THIS DOCUMENT REPRESENTS ALL INCORPORATED AMENDMENTS, EXHIBITS AND ATTACHEMENTS FROM JANUARY 2019 THROUGH AMENDMENT #2. AMENDMENT #2 IS EFFECTIVE JULY 1, 2019.

Washington State Health Care Authority	**WASHINGTON APPLE HEALTH** **INTEGRATED FOSTER CARE**	HCA Contract Number: Contractor Contract Number: ☐ Competition Exempt

THIS AMENDMENT is between the Washington State Health Care Authority, hereinafter referred to as "HCA," and the party whose name appears below, hereinafter referred to as the "Contractor."

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)	
Coordinated Care of Washington, Inc.		
1145 Broadway, Suite 300 Tacoma, WA 98402	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 603293815	HCA INDEX NUMBER

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS
Jennifer Carlisle	(253) 442-1489	JECARLISLE@coordinatedcarehealth.com

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IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S)

CONTRACT START DATE **July 1, 2019**	**CONTRACT END DATE** **December 31, 2020**

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

REASON FOR AMENDMENT: Contract for Apple Health Integrated Foster Care Services

EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:

☒ Exhibits (specify): Exhibit A-IFC – Integrated Foster Care rates; Exhibit B, Access to Care Standards [removed]; Exhibit C, Designation of Behavioral Health Providers; Exhibit D, Value-Based Purchasing; Exhibit E, Challenge Pool Value-Based Purchasing Incentives; Exhibit F, Instructions for Medical Loss Ratio (MLR) Reporting; Exhibit G, Data Use, Security and Confidentiality; Exhibit H, [intentionally left blank]; Exhibit I, [intentionally left blank]; and Exhibit J, RAC Codes.

☒ Attachment (specify): Attachment 1 – Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D; Attachment 2 – 2019 Performance Measures; Attachment 3, Monthly Certification Letter; Attachment 4 – RFP 15-002 – Apple Health – Foster Care (Incorporated by reference, available upon request); Attachment 5 – Contractor's Response to RFP 15-002 – Apple Health – Foster Care (Incorporated by reference, available upon request);, and Attachment 6, Oral Health Connections Pilot Project.

☐ No Exhibits

Approval from the federal Centers for Medicare and Medicaid Services (CMS) is required for this Contract. Should CMS fail to approve this Contract is null and void.

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

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED
	Annette Schuffenhauer, Chief Legal Officer Division of Legal Services	

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1 DEFINITIONS

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

1.1 Access

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

1.2 Access to Care Standards (ACS)

"Access to Care Standards (ACS)" means minimum medical necessity standards for Medicaid eligible persons to access mental health services administered through the Behavioral Health Organizations (BHOs) under contract with HCA.

1.3 Accountable Community of Health (ACH)

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

1.4 Actuarially Sound Capitation Rates

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

1.5 Acute Withdrawal Management

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

1.6 Administrative Day

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

1.7 Administrative Hearing

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

1.8 Adoptive Parent(s)

"Adoptive Parent(s)" means the person or persons who have legally adopted a child formerly in the placement and care authority of Department of Children, Youth and Families (DCYF).

1.9 Advance Directive

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

1.10 Adverse Benefit Determination

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

1.10.1 The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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

1.10.3 The denial, in whole or in part, of payment for a service;

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

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

1.10.6 The failure of the Contractor to act within the timeframes for resolution and notification of Appeals and Grievances;

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

1.10.8 For a rural area resident with only one Managed Care Organization (MCO) available, the denial of an Enrollee's request under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the Contractor's network; or, for a plan's denial of coverage by an out-of-network provider when the in-network providers do not have the needed training, experience, and specialization, or do not provide the service the Enrollee seeks, when

receiving all care in-network would subject the Enrollee to unnecessary risk, or when other circumstances warrant out-of-network treatment.

1.11 Adverse Childhood Experiences (ACES)

"Adverse Childhood Experiences (ACES)" means ten categories of experience that can contribute to the amount of toxic stress experienced through the first 18 years of life. The ten categories are:

1.11.1 Physical Abuse

1.11.2 Sexual Abuse

1.11.3 Emotional Abuse

1.11.4 Physical Neglect

1.11.5 Emotional Neglect

1.11.6 Drug or alcohol addicted family member

1.11.7 Mentally ill, depressed or suicidal person in the home

1.11.8 Witnessing domestic violence against a parent or guardian

1.11.9 Incarceration of any family member

1.11.10 Loss of a parent or death, abandonment or divorce

1.12 Aging and Long Term Support Administration

"Aging and Long-Term Support Administration (ALTSA)" means the administration within the state Department of Social and Health Services (DSHS) responsible for administering long-term care and supports to individuals who are functionally and financially eligible to receive such services, including those provided by ALTSA-contracted Area Agencies on Aging (AAAs).

1.13 Alcohol/Drug Screening and Brief Intervention

"Alcohol/Drug Screening and Brief Intervention" means a combination of services designed to screen for risk factors that appear to be related to alcohol and other drug disorders, provide interventions to enhance patient motivation to change and make appropriate referrals as needed.

1.14 All Payer Claims (APC) Database

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

1.15 Allegation of Fraud

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

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

1.15.1 Fraud hotline complaints;

1.15.2 Claims data mining; and

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

1.16 Alternative Benefit Plan (ABP)

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

1.17 American Society of Addiction Medicine (ASAM)

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

1.18 American Society of Addiction Medicine (ASAM) Criteria

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

1.19 Ancillary Services

"Ancillary Services" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy (WAC 182-500-0010).

1.20 Appeal

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

1.21 Appeal Process

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

1.22 Assessment (Substance Use Disorder (SUD))

"Assessment" means activities conducted to evaluate an individual to determine placement in accordance with the American Society of Addiction Medicine (ASAM) patient placement criteria.

1.23 Auxiliary Aids and Services

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

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

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

1.23.3 Acquisition or modification of equipment or devices; and

1.23.4 Other similar services and actions.

1.24 Behavioral Health

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

1.25 Behavioral Health Agency

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

1.26 Behavioral Health Assessment System (BHAS)

"Behavioral Health Assessment System (BHAS)" means an online Child and Adolescent Needs and Strengths (CANS) data entry and reporting system that provides CANS data in real time to clinicians, supervisors, agency administrators, BHO and AH-IFC administrators, as well as HCA staff, for quality improvement purposes. The reports in this system are explicitly designed to provide on-demand, multi-level feedback and are updated in real-time.

1.27 Behavioral Health Administrative Services Organization (BH-ASO)

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

1.28 Behavioral Health Organization (BHO)

"Behavioral Health Organization (BHO)" means a county authority, or a group of county authorities, or other entity recognized by HCA in contract, in a defined Regional Service Area (RSA).

