; they cannot also be eligible for other Medicaid benefits. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

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

viii. Other Full Benefit Dual Eligible (FBDE): An individual who does not meet the income and/or resource criteria for QMB or SLMB but is eligible for Categorically Needy (CN) Medicaid or Medically Needy (MN) through coverage groups based on MN spend-down status, special income levels for institutionalized individuals, home and community-based waivers, or those with blindness or disability who are working and enrolled in Apple Health for Workers with Disabilities. HCA-

funded buy-in pays for Part A, if not free to the individual, and Part B premiums. Medicaid does not pay towards OOP costs for the deductible, premium, coinsurance, or copayments for Medicare Part D prescription drug coverage.

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

2.20 **"Highly Integrated Dual Eligible (HIDE) Special Needs Plan"** are D-SNPs that provide coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid managed care plan), including LTSS, behavioral health, or both, under a capitated contract with the state Medicaid agency as defined by 42 CFR 422.2.

2.21 **"Home and Community Based Services"** provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

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

2.23 **"Information and Communication Technology" or "ICT"** means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Examples include computers and peripheral equipment; information kiosks and transaction machines; telecommunications equipment; customer premises equipment; multifunction office machines; software; applications; websites; videos; and electronic documents.

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

2.25 **"Marketing"** means a subset of communications and must, unless otherwise noted, adhere to all communication requirements. To be considered marketing, communications materials must meet both intent and content standards. In evaluating the intent of an activity or material, HCA will consider objective information including, but not limited to, the audience, timing, and other context of the activity or material, as well as other information communicated by the activity or material. The organization's stated intent will be reviewed but not solely relied upon. These activities are directed from the Contractor or third-party sub-Contractor to a Potential Enrollee or Enrollee who is enrolled with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or either not enroll or to end

their enrollment with another HCA-Contracted MCO. Marketing communications include written, oral, in-person (telephonic or face-to-face), or electronic methods of communication, including email, text messaging, and social media (Facebook, Instagram and X).

2.26 **"Medically Necessary Services"** means a requested service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the client that endanger life, 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. There is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (182-500-0070).

2.27 **Medicare Data Use Requirements"** refers to the documents attached and incorporated into this SMAC as Schedules 1, and 2, which set out the terms and conditions Contractor must agree to for the access to and use of Medicare Data for the Members who are dually eligible in the Medicare and Medicaid programs.

2.28 **"Member"** means a full or partially dual eligible individual who has elected to enroll with the Contractor.

2.29 **"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 (including or excluding zip code), telephone numbers, social security numbers, driver's license numbers, credit card numbers, any other identifying numbers, and any financial identifiers.

2.30 **"Potential Member"** means any individual who qualifies for enrollment in Medicare and Medicaid as a Dual Eligible Beneficiary and who is not enrolled with any Dual Special Needs Plan.

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

2.32 **"Service Area"** means those counties or zip codes where Contractor operates as approved by CMS and HCA and described in Attachment 3, attached hereto.

2.33 **"Sub-Contractor"** means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under this SMAC.

2.34 **"Supplemental Benefits"** means services or benefits that are mandatory or optional health care services that are intended to maintain or improve the health status of

members, for which the Contractor incurs a cost or liability under an Contractor (not solely an administrative processing cost) consistent with 42 CFR 422.102. See Attachments 4 and 5 for Supplemental Benefits offered under this SMAC.

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

2.36 **"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.

2.37 **"Value-Added Items and Services (VAIS)"** are items and services that are not plan benefits, are not part of the MAO plan's benefit package, and may not be marketed to prospective members or used as an inducement or incentive for enrollment. VAIS are non-Medicare covered services or items, typically discounts, offered by a VAIS provider to the members of an Contractor. VAIS must be offered in accordance with Federal Guidance. See Attachments 4 and 5 for VAIS offered under this SMAC.

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

3. SPECIAL TERMS AND CONDITIONS

3.1 PERFORMANCE EXPECTATIONS

Expected performance under this Contract includes, but is not limited to, the following:

3.1.1 Knowledge of applicable state and federal laws and regulations pertaining to subject of Contract;

3.1.2 Use of professional judgment;

3.1.3 Collaboration with HCA staff in Contractor's conduct of the services;

3.1.4 Conformance with HCA directions regarding the delivery of the services;

3.1.5 Timely, accurate and informed communications;

3.1.6 Regular completion and updating of project plans, reports, documentation and communications;

3.1.7 Regular, punctual attendance at all meetings; and

3.1.8 Provision of high-quality services.

Prior to payment of invoices, HCA will review and evaluate the performance of Contractor in accordance with Contract and these performance expectations and may withhold payment if expectations are not met or Contractor's performance is unsatisfactory.

3.2 TERM

3.2.1 The initial term of the Contract will commence on January 1, 2025, and continue through December 31, 2025, unless terminated sooner as provided herein.

3.2.2 This Contract may be extended by mutually agreed amendment in whatever time increments HCA deems appropriate. No change in terms and conditions will be permitted during these extensions unless specifically agreed to in writing.

3.2.3 Work performed without a contract or amendment signed by the authorized representatives of both parties will be at the sole risk of the Contractor. HCA will not pay any costs incurred before a contract or any subsequent amendment(s) is fully executed.

3.3 CONTRACTOR AND HCA CONTRACT MANAGERS

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

CONTRACTOR Contract Manager Information		**Health Care Authority Contract Manager Information**	
Name:		Name:	Johnny Shults
Title:		Title:	Section Supervisor
Address:		Address:	Health Care Authority 626 8th Avenue SE Olympia, WA 98504
Phone:		Phone:	(360) 725-0480

Email:		Email:	Johnny.shults@hca.wa.gov

3.4 LEGAL NOTICES

Any notice or demand or other communication required or permitted to be given under this Contract or applicable law is effective only if it is in writing and signed by the applicable party, properly addressed, and delivered in person, via email, or by a recognized courier service, or deposited with the United States Postal Service as first-class mail, postage prepaid certified mail, return receipt requested, to the parties at the addresses provided in this section.

3.4.1 In the case of notice to the Contractor:

Attention:

In the case of notice to HCA:
Attention: Contracts Administrator
Health Care Authority
Division of Legal Services
Post Office Box 42702
Olympia, WA 98504-2702
contracts@hca.wa.gov

3.4.2 Notices are effective upon receipt or four (4) Business Days after mailing, whichever is earlier.

3.4.3 The notice address and information provided above may be changed by written notice of the change given as provided above.

3.5 INCORPORATION OF DOCUMENTS AND ORDER OF PRECEDENCE

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

3.5.1 Attachment 8, Data Sharing Terms (including the Washington OCIO Security Standard 141.10)

3.5.2 Applicable Federal and State of Washington statutes and regulations;

3.5.3 Recitals;

3.5.4 Special Terms and Conditions;

3.5.5 General Terms and Conditions;

3.5.6 Attachment 1, Statement of Work

3.5.7 Attachment 2, Covered Dual Eligible Recipient Aid Categories;

3.5.8 Attachment 3, Service Area Washington;

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

3.5.10 Attachment 5, Summary of Supplemental Benefits and Value-Added Items and Services (VAIS) for Partial Dual Eligible Members;

3.5.11 Attachment 6, Summary of Behavioral Health Benefits Covered Under IMC Contract;

3.5.12 Attachment 7, Health Home; and

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

3.6 INSURANCE

The Contractor must provide insurance coverage as set out in this section. The intent of the required insurance is to protect the State should there be any claims, suits, actions, costs, damages or expenses arising from any negligent or intentional act or omission of Contractor or Subcontractor, or agents of either, while performing under the terms of this Contract. Contractor must provide insurance coverage that is maintained in full force and effect during the term of this Contract, as follows:

3.6.1 Commercial General Liability Insurance Policy - Provide a Commercial General Liability Insurance Policy, including contractual liability, in adequate quantity to protect against legal liability arising out of contract activity but no less than $1 million per occurrence/$2 million general aggregate. Additionally, Contractor is responsible for ensuring that any Subcontractors provide adequate insurance coverage for the activities arising out of Subcontracts.

3.6.2 Business Automobile Liability. In the event that services delivered pursuant to this Contract involve the use of vehicles, either owned, hired, or non-owned by the Contractor, automobile liability insurance is required covering the risks of bodily injury (including death) and property damage, including coverage for contractual liability. The minimum limit for automobile liability is $1,000,000 per occurrence, using a Combined Single Limit for bodily injury and property damage.

3.6.3 Professional Liability Errors and Omissions – Provide a policy with coverage of not less than $1 million per claim/$2 million general aggregate.

3.6.4 Industrial Insurance Coverage

Prior to performing work under this Contract, Contractor must provide or purchase industrial insurance coverage for the Contractor's employees, as may be required of an "employer" as defined in Title 51 RCW and must maintain full compliance with Title 51 RCW during the course of this Contract.

3.6.5 The insurance required must be issued by an insurance company/ies authorized to do business within the state of Washington, and must name HCA and the state of Washington, its agents and employees as additional insureds under any Commercial General and/or Business Automobile Liability policy/ies. All policies must be primary to any other valid and collectable insurance. In the event of cancellation, non-renewal, revocation or other termination of any insurance coverage required by this Contract, Contractor must provide written notice of such to HCA within one (1) Business Day of Contractor's receipt of such notice. Failure to buy and maintain the required insurance may, at HCA's sole option, result in this Contract's termination.

3.6.6 Upon request, Contractor must submit to HCA a certificate of insurance that outlines the coverage and limits defined in the Insurance section. If a certificate of insurance is requested, Contractor must submit renewal certificates as appropriate during the term of the contract.

3.6.7 The Contractor certifies that it is self-insured, is a member of a risk pool, or maintains the types and amounts of insurance identified above and will provide certificates of insurance to that effect to HCA upon request.

4. GENERAL TERMS AND CONDITIONS

4.1 ACCESS TO DATA

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

4.2 **ACCESSIBILITY**

4.2.1 REQUIREMENTS AND STANDARDS. Each Information and Communication Technology (ICT) product or service furnished under this Contract shall be accessible to and usable by individuals with disabilities in accordance with the Americans with Disabilities Act (ADA) and other applicable Federal and State laws and policies, including OCIO Policy 188, *et seq*. For purposes of this clause, Contractor shall be considered in compliance with the ADA and other applicable Federal and State laws if it satisfies the requirements (including exceptions) specified in the regulations implementing Section 508 of the Rehabilitation Act, including the Web Content Accessibility Guidelines (WCAG) 2.1 Level AA Success Criteria and Conformance Requirements (2008), which are incorporated by reference, and the functional performance criteria.

4.2.2 DOCUMENTATION. Contractor shall maintain and retain, subject to review by HCA, full documentation of the measures taken to ensure compliance with the applicable requirements and functional performance criteria, including records of any testing or simulations conducted.

4.2.3 REMEDIATION. If Contractor claims that its products or services satisfy the applicable requirements and standards specified in Section 4.2.1 and it is later determined by HCA that any furnished product or service is not in compliance with such requirements and standards, HCA will promptly inform Contractor in writing of noncompliance. Contractor shall, at no additional cost to HCA, repair or replace the non-compliant products or services within the period specified by HCA. If the repair or replacement is not completed within the specified time, HCA may cancel the Contract, delivery, task order, or work order, or purchase line item without termination liabilities or have any necessary changes made or repairs performed by employees of HCA or by another contractor, and Contractor shall reimburse HCA for any expenses incurred thereby.

4.2.4 INDEMNIFICATION. Contractor agrees to indemnify and hold harmless HCA from any claim arising out of failure to comply with the aforesaid requirements.

4.3 **AMENDMENTS**

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

4.4 **ASSIGNMENT**

4.4.1 This SMAC and the rights and obligations of the parties under this SMAC will be assigned, in whole or in part, by the Contractor only with the prior written consent of the HCA point of contact identified in the Notices section.

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

4.5 COMPLIANCE WITH APPLICABLE LAW

4.5.1 The Contractor and its sub-Contractors will comply with all applicable federal, state, and local laws, regulations, and rules, as amended.

4.6 CONFIDENTIALITY

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

4.6.1.1 As provided by law; or

4.6.1.2 In the case of Personal Information, with the prior written consent of the person or personal representative of the person who is the subject of the Personal Information. Data Shared by the Contractor.

4.6.1.3 If Data access is to be provided to a Subcontractor under this SMAC, the Contractor must include all the Data security terms, conditions, and requirements set forth in this SMAC in any such Subcontract or agreement. In no event will the existence of the Subcontract operate to release or reduce the liability of the Contractor to HCA for any breach in the performance of the Contractor's responsibilities.

4.6.1.4 If the Contractor is aware of national or local media outlets running or will run articles implicating the plan in any negative activities including but not limited to lawsuits or breaches, the Contractor will notify HCA within one (1) day and provide a brief assessment on impacts to the State of Washington.

4.7 CONSTRAINTS

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

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

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

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

4.8 CORRECTIVE ACTION PLAN (CAP)

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

4.9 DISPUTES

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

4.9.2 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 the following:

4.9.1.1 The disputed issue(s).

4.9.1.2 An explanation of the positions of the parties.

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

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

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

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

4.9.6 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).

4.9.7 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.

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

4.10 ENTIRE AGREEMENT

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

4.11 FORCE MAJEURE

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

4.12 GOVERNING LAW

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

4.13 INDEMNIFICATION AND HOLD HARMLESS

4.13.1 Each party will be responsible for its acts and omissions and the acts and omissions of its agents and employees. Each party to this SMAC will defend, protect, and hold harmless the other party from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent acts and omissions of the first party, or agents of the first party, while performing under the terms of this SMAC except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission on the part of the second party. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The 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.