1.29 Breach

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

1.30 Brief Intervention

"Brief Intervention" means a time limited, structured behavioral intervention using Substance Use Disorder Brief Intervention techniques, such as evidence-based motivational interviewing, and referral to treatment services when indicated. Services may be provided at, but not limited to, sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

1.31 Brief Intervention (Mental Health)

"Brief Intervention" means solution-focused and outcomes-oriented cognitive and behavioral interventions intended to resolve situational disturbances. These services do not require long term-treatment, and do not include ongoing care, maintenance, or monitoring of the individual's current level of function or assistance with self-care or life skills training.

1.31.1 An agency providing Brief Intervention treatment services to individuals must meet the individual service plan requirements and ensure the individual service plan identifies a course of treatment to be completed in six (6) months or less.

1.31.2 The additional assessment and individual service plan requirements do not apply to Brief Intervention treatment.

1.31.3 An individual may move from Brief Intervention treatment to longer-term outpatient mental health services at any time.

1.32 Brief Outpatient Treatment (Substance Use Disorder)

"Brief Outpatient Treatment (Substance Use Disorder)" means an assessment and services provided to an individual designed to screen for risk factors that appear to be related to substance use disorders, and a coordinated, concentrated program of individual and group counseling, education, and activities in accordance with ASAM criteria.

1.33 Business Associate Agreement

"Business Associate Agreement" means an agreement under the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA),

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

1.34 **Business Day/Hours**

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

1.35 **CAHPS® Database**

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

1.36 **Capacity Threshold**

"Capacity Threshold" means the capacity to serve at least sixty (60) percent of Apple Health eligible individuals in a service area in each of the following six (6) critical provider types: hospital, behavioral health, primary care, pharmacy, obstetrical, and pediatricians.

1.37 **Care Coordination Organization (CCO)**

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

1.38 **Caregiver Activation Measure (CAM)**

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

1.39 **Care Management**

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

1.40 **Care Manager (CM)**

"Care Manager (CM)" means an individual employed by the Contractor or a contracted organization who provides Care Management services. Care Managers shall be licensed as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician

assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists, social workers with a Masters in Social Work (MSW), or shall be social service or healthcare professionals with a Bachelors in Social Work or closely related field, Indian Health Service Community Health Representatives (CHR), or certified chemical dependency professionals.

1.41 **Caregiver**

"Caregiver" For the purposes of this program, Caregiver means an adoptive parent OR a licensed foster parent, relative caregiver, or other suitable placement, designated by the Department of Children, Youth and Families (DCYF) to care for a child until a permanent placement can be arranged.

1.42 **Case Management (SUD)**

"Case Management (SUD)" means services provided by a Chemical Dependency Professional (CDP), CDP Trainee, or person under the clinical supervision of a CDP who will assist clients in gaining access to needed medical, social, education, and other services. Does not include direct treatment services in this sub element. This covers costs associated with case planning, case consultation and referral services, and other support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities.

1.43 **Centers for Medicare and Medicaid Services (CMS)**

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

1.44 **Certified Chemical Dependency Professional (CDP)**

"Certified Chemical Dependency Professional (CDP)" means an individual who is certified according to RCW 18.205.020 and the certification requirements of WAC 246-811-030 to provide chemical dependency counseling (Substance Use Disorder [SUD] services).

1.45 **Certified Electronic Health Record Technology (CEHRT)**

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

1.46 Certified Peer Counselor (CPC)

"Certified Peer Counselor (CPC)" means individuals that have met the requirements in WAC who help individuals and families identify and meet goals that promote recovery and resiliency and help to identify services and activities to reach these goals. For more information: https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/peer-support.

1.47 Child and Family Team (CFT)

"Child and Family Team (CFT)" means a team that includes the Enrollee, their family, the child's natural and professional support system, and behavioral health providers involved with the family. This team collaborates to develop, evaluate and modify a cross system care plan in accordance with the Washington Children's Mental Health System Principles to support the restoration of a higher level of functions for the youth and family.

1.48 Child Health and Education Tracking (CHET) Program

"Child Health and Education Tracking (CHET) Program" means the set of screenings that is conducted by DCYF screeners within thirty (30) calendar days of a child or youth's placement into foster care, as part of an initial foster care placement. CHET screenings are conducted by DCYF specialized social workers using standardized, validated tools and reviews the following five domains:

1.48.1 Physical Health

1.48.2 Developmental

1.48.3 Educational

1.48.4 Social/Emotional

1.48.5 Connections

1.49 Child Study and Treatment Center (CSTC)

"Child Study and Treatment Center (CSTC)" means the Department of Social and Health Services' child psychiatric hospital.

1.50 Children with Special Health Care Needs

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

1.50.1 Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;

1.50.2 Eligible for Medicaid under Section 1902(e)(3) of the Act;

1.50.3 In foster care or other out-of-home placement;

1.50.4 Receiving foster care or adoption assistance; and/or

1.50.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section

501(a)(1)(D) of Title V of the Social Security Act.

1.51 Children's Behavioral Health Measures of Statewide Performance (CBH-MSP)

"Children's Behavioral Health Measures of Statewide Performance (CBH-MSP)" means a framework of goals, outcomes, and indicators developed by a group of Washington State children's mental health stakeholders. The goals, outcomes, and measures are used to monitor and evaluate the performance of Washington State's System of Care for children and adolescents with mental health and/or alcohol or Substance Use Disorder treatment needs. These measures are maintained by the Washington Department of Social and Health Services, Research and Data Analysis Administration. (See https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/Childrens_Behav_Health_Measures_v28.pdf).

1.52 Children's Health Insurance Program (CHIP)

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

1.53 Children's Long Term Inpatient Program (CLIP)

"Children's Long Term Inpatient Program (CLIP)" means the most intensive long-term inpatient psychiatric treatment available to all Washington State residents, ages 5 to 17 years of age. CLIP is a medically based treatment approach providing 24 hour psychiatric treatment in a highly structured setting designed to assess, treat, and stabilize youth diagnosed with psychiatric and behavioral disorders. CLIP also provides an opportunity for parents to learn new skills and strategies to effectively understand and manage their child and youth's illness.

1.54 Children's Long Term Inpatient Programs Administration (CLIP Administration)

"Children's Long Term Inpatient Programs Administration (CLIP Administration)" means an independent entity designated by the state as the authority for clinical decision-making regarding admission to and discharge from publically funded beds in the statewide CLIP program. The CLIP Administration Office collaborates with the BHOs, MCOs and BH-ASOs to ensure that only those children and youth who meet medical necessity criteria are admitted to a CLIP facility and that discharges occur with thoughtful planning and consideration of the needs of the youth and family.

1.55 Chronic Condition

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

1.56 Chronic Disease Self-Management Education (CDSME)

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

1.57 Client

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

1.58 Clinical Data Repository (CDR)

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

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

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

1.60 Cold Call Marketing

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

1.61 Community Behavioral Health Advisory (CBHA) Board

"Community Behavioral Health Advisory (CBHA) Board" means an advisory board representative of the demographic characteristics of the RSA, in accordance with WAC 182-538D-0252.