4.14 NONDISCRIMINATION

4.14.1 Nondiscrimination Requirement. During the term of this Contract, Contractor, including any subcontractor, shall not discriminate on the bases enumerated at RCW 49.60.530(3); Title VII of the Civil Rights Act, 42 U.S.C. §12101 et seq.; the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. §12101 et seq., and 28 C.F.R. Part 35. In addition, Contractor, including any subcontractor, shall give written notice of this nondiscrimination requirement to any labor organizations with which Contractor, or subcontractor, has a collective bargaining or other agreement.

4.14.2 Obligation to Cooperate. Contractor, including any subcontractor, shall cooperate and comply with any Washington state agency investigation regarding any

allegation that Contractor, including any subcontractor, has engaged in discrimination prohibited by this Contract pursuant to RCW 49.60.530(3).

4.14.3 Default. Notwithstanding any provision to the contrary, HCA may suspend Contractor, including any subcontractor, upon notice of a failure to participate and cooperate with any state agency investigation into alleged discrimination prohibited by this Contract, pursuant to RCW 49.60.530(3). Any such suspension will remain in place until HCA receives notification that Contractor, including any subcontractor, is cooperating with the investigating state agency. In the event Contractor, or subcontractor, is determined to have engaged in discrimination identified at RCW 49.60.530(3), HCA may terminate this Contract in whole or in part, and Contractor, subcontractor, or both, may be referred for debarment as provided in RCW 39.26.200. The Contractor or subcontractor may be given a reasonable time in which to cure this noncompliance, including implementing conditions consistent with any court-ordered injunctive relief or settlement agreement.

4.14.4 Remedies for Breach. Notwithstanding any provision to the contrary, in the event of Contract termination or suspension for engaging in discrimination, Contractor, subcontractor, or both, shall be liable for contract damages as authorized by law including, but not limited to, any cost difference between the original contract and the replacement or cover contract and all administrative costs directly related to the replacement contract, which damages are distinct from any penalties imposed under Chapter 49.60, RCW. HCA shall have the right to deduct from any monies due to Contractor or subcontractor, or that thereafter become due, an amount for damages Contractor or subcontractor will owe HCA for default under this provision.

4.15 NO ENDORSEMENT

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

4.16 NO THIRD-PARTY BENEFICIARIES

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

4.17 PUBLIC DISCLOSURE

4.17.1 Contractor acknowledges that this SMAC is a public record pursuant to chapter 42.56 of the Revised Code of Washington. Any documents submitted to HCA by the Contractor may be construed as “public records” and therefore subject to public disclosure, except as otherwise provided in 42.56 RCW or other applicable law. HCA may post a “model” contract of this SMAC on the HCA website.

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

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

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

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

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

4.17.6.1 Litigation, with an appropriate court order;

4.17.6.1.1 HCA will provide the contractor with notice and opportunity to file legal proceedings in accordance with subsection 2.18.3.

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

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

4.17.6.2 Disclosures of information that is not directly identifiable by Contractor, including disclosures;

4.17.6.3 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;

4.17.6.4 Disclosures of aggregated information; and

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

4.18 RECORDS AND DOCUMENT REVIEW

4.18.1 The Contractor agrees to maintain for 10 years from the expiration or termination of the SMAC: books, records, documents, and other evidence of accounting procedures and practices that are sufficient to the following:

4.18.1.1 Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the bid) of the Contractor.

4.18.1.2 Enable CMS to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Contractor's CMS contract, and the facilities of the Contractor.

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

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

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

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

4.18.2.1 Include at least records of the following:

4.18.2.1.1 Ownership and operation of the Contractor's financial, medical, and other record-keeping systems.

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

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

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

4.18.2.3 Agreements, contracts, and subcontracts.

4.18.2.4 Franchise, marketing, and management agreements.

4.18.2.5 Schedules of charges for the Contractor's fee-for-service patients.

4.18.2.6 Matters pertaining to costs of operations.

4.18.2.7 Amounts of income received by source and payment.

4.18.2.8 Cash flow statements.

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

4.19 RESERVATION OF RIGHTS AND REMEDIES

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

4.20 SEVERABILITY

4.20.1 Whenever possible, each provision of this SMAC will be interpreted in such a manner as to be effective and valid under applicable law. If any provision of this SMAC is held to be invalid, illegal, or unenforceable under any applicable law or rule, the validity, legality, and enforceability of the other provisions of this SMAC will not be affected or impaired thereby.

4.21 TERMINATION

4.21.1 This SMAC may be terminated under the following conditions:

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

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

4.21.1.3 HCA may terminate the SMAC in whole or in part and at any time when, in its sole discretion, it determines that termination is in the best interests of HCA. The termination will be effective on the date specified in HCA's notice of termination. HCA will provide the

Contractor with written notice of such termination at least 30 calendar days prior to the effective date of termination unless HCA determines that circumstances warrant a shorter notice period.

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

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

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

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

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

4.22 SANCTIONS AND LIQUIDATED DAMAGES

4.22.1 The Contractor’s failure to comply with the terms of this contract or any corrective action plan may result in the imposition of sanctions under the Sanctions section of this contract. Additionally, HCA may also impose liquidated damages under the Liquidated Damages section of this contract. 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 contract.

4.23 WAIVER

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

ATTACHMENT 1: STATEMENT OF WORK

1. CONTRACTOR OBLIGATIONS

1.1 ELIGIBILITY AND ENROLLMENT

1.1.1 Service Area

1.1.1.1 The Contractor may offer a Dual Eligible SNP to eligible beneficiaries who reside in those counties where the Contractor offers such benefit plan under its MA Agreement. Specific counties or zip codes covered by this SMAC are described in Attachment 3.

1.1.2 Eligibility Verification

1.1.2.1 HCA will provide Contractor a method of verifying Medicaid eligibility which may include, but is not limited to, verification through a systems query to a state eligibility data system, and a list of state RACs for eligibility determination.

1.1.2.2 HCA will provide the Contractor with a weekly list of IMC individuals enrolled in their corresponding plan who are eligible or will become eligible for Medicare. The Contractor may conduct outreach and Default Enrollment in approved areas using this list. The file will be named DSNP Default Enrollment [Plan Name]. The file will be posted weekly to the Contractor MFT site.

1.1.3 Enrollment

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

1.1.3.1.1 The Contractor will verify Dual Eligible Member eligibility and plan enrollment as needed using the verification process identified in the Eligibility and Enrollment Section of this SMAC.

1.1.3.1.2 The Contractor will report to HCA any changes in Dual Eligible Member eligibility. Changes include

but are not limited to moving out of state, deaths, or loss of eligibility.

1.1.4 The Contractor must have separate Plan Benefit Packages (PBP) for full dual eligible Members and partial dual eligible Members. The Contractor will develop separate Medicare PBPs for coordination only and HIDE designated service areas. The Contractor's PBPs and eligible Member categories are detailed in Attachment 3. Each PBP must meet requirements under this SMAC to include:

1.1.4.1 Each PBP must be submitted in writing to HCA via email to HCA DSNP HCADSNP@hca.wa.gov within 30 days of submittal to CMS;

1.1.4.2 Ensure that beneficiaries are enrolled with the PBP that fits their benefit category.

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

1.1.4.4 Meet all Medicare requirements.

1.1.5 Default Enrollment Process

1.1.5.1 The Contractor shall conduct Default Enrollment in HCA approved counties as provided by 42 CFR 422.66 and 422.68.

1.1.5.2 Default Enrollment

1.1.5.2.1 The Contractor will conduct Default Enrollment for eligible beneficiaries who receive medical assistance benefits, and who become newly Medicare eligible either by age or disability. The Contractor shall perform the Default Enrollment process as provided by 42 CFR 422.66 and 422.68.

1.1.5.2.2 Prior to any initial default enrollment activities or any submissions to CMS regarding default enrollment, the Contractor will be required to meet all network alignment requirements and receive approval from HCA.

1.1.5.2.3 The Contractor will be required to use the approved Default Enrollment notice. No changes shall be made without prior written approval from the HCA.

1.1.6 Through this Agreement, in conformance with 42 CFR 422.66(c)(2)(i)(B) and 42 CFR 422.107, HCA approves the Contractor's implementation of

the Default Enrollment process subject to CMS' prior approval as per the requirements 422.66(c)(2)(i)(E), (F), and (G) inclusive; 422.66(c)(2)(ii); and other CMS-published regulatory guidance as applicable. The Contractor shall be responsible for obtaining initial Default Enrollment process approval from HCA and CMS. The Contractor will coordinate with HCA regarding those activities necessary to obtain prior approval. The Contractor shall forward to HCA a copy of CMS' Default Enrollment process prior approval notification or correspondence to the Contractor within 10 calendar days of receipt. The Contractor shall not conduct any Default Enrollment activities without receiving all final approvals from HCA and CMS and upon written approval from HCA. The Contractor shall give HCA 30-days advance notice prior to full implementation.

1.1.7 The Contractor shall also be responsible for coordinating those necessary activities to renew any existing Default Enrollment process approval(s) with HCA and CMS, as per the requirements of 42 CFR 422.66(c)(2)(ii), so that any such subsequent CMS approval(s)/renewal(s) of an existing approved Default Enrollment process shall be effective no later than 120 calendar days prior to the expiration of the existing CMS approval requested to be renewed. The Contractor shall coordinate with HCA regarding those activities necessary to obtain such CMS renewal approval(s) of an existing Default Enrollment process. The Contractor shall forward to HCA copies of its Default Enrollment process renewal notification and materials to CMS, and CMS' renewal approval(s) notification or correspondence to the Contractor, within 10 calendar days of receipt.

1.1.8 The Contractor shall achieve and maintain a minimum 3.0 overall plan Star rating as assigned by CMS on the Medicare Advantage and Part D Star Ratings report to implement the Default Enrollment process. The Contractor's implementation of the Default Enrollment process shall be revoked by HCA and CMS if a minimum 3.0 overall plan Star rating is not maintained, and Default Enrollment cannot be re-applied for with CMS until the Contractor has subsequently achieved this minimum Star rating and notified in writing to HCA.

1.1.9 If the Contractor's MA Plan is a low enrollment plan and deemed 3 stars per 42 CFR 422.66 (c)(2)(F) and 42 CFR 422.252 the Contractor will provide to HCA a summary quality report demonstrating the quality plan the Contractor will implement to show how they will meet HEDIS scores if measured. If the Contractor has an existing low enrollment plan rated less than 3 stars, the quality plan must demonstrate how that low enrollment plan would have achieved 3 stars if rated.

1.1.10 The Contractor shall achieve and maintain a 95% alignment of their Medicare network to their Medicaid Network to implement the Default

Enrollment process. The Contractor's implementation of the Default Enrollment process shall be revoked by HCA if a minimum of 95% is not achieved and maintained. Default Enrollment approval cannot be re-applied for with HCA until the Contractor has achieved 95% alignment or higher as allowed by HCA.

1.1.11 Through the implementation of the Default Enrollment process, HCA shall provide the Contractor with information necessary to prospectively identify those HCA categorically eligible members who are or will be in their Medicare Initial Coverage Election Period.

1.1.12 The Contractor shall report quarterly, by month, to HCA its Default Enrollment activities on an HCA approved template. Reports are due on the last day of the month following the end of each quarterly reporting period. The reports are due by: July 31(April-June); October 31 (July-September); January 31 (October-December); and April 30 (January-March). The report will be submitted to the Contractor MFT site.

1.2 MODEL OF CARE

The Contractor will include in its Model of Care (MOC):

1.2.1 A health home program, in alignment with the Medicaid Health Home program, will be made available to all eligible full-dual D-SNP enrollees who meet eligibility criteria for the Health Homes program. The Contractor may offer Health Homes to all Partial Dual eligible clients who meet criteria. If the Contractor offers the Health Home program to partial-dual eligible clients, the plan will ensure the program is made available at no cost to the partial-dual member.

1.2.1.1 A method for identification of members currently receiving Home and Community Based Services and how the Contractor will address the unique challenges of this population in the State of Washington.

1.2.1.1.1 The language will specifically identify knowledge of the LTC system and who to communicate with to coordinate care for individuals receiving or needing LTC services.

1.2.1.2 A method for identification of members with significant behavioral health conditions and how the Contractor will address the unique challenges of this population in the State of Washington.

1.2.1.3 The language will specifically identify knowledge of who to communicate with to coordinate care for individuals and when coordination should occur.

1.3 CMS MODEL OF CARE APPROVAL (MOC)

1.3.1 The Contractor will submit to HCA within 10 days of approval via –mail - HCADSNP@hca.wa.gov:

1.3.1.1 The approved Model of Care; and

1.3.1.2 One of the following:

1.3.1.2.1 Written approval from CMS of the Model of Care; or

1.3.1.2.2 The full NCQA accreditation report and accreditation status results within 30 days of each accreditation visit for any accreditation applicable to this SMAC (42 CFR 422.152(g)); or

1.3.1.2.3 NCQA Medicare Advantage Deeming status (42 CFR 422.158).

1.3.2 If the Contractor makes any changes to their MOC, the Contractor will resubmit their MOC to HCA within thirty (30) days of submission to CMS.

1.3.2.1 The Contractor will include as part of their training for staff and providers the following Washington-specific topics:

1.3.2.1.1 The Contractor's responsibility for coordination of Medicare and Medicaid benefits and grievances for Dual Eligible SNP Members.

1.3.2.1.2 Health Home;

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

1.3.2.1.4 Programs to address health disparities, especially where evidence of inequity of health outcomes is measured;

1.3.2.1.5 Supply education to providers regarding the different plan benefit packages (PBPs) available.

1.3.2.1.6 How Long-Term Services and Supports are provided in the State of Washington and the role of the DSNP Care Coordinators in collaborating with the long-term care system in serving Dual Eligible populations.

1.3.3 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.

1.3.4 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).

1.4 CONTRACTOR QUALITY ASSURANCE

1.4.1 Quality Measures:

1.4.1.1 The Contractor will submit via email to HCADSNP@hca.wa.gov annual HEDIS® reports, CAHPS® if participating, and any other quality strategies and evaluations. HEDIS® and CAHPS® reports must be submitted within 30 calendar days of report completion.

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

1.4.1.3 The Contractor will provide their Medicare Advantage (Medicare Part C) and Medicare Part D Star Ratings to HCA within 30 calendar days of the Contractor receiving their official report by email to HCADSNP@hca.wa.gov.

1.4.1.4 If Star Report is less than 4 stars, the Contractor will consult with HCA and provide an action plan on steps the Contractor is taking to raise score in the State of Washington within 90 days of the final draft.

1.5 CARE COORDINATION

1.5.1 Coordination of Health Care Services

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

1.5.1.2 The Contractor's responsibility to coordinate services.

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

1.5.1.2.2 If a Dual Eligible Member is enrolled with the Contractor for both Medicare and Medicaid benefits, the Contractor is responsible for coordinating all benefits covered by both Medicare and Medicaid.

1.5.1.2.2.1 The Contractor will coordinate with all contracted DSNPs and BHSOs in the state of Washington to develop Contact Names and a referral process to be used by their care coordination teams for coordinating across BHSO and MA plan.

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

1.5.1.2.4 If a Dual Eligible Member is not enrolled with the Contractor companion Medicaid BHSO MCO for Medicaid benefits, the Contractor shall coordinate Medicaid-only benefits with the Dual Eligible Member's assigned MCO for BHSO services. Coordination of Medicaid benefits is not the Dual Eligible Member's responsibility.

1.5.1.3 Care Coordination General Requirements. The Contractor will:

1.5.1.3.1 Have access to and ensure utilization of the Predictive Risk Intelligence System (PRISM) to obtain a more comprehensive overview of a member's health and patterns of service use, and to identify gaps in needed care.

1.5.1.3.2 Utilize Benefit Enrollment information to identify and develop a standard for when to coordinate care for members receiving HCBS and BHSO benefits.

1.5.1.3.3 Participate in care coordination efforts facilitated by the state and utilize any tools and processes developed through these efforts.

1.5.1.3.4 Affiliated staff shall provide interventions and work with enrollees to address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices;

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

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

1.5.1.3.7 Contractor will develop policies and procedures for care coordination to include:

1.5.1.3.7.1 The Contractor will partner with ALTSA, HCA, DSHS, and other stakeholders on services provided to enrollees.

1.5.1.3.7.2 Transitions of care processes for Enrollees moving from IMC to the DSNP program and their corresponding BHSO if eligible.

1.5.1.3.8 The Contractor shall ensure continuity of care for Members with chronic or acute physical or behavioral health conditions. The Contractor shall

ensure continued access to services during a transition between FFS and the Contractor's MA Plan, or from one Integrated Managed Care or BHSO to another MA plan, consistent with the Contractor's Model of Care (42 C.F.R. § 422.101). The Contractor shall ensure medically necessary care for Members is not interrupted during transitions from one setting or level of care to another or transitioning from Behavioral Health or Correctional Facilities. (42 CFR § 422.112)

1.5.1.3.8.1 The Contractor shall coordinate with its Integrated Managed Care Plan to identify and utilize the same or comparable questions required by Medicaid for the Health Risk Assessment to assess health-related social needs (HRSN). Questions at a minimum will address housing stability, food security, and access to transportation. These questions will be provided to the Contractor as developed. If questions are not identical, the Contractor will submit to HCA their selected questions for approval.

1.5.1.3.8.2 The aggregated responses will be provided annually to HCA by December 30th of the contract year in the HRSN report. The report will cover 12/1 of the previous contract year through 11/30 of the current contract year. A template will be provided to the Contractor by HCA no later than October 1 of the contract year.

1.5.1.3.8.3 The Contractor will coordinate with HCA, DSHS, and the other Contractors to discuss and develop proposed benefits for the next SMAC development.

1.5.1.3.8.4 The Contractor will develop policies and procedures for coordinating

HRSN with existing state resources when supplemental benefits do not cover the benefit is exhausted.

1.5.1.3.8.5 The Contractor will participate in staffing meetings to address complex discharge cases involving Dual Eligible Members as necessary, or when requested, to support discharge and transitions of care.

1.5.1.4 The Contractor shall support Information Sharing to Improve Care Coordination and Care Outcomes by:

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

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

1.5.1.4.3 The Contractor will have policies and protocols to coordinate services between settings of care and include all relevant parties involved in discharge or transition planning, including HCS if the member receives HCBS services. This coordination will

include appropriate discharge planning for short-term and long-term hospital and institutional stays:

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

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

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

1.5.1.4.4 The Contractor will have policies and protocols for sharing information with system partners such as the Department of Social and Health Services (DSHS) Aging and Long-Term Support Administration (ALTSA), Home Community Services (HCS), and Developmental Disabilities Administration (DDA), and other MCOs or DSNPs serving the Member to reduce duplication of assessment and care planning activities.

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

1.5.1.4.5.1 The Contractor will submit a data file monthly of all referrals for all DSNP enrollees no later than the 1st of the next month to the Contractor's MFT site.

1.5.1.4.6 For Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, Contractor will have a mechanism in place to allow

Members to directly access a specialist (e.g., through a standing referral or an approved number of visits) as appropriate for the Member's condition and identified needs. The Contractor will work to ensure the services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the Member's ongoing need for such services and support.

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

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

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

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

1.5.1.6 Where services are covered by Medicare or other Third Party, the Contractor shall ensure the provider is paid accordingly and then coordinate any remaining payment or balance with the BHSO as appropriate. The Contractor will develop a process to assist and refer eligible claims to the BHSO to ensure prompt payment when requested by the Provider.

1.6 NETWORK AND ACCESS TO CARE

1.6.1 The Contractor Participating Providers

1.6.1.1 The Contractor maintains contracts with participating providers whereby Contractor assures adequate access and availability to Members for all

medically necessary covered Services, following CMS access standards and guidelines. The Contractor maintains policies and procedures to regularly monitor the access and availability of such participating providers to ensure Contractor consistently meets such access standards and guidelines. Contractor agrees to maintain a contracted participating provider network which is qualified to serve the Members enrolled in Contractor under the SNP, including any specific special medical care needs of such membership which are covered benefits under the SNP.

1.6.1.2 In counties where the Contractor (or another organization under the same parent company) has an IMC contract, the Contractor will align its Medicare network with its affiliated IMC Medicaid network, with respect to the Medicare required network provider types as defined by the Health Services Delivery (HSD) table.

1.6.1.3 By November 1 of each calendar year, the Contractor will provide: a list of all counties and relative percentages for the next upcoming contract year showing the alignment percentage. In counties where less than 80% percent of their Medicaid providers for CMS critical specialties also contract for and accept Medicare members for the current plan year, the Contractor will develop an action plan to reach at least 80% alignment by November 1. This will be provided to HCA via email to HCADSNP@hca.wa.gov, utilizing the Network Alignment Template.

1.6.2 In counties where the Contractor is considered Coordination Only, the Contractor will work to contract with providers who also accept Medicaid clients.

1.6.3 In counties where the MA Health Plan (or another organization under the same parent company) does not have an IMC contract in the same service area as their DSNP and is considered Coordination Only, the Contractor will complete the network alignment report and indicate the percentage of the network providers in that county that also accepts Medicaid clients.

1.6.4 If the MCO does not offer a Medicaid option in the same service area as their DSNP and is considered Coordination only to the Contractor will complete the network alignment report and indicate the percentage of the network in that county that also accepts Medicaid clients.

1.6.5 If the Contractor is not at 80% in a county where the Contractor is considered Highly Integrated and offers a Medicaid plan, they may not market their DSNP to Dual eligible Members or utilize any information provided by the HCA for outreach purposes.

1.6.6 If the Contractor fails to reach 80% by June 1, of the current contract year, the Contractor may not market their contract as a Highly Integrated Dual Eligible Plan for the remainder of the contract year.

1.6.7 The Contractor will notify HCA of any changes in contract that may result in less than 80% percent alignment within 30 days of determination.

1.6.8 If the Contractor fails to reach 80% network alignment across all service areas by June 1 of the current contract year, the plan may be subject to termination and be reported to CMS as in violation.

1.6.8.1 In all counties where alignment is found to be below 80%, all marketing of DSNP materials will be prohibited. HCA will no longer provide access to Medicare eligible member information.

1.6.8.2 The HCA will work closely with the MA Plan to address deficiencies including requiring Corrective Action Plans prior to initiating termination actions.

1.6.9 Effective for the third quarter of 2025, on a quarterly basis, the Contractor shall provide documentation of its Provider Network including provider types necessary for Medicare network adequacy and all specialty provider types. Documentation shall be submitted no later than the 15th of the first month for the current reporting quarter. Reports are due: January 15 (October through December); April 15 (January through March); July 15 (April through June); and October 15 (July through September).

1.6.10 The Contractor shall also submit updated provider network information within five (5) Business Days of receipt of a request from HCA and provide prompt notice of 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.

1.6.11 Contractors with greater than 80% alignment in a county may work with HCA, their Medicaid 834 file, and Medicare Eligibility Report to conduct outreach to potential members who are becoming eligible for Medicare due to age or disability in that county based on their annual Network Alignment report.

1.6.12 The network alignment report may include access to Indian Health Care Services who have elected to contract with the Contractor. The overall percentage determined for Indian Health Care providers will not be taken into consideration in the final 80% alignment calculation.

1.6.13 The network alignment report will also include specialty providers not included by CMS for determining network adequacy including DME providers. The template report may be updated annually to identify providers of focus. These providers will not be taken into consideration in the final alignment calculations.

1.6.14 A written assessment of health equity, including identification of health disparities and access to care across all counties the Contractor serves.

1.6.15 Plans to expand their MA Health plan to completely align with the service area of the affiliated Medicaid managed care plan.

1.6.16 The Contractor may resubmit their report by June 1, 2025, for HCA approval to conduct Default Enrollment in new areas.

1.6.17 The Contractor will be required to include in their November 1, 2025, Default Enrollment report how they will reach 95% alignment in all areas they operate a DSNP.

1.6.17.1 When the Contractor offers a supplemental dental benefit, they will work to ensure that:

1.6.17.1.1 Medicaid Dental Providers are represented in their network, or,

1.6.17.1.2 The Dental Provider coordinates care with a Medicaid provider when dental supplemental benefits are exhausted.

1.6.17.1.2.1 The Contactor will develop a methodology for tracking utilization of supplemental benefits to ensure that Medicare supplemental benefits are utilized prior to utilization of the Medicaid service. Once benefits are exhausted, the MA plan will assist members by redirecting to Medicaid resources they may be eligible to receive.

1.7 POLICIES AND PROCEDURES

1.7.1 The Contractor will submit to HCA a list of internal policies and procedures and, make available for viewing any policy and procedure pertaining to this SMAC upon request from HCA.

1.8 BEHAVIORAL HEALTH SERVICES

1.8.1 The MA Health plan will develop the necessary agreements to coordinate with HCA Behavioral Health Administrative Services Organizations (BH-ASO) to support crisis and ombuds services. Final contracts will be made available to HCA upon request.

1.9 HEALTH HOME PROGRAM

1.9.1 The Contractor must:

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

1.9.1.2 Use template health home contract provided by HCA to contract with the community-based organizations to provide Health Home Services. Any changes to the template will require advance written approval from HCA.

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

1.9.2 Health Home program shall be community-based, integrated, and coordinated across medical, behavioral health, and long-term services and supports to members based on the services described in Section 1945(h)(4) of the Social Security Act. See Attachment 7 for program specific requirements.

1.10 COST SHARING

1.10.1 Beneficiary Enrollment and Financial Protection

1.10.1.1 The Contractor must provide each prospective Dual Eligible SNP Member, prior to enrollment, with a comprehensive written statement of benefits and cost sharing protections under MA Health Plan's SNP as compared to protections under the relevant State Medicaid plan. The Contractor is prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the State Medicaid plan if the Member were not enrolled in the MA Health Plan's Dual Eligible SNP. This requirement is to assist a prospective dual-eligible Member to determine if they will receive any value from enrolling in the Dual Eligible SNP that is not already available under the State Medicaid program.

1.10.2 The Contractor Member Financial Protections

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

1.11 MEMBER RIGHTS AND PROTECTIONS

1.11.1 The Contractor will comply with state and federal laws pertaining to Member rights under the Washington State Patient Bill of Rights and ensure its staff and

affiliated providers or sub-Contractors protect and promote those rights when furnishing services to Members.