1.62 Community Health Workers (CHW)

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

1.63 Comparable Coverage

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

1.64 Complex Case Management (CCM)

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

1.65 Comprehensive Assessment Report and Evaluation (CARE)

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

1.66 Concurrent Review

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

1.67 Confidential Information

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

1.68 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

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

1.69 Continuity of Care

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

1.70 Continuity of Care Document (CCD)

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

1.71 Contract

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

1.72 Contractor

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

1.73 Contracted Services

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

1.74 Copayment

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

1.75 Covered Services

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

1.76 Credible Allegation of Fraud

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

1.77 Crisis Services

"Crisis Services" means evaluation and treatment of mental health crisis to all Medicaid-enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis Services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis Services may be provided prior to completion of an Intake Evaluation. Services are provided by or under the supervision of a Mental Health Professional. Crisis Services have been expanded to include evaluation and treatment for clients experiencing a crisis, related to a SUD.

1.78 Critical Providers

"Critical Providers" means the health care provider types without which a Managed Care Organization cannot provide a viable program. For the purposes of this Contract, Critical Providers are: Hospitals, Primary Care Providers and Pediatric Primary Care Providers, and Mental Health Providers.

1.79 Day Support

"Day Support" means an intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid Enrollees to promote improved functioning or a restoration to a previous higher level of functioning.

1.80 **Debarment**

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

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

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

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

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

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

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

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

1.83 **Designated Crisis Responder (DCR)**

"Designated Crisis Responder (DCR)" means a mental health professional appointed by the county, or the Behavioral Health Organization. The Designated Crisis Responder has all the powers and duties of a designated mental health professional as well as the powers and duties of a designated chemical dependency specialist under RCW 71.05.760.

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

"Division of Behavioral Health and Recovery (DBHR)" means the HCA division that administers state only, federal block grant, and Medicaid funded behavioral health programs.

1.85 **Director**

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

1.86 **Driving Under the Influence (DUI) Assessment**

"Driving Under the Influence (DUI) Assessment" means the comprehensive screening and assessment process provided to an individual to determine the individual's involvement with alcoholism, intoxication, and substance use disorder, and the appropriate support services and course of treatment.

1.87 **Duplicate Coverage**

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

1.88 **Durable Medical Equipment (DME)**

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

1.88.1 Can withstand repeated use;

1.88.2 Is primarily and customarily used to serve a medical purpose;

1.88.3 Generally is not useful for a person in the absence of illness or injury; and

1.88.4 Is appropriate for use in the client's place of residence.

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

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

1.90 **Electronic Health Record (EHR)**

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

1.91 **Emergency Care for Mental Health Condition**

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

1.92 Emergency Department Information Exchange™ (EDIE)

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

1.93 Emergency Fill

"Emergency Fill" means the dispensing of a prescribed medication to an Enrollee by a licensed pharmacist who has used his or her professional judgment in identifying that the Enrollee has an Emergency Medical Condition for which lack of immediate access to pharmaceutical treatment would result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.94 Emergency Medical Condition

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a)).

1.95 Emergency Medical Transportation

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

1.96 Emergency Room Care

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

1.97 Emergency Services

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

1.98 Encrypt

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

1.99 Enrollee

"Enrollee" means an individual who is enrolled in an Apple Health Managed Care program through a Managed Care Organization (MCO) having a contract with HCA (42 C.F.R. § 438.10(a)).

1.100 Essential Behavioral Health Administrative Functions

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

1.101 Evaluation and Treatment

"Evaluation and Treatment" means services provided in freestanding inpatient residential (non-hospital/non-Institution for Mental Disease (IMD) facilities licensed and certified by the Department of Health to provide medically necessary evaluation and treatment to the Medicaid-enrolled individual who would otherwise meet hospital admission criteria. Evaluation and Treatment includes emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder. (RCW 71.05.020).

1.102 Evidence-Based Practices (EBPs)

"Evidence-Based Practices (EBPs)" means a program or practice that has been tested in heterogeneous or intended populations with multiple randomized, or statistically controlled evaluations, or both; or one large multiple site randomized, or statistically controlled evaluation, or both, where the weight of the evidence from review demonstrates sustained improvements in at least one outcome. "Evidence-Based" also means a program or practice that can be implemented with a set of procedures to allow successful replication in Washington and, when possible, is determined to be cost-beneficial per the Washington State Institute for Public Policy (WSIPP).

1.103 Exception to Rule (ETR)

"Exception to Rule (ETR)" means a request by an Enrollee or a requesting provider for the Enrollee to receive a non-covered health care service according to WAC 182-501-0160.

1.104 Excluded Benefit

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

1.105 External Entities (EE)

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

1.106 **External Quality Review (EQR)**

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

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

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

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

"External Quality Review Report (EQRR)" means a detailed technical report that describes the manner in which the data from all activities described in External Quality Review provisions of Section 7.6 and conducted in accordance with 42 C.F.R. § 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness, and access to the care furnished by the Contractor.

1.109 **Facility**

"Facility" means but is not limited to: a hospital, an inpatient rehabilitation center, Long-Term and Acute Care (LTAC), skilled nursing facility, and nursing home.

1.110 **Family Treatment**

"Family Treatment" means behavioral health counseling provided for the direct benefit of a Medicaid-enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants.

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

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

1.112 **First Responders**

"First Responders" means police, sheriff, fire, emergency, medical and hospital emergency rooms, and 911 call center.

1.113 **Foster Care**

"Foster Care" means the placement of a child by DCYF or a licensed child placing agency in a home or facility licensed pursuant to chapter 74.15 RCW, or in a home or facility that is not required to be licensed.

1.114 Foster Care Alumni (Alumni)

"Foster Care Alumni" or "Alumni" means a young adult between the ages of 18 and 26 who has aged out of the foster care system but who is still eligible for Medicaid in accordance with Section 1902(a)10(A)(i)(IX) of the Social Security Act and applicable Washington State Law.

1.115 Fostering Well Being (FWB)

"Fostering Well Being" or "FWB" means the unit within the DSHS Aging and Long Term Supports Administration that provides health care coordination services and assistance to foster children in accessing providers or health supplies.

1.116 Foundation for Health Care Quality

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

1.117 Fraud

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

1.118 Grievance

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

1.119 Grievance and Appeal System

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

1.120 Grievance Process

"Grievance Process" means the procedure for addressing Enrollees' Grievances (42 C.F.R. § 438.400(b)).

1.121 Group Treatment Services

"Group Treatment Services" means services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual

Service Plan (ISP). Goals of Group Treatment may include: developing self-care and/or life skills enhancing interpersonal skills; mitigating the symptoms of mental illness and lessening the results of traumatic experiences; learning from the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a Mental Health Professional to two or more Medicaid-enrolled individuals at the same time. Staff to client ratio is no more than 1:12. Maximum group size is twenty-four (24).