1.11.2 General Member Rights. Member will:

1.11.2.1 Be always treated with dignity and respect;

1.11.2.2 Be protected from discrimination;

1.11.2.3 Have personal and health information kept private;

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

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

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

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

1.11.2.8 Get Medicare-covered services in an emergency;

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

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

1.11.2.11 File grievances, including complaints about quality of care, and other concerns with Contractor.

1.11.3 Member Provider Choice. Member has the right to:

1.11.3.1 Choose health care providers within the plan;

1.11.3.2 Receive treatment from their provider:

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

1.11.3.2.2 Women have the right to go directly to a women's health care specialist without a referral within the

plan for routine and preventive health care services.

1.11.3.2.3 Know how their providers are paid.

1.12 GRIEVANCE AND APPEALS

1.12.1 The Contractor will assist Members in accessing the Medicaid and/or Medicare Grievance and Appeals System(s).

1.12.2 The Contractor will develop policies and procedures around assisting Members in accessing Grievance and Appeal systems for both Medicare and Medicaid. These shall be provided to HCA upon request.

1.12.2.1 Trainings should clearly outline how to assist Members with accessing grievance Systems.

1.12.2.2 The Contractor will also have policies on how to work with BH Ombuds in the state of Washington.

1.12.3 The Contractor will coordinate with all contracted DSNPs and BHSOs in the state of Washington to develop Contact Names and a referral process to be used by their Grievance and Appeals teams for directing members and providers for grievances referring behavioral health to the appropriate resources. The referral must include steps for a warm handoff as necessary to ensure prompt review. The Contractor shall prepare and provide a report upon request of all grievances that were received and referred to the BHSO.

1.12.4 The Contractor process must include how to access State and Federal ombuds services.

1.12.5 Where the Member is aligned for Behavioral and Physical Health services the Contractor shall track and report all grievances for dual eligible members. This report shall be made available upon request.

1.13 BENEFITS

1.13.1 Benefits Comparison Charts Information Sharing

1.13.2 Medicare Plan Benefit Package (PBP) – the Contractor must develop separate benefit packages.

1.13.2.1 The Contractor will develop separate Medicare PBPs for partial dual eligible plans and fully dual eligible plans;

1.13.2.2 The Contractor will develop separate Medicare PBPs for coordination only and HIDE designated service areas.

1.13.2.3 The Contractor shall ensure that Beneficiaries are enrolled in the PBP that aligns with their state eligibility and service area.

1.13.2.4 On an annual basis, Contractor will determine its benefits, including Value-Added Items and Services (VAIS), and supplemental benefits for the chronically ill for the calendar year that will be provided to Dual Eligible Members under the Dual Eligible SNP. Such benefits will be approved by CMS prior to January 1 of each successive calendar year. This will include listing their maximum-out-of-pocket (MOOP) limit (42 C.F.R § 422.100 (4))

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

1.13.2.5.1 A list of benefits offered by the Contractor;

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

1.13.2.5.3 Contractor's defined cost sharing for each benefit;

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

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

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

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

1.13.2.6.2 The Contractor will distribute such Comparison Charts to Contractor participating providers for the express purpose

of providing education and resources to Contractor participating providers to enable efficient and appropriate collection of applicable cost sharing under Contractor's Dual Eligible SNP plan benefits and as required by the Beneficiary Enrollment and Financial Protection section of this SMAC.

1.13.2.6.3 The Contractor will distribute such Comparison Charts to Dual Eligible Members under the Dual Eligible SNP and make available to staff for Member questions regarding benefits and the Comparison Chart.

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

1.13.3 Medicaid Benefit Information

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

1.13.4 Telehealth

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

1.14 REPORTING REQUIREMENTS

1.14.1 The Contractor shall provide all SMAC Reporting Deliverables timely, as directed by the HCA. All emails submissions must include HCADSNP@hca.wa.gov in addition to any identified contacts.

1.14.2 The Contractor shall provide timely notification of all admissions to a hospital or skilled nursing facility (SNF) for a subpopulation of Members receiving Medicaid Long Term Services and Supports with RAC and Group Codes, in Attachment 2.

1.14.3 The Contractor will provide a report via SFT in the established HCA template on a weekly basis due close of business Monday for the previous week, Sunday

through Saturday. The report will contain all full dual Members who are currently receiving HCBS services and are currently admitted to a hospital or SNF for any reason. This report shall only include those Members who are currently admitted, all members who transition from an inpatient setting will be removed prior to the next submission. An email will be sent to HCA at HCADSNP@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification the report is available. Reports will include:

1.14.3.1 Name of Member;

1.14.3.2 ProviderOne ID;

1.14.3.3 Hospital or Skilled Nursing Facility (SNF);

1.14.3.4 Date of Admission;

1.14.3.5 Admitting Diagnosis;

1.14.3.6 Diagnosis Code;

1.14.3.7 Point of Contact;

1.14.3.8 County the Member resides in; and

1.14.3.9 Member-enrolled BHSO.

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

1.14.4.1 Number and Percentage of population hospitalized;

1.14.4.2 Percentage of population having care coordination prior to hospitalization;

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

1.14.4.4 Number and percentage of population accepting care coordination;

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

1.14.4.6 Average length of stay;

1.14.4.7 Number and percentage of Member's that remain hospitalized when not medically necessary; and

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

1.14.5 The Contractor will provide a Membership Churn report via SFT to HCA and DSHS ALTSA on an annual basis due July 31st for the prior contract year. If the date falls on a weekend, the report will be due by close of business on the next business day. An email will be sent to HCA at HCADSNP@hca.wa.gov and DSHS ALTSA at DSNPLTSSreporting@dshs.wa.gov with a notification that the report is available. Report will include:

1.14.5.1 Annual state level reporting;

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

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

1.14.5.4 Root cause analysis and connection to quality strategy.

1.14.6 The Contractor will submit a monthly Health Home Services report, due by the last day of the month showing the month prior, on an HCA-provided template by email to HCADSNP@hca.wa.gov. HCA may request off-cycle updates to this report.

1.15 ENCOUNTER SUBMISSION

1.15.1 The Contractor shall submit and maintain accurate, timely, and complete encounter data. The Contractor shall comply with all the following:

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

1.15.3 Submit to HCA complete, accurate, and timely data for all services for which the Contractor provided services under this SMAC as reported to CMS.

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

1.15.5 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.

1.15.6 The Contractor shall submit to HCA, without alteration, omission, or splitting, all available claim data in its entirety from the Contractor's submission to CMS, except for the addition of the Medicaid enrolled ProviderOne ID.

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

1.15.7 The Contractor will submit and maintain encounter data. Encounter data submitted should include medical and pharmacy encounters. The MA plans will not use encounter data submitted to HCA to seek payment of any kind.

1.15.8 The Contractor will develop and provide a Washington specific summary of provider networks, drug coverages, plan benefits, care coordination, supplemental benefits, and VAIS to assist with helping potential Members make plan choices to the Statewide Health Insurance Benefits Advisors (SHIBA). This information will be developed in a format decided by HCA and SHIBA to best support outreach efforts. This will be provided to HCADSNP@hca.wa.gov via email annually in advance of open enrollment using the template provided by HCA no later than October 5th of each calendar year. This report will be shared by DSHS and HCA with the Area Agencies on Aging and posted to the HCA website.

1.16 TRANSACTION STANDARDS

1.16.1 The data quality standards listed within this SMAC are incorporated by reference into this SMAC. 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.

1.16.2 Additional details can be found in the Encounter Data Reporting Guide published by HCA. The Encounter Data Reporting Guide, as currently existing and hereafter amended, is hereby incorporated by reference into this SMAC.

1.16.3 HCA may change the Encounter Data Reporting Guide with 90 calendar days written notice to the Contractor.

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

1.16.5 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to sub-Contractors.

2. ENROLLEE ADVISORY COMMITTEE

2.1 ENROLLEE ADVISORY COMMITTEE GUIDELINES

2.1.1 Consistent with 42 CFR 422.107(f), the Contractor will develop an Enrollee Advisory Committee.

2.1.2 The enrollee advisory committee must include at least a reasonably representative sample of the population enrolled in the dual eligible special needs plan or plans, or other individuals representing those enrollees, and solicit input on, among other topics, ways to improve access to covered services, coordination of services, and health equity for underserved populations.

2.1.3 Rules for participation and the member selection process will be posted on the Contractor Website.

2.1.4 Agendas and Meeting notes shall be provided to HCA upon request.

2.1.5 At least one member from the Statewide Health Benefits Advisors, The Department of Social and Health Services, and the Health Care Authority shall be invited to attend the meetings. These will be non-voting members,

2.1.6 By December 1 of each year, the Contractor will provide an annual report summarizing;

2.1.7 All high-level topics discussed;

2.1.8 All Action items taken to address plan performance in the current year;

7.1.8.1 All Action items that will address plan performance in the coming year.

2.2 COMMUNITY STAKEHOLDER GROUP

2.2.1 The Contractor may also develop a second community Stakeholder group that includes community organizations but must also include at least two Enrollees. All requirements for the Enrollee Advisory Committee must apply to this group as well.

3. CONTRACTING WITH WASHINGTON TRIBES

3.1 The Contractor shall coordinate with and pay all IHCPs who provide a service to AI/AN Beneficiaries under this contract regardless of the IHCP's decision whether to subcontract.

3.2 The Contractor will pay IHS facilities and Tribal 638 Facilities, including Tribal FQHCs, the full IHS encounter rate for each qualifying outpatient service furnished to an AI/AN Enrollee by an IHS or Tribal 638 Facility, including Tribal FQHC.

3.3 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.

4. SANCTION AND LIQUIDATED DAMAGES

4.1 In the event the Contractor fails to meet one or more of its obligations under this contract HCA, in its sole discretion may require the Contractor to devise a CAP for HCA approval or implement a CAP developed by HCA:

4.2 Until the default is cured or any resulting dispute is resolved in the Contractor's favor, HCA may: (i) impose sanctions or liquidated damages, (ii) limit the ability of Contractor to conduct outreach or marketing activities within specific counties or across the state including any national marketing campaigns and/or (iii) suspend or terminate Default Enrollment activities.

4.3 HCA must provide a reasonable cure period and impose a CAP on the Contractor prior to imposing sanctions.

4.4 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 failure in this regard as default. The Contractor will be in default, and HCA may impose reasonable sanctions.

4.4.1 Sanctions are distinct from liquidated damages and are not mutually exclusive.

4.5 Sanctions are intended as a penalty for default, whereas liquidated damages are intended as a remedy for noncompliance where the non-compliance resulted in cost to the HCA or DSHS to correct.

4.6 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accordance with applicable law including 42 CFR 42.422 subpart 0 against the Contractor, without a cure period, for:

4.7 Failing to provide Medically Necessary Services that the Contractor is required to provide, under law or under this contract, to a Member covered under this contract.

4.8 Acting to discriminate against Members based on their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a Member, except as permitted under law or under this contract, or any practice that would reasonably be expected to discourage enrollment by Members whose

medical condition or history indicates probable need for substantial future medical services.

4.9 Misrepresenting or falsifying information that it furnishes to CMS or HCA.

4.10 Misrepresenting or falsifying information that it furnishes to Member, Potential Member, or any of its sub-Contractors.

4.11 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.

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

4.13 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. HCA OBLIGATIONS

5.1 HCA'S FINANCIAL RESPONSIBILITY

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

5.2 MEDICAID PROVIDER PARTICIPATION

5.2.1 HCA will provide Contractor with access to available information to enable Contractor to verify provider participation in the State's Medicaid programs.

5.3 SMAC MONITORING

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

6. FEDERAL AUDITS

6.1 Within 90 days of the receipt of the audit findings, the Contractor shall provide HCA with a summary of any audit findings identified by CMS for its contract.

6.1.1 The Contractor will conduct an analysis of any activities that directly or indirectly impacted the State of Washington and how it will be addressed.

6.1.2 The Contractor will provide a report to HCA of their analysis and any Corrective Action plans developed.

6.2 HCA reserves the right to audit the Contractor including but not limited to claims paid, referrals, and utilization management to support Program Integrity and contract monitoring activities.

7. MARKETING

7.1 MARKETING

7.1.1 HCA must review and provide written approval for all marketing materials in which HCA's name or Medicaid is mentioned, language is used, or Internet links are provided from which the connection of HCA's name with Contractor's Services may, in HCA's judgment, be inferred or implied, prior to distribution. Marketing materials must be developed and submitted in accordance with the Medicare Marketing Guidelines and any guidance developed and distributed by HCA. Marketing materials include any items developed by the Contractor for distribution to Members or potential Members that are intended to provide information about the Contractor's benefits administration, including:

7.1.1.1 Print media;

7.1.1.2 Websites; and

7.1.1.3 Electronic Media (Television/Radio/Internet/Social Media).

7.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate, or misleading information (42 C.F.R. § 422.2262).

7.1.3 Marketing materials must be distributed only in service areas the Contractor is approved to serve. Default Enrollment materials may only be utilized in counties where the Contractor has received written HCA approval in advance to conduct Default Enrollment outreach.

7.1.3.1 In areas where Contractor service areas align with the Contractor's Medicaid IMC contract, HCA may collaborate on marketing materials to support aligned enrollment and care coordination.

7.1.3.2 In areas where the MA plan does not have an aligned service area and/or offers a Coordination Only Special Need Plan, the Contractor may only market their DSNP in accordance with HCA guidelines for these types of plans.

7.1.4 Coordination only plan where they achieve a Star Rating of four (4) stars or more, they may market their plan under the following conditions:

7.1.4.1 To support Care Coordination.

7.1.4.2 Communicate clearly outlined policies for referral and coordination.

7.1.4.3 Support transition from One MA Plan to the Contractor or from Medicaid to the MA Plan.

7.1.4.4 Provide standard marketing materials approved by CMS.

7.1.5 Coordination only plan where they achieve a Star Rating of Three (3) stars or more, they may share information for their plan under the following conditions:

7.1.5.1 To support Care Coordination.

7.1.5.2 Communicate clearly outlined policies for referral and coordination.

7.1.5.3 Support transition from One MA Plan to the Contractor or from Medicaid to the MA Plan.

7.1.6 Marketing material distributed by the Contractor or Third-Party Marketing Organization must not contain an invitation, implied or implicit, for a Member to change from one AH-IMC BHSO (or Fee-to-Service Medicaid Program for AI/AN Members) to the Contractor's corresponding BHSO or imply that the Contractor's benefits are substantially different from any other AH-IMC BHSO. This does not preclude the Contractor from distributing state-approved communications to Members regarding the scope of their own benefits.

7.1.7 Marketing materials must be in compliance with federal rules regarding translation and Interpreter services (42 § 422.2267). Marketing materials distributed in English must give directions for obtaining understandable materials in the population's primary languages.

7.1.8 The Contractor must comply with all relevant Federal and state laws, including, when applicable, the anti-kickback statute and the civil monetary penalty prohibiting inducements to beneficiaries.

7.1.9 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the federal or state government, or a similar entity (42 C.F.R. § 422.226(a)(1)(xi))

7.2 INFORMATION REQUIREMENTS FOR MEMBERS AND POTENTIAL MEMBERS

7.2.1 The Contractor shall provide to Potential Members and New Members the information needed to understand benefit coverage and obtain care in

accordance with 42 CFR 422.2267(e) and the Equal Access for Members and Potential Members with Communication Barrier section of this contract.

7.2.2 The Contractor shall notify Members of their ability to request the information in their chosen language.

7.2.3 The Contractor shall include with all written materials a tagline and information on how the Member can request Auxiliary Aids and Services including the provision of information in an alternative language and format that is understandable to the Member. If the Member requests the tagline in 12-point font, the Contractor shall provide it to the Member in either paper form or electronically within five (5) Business Days.

7.2.4 The Contractor shall submit branding materials developed by the Contractor that specifically mention Medicaid, AH–FIMC, or HCA for review and approval. No such materials shall be disseminated to Members, Potential Members, providers, or other members of the public without HCA's approval.

7.2.5 The Contractor shall submit for approval Member information developed by the Contractor that specifically mentions HCA, AH-IMC, or the specific benefits provided under Medicaid at least thirty (30) calendar days prior to distribution for review and approval.

7.2.6 The Contractor will have a written process for development, review, and approval of all marketing and Member 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.

7.3 EQUAL ACCESS FOR MEMBERS AND POTENTIAL MEMBERS WITH COMMUNICATION BARRIERS

7.3.1 The Contractor shall assure equal access for all Members and Potential Members when oral or written language communications create a barrier to such access. (42 C.F.R. § 422.2267).

7.3.1.1 Oral Information

7.3.1.1.1 The Contractor shall ensure interpreter services are provided free of charge for Members and Potential Members with a primary language other than English or those who are Deaf, Deaf/Blind, or Hard of Hearing. This includes oral interpretation, Sign Language (SL), and the use of auxiliary aids and services as required by CMS (42 C.F.R. § 422.2267). Interpreter services shall be provided for 80% of interactions within 8 minutes of request between

such Members or Potential Members and the Contractor (42 C.F.R. § 422.111) or any of its providers including, but not limited to:

7.3.1.1.1.1 Customer service,

7.3.1.1.1.2 All interactions with any provider for any covered service,

7.3.1.1.1.3 Emergency Services, and

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

7.3.2 Written Information

7.3.2.1 The Contractor shall provide all generally available and Member-specific written materials through auxiliary aids and services in a manner that takes into consideration the special needs of Members and Potential Members (42 C.F.R. § 422.2264 (c)) and 42 CFR 423.2267(a)(3)). For the purposes of this subsection, the Member's preferred language may not be the same as their primary language. The Contractor must translate materials into the Member's preferred language.

7.3.2.1.1 The Contractor shall include with all written material in a conspicuously visible font size tagline, information on how the Member or Potential Member can request Auxiliary Aids and Services, including the provision of information in an alternative language and format that is understandable to the Member or Potential Member.

7.3.2.1.2 The Contractor shall translate all required documents into the same languages required by Medicaid.

7.3.2.1.3 If 5 percent or 1,000, whichever is less, of the Contractor's members speak a language other than English, standardized materials, must be translated into that language.

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

7.3.2.1.4.1 Translating the material into the Member's or Potential Member's preferred language.

7.3.2.1.4.2 Providing the material in an audio format in the Member's or Potential Member's preferred language.

7.3.2.1.4.3 Having an interpreter read the material to the Member or Potential Member in the Member's preferred language.

7.3.2.1.4.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Member or Potential Member. The Contractor shall document the Member's or Potential Member's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).

7.3.2.1.4.5 Providing the material in English, if the Contractor documents the Member's or Potential Member's preference for receiving material in English.

7.4 SUMMARY

7.4.1 The Contractor shall ensure that all written information provided to Members or Potential Members is accurate, not misleading, comprehensible to its intended audience, designed to provide the greatest degree of understanding, written at the sixth-grade reading level, provided in no smaller than 12 point font, Times New Roman or equivalent, and fulfills other requirements of the contract as may be applicable to the materials (42 C.F.R. § 438.10(d)(6), 42 CFR § 422.2267).

7.4.2 If the Contractor provides required materials electronically, it must meet the following requirements:

7.4.2.1 Ensure the process is voluntary and the member's approval is documented except for materials expressly allowed under 42 C.F.R. § 422.2267(d)(2)(i).

7.4.2.2 Have safeguards to ensure a member's contact information is correct and current, ensure materials are sent and received timely, and important materials are identified in a way members understand the importance.

7.4.2.3 The format is readily accessible and takes into consideration the special needs of Member and Potential Members with disabilities or limited English proficiency.

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

7.4.2.5 The information is provided in an electronic form which can be electronically retained and printed.

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

7.5 MEMBER COMMUNICATION

7.5.1 The Contractor will ensure all Member communications are in accordance with 42 C.F.R. Subpart V and 42 CFR 422.2267(e).

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

7.5.2 The Contractor shall have a Washington-specific information webpage to support members and providers with accessing services in Washington State. Changes to the member website will be submitted prior to implementation for review. Changes to Provider facing website must be submitted within 5 business days of request.

7.6 PRISM ACCESS

7.6.1 Purpose: To provide Contractor, and sub-Contractors, with access to pertinent Member-level Medicaid and when appropriate Medicare Data via look-up access to the online PRISM application and to provide Contractor staff and sub-Contractor staff who have a need-to-know Member-level Data to coordinate care, improve quality, and manage services for their Members.

7.6.2 Justification: The Data being accessed is necessary for the Contractor to provide care coordination, quality improvement, and case management services for Members.

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

7.6.4 System Access

7.6.4.1 The Contractor may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this contract.

7.6.4.2 The 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.

7.6.4.3 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.

7.6.4.4 The Contractor must access these systems through SecureAccessWashington (SAW), or another method of secure access approved by the HCA and DSHS.

7.6.4.5 DSHS will grant the appropriate access permissions to Contractor employees or sub-Contractor employees.

7.6.4.6 HCA and DSHS do not allow shared User IDs and passwords for use with Confidential Information or to access systems that contain Confidential Information. The Contractor must ensure that only Authorized Users access and use the systems and do not allow employees, agents, or sub-Contractors who are not authorized to borrow a User ID or password to access any systems.

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

7.6.4.8 The 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 investigate possible violations of this Attachment, federal, or state laws and regulations governing access to Protected Health Information.

ATTACHMENT 2: RAC CODES

Apple Health Fully Integrated Managed Care (AH-FIMC)
Medical and Behavioral Health (BH)

Attachment J: RAC Codes — Medicare status code 02,04,06,08

Category	Description	BSP	Medicaid Service Level	Current RACs (*Disabled RACs are in **bold**)
(a) Apple Health Family = Healthy Options (HO) **CNP**	Washington Apple Health managed care for families (parents, children, and pregnant women)	CN	QMB +	**1018**, **1023**, 1026, 1197, 1198, 1199, 1200, 1202, 1203, 1204, 1205, 1274
(b) Apple Health Blind Disabled = Healthy Options Blind/Disabled (HOBD) **CNP**	Washington Apple Health managed care for blind/disabled clients. Supplemental Security Income (SSI) and SSI related. Categorically Needy Program and may receive home and community-based waiver/hospice services	CN	QMB QMB +	**1047**, **1105**, **1107**, **1110**, **1111**, **1121**, **1134**, **1147**, **1150**, **1151**, **1153**, **1175**, **1219**, **1221**, **1224**, **1225**, **1237**, **1239**, **1245**, **1247**, **1252**, **1253**, **1254**, **1255**, **1258**, **1259**, **1261**, **1263**, **1267**, **1268**, **1269, 1271**
	Categorically Needy Program, Long-Term Care child <19, pregnant age 19> in hospital or facility over 30 days; or 19-22 in a mental institution since before 21st birthday	CN	QMB QMB +	1052, 1053, 1055 *living arrangement/institutional status code is "not IM
	Categorically Needy Program, Long-Term Care 65+ *Added to HOBD program effective 04/01/2016	CN	QMB QMB +	1065, 1068, 1071, 1073 *living arrangement/ institutional status "not IM"
	Categorically Needy Program, Long-Term Care, Blind/Disabled *Added to HOBD program effective 04/01/2016	CN	QMB QMB +	1067, 1070, 1162, 1163 *living arrangement/ institutional status "not IM"
	Categorically Needy Program, 65+ *Added to HOBD program effective 04/01/2016	CN	QMB QMB +	1046, 1104, 1106, 1108, 1109, 1146, 1148, 1149, 1152, 1174, 1218, 1220, 1222, 1223, 1236, 1238, 1244, 1246, 1248, 1249, 1250, 1251, 1256, 1257, 1260, 1262, 1264, 1265, 1266
(c) Apple Health Adult Coverage (AHAC) **ABP**	Washington Apple Health managed care for single adults (expansion population). Categorically Needy Program plus habilitative services	ABP	QMB QMB +	1201, 1217, 1275

(d) State Children's Health Insurance Program (SCHIP) **CNP**	Children with incomes above Medicaid limit. Are enrolled in Apple Family Health = Healthy Options but pay a small premium. Categorically needy program benefits.	CNP	QMB QMB +	1140, 1206, 1207

*Medicaid clients who are exempt from AH-FIMC will be enrolled into a BHSO plan to access their behavioral health services.

Behavioral Health Services Only (BHSO)
Mental Health and Substance Use Disorder Services
Fee for Service Medical

Medicaid Dual Eligible Population (a)

Medicare Savings Program (MSP) RACs by themselves pay Medicare premiums only; when used in combination with a Medicaid RAC with CNP or MNP benefits and Medicare Status code 2, 2H, 4, 4H the client becomes a Dual and Behavioral Health Services Only (BHSO) premiums are paid.

The H Modifier will indicate eligibility for Health Home Program. This will not indicate if the individual is engaged or enrolled.

Medicare Status Code 8 or 8H in combination with any Medicaid RAC CNP or MNP the client becomes a Dual and would receive BHSO in the Early Adopter program.

Category	**Description**	**BSP**	**Medicaid Service Level**	**Current RACS** (*Disabled RACs are in **bold**)
MSP Medicare Savings Program	Medicare Savings Program: state only pays deductible, coinsurance, or premiums	Partial	Partial	1112, 1113, 1114, 1115, 1116, 1117, 1118

Comparable Coverage (Third Party Insurance/Liability) (c)
A Medicaid client who also has other insurance that HCA has determined provides a full scope of health care benefits.