1.122 **Guideline**

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

1.123 **Habilitation Services**

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

1.124 **Habilitative Devices**

"Habilitative Devices" means prosthetics, orthotics and related supplies.

1.125 **Health Care Authority (HCA)**

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

1.126 **Health Care Coordination**

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

1.127 Health Care Coordinator

"Health Care Coordinator" means a health care professional or group of professionals, licensed in the state of Washington, who is responsible for providing health care coordination services to Enrollees. Health Care Coordinators may be:

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

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

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

1.128 Health Care Professional

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

1.129 Health Care Provider (HCP)

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

1.130 Health Care Services

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

1.131 Health Care Settings (HCS)

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

1.132 Health Home

"Health Home" means an entity composed of community-based providers, qualified by the state to provide Health Home Services to Medicaid Enrollees under Section 2703 of the Affordable Care Act of 2010. The entity is responsible for coordinating and integrating care across the continuum of services needed and used by eligible Enrollees.

1.133 Healthcare Effectiveness Data and Information Set (HEDIS®)

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

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

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

1.135 Health Information Technology (HIT)

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

1.136 Health Insurance

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

1.137 Health Technology Assessment (HTA)

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

1.138 High Intensity Treatment

"High Intensity Treatment" means intensive levels of service provided to Medicaid-enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's needs. Twenty-four (24) hours per day, seven (7) days per week, access is required if necessary.

1.139 Home Health Care

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

1.140 Hospice Services

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

1.141 Hospitalization

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

1.142 Hospital Outpatient Care

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

1.143 Improper Payment

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

1.144 Indian Health Care Provider (IHCP)

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

1.145 **Individual Service Plan (ISP)**

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

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

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

1.147 **Individual with Special Health Care Needs**

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

1.147.1 Has a biologic, psychological, or cognitive basis;

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

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

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

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

1.148 **Individual Treatment Services**

"Individual Treatment Services" means a set of treatment services designed to help a Medicaid-enrolled individual attain goals as prescribed in his/her Individual Service Plan (ISP). These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid-enrolled individual. This service is provided by or under the supervision of a Mental Health Professional.

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

"Inpatient/Residential Substance Abuse Treatment Services" means rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Enrollees who are harmfully affected by the use of mood-altering chemicals or have been diagnosed

with a Substance Use Disorder (SUD). Techniques have a goal of abstinence for individuals with SUDs. Provided in certified residential treatment facilities with sixteen (16) beds or less. Excludes room and board. Residential treatment services require additional program-specific certification by HCA, Division of Behavioral Health and Recovery and include:

1.149.1 Intensive inpatient services;

1.149.2 Recovery house treatment services;

1.149.3 Long-term residential treatment services; and

1.149.4 Youth residential services.

1.150 **Intake Evaluation**

"Intake Evaluation" means an evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except Crisis Services, Stabilization Services and Freestanding Evaluation and Treatment. The intake evaluation must be initiated within ten (10) business days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) business days. Routine services, such as Rehabilitation Case Management may begin before the completion of the intake once medical necessity is established. This service is provided by a Mental Health Professional.

1.151 **Intensive Inpatient Residential Services**

"Intensive Inpatient Residential Services" means a concentrated program of Substance Use Disorder treatment, education, and related activities for individuals diagnosed with a Substance Use Disorder excluding room and board in a twenty-four-hour-a-day (24) supervised facility. (The service as described satisfies the level of intensity in ASAM Level 3.5).

1.152 **Intensive Outpatient Treatment**

"Intensive Outpatient Treatment" means services provided in a non-residential intensive patient centered outpatient program for treatment of SUD. (The service as described satisfies the level of intensity in ASAM Level 2.1).

1.153 **Interdisciplinary Care Conferences (ICCs)**

"Interdisciplinary Care Conferences (ICCs)" means structured and documented communication between the Enrollee and Health Care Providers to establish prioritize and achieve Enrollee-centric health care and social service treatment goals.

1.154 **Interoperable Health IT**

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

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

"Institute for Mental Disease (IMD)" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of Individuals with mental diseases.

1.156 **Involuntary Treatment Act (ITA)**

"Involuntary Treatment Act (ITA)" allows for individuals to be committed by court order to a facility for a limited period of time. Involuntary civil commitments are meant to provide for the evaluation and treatment of individuals with a behavioral health disorder and who may be either gravely disabled or pose a danger to themselves or others, and who refuse or are unable to enter treatment on their own. An initial commitment may last up to seventy-two (72) hours, but, if necessary, individuals can be committed for additional periods of fourteen (14), ninety (90), and one hundred eighty (180) calendar days (RCW 71.05.180, RCW 71.05.230, RCW 71.05.240, and RCW 71.05.290).

1.157 **Involuntary Treatment Act Services**

"Involuntary Treatment Act Services" includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with chapters 71.05 and 71.34 RCW, and RCW 71.24.300.

1.158 **Large Rural Area**

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

1.159 **Less Restrictive Alternative Treatment (LRA)**

"Less Restrictive Alternative Treatment (LRA)" means a program of individualized treatment in a less restrictive setting than inpatient treatment that includes the services described in RCW 71.05.585.

1.160 **Level of Care Guidelines**

"Level of Care Guidelines" means the criteria the Contractor uses in determining which individuals within the target groups identified in the Contractor's policy and procedures will receive services.

1.161 **Limitation Extension (LE)**

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

1.162 **Limited English Proficient (LEP)**

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

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

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

1.164 **Long Term Care Residential Treatment**

"Long Term Care Residential Treatment" means the care and treatment of chronically impaired individuals diagnosed with Substance Use Disorder with impaired self-maintenance capabilities including personal care services and a concentrated program of Substance Use Disorder treatment, individual and group counseling, education, vocational guidance counseling, and related activities for individuals diagnosed with Substance Use Disorder excluding room and board in a twenty-four-hour-a-day, supervised Facility. (The service as described satisfies the level of intensity in ASAM Level 3.3).

1.165 **Managed Care**

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

1.166 **Managed Care Organization (MCO)**

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

1.167 **Marketing**

"Marketing" means any promotional activity or communication with a potential Enrollee that is intended to increase a Contractor's membership or to "brand" a Contractor's name or organization. These activities are directed from the Contractor to a Potential Enrollee or Enrollee who is enrolled with another HCA-contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or to end their enrollment with another HCA-contracted MCO. Marketing communications include: written, oral, in-person (telephonic or face-to-face), or electronic methods of communication, including email, text messaging, and social media (Facebook, Instagram, and Twitter).

1.168 **Marketing Materials**

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

1.169 **Material Provider**

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

1.170 **Maternity Support Services (MSS)**

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

1.171 **Medicaid Fraud Control Division (MFCD)**

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

1.172 **Medicaid State Plan**

"Medicaid State Plan" means the binding written agreement between the state and CMS that describes how the Medicaid program is administered and determines the Covered Services for which the state will receive federal financial participation.