Behavioral Health Services Only (BHSO)
Mental Health and Substance Use Disorder Services
Fee for Service Medical

Spend-down (d)

Category	Description	BSP	Medicaid Service Level	Current RACS (*Disabled RACs are in **bold**)
LCP-MNP Spenddown child under 19	Limited Casualty- Medically Needy Program, spenddown child under 19	MN	Partial dual until they meet spenddown then are MN	1039
LCP-MNP, Duals, 65+, Spenddown	Limited Casualty-Medically Needy Program, dual coverage on spenddown	MN	Partial dual until they meet spenddown then are MN	1124
LCP-MNP, Spenddown, Blind/Disabled	Limited Casualty-Medically needy Program on spenddown, blind/disabled	MN	Partial dual until they meet spenddown then are MN	**1126**
LCP-MNP, Pregnancy, Spenddown	Limited Casualty-Medically Needy Program, pregnancy on spenddown	MN	Partial dual until they meet spenddown then are MN	1101, 1102
LCP-MNP, ALF, 65+,	Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home, or other DDD group home). 65+ and may have spenddown	MN	Partial dual until they meet spenddown then are MN	1048

LCP-MNP, ALF, Blind/Disabled	Limited Casualty - Medically Needy Program, living in Alternate Living Facility (adult family home, boarding home, or other DDD group home). Blind/disabled and may have spenddown	MN	Partial dual until they meet spenddown then are MN	**1049**
LCP-MNP, LTC, Spenddown, Blind/Disabled	Limited Casualty-Medically Needy Program on spenddown, blind/disabled		Partial dual until they meet spenddown then are MN	**1086**, **1091**
LCP-MNP, Dual, 65+, LTC, Spenddown	Limited Casualty-Medically Needy Program, long term care with dual coverage, 65+, spenddown	MN	Partial dual until they meet spenddown then are MN	1083, 1088

Behavioral Health Services Only (BHSO)
Mental Health and Substance Use Disorder Services
Fee for Service Medical

Institution for Mental Disease (e)

Category	**Description**	**BSP**	**Medicaid Service Level**	**Current RACS** (*Disabled RACs are in **bold**)
CNP, Institutional SSI, and Institutional SSI Related in IMD (child under 22), Blind/Disabled	Categorically Needy Program, blind/disabled in Institution for Mental Disease Long Term Care (child under 22)	CN		**1164**, **1165**, **1168**, **1169**
CNP, Institutional SSI, and Institutional SSI Related in IMD 65+	Categorically Needy Program, SSI eligible, , in Institution for Mental Disease (65+)	CN		1066, 1069, 1072, 1074

MNP, Institutional SSI, and Institutional SSI Related in IMD, Blind/Disabled	Medically Needy Program, blind/disabled, in Institution for Mental Disease, age <=22 may have spenddown	MN	Partial dual until they meet spenddown then are MN	**1166**, **1167**
LCP-**MNP**, Institutional SSI, and Institutional SSI Related in IMD, Spenddown	Limited Casualty -Medically Needy Program, in Institution for Mental Disease, (65+) may have spenddown	MN	Partial dual until they meet spenddown then are MN	1084, 1089
CNP, LTC	Categorically Needy Program, Long-Term Care child <19, pregnant woman age 19> in hospital or facility over 30 days; or 19-22 in a mental institution since before 21st birthday; or 65> in mental institution	CN	X	1052, 1053, 1055 If living arrangement or institutional status code is "IM"
LCP-**MNP**, LTC	Limited Casualty - Medically Needy Program, Long Term Care, in institution for Mental Disease, may have spenddown.	MN	Partial dual until they meet spenddown then are MN	1059, 1061
Pregnant Women non-citizens (undocumented) (f)				
CNP, MAGI, Federally funded pregnancy for non-citizens (**undocumented**)	Categorically Needy Program, Modified Adjusted Gross Income, Federally funded pregnancy for non-citizens (**undocumented**)	CN	X	1096, 1209
CNP, BCCTP	Categorically Needy Program, Breast and Cervical Cancer Treatment Program for women (BCCTP)	CN	X	1123

Behavioral Health Services Only (BHSO) **Mental Health and Substance Use Disorder Services** **Fee for Service Medical**				
Foster Care (g)				
Category	**Description**	**FIMC**	**BHSO**	**Current RACS** (*Disabled RACs are in **bold)**

Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	CN		**1014**, **1015**, **1016**, **1017**, **1019**, **1020**, **1021**, **1022**
CNP, Foster Care Alumni	Categorically Needy, Foster Care under 26 (if in Foster Care at age 18)	CN		1196
Hospice (h)				
CNP, Hospice, SSI, CNIL, SIL, 65+	Hospice Categorically Needy Income level, Special Income Level to determine eligibility, 65+	CN	X	1240, 1241
CNP, Hospice, SSI, CNIL, SIL, Blind/Disabled	Hospice Categorically Needy Income level, Special Income Level to determine eligibility, blind /disabled	CN	X	**1242**, **1243**
Long Term Care Institutional (i)				
CNP, LTC,65+	Categorically Needy Program, Long- Term Care 65+	CN	X	1065, 1068, 1071, 1073 living arrangement /institutional status “IM”
CNP, SSI or SSI related institutional, Blind/Disabled	Categorically Needy Program, Long-Term Care, blind/disabled	CN	X	**1067**, **1070**, **1162**, **1163** living arrangement /institutional status “IM”

Refugees (j)				
CNP, Family LTC, Adults	Categorically Needy Family Long Term Care; adult Refugee with date of entry <= 7 months; in hospital or LTC facility over 30 days	CN	X	1054
CNP, Refugee adult or child	Refugee Medical Assistance	CN	X	1103

Breast and Cervical Cancer (k)				
CNP, BCCTP	Categorically Needy Program, Breast and Cervical Cancer Treatment Program (BCCTP) for women	CN	X	1122

Pregnant Women (not federally qualified) (l)				
CNP	Categorically Needy Magi Pregnancy Medicaid; for pregnant women who are not federally qualified due to citizenship/alien status.	Not Eligible	Not Eligible	1209

- 00-Not Dual, Not a Medicare Beneficiary
    - Client will have a Medical RAC identified.
    - No Medicare entitlement segment (A or B)
- 02-Full Benefit Dual with QMB
    - Beneficiary is an S03
    - May also have a medical RAC
- 04-Full Benefit Dual with SLMB
    - Beneficiary is an S05
    - May also have a medical RAC
- 08-Other Dual Eligible with Medicaid coverage no MSP
        - Beneficiary will have Medical RAC 1000 thru 1999

** The Updated LTC RAC list will be added after first intial review**

ATTACHMENT 3: SERVICE AREA WASHINGTON

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

H Contract	PBP	Plan Name	MSP Eligible Categories	Service Area

ATTACHMENT 4: SUMMARY OF SUPPLEMENETAL BENEFITS AND VALUE-ADDED ITEMS AND SERVICES (VAIS) FOR FULL DUAL ELIGIBLE MEMBERS

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

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

ATTACHMENT 5: SUMMARY OF SUPPLEMENTAL BENEFITS AND VALUE-ADDED ITEMS AND SERVICES (VAIS) FOR PARTIAL DUAL ELIGIBLE MEMBERS

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

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

ATTACHMENT 6: SUMMARY OF BEHAVIORAL HEALTH BENEFITS COVERED UNDER IMC CONTRACT

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

1. Behavioral health services as described in Section 13d, Rehabilitative Services, of the Medicaid State Plan
2. Inpatient Behavioral Health Services as defined by the Medicaid State Plan:
    a. Consultations with specialty providers, including psychiatric or psychology consultations, are covered during hospital stays.
    b. Inpatient professional mental health services associated with an AH-IMC behavioral health approved ITA or voluntary inpatient psychiatric admission.
    c. Inpatient psychiatric mental health services except when the Member is approved for placement in a state hospital.
    d. Covered services provided during an inpatient admission for medical detoxification services.
    e. Inpatient Withdrawal Management (substance acute withdrawal management) Services required for the care and/or treatment of individuals intoxicated or incapacitated by substances while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from substances. Services are provided in facilities with sixteen (16) beds or less and exclude room and board. Services include:
        i. Screening and acute withdrawal management; and
        ii. Counseling of persons admitted to a program within a certified Facility, regarding their illness in order to stimulate motivation to obtain further treatment and referral of detoxified persons with SUD to other appropriate substance use disorder treatment service providers.
    f. Inpatient/Residential Substance Abuse Treatment Services: Rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Members who are harmfully affected by the use of mood-altering substances or have been diagnosed with a SUD. Techniques have a goal of recovery for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board.
    g. Court-ordered behavioral health Involuntary Treatment Act (ITA) commitment inpatient admission, except those identified as exclusions to the BHSO.
    h. IMD Services. Covered Services provided to Members who are primarily receiving short-term treatment and withdrawal management services for SUD in

facilities that meet the definition of an IMD which are not otherwise matchable expenditures under Section 1903 of the Social Security Act. Excludes room and board.

3. Medication Assisted Treatment, including assessment, counseling, medical management, and prescribing to assist clients in treatment for SUD in a medical office setting.
4. MAT includes medications prescribed or administered as part of a MAT protocol, except for methadone, when treatment is provided in.
    a. a SUD clinic setting.
5. Outpatient Behavioral Health Services as defined in the Medicaid State Plan:
    a. Brief Intervention Treatment.
    b. Day Support, including in a club house setting.
    c. Family Treatment.
    d. Freestanding Evaluation and Treatment.
    e. Mental Health Group Treatment Services.
    f. High Intensity Treatment.
    g. Individual Treatment Services.
    h. Intake Evaluation.
    i. Medication Management.
    j. Medication Monitoring.
    k. Mental Health Peer Support Services.
    l. Psychological Assessment.
    m. Rehabilitation Case Management.
    n. Residential Mental Health Services.
    o. Stabilization Services.
    p. Special Population Evaluation.
    q. Therapeutic Psychoeducation.
    r. Substance Use Disorder Case Management.
    s. Substance Use Disorder Outpatient Services.
    t. Opiate Substitution Treatment;
    u. Medication Assisted Treatment;
    v. Collaborative Care Services;
    w. The IMC Contractor shall ensure Medication Management is:
        i. Provided by the PCP; or

ii. Provided in conjunction with a Mental Health

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

iv. Provided by an appropriate behavioral health specialist; and

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

x. Substance Use Disorder Peer Support Services.

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

ATTACHMENT 7: HEALTH HOME PROGRAM

1. Health Home Definitions

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

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

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

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

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

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

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

1.8. "Eligibility" Means a full dual member, and a partial dual member if the Contractor chooses to provide the Health Home program to partial dual members, who has a chronic condition and a PRISM score of at least 1.5.

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

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

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

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

1.13. "Health Home Participation Authorization and Information Sharing Consent

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

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

1.14.1. Comprehensive Care Management

1.14.2. Care Coordination and Health Promotion

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

1.14.4. Individual and Family Support

1.14.5. Referral to Community and Social Support Services

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

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

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

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

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

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

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

2. Health Home Program for DSNP MA Health Members

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

2.2. The Contractor shall ensure that the following are operational:

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

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

3. Health Home Eligibility and Enrollment

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

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

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

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

3.2. Contractor 834 file will include a HH "Y" indicator.

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

3.2.2. The Contractor will contact the Lead to determine which members are engaged.

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

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

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

4. Assignment

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

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

4.1.2. Contractor shall assign to a community-based lead:

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

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

4.2. Contractor shall assign to an internal lead:

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

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

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

5. Health Action Plan (HAP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.2.11. A completed and updated HAP with the member's goals and action steps must be provided to the member and with the member's consent shared with the member's caregiver and family in a format that is easily understood. Any additional information shall be included as an addendum to the HAP.

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

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

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

5.2.15. The Health Home Care Coordinator shall meet with the member in-

person to complete the HAP, including the following:

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

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

5.2.15.3. Evaluate the member's support system; and

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

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

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

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

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

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

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

6. Health Home Key Services

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

6.2. Comprehensive Care Management Services

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

directed, person-centered health goals designed to attain recovery, improve functional or health status, or prevent or slow declines in functioning.

6.3. Care Coordination

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

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

6.4. Health Promotion

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

6.5. Transitional Care

6.5.1. Comprehensive transitional care is provided to prevent beneficiary

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

6.5.2. Transitional care planning includes:

6.5.2.1. A notification system with managed care plans, hospitals, nursing facilities, and residential/rehabilitation facilities to provide the health home prompt communication of a beneficiary's admission and/or discharge from an emergency department, inpatient facility, skilled nursing or residential/rehabilitation facility, and with proper, permissions, a substance use disorder treatment setting. Progress notes or a case file will document the notification. The HAP is updated as a part of transition planning.

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

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

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

6.6. Individual and family support

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

6.6.2. The Care Coordinator will:

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

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

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

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

6.7. Referral to community and social support services

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

7. Compensation and Payment

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

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

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

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

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

7.1.1.4. The Contractor will pay $884.89 for Outreach, Engagement, and HAP Development once in a lifetime per Beneficiary.

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

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

7.1.3.1. Actively engaged in achieving health action goals,

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

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

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

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

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

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

7.1.4.4. Promoting optimal clinical outcomes, including a description of how progress toward outcomes will be measured through the HAP;

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

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

conditions and improve adherence to prescribed treatment; and

7.1.4.7. The Contractor will pay $319.92 per Beneficiary per month for intensive Health Home Care Coordination.

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

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

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

7.1.5.3. The Contractor will pay $204.29 per Beneficiary per month for Low-level Health Home Care Coordination.

7.1.6. The Contractor shall pay the Indian Health Services Tribal Encounter Rate for each qualifying event. The Encounter Rate is determined annually by the Indian Health Services. Paid encounters will be adjusted to reflect the IHS rate for the beginning of the calendar year.

7.1.7. Payment to Subcontracted Care Coordination Organizations (CCOs): The Lead may retain up to a maximum of 10% from each rate tier listed above for administrative costs.

ATTACHMENT 8: DATA SECURITY REQUIREMENTS

1. Description of Data to be Shared / Data Licensing Statements

Data Licensing Statements are the written statements that determine the following issues, at a minimum:

1.1 Identification of the purpose of the file;

1.2 Identification of costs (if any);

1.3 Identification of transmission method; and

1.4 Identification of the file layout.

There must be at least one Data Licensing Statement attached hereto, but more than one Data Licensing Statement may be included or incorporated into this Contract at different times. Each Data Licensing Statement is incorporated into this Contract by using the same Attachment reference letter (A) and then further marking it with sequential identifying numbers (A1, A2, A3).

2. HCA System Access Requirements and Process

2.1 The Contractor may request access to the PRISM system for up to 150 Authorized Users under this Contract.

2.1.1 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.

2.1.2 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.

2.1.3 Contractor must access these systems through SecureAccessWashington (SAW) or through another method of secure access approved by the HCA and DSHS.

2.1.4 DSHS will grant the appropriate access permissions to Contractor employees or Subcontractor employees.

2.1.5 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.

2.1.6 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.

2.1.7 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.

2.2 The Contractor Contract Manager, identified in Section 0 must send the request to the HCA Security Help Desk at HCAITSecurity@hca.wa.gov.