1.173 **Medically Necessary Services**

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

1.174 **Medically Intensive Children's Program (MICP)**

"Medically Intensive Children's Program (MICP)" means the program within the Developmental Disabilities Administration that provides in-home private duty

nursing services to eligible children ages 0 to 18 who have medically intensive needs.

1.175 **Medical Loss Ratio (MLR)**

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

1.176 **Medication Assisted Treatment (MAT)**

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

1.177 **Medication Management**

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

1.178 **Medication Monitoring**

"Medication Monitoring" means face-to-face, one-on-one cueing, observing, and encouraging a Medicaid-enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform Medication Management services for the direct benefit of the Medicaid-enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes.

Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a Mental Health Professional. Time spent with the Enrollee is the only direct service billable component of this modality.

1.179 **Mental Health Advance Directive**

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

1.180 **Mental Health Group Treatment Services**

"Mental Health Group Treatment Services" means services provided to Medicaid-enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan (ISP). Goals of Group Treatment may include: developing self-care and/or life skills enhancing interpersonal skills; mitigating the symptoms of mental illness and lessening the results of traumatic experiences; learning from

the perspective and experiences of others and counseling/psychotherapy to establish and/or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of others' right to confidential treatment and must be able to integrate feedback from other group members. These services are provided by or under the supervision of a Mental Health Professional to two or more Medicaid-enrolled individuals at the same time. Staff to client ratio is no more than 1:12. Maximum group size is twenty-four (24).

1.181 **Mental Health Parity**

"Mental Health Parity" means the Washington Office of the Insurance Commissioner rules for Behavioral Health parity, inclusive of mental health and Substance Use Disorder benefits shall apply to this Contract (WAC 284-43-7000 to-7080).

1.182 **Mental Health Professional**

"Mental Health Professional" means:

1.182.1 A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

1.182.2 A person who is licensed by the Department of Health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapy associate;

1.182.3 A person with a master's degree or further advanced degree in counseling or one of the behavioral sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional; or

1.182.4 A person who has an approved exception to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by the DSHS Division of Behavioral Health and Recovery before July 1, 2001.

1.183 **Mental Health Services Provided in Residential Settings**

"Mental Health Services provided in Residential Settings" means a specialized form of rehabilitation service (non-hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High housing, SRO apartments) for extended hours to provide direct

mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include Medication Management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment.

1.184 **Multidisciplinary Team**

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

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

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

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

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

1.187 **Natural Supports**

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

1.188 **Network**

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

1.189 **Network Adequacy**

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

1.190 **Neurodevelopmental Centers**

"Neurodevelopmental Centers" means a group of community non-profit and hospital-based agencies as designated by the Department of Health who provide

therapy and related services to young children with neuromuscular or developmental disorders. Services may include speech, occupational, and physical therapies, along with other specialties such as nutrition, social work, and adaptive equipment.

1.191 Non-Participating Provider

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

1.192 Non-Quantitative Treatment Limits (NQTL)

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

1.193 Office of Inspector General (OIG)

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

1.194 OneHealthPort (OHP)

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

1.195 Opiate Treatment Program (OTP)

"Opiate Treatment Program (OTP)" means a designated program that dispenses approved medication as specified in 32.C.F.R. Part 291, for opioid treatment programs in accordance with WAC 246-341-1000.

1.196 Oral Health Connection Pilot

"Oral Health Connection Pilot" means a project to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not including Dual Eligible Clients) located in Cowlitz, Thurston or Spokane counties are those that qualify for this pilot. See Attachment 7, Oral Health Connections Pilot Project.

1.197 Outcomes

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

1.198 Outpatient Treatment for Substance Use Disorder

"Outpatient Treatment for Substance Use Disorder” means services provided in a non-residential Substance Use Disorder treatment Facility. Outpatient treatment services must meet the criteria in the specific modality provisions. Services are specific to client populations and broken out between group and individual therapy. (The service as described satisfies the level of intensity in ASAM Level 1).

1.199 Overpayment

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

1.200 Parent Patient Activation Measure (PPAM)

“Parent Patient Activation Measure (PPAM)” is an assessment that gauges the knowledge, skills and confidence of the parent’s management of their child’s health.

1.201 Participating Rebate Eligible Manufacturer

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

1.202 Participating Provider

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

1.203 Partnership Access Line (PAL)

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

1.204 Patient Activation Measure (PAM)

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

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

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

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

1.205 Patient Days of Care

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

1.206 Patient Health Questionnaire (PHQ-9)

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

1.207 Pediatric Interim Care (PIC)

"Pediatric Interim Care (PIC)" means the three programs [Catholic Community Services (Tacoma), Providence Everett, Pediatric Intensive Care Program (Kent)] available in Washington that provide services to families of drug/alcohol affected children under the age of three years. Program services may include a combination of specialized group care, foster care, family support, foster family training and support, aftercare services, wraparound services and/or other services. Depending on the program, services are facility-based, home based, or via support services but no placement.

1.208 Pediatric Symptom Checklist – 17

"Pediatric Symptom Checklist – 17" means a brief screening questionnaire that is used by pediatricians and other health professionals to improve the recognition and treatment of psychosocial problems in children.

1.209 Peer Support

"Peer Support" means services provided by certified peer counselors to Medicaid-enrolled individuals under` the consultation, facilitation, or supervision of a Mental Health Professional or Chemical Dependency Professional who understands

rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Clients actively participate in decision-making and the operation of the programmatic supports.

1.210 Personal Information

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

1.211 Physician Group

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

1.212 Physician Incentive Plan

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

1.213 Physician's Orders for Life Sustaining Treatment (POLST)

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

1.214 Physician Services

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

1.215 Placement Moves

"Placement Moves" means the movement of a child in state custody from one foster home, group care facility or living situation to another.

1.216 Plan

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

1.217 Population Health Management Systems (PHMS)

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

1.218 Post-Service Review

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

1.219 Post-Stabilization Services

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

1.220 Potential Enrollee

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

1.221 Practice Transformation Hub

"Practice Transformation Hub" means providing training, tools, and technical assistance to support Health Care Providers in transformative practice change efforts that promote optimal preventive services and chronic disease management.

1.222 Predictive Risk Intelligence System (PRISM)

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

1.223 Premium

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

1.224 Prescription Drug

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

1.225 Prescription Drug Coverage

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

1.226 Primary Care Provider (PCP)

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438.2. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

1.227 Primary/Preferred Language

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

1.228 Primary Point of Contact (PPC)

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

1.229 Prior Authorization

"Prior Authorization" means the requirement that a provider must request, on behalf of an Enrollee and when required by rule or HCA billing instructions, the HCA or the HCA's designee's approval to provide a health care service before the Enrollee receives the health care service, prescribed drug, device, or drug-related supply. The HCA or the HCA's designee's approval is based on medical necessity. Receipt of prior authorization does not guarantee payment. Expedited prior authorization and limitation extension are types of prior authorization (WAC 182-500-0085).

1.230 **Program Integrity**

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

1.231 **Promising Practice**

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

1.232 **Provider**

"Provider" means any individual or entity engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the State in which it delivers the services (42 C.F.R. § 438.2).

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

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

1.234 **ProviderOne**

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

1.235 **Provider Performance Profile (PPP)**

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

1.236 **Psychological Assessment**

"Psychological Assessment" means all psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a client's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

1.237 **Quality of Care**

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

1.238 **Quantitative Treatment Limitations (QTL)**

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

1.239 **Recovery**

"Recovery" means the process by which people are able to return to a healthy condition, live, work, learn, and participate fully in their communities.

1.240 **Regional Service Area (RSA)**

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

1.241 **Regulation**

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

1.242 **Rehabilitation Case Management**

"Rehabilitation Case Management" means a range of activities conducted in or with a Facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of Case Management in order to ensure timely and appropriate treatment and Health Care Coordination.

1.243 **Rehabilitation Devices**

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

1.244 **Rehabilitation Services**

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

1.245 **Relative Placement**

"Relative Placement" means a placement of a court ordered dependent child or youth by DCYF with the child's relative in a licensed or unlicensed, unpaid foster home.

1.246 Research-Based Practices

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

1.247 Residential Mental Health Services

"Residential Mental Health Services" means a specialized form of rehabilitation service (non-hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid-enrolled individuals receiving this service present with severe impairment in psychosocial functioning or have apparent mental illness symptoms with an unclear etiology due to their mental illness. Treatment for these individuals cannot be safely provided in a less restrictive environment and they do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, Single Room Occupancy (SRO) apartments) for extended hours to provide direct mental health care to a Medicaid Enrollee. Therapeutic interventions both in individual and group format may include Medication Management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of eight (8) hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

1.248 Resilience

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

1.249 Revised Code of Washington (RCW)

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

1.250 Risk

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

1.251 **Rural Area**

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

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

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

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

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

1.254 **Second Opinion Network (SON)**

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

1.255 **Secure Detox Facility**

"Secure Detox Facility" means a facility operated by either a public or private agency as defined in RCW 71.05.020 that provides involuntary treatment to individuals detained for SUD ITA up to ASAM withdrawal management level 3.7.

1.256 **Secured Area**

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

1.257 **Security Incident**

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

1.258 **Single Case Agreement**

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

1.259 **Social Service Specialist/Social Worker**

"Social Service Specialist/Social Worker" means the DCYF position responsible for meeting all casework management directives as required by law, policy and other mandates, including but not limited to, meeting documentation and payment initiation requirements for accurate and timely entries into the DCYF data collection system, Famlink, and accomplishing the overall goals of developing partnerships with families, focusing on practical everyday life tasks and promoting specific skills tied to the family's tasks.

1.260 **Special Population Evaluation**

"Special Population Evaluation" means an evaluation by a children's, geriatric, disabled, or ethnic minority mental health specialist. The evaluation considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a client's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

1.261 **Specialist**

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

1.262 **Stabilization Services**

"Stabilization Services" means services provided to Medicaid-enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting that provides safety for the individual and the Mental Health Professional. Stabilization Services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to Crisis Services; and b) other individuals determined by a Mental Health Professional to need additional Stabilization Services. Stabilization Services may be provided prior to an Intake Evaluation for mental health services.

1.263 **Sub-Acute Withdrawal Management**

"Sub-Acute Withdrawal Management" means costs incurred for withdrawal management services provided to an individual to assist in the process of withdrawal from a psychoactive substance in a safe and effective manner. Sub-Acute is nonmedical withdrawal management or patient self-administration of withdrawal medications ordered by a physician.

1.264 **Subcontract**

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

1.265 **Subcontractor**

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

1.266 **Substance Use Disorder (SUD)**

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

1.267 **Substantial Financial Risk**

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

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

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

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

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

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

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

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

1.269 **System of Care (SOC)**

"System of Care (SOC)" means a spectrum of effective, community-based services and supports for Enrollees with or at risk for chronic conditions, including behavioral health conditions, or other challenges and their families. SOCs are organized into a coordinated network, build meaningful partnerships with Enrollees and their families, and address their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

1.269.1 SOCs involve partnerships with the Enrollee and the Enrollee's support network and include the provision of services and resources from clinical and social service agencies. SOC services are coordinated and intended to achieve optimal Enrollee health outcomes. Systems of care include services delivered in a variety of settings, including primary care or other medical care settings; behavioral health settings; and/or co-located physical and behavioral health care.

1.269.2 Systems of care provide Care Coordination and Care Management or similar mechanisms at the practice level to ensure that multiple services are delivered in a coordinated and therapeutic manner and Enrollees and their families can move through the system of services in accordance with their changing needs.

1.269.3 Systems of care are supported by protocols and agreements defined and documented between community-based HCS clinics/agencies and social service agencies for communicating and facilitating care for the Enrollee (e.g. case conferencing). These protocols and operating agreements are developed in collaboration with the Accountable Community of Health (ACH) staff.

1.270 **Therapeutic Psychoeducation**

"Therapeutic Psychoeducation" means informational and experiential services designed to aid Medicaid-enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support in the management of psychiatric conditions, increase knowledge of mental illnesses and understanding the importance of their individual plans of care. These services are exclusively for the benefit of the Medicaid-enrolled individual and are included in the Individual Service Plan (ISP).

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc. Services are provided at locations convenient to the client, by or under the supervision of a Mental Health Professional. Classroom style teaching, Family Treatment, and individual treatment are not billable components of this service.

1.271 **Tracking**

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

1.272 **Transitional Age Youth (TAY)**

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

1.273 **Transitional Healthcare Services (THS)**

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

1.274 **Transport**

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

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

1.274.2 Is accomplished other than via a Trusted System.

1.275 **Trauma-Informed Care**

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

1.276 **Unique User ID**

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

1.277 **Urgent Care**

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

1.278 **Urgent Care Center**

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

1.279 **Urgent Medical Condition**

"Urgent Medical Condition" means a medical or Behavioral Health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within twenty-four (24) hours of the request, the person's situation is likely to deteriorate to the point that emergent services are necessary.

1.280 **Validation**

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

1.281 **Washington Administrative Code (WAC)**

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

1.282 **Washington Apple Health (AH)**

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

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

"Washington Apple Health Foster Care (AHFC)" means a managed care program developed specifically to meet the needs of children and youth in foster care and adoption support programs, and former foster children between the ages of 18 and 26 who are eligible for medical coverage as a result of the Affordable Care Act.