2.3 The Contractor must access the system(s) through the State Governmental Network (SGN), or SecureAccessWashington (SAW), or through another method of secure access approved by HCA in writing.

2.4 Contractor Point of Contact. The Contractor Point of Contact will be the single source of access requests and the person HCA will contact for any follow-up information or to initiate an audit under this Contract. Contractor Point of Contact may be changed by written notice to the HCA Security Help Desk, email acceptable, with a copy to the HCA Contract Manager and HCA Office of Contracts and Procurements at contracts@hca.wa.gov.

Name or Title	
Address	
Telephone	
Email	

2.5 HCA will grant the appropriate access permissions to Contractor Authorized Users within 30 calendar days from the date of receipt of a complete and accurate request form. HCA will respond within 5 business days of receipt of request form if there is a need for clarification or revisions to any inaccurate or incomplete request form(s).

2.6 HCA does ***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 system(s) in this Contract, use only their own User ID and password to access the system(s), and do not allow employees or others who are not authorized to borrow a User ID or password to access any system(s).

2.7 Contractor must notify HCA within 5 business days whenever an Authorized User who has access to the Data is no longer employed by the Receiving Part or whenever an Authorized User's duties change such that the user no longer requires access to the Data.

2.8 Contractor's access to the systems may be continuously tracked and monitored. HCA reserves the right, at any time, to terminate Data access for an individual, conduct audits of system(s) access and use, and to investigate possible violations of

this Contract and/or violations of federal and state laws and regulations governing access to PHI.

3. Data Classification

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 WaTech Data Classification Standard at: https://watech.wa.gov/sites/default/files/2023-12/Data%20Classification%20Standard_Approved_2023.pdf, and which is hereby incorporated by reference.

The Data that is the subject of this Contract is classified as indicated below:

3.1 ☐ Category 1 – Public Information

Public information is information that can be or currently is released to the public. It does not need protection from unauthorized disclosure but does need integrity and availability protection controls.

3.2 ☐ Category 2 – Sensitive Information

Sensitive information may not be specifically protected from disclosure by law and is for official use only. Sensitive information is generally not released to the public unless specifically requested.

3.3 ☐ Category 3 – Confidential Information

Confidential information is information that is specifically protected from disclosure by law. It may include but is not limited to:

A. Personal Information about individuals, regardless of how that information is obtained;

B. Information concerning employee personnel records;

C. Information regarding IT infrastructure and security of computer and telecommunications systems;

3.4 ☒ Category 4 – Confidential Information Requiring Special Handling

Confidential information requiring special handling is information that is specifically protected from disclosure by law and for which:

A. Especially strict handling requirements are dictated, such as by statutes, regulations, or agreements;

B. Serious consequences could arise from unauthorized disclosure, such as threats to health and safety, or legal sanctions.

4. Constraints on Use of Data/Limited License

4.1 Subject to the Terms and Conditions of this Contract, HCA hereby grants Contractor a limited license for the access and Permissible Use of Data. This grant of access may not be deemed as providing Contractor with ownership rights to the Data. The Data being shared/accessed is owned and belongs to HCA.

4.2 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 and justification of this Contract as set out in the Data Licensing Statement(s). Any Use or reporting (including of artificial intelligence tools) that is not within the Purpose of this DSA is not permitted without HCA's prior written consent.

4.3 This Contract does not constitute a release for Contractor to share the Data with any third parties, including Subcontractors, even if for authorized use(s) under this Contract, without the third party release being approved in advance by HCA and identified in the Data Licensing Statement(s).

4.4 Derivative Data Product Review and Release Process.

A. All reports derived from Data shared under this Contract, produced by Contractor that are created with the intention of being published for or shared with external customers (Data Product(s)) must be sent to HCA for review of usability, data sensitivity, data accuracy, completeness, and consistency with HCA standards prior to disclosure. This review will be conducted, and response of suggestions, concerns, approval, or notification of additional review time needed provided to Receiving Party within 10 business days. HCA reserves the right to extend the review period as needed for approval or denial.

B. Small Numbers. Contractor will adhere to *HCA Small Numbers Standards*, Attachment C. HCA and Contractor may agree to individual Permissible Use exceptions to the Small Numbers Standards, in writing (email acceptable).

4.5 Any disclosure of Data contrary to this Contract is unauthorized and is subject to penalties identified in law.

4.6 The Receiving Party must comply with the Minimum Necessary Standard, which means that Receiving Party will use the least amount of PHI necessary to accomplish the Purpose of sharing as described in the attached Attachment A(s): Data Licensing Statement(s).

A. Receiving Party must identify:

i. Those persons or classes of persons in its workforce who need access to PHI to carry out their duties; and

ii. 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.

B. Receiving Party 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 the attached Data Licensing Statement(s).

5. Data Modification(s)

Any modification to the Purpose, Justification, Description of Data to be Shared/Data Licensing Statement(s), and Permissible Use, is required to be approved through HCA's Data Request Process. Contractor must notify HCA's Contract Manager of any requested changes to the Data elements, use, records linking needs, research needs, and any other changes from this Contract, immediately to start the review process. Approved changes will be documented in an Amendment to the Contract.

6. Security of Data

6.1 Security Awareness Program

The Receiving Party must have a Security Awareness Program. This program must:

a. Be issued biennially, or more frequently, for all Receiving Party's employees or Subcontractors whose roles are associated with the Data contemplated in this DSA; and

b. At HCA's request, Receiving Party will provide documentation demonstrating its Security Awareness Program and associated training.

6.2 Data Protection

The Contractor must protect and maintain all Confidential Information gained by reason of this Contract 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:

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

B. Physically securing any computers, documents, or other media containing the Confidential Information.

6.3 Data Security Standards

A. The Contractor must comply with the Data Security Requirements set out in Attachment B and all Washington OCIO Security Policies and Standards a copy of which is available via hyperlink at https://watech.wa.gov/sites/default/files/2023-12/141.10_SecuringITAssets_2023_12_Parts_Rescinded.pdf. All Washington OCIO Security Policies and Standards are hereby incorporated by reference into this DSA.

B. The Contractor must have a policy regarding monitoring and enforcement of the Data protection requirements specific in this DSA.

6.4 Data Disposition and Retention

A. Contractor will dispose of HCA Data in accordance with this section.

B. Upon request by HCA, or at the end of the Contract term, or when no longer needed, Confidential Information/Data must be disposed of as set out in Attachment B, *Data Security Requirements*, Section 0 *Data Disposition,* except as required to be maintained for compliance or accounting purposes. Contractor will provide written certification to HCA of disposition using Attachment D, *Certification of Destruction/Disposition of Confidential Information*.

C. For the purpose of this section, "fiscal year" means the 12-month period of July 1 to June 30. Claims Data will not be kept or maintained beyond 10 years after the end of the fiscal year in which the claim is dated. Client Data, not including Claims Data, will not be kept or maintained beyond 10 years from the date received from HCA. Any other Data will not be kept or maintained beyond 10 years from the date received from HCA. At that time Data and derivative Data Products must be disposed of in accordance with subsection 0.

7. Data Confidentiality and Non-Disclosure

7.1 Data Confidentiality.

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, justification, and Permissible Use of this Contract, as set out in the attached Data Licensing Statement(s), except: (a) as provided by law; or (b) with the prior written consent of the person or personal representative of the person who is the subject of the Data.

7.2 Non-Disclosure of Data

The Contractor must ensure that all that all Authorized Users, including 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 made aware of the use restrictions and protection requirements of this Contract before gaining access to the Data identified herein. For avoidance of doubt, the Contractor must also instruct and make any new employee aware of the use restrictions and protection requirements of this DSA before they gain access to the Data.

The Contractor must ensure that each Authorized User who will access the Data adheres to confidentiality and non-disclosure obligations at least as restrictive as those contained in this agreement. The Contractor must retain a signed copy of its confidentiality and non-disclosure obligations for a minimum of six years from the date the Authorized User's access to the Data ends. The documentation must be available to HCA upon request.

7.3 Penalties for Unauthorized Disclosure of Data

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

The Contractor accepts full responsibility and liability for any noncompliance by itself, its employees, and its Subcontractors with these laws and any violations of the Contract.

8. Data Shared with Subcontractors

If Data access is to be provided to a Subcontractor under this Contract it will only be for the Permissible Use authorized by HCA and the Contractor must include all of the Data security terms, conditions and requirements set forth in this Attachment in any such Subcontract. In no event will the existence of the Subcontract operate to release or reduce the liability of the Contractor to HCA for any Data Breach in the performance of the Contractor's responsibilities.

9. Audit

9.1 At HCA's request or in accordance with OCIO 141.10, Contractor shall obtain audits covering Data Security and Permissible Use. Contractor may cover both the Permissible Use and the Data Security Requirements under the same audit, or under separate audits. The term, "independent third-party" as referenced in this section means an outside auditor that is an independent auditing firm.

9.2 Data Security audits must demonstrate compliance with Data Security standards adopted by the Washington State Office of the Chief Information Officer (OCIO), and as set forth in Attachment B, *Data Security Requirements*. At a minimum, audit(s) must determine whether Data Security policies, procedures, and controls are in place to ensure compliance with all Data Security Requirements set forth herein and as required by state and federal law.

9.3 Permissible Use Audits must demonstrate compliance with Permissible Use standards as set forth in this Contract and each Attachment A. Audit(s) must determine whether Permissible Use policies, procedures, and controls are in place to ensure compliance with all Permissible Use requirements in this Contract.

9.4 HCA may monitor, investigate, and audit the use of Personal Information received by Contractor through this Contract. The monitoring and investigating may include the act of introducing data containing unique but false information (commonly referred to as "salting" or "seeding") that can be used later to identify inappropriate use or disclosure of Data.

9.5 During the term of this Contract and for six (6) years following termination or expiration of this Contract, HCA will have the right at reasonable times and upon no less than five (5) business days prior written notice to access the Contractor's records and place of business for the purpose of auditing and evaluating the Contractor's compliance with this Contract and applicable laws and regulations.

10. Data Breach Notification and Obligations

10.1 The Data Breach or potential compromise of Data shared under this Contract must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov within one (1) business day of discovery.

10.2 If the Data Breach or potential compromise of Data includes PHI, and 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:

A. The identification of each individual whose PHI has been or may have been improperly accessed, acquired, used, or disclosed;

B. 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;

C. A description of the types of PHI involved;

D. The investigative and remedial actions the Contractor or its Subcontractor took or will take to prevent and mitigate harmful effects and protect against recurrence;

E. Any details necessary for a determination of the potential harm to Clients whose PHI is believed to have been used or disclosed and the steps those Clients should take to protect themselves; and

F. Any other information HCA reasonably requests.

10.3 The Contractor must also 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.

10.4 If notification must, in the sole judgement of HCA, must be made Contractor will further cooperate and facilitate notification to necessary individuals, to the U.S. Department of Health and Human Services (DHHS) Secretary, and to the media. At HCA's discretion, Contractor may be required to directly perform notification requirements, or if HCA elects to perform the notifications, Contractor must reimburse HCA for all costs associated with notification(s).

10.5 Contractor is responsible for all costs incurred in connection with a security incident, Data Breach, or potential compromise of Data, including:

A. The reasonable costs of notification to individuals, media, and governmental agencies and of other actions HCA reasonably considers appropriate to protect HCA clients.

B. 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 Data Breach notification laws;

C. Notification and call center services, and other appropriate services (as determined exclusively by HCA) for individuals affected by a security incident or Data Breach, including fraud prevention, credit monitoring, and identify theft assistance; and

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

E. Compensation to HCA clients for harms caused to them by any Data Breach or possible Data Breach.

10.6 Any Breach of this section may result in termination of the Contract and the demand for return or disposition, as described in Section 0, of all HCA Data.

10.7 Contractor's obligations regarding Data Breach notification survive the termination of this Contract and continue for as long as Contractor maintains the Data and for any Data Breach or potential compromise, at any time.

11. HIPAA Compliance

11.1 Contractor must perform all of its duties, activities, and tasks under this Attachment in compliance with HIPAA, and all applicable regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable.

11.2 Within ten (10) Business Days, Contractor must notify the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov of any complaint, enforcement, or compliance action initiated by the Office for Civil Rights based on an allegation of violation of HIPAA 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 and for any sanction imposed against its Subcontractors or agents for which it is found liable.

12. Data Breach Response Insurance Requirements

For the term of this Contract and 3 years following its termination or expiration, Contractor must maintain insurance to cover costs incurred in connection with a security incident, Data Breach, or potential compromise of Data, including:

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 Data Breach notification laws;

12.2 Notification and call center services for individuals affected by a security incident, or Data Breach;

12.3 Data Breach resolution and mitigation services for individuals affected by a security incident or Data Breach, including fraud prevention, credit monitoring, and identity theft assistance; and

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 or security law(s) or regulation(s).

13. Survival Clauses

The terms and conditions contained in this Attachment that by their sense and context are intended to survive the expiration or other termination of this Attachment must survive. Surviving terms include but are not limited to: *Constraints on Use of Data / Limited License, Security of Data, Data Confidentiality and Non-Disclosure, Audit, HIPAA Compliance, Data Breach Notification and Obligations and Data Breach Response Coverage Requirements.*

Attachment A1: Data Licensing Statement

1. Background

This attachment covers all data sharing, collection, maintenance, and Use of Data by Contractor for work performed under this Contract.

2. Justification and Authority for Data Sharing

The Data to be shared under this Contract are necessary for Contractor to provide care coordination, quality improvement, and case management services for Enrollees.