1.284 **Washington Apple Health Integrated Foster Care (AH-IFC)**

"Washington Apple Health –Integrated Foster Care (AH-IFC)" means the program covered under this Contract under which behavioral health services are added to the Apple Health Foster Care (AHFC) contract.

1.285 **Washington State Children's System of Care**

"Washington State Children's System of Care" means Washington State's efforts to develop a systematic approach to serving children and Youth with needs for intensive, behavioral health home, and community-based services, including recovery support services.

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

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

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

"Wraparound with Intensive Services (WISe)" means a range of services that are individualized, intensive, coordinated, comprehensive, culturally competent, and provided in the home and community. The WISe Program serves children and youth under the age of 21 who are experiencing mental health symptoms that are causing severe disruption in behavior, and/or interfering with functioning in family, school, or with peers requiring:

1.287.1 the involvement of the mental health system and other child serving systems and supports;

1.287.2 intensive care collaboration; and

1.287.3 ongoing intervention to stabilize the youth and family in order to prevent more restrictive or institutional placement.

1.288 **Young Adult**

"Young Adult" means a person from age eighteen (18) through age twenty (20).

1.289 **Youth**

"Youth" means, in general terms, a person from age thirteen (13) through age eighteen (18). Specific programs may assign a different age range for Youth. Early Periodic Screening Diagnosis and Treatment (EPSDT) defines youth as an individual up to age 21.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

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

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

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

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

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

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

2.2 Assignment

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

2.3 Billing Limitations

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

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

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

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

2.3.3.2 The servicing provider must submit a claim to the Contractor

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

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

2.4 Compliance with Applicable Law

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

2.4.1 Title XIX and Title XXI of the Social Security Act;

2.4.2 Title VI of the Civil Rights Act of 1964;

2.4.3 Title IX of the Education Amendments of 1972, regarding any education programs and activities;

2.4.4 The Age Discrimination Act of 1975;

2.4.5 The Rehabilitation Act of 1973;

2.4.6 The Budget Deficit Reduction Act of 2005;

2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA);

2.4.8 The Anti-Kickback Statute 42 U.S.C. § 1320a-7b;

2.4.9 The Health Insurance Portability and Accountability Act (HIPAA);

2.4.10 The American Recovery and Reinvestment Act (ARRA);

2.4.11 The Patient Protection and Affordable Care Act (PPACA or ACA);

2.4.12 The Health Care and Education Reconciliation Act;

2.4.13 The Public Assistance Act, Title 74 RCW;

2.4.14 The Mental Health Parity and Addiction Equity Act (MHPAEA) and final rule;

2.4.15 Federal 1915(B) Mental Health Waiver;

2.4.16 Medicaid State Plan;

2.4.17 42 C.F.R. § 438;

2.4.18 45 C.F.R. § 96, Block Grants;

2.4.19 45 C.F.R. § 96.126, Capacity of Treatment for Intravenous Substance Abusers who Receive Services under Block Grant funding;

2.4.20 Chapter 71.05 RCW, Mental Illness;

2.4.21 Chapter 71.24 RCW, Community Mental Health Services Act;

2.4.22 Chapter 71.34 RCW, Mental Health Services for Minors;

2.4.23 Chapter 74.09 RCW, Medical Care;

2.4.24 Community Mental Health and Involuntary Treatment Programs;

2.4.25 Behavioral Health Services Administrative Requirements;

2.4.26 Outpatient Mental Health Services;

2.4.27 Substance Use Disorder Services;

2.4.28 Chapter 43.20A RCW, Department of Social and Health Services;

2.4.29 Senate Bill 6312 (Chapter 225, Laws of 2014), State Purchasing of Mental Health and Chemical Dependency Treatment Services;

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

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

2.4.31.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.

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

2.4.31.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

2.4.31.4 Those specified in Title 18 RCW for professional licensing.

2.4.32 Industrial Insurance – Title 51 RCW.

2.4.33 Reporting of abuse as required by RCW 26.44.030 and RCW 74.34.

2.4.34 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2.

2.4.35 EEO Provisions.

2.4.36 Copeland Anti-Kickback Act.

2.4.37 Davis-Bacon Act.

2.4.38 Byrd Anti-Lobbying Amendment.

2.4.39 All federal and state nondiscrimination laws and regulations.

2.4.40 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit Enrollees with disabilities from obtaining contracted services.

2.4.41 The Contractor shall not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under the Medicaid State Plan.

2.4.42 Any other requirements associated with the receipt of federal funds.

2.5 Covenant Against Contingent Fees

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

2.6 Debarment Certification

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

2.7 Defense of Legal Actions

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

2.8 Disputes

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

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

2.8.1.1 The disputed issue(s).

2.8.1.2 An explanation of the positions of the parties.

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

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

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

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

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

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

under this Contract.

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

2.9 Force Majeure

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

2.10 Governing Law and Venue

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

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

2.11 Independent Contractor

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

2.12 Insolvency

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

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

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

Enrollees for Contracted services (42 C.F.R. § 438.106(b)(1)).

2.12.3 The Contractor shall, in accord with RCW 48.44.055 or RCW 48.46.245, provide for the continuity of care for Enrollees.

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

2.13 Inspection

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

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

2.14 Insurance

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

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

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

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

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

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

2.14.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.

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

2.14.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

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

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

2.14.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the Contractor is self-

insured, carries coverage adequate to meet the requirements of this Section, will treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

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

2.14.12.1 Computer forensics assistance to assess the impact of a data breach, determine root cause, and help determine whether and the extent to which notification must be provided to comply with Breach Notification Laws (45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; and WAC 284-04-625).

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

2.14.12.3 Breach resolution and mitigation services for individuals affected by a security incident, or privacy Breach, including fraud prevention, credit monitoring and identity theft assistance.

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

2.15 Records

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

2.15.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of ten (10) years after final payment is made under this Contract. However, when an inspection, audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of ten (10) years following resolution of such action (42 C.F.R. § 438.3(h)).

2.15.3 The Contractor and the Contractor’s subcontractors shall retain, as applicable, enrollee grievance and appeal records in 42 C.F.R. § 438.416, base data in 42 C.F.R. § 438.5(c), MLR reports in 42 C.F.R. § 438.8(k), and the data, information, and documentation specified in 42 C.F.R. § 438.604, § 438.606, § 438.608, and § 438.610 for a period of no less than ten (10) years.

2.15.4 The Contractor acknowledges the HCA is subject to the Public Records

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

2.16 Mergers and Acquisitions

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

2.17 Contractors Located Outside of the United States

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

2.18 Notification of Organizational Changes

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

2.19 Order of Precedence

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

2.19.1 Federal statutes and regulations applicable to the services provided under this Contract.

2.19.2 State of Washington statutes and regulations to the services provided under this Contract.

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

2.19.4 General Terms and Conditions of this Contract.

2.19.5 Attachment 4 – RFP 15-002 – Apple Health – Foster Care (Incorporated by reference, available upon request).

2.19.6 Attachment 5 – Contractor's Response to RFP 15-002 – Apple Health –

Foster Care (Incorporated by reference, available upon request).