3. Purpose / Use / Description of Data

The purpose of this Attachment is to provide terms and conditions under which HCA will allow the restricted use of its Data to the Contractor, and under which the Contractor may receive and use the Data. This Attachment ensures that HCA Data is provided, protected, and used only for purposes authorized by state and federal law governing such Data use.

The scope of this Attachment only provides the Contractor with access and Permissible Use of Data; it does not establish an agency relationship or independent contractor relationship between HCA and the Contractor.

3.1 Permissible Use: Contractor may only use the Data for the purposes of care coordination and quality improvement purposes, and no other purposes. The Data in PRISM cannot be used for research.

Authorized Users: Contractor may request access for specific Authorized Users with a need-to-know to view Data in the PRISM System under this Contract.

3.2 File Layout: The Parties will exchange Data using the mutually agreed upon file layouts below. The Parties may edit and/or change the *File Layout* as considered necessary.

A. Method of Access/Transfer: Once an established Secure Data Transfer connection with the host computer at Contractor's location is confirmed, HCA will provide Data listed in *File Layout* list below, to Contractor.

B. Delivery Method: CSV

C. Frequency of Data Delivery: HCA will transmit Data on a weekly basis.

D. Costs: N/A

E. Data to be shared: Client identifies via Provider One ID and Medicaid ID

Attachment B: Data Security Requirements

1. Definitions

In addition to the definitions set out in the Data Use, Security, and Confidentiality Attachment, the definitions below apply to this Attachment.

1.1 "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.

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

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

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

1.2 "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).

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

1.4 "Secured Area" means an area to which only Authorized Users have access. Secured Areas may include buildings, rooms, or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

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

1.6 "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.

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

2. Data Transmission

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

2.2 When transmitting HCA's Confidential Information via paper documents, the Contractor must use a Trusted System and must be physically kept in possession of an authorized person.

3. Protection of Data

The Contractor agrees to store and protect Confidential Information as described:

3.1 Data at Rest:

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

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

i. 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.

ii. 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:

a. Encrypting with NIST 800-series approved algorithms. Encryption keys will be stored and protected independently of the data;

b. Control access to the devices with a Unique User ID and Hardened Password or stronger authentication method such as a physical token or biometrics;

c. Keeping devices in locked storage when not in use;

d. Using check-in/check-out procedures when devices are shared;

e. Maintain an inventory of devices; and

f. Ensure that when being transported outside of a Secured Area, all devices with Data are under the physical control of an Authorized User.

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

4. Data Segregation

HCA's Data received under this 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.

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

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

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

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

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

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

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

4.3 Contractor must designate and be able to identify all computing equipment on which they store, process and maintain HCA Data. No Data at any time may be processed on or transferred to any portable storage medium. Laptop/tablet computing devices are not considered portable storage medium devices for purposes of this Contract provided it is installed with end-point encryption.

5. Data Disposition

5.1 Consistent with Chapter 40.14 RCW, Contractor shall erase, destroy, and render unrecoverable all HCA Confidential Data and certify in writing that these actions have been completed within thirty (30) days of the disposition requirement or termination of this Contract, whichever is earlier. At a minimum, media sanitization is to be performed according to the standards enumerated by NIST SP 800-88r1 Guidelines for Media Sanitization.

5.2 For HCA's Confidential Information stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 0, above. Destruction of the Data as outlined in this section of this Attachment may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

6. Network Security

Contractor's network security must include the following:

6.1 Network firewall provisioning;

6.2 Intrusion detection;

6.3 Quarterly vulnerability assessments; and

6.4 Annual penetration tests.

7. Application Security

Contractor must maintain and support its software and subsequent upgrades, updates, patches, and bug fixes such that the software is, and remains secure from known vulnerabilities.

8. Computer Security

Contractor shall maintain computers that access Data by ensuring the operating system and software are updated and patched monthly, such that they remain secure from known vulnerabilities. Contractor

computer device(s) must also be installed with an Anti-Malware solution and signatures updated no less than monthly.

9. Offshoring

9.1 Contractor must maintain all hardcopies containing Confidential Information only from locations in the United States.

9.2 Contractor may not directly or indirectly (including through Subcontractors) transport any Data, hardcopy or electronic, outside the United States unless it has advance written approval from HCA.

Attachment C: HCA Small Numbers Standard

1. Why do we need a Small Numbers Standard?

It is the Washington State Health Care Authority's (HCA) legal and ethical responsibility to protect the privacy of its clients and members. However, HCA also supports open data and recognizes the ability of information to be used to further HCA's mission and vision. As HCA continues down the path of Data Governance maturity, establishing standards such as this is key in helping HCA analysts and management meet the needs of external data requestors while maintaining the trust of our clients and members and complying with agency, state and federal laws and policies.

Publishing data products that include small numbers creates two concerns. As a reported number gets smaller, the risk of re-identifying an HCA client or member increases. This is especially true when a combination of variables are included in the data product to arrive at the small number (e.g. location, race/ethnicity, age, or other demographic information).

Small numbers can also create questions around statistical relevance. When it comes to publicly posting data products on HCA's internet site, or sharing outside the agency, the need to know the exact value in a cell that is less than 11 must be questioned.

As the agency moves away from traditional, static reports to a dynamic reporting environment (e.g. Tableau visualizations), it is easier for external data consumers to arrive at small numbers. Further, those external consumers have an increasing amount of their own data that could be used to re-identify individuals. As a result, more rigor and a consistent approach needs to be in place to protect the privacy of HCA's clients and members. Until now, some HCA data teams have elected to follow small numbers guidelines established by the Department of Health, which include examples of suppression methods for working with small numbers. HCA is now establishing its own standard, but is planning to work with DOH and other agencies dealing with healthcare data to try and develop a consistent small numbers methodology at a statewide level.

2. Scope

HCA often uses Category 4 data to create summary data products for public consumption. This Standard is intended to define one of the requirements for a summary data product to be considered Category 1. Specifically, it is intended to define the level of suppression that must be applied to an aggregated data product derived from Category 4 data for the data product to qualify as Category 1. Category 1 products are data products that are shared external to the agency, in large part those products that are posted on HCA's Internet website (www.hca.wa.gov). The primary scope of this Standard is for those data products posted publicly (e.g. on the website), or, shared as public information.

The following are examples of when this Standard **does not** apply to data products are:

2.1 Those shared directly with an external entity outside HCA, the Standard suppression of small numbers would not be required. However, you should notify the recipient that the data products contain sensitive information and should not be shared or published.

2.2 Those exchanged under a data share agreement (DSA) that will not be posted or shared outside the Contractor.

2.3 Those created for HCA-only internal use.

This standard does not supersede any federal and state laws and regulation.

3. Approach

In 2017, an impromptu workgroup was formed to tackle the issue of small numbers and determine what the general approach for handling data products that contain them would be. This initial effort was led by the agency's Analytics, Interoperability and Measurement (AIM) team who had an immediate need for guidance in handling and sharing of data products containing small numbers. The result of that work was a set of Interim Small Numbers Guidelines, which required suppression of cells containing values of less than 10. In addition, data products that contain small numbers are considered Category 2 under HCA's Data Classification Guidelines.

In spring 2018, a new cross-divisional and chartered Small Numbers Workgroup was formed to develop a formal agency standard. Representatives from each of the major HCA divisions that produce data and analytic products were selected. The charter, complete with membership, can be found here (available to internal HCA staff only). The Workgroup considered other state agency standards, and national standards and methods when forming this standard. The Workgroup also consulted business users and managers to determine the potential impact of implementing a small numbers suppression standard. All of this information was processed and used to form the HCA Small Numbers Standard.

4. State and National Small Numbers Standards Considered

When developing these standards, HCA reviewed other organizations' small numbers standards at both a state and federal level. At the state level, DOH recently published a revised Small Numbers Standard, which emphasizes the need for suppression for both privacy concerns and statistical relevance. HCA also convened a meeting of other state agencies to discuss their approach and policies (if any) around Small Numbers. Feedback from that convening was also taken into consideration for this Standard as well.

Federal health organizations such as the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS) also maintain small numbers standards. HCA's federal oversight agency and funding partner, the Centers for Medicare and Medicaid Services (CMS) adopts suppression of any cell with a count of 10 or less.

5. WA Health Care Authority Small Numbers Standard

Any HCA external publication of data products are to be compliant with both HIPAA and Washington State privacy laws. Data products are not to contain small numbers that could allow re-identification of individual beneficiaries. HCA analysts are to adhere to the following requirements when developing Category 1 data products for distribution and publication. Category 1 data is information that can be released to the public. These products do not need protection from unauthorized disclosure but do need integrity and availability protection controls. Additionally, all contractors (state and private) that use HCA's data to produce derivative reports and data products are required to adhere to this standard as well. HCA's Contracts team will ensure that proper contractual references are included to this and all HCA Data Release and Publishing Standards. The requirements discussed herein are not intended for Category 2, Category 3, or Category 4 data products.

6. HCA's Small Number Standard:

6.1 There are no automatic exemptions from this standard.

6.2 (See Exception Request Process section below).

6.3 Standard applies for all geographical representations, including statewide.

6.4 Exceptions to this standard will be considered on a case-by-case basis (see *Exception Request Process* section later in this document for more information).

6.5 Ensure that no cells with 0 < n < 11 are reported (0 < n < 11 suppressed).

6.6 Apply a marginal threshold of 1 – 10 and cell threshold of 1 – 10 to all tabulations.

6.7 (0 < n < 11 suppressed).

6.8 To protect against secondary disclosure, suppress additional cells to ensure the primary suppressed small value cannot be recalculated.

6.9 Suppression of percentages that can be used to recalculate a small number is also required.

6.10 Use aggregation to prevent small numbers but allow reporting of data. Age ranges are a very good example of where aggregation can be used to avoid small numbers but avoid suppressing data (see example below).

7. Small Numbers Examples

7.1 Example (Before Applying Standard)

Client Gender	County	Accountable Community of Health (ACH)	Statewide
Male	6	8	14
Female	11	15	26
TOTAL	17	23	40

7.2 Example (After Applying Standard)

Client Gender	County	ACH	Statewide
Male	---[1]	---	14
Female	11	15	26
TOTAL	---	---	40

[1]In order to protect the privacy of individuals, cells in this data product that contain small numbers from 1 to 10 are not displayed.

The above examples show in order to comply with the standard, analysts must not only suppress directly those cells where n < 11, but also in this case secondary suppression is necessary of the county and ACH totals in order to avoid calculation of those cells that contained small numbers.

7.3 Example (Suppression with no aggregation)

Age Range	County	ACH	Statewide
0-3	5 (would be suppressed)	8 (would be suppressed)	13 (would be suppressed)

4-6	7 (would be suppressed)	18	25 (would be suppressed)
	15	23	38
10-12	24	33	57
TOTAL	51 (would be suppressed)	82 (would be suppressed)	133

7.4 Example (Using aggregation instead of suppression)

Age Range	County	ACH	Statewide
0-6	12	26	38
7-9	15	23	38
10-12	24	33	57
TOTAL	51	82	133

The above examples provide guidance for using aggregation to avoid small number suppression and still provide analytic value to the end user. Aggregation is an excellent method to avoid presenting information with many holes and empty values.

8. Exception Request Process

To request an exception to this standard, Receiving Party must do the following:

8.1 Send an e-mail to HCAData@hca.wa.gov containing the following information:

A. A copy of the data product, or a sample of the data product if sending the entire data products is not feasible due to size.

B. Rationale and reason for publishing the product containing small numbers.

C. Impact if the product is not published.

D. Intended audience for the data product.

E. Why aggregation is not an acceptable mitigation.

8.2 Requests are jointly reviewed by the HCA Privacy Officer and Data Governance Program Manager.

If the HCA Privacy Officer and Data Governance Program Manager deem necessary, the request will be escalated up through HCA's Data Utilization Committee for a final decision.

HCA's Data Governance Program Manager will inform requestor the final decision along with any necessary handling instructions for the product if it is allowed to be shared or posted.

Decisions for each exception will be documented on the HCA Data Governance Decision Log.

Those approved exceptions for publishing small numbers will be considered in future updates of this standard.

Attachment D: Certification of Destruction/Disposal of Confidential Information

(To Be Filled Out and Returned to HCA Upon Termination of Contract)

NAME OF CONTRACTOR:	CONTRACT #:

_____ (Contractor) herby certifies that the data elements listed below or attached, received as a part of the data provided in accordance with DSA have been:

☐ DISPOSED OF/DESTROYED ALL COPIES

You certify that you destroyed, and returned if requested by HCA, all identified confidential information received from HCA, or created, maintained, or received by you on behalf of HCA. You certify that you did not retain any copies of the confidential information received by HCA.

Description of Information Disposed of/ Destroyed:

Date of Destruction and/or Return:

Method(s) of destroying/disposing of Confidential Information:

Disposed of/Destroyed by:

Signature		Date
Printed Name:		
Title:		

Medicare Data Use Requirements Documents

Schedule 1: Medicare Part D – Conflict of Interest Attestation

Schedule 2: PRISM Access Request Form

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]

SCHEDULE 2: PRISM ACCESS REQUEST FORM

Washington State Department of Social & Health Services
Transforming lives

PRISM Access Request for Multiple Organizations

Washington State Health Care Authority

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)

PRISM ACCESS REQUEST FOR MULTIPLE ORGANIZATIONS
DSHS 17-208A (08/2018)

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

PRISM ACCESS REQUEST FOR MULTIPLE ORGANIZATIONS
DSHS 17-208A (08/2018)