2.19.7 Any other term and condition of this Contract and exhibits.

2.19.8 Any other material incorporated herein by reference.

2.20 Severability

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

2.21 Survivability

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

2.21.1 Cover hospitalized Enrollees until discharge consistent with this Contract.

2.21.2 Submit all data and reports required in this Contract.

2.21.3 Provide access to records required in accord with the Inspection provisions of this Section.

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

2.21.5 Repay any overpayments within sixty (60) calendar days of discovery by the Contractor or its subcontractors of the overpayment, or within sixty (60) calendar days of notification by HCA, MFCD, or other law enforcement agency, (42 U.S.C. 1320a-7k(d)) and that:

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

2.21.5.2 Are identified through an HCA audit or other HCA administrative review at any time on or before ten (10) years from the date of the termination of this Contract (42 C.F.R. § 438.3(h)); or

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

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

2.22 Waiver

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

2.23 Contractor Certification Regarding Ethics

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

2.24 Health and Safety

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

2.25 Indemnification and Hold Harmless

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

2.26 Industrial Insurance Coverage

The Contractor shall comply with the provisions of Title 51 RCW, Industrial Insurance. If the Contractor fails to provide industrial insurance coverage or fails to pay premiums or penalties on behalf of its employees, as may be required by law, HCA may collect from the Contractor the full amount payable to the Industrial

Insurance accident fund. HCA may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries, (L&I) Division of Insurance Services. This provision does not waive any of L&I's rights to collect from the Contractor.

2.27 No Federal or State Endorsement

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

2.28 Notices

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

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

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

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

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

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

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

2.29 Notice of Overpayment

2.29.1 A notice of overpayment to the Contractor will be issued if HCA determines an overpayment has been made.

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

2.29.2.1 Comply with all of the instructions contained in the Notice of Overpayment;

2.29.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;

2.29.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;

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

2.29.2.5 Include a copy of the Notice of Overpayment.

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

2.29.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment within sixty (60) calendar days from the date of receipt, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this contract; or any other collection action available to HCA to satisfy the overpayment debt.

2.29.5 Nothing in this Contract limits HCA's ability to recover overpayments under applicable law.

2.30 Proprietary Data or Trade Secrets

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

2.30.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (chapter 42.56 RCW) or otherwise for data or Claims

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

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

2.31 Ownership of Material

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

2.32 Solvency

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

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

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

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

otherwise materially affect the relationship of the parties under this Contract.

2.32.5 The Contractor shall notify HCA within twenty-four (24) hours after any action by the OIC which may affect the relationship of the parties under this Contract.

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

2.33 Conflict of Interest Safeguards

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

2.34 Reservation of Rights and Remedies

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

2.35 Termination for Default

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

by a court of competent jurisdiction.

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

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

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

2.35.2.3 One of the Contractor's owners failed to timely submit accurate information required under 42 C.F.R. § 455, Subpart E. (42 C.F.R. § 455.416(d)).

2.35.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information required under 42 C.F.R. § 455, Subpart E. (42 C.F.R. § 455.416(d)).

2.35.2.5 One of the Contractor's owners did not cooperate with any screening methods required under 42 C.F.R. § 455, Subpart E.

2.35.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last ten (10) years. (42 C.F.R. § 455.416(b)).

2.35.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program. (42 C.F.R. § 455.416(c)).

2.35.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) calendar days of a CMS or HCA request. (42 C.F.R. § 455.416(e); 42 C.F.R. § 455.450(d)).

2.35.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits under 42 C.F.R. §455.432. (42 C.F.R. § 455.416(f)).

2.35.2.10 The Contractor has falsified any information provided on its application. (42 C.F.R. § 455.416(g)).

2.36 **Termination for Convenience**

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second day after the mailing, terminate this Contract in whole or in part when it is in the best interest of HCA, as determined by HCA in its sole discretion. If this Contract is so terminated, HCA

shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date of termination.

2.37 Termination due to Federal Impact

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

2.38 Terminations: Pre-termination Processes

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

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

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

2.38.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA shall:

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

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

2.38.2.3 For an affirming decision, give Enrollees notice of the termination and information consistent with 42 C.F.R. § 438.10 on their options for receiving Medicaid services following the effective date of termination.

2.39 Savings

In the event funding from any state, federal, or other sources is withdrawn, reduced, or limited in any way after the date this Contract is signed and prior to the

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

2.40 Termination - Information on Outstanding Claims

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

2.41 Administrative Simplification

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

2.41.1 To maximize understanding, communication, and administrative economy among all managed care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:

- 2.41.1.1 Current Procedural Terminology (CPT)
- 2.41.1.2 International Classification of Diseases (ICD)
- 2.41.1.3 Healthcare Common Procedure Coding System (HCPCS)
- 2.41.1.4 CMS Relative Value Units (RVUs)
- 2.41.1.5 CMS billing instructions and rules
- 2.41.1.6 NCPDP Telecommunication Standard D.O.
- 2.41.1.7 Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

2.41.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding that leads to inappropriate payments. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing Medicaid claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

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

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

2.41.5 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

3 MARKETING AND INFORMATION REQUIREMENTS

3.1 Marketing

3.1.1 All marketing materials must be reviewed by and have written approval of HCA prior to distribution (42 C.F.R. § 438.104(b)(1)(i)). Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by the HCA. Marketing materials include any items developed by the Contractor for distribution to Enrollees or potential Enrollees that are intended to provide information about the Contractor's benefit administration, including:

3.1.1.1 Print media;

3.1.1.2 Websites; and

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

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

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

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

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

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

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

3.1.6 The Contractor must not seek to influence enrollment in conjunction with the sale or offering of any other insurance (42 C.F.R. § 438.104(b)(1)(iv)).

3.1.7 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 C.F.R. § 438.104(b)(1)(v)).

3.1.8 The Contractor must not make any assertion or statement, whether written or oral, in marketing materials that a potential Enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits (42 C.F.R. § 438.104(b)(2)(i)).

3.1.9 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the federal or state government or similar entity (42 C.F.R. § 438.104(b)(2)(ii)).

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

3.2 Information Requirements for Enrollees and Potential Enrollees

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

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

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

3.2.4 In addition to the Apple Health Integrated Foster Care handbook produced by the Contractor for this program using HCA's template, the Contractor shall produce information specific to IFC, and shall provide this information to IFC Enrollees and caregivers. The Contractor must also provide the information to Potential Enrollees who request it. IFC-specific information includes:

3.2.4.1 How to access covered benefits, including those required by children transitioning new placement; those requiring prior authorization; how to get expedited prior authorization for services, prescriptions and supplies needed on an emergent basis, including prescriptions needed to treat mental health conditions.

3.2.4.2 The prohibition on charging Enrollees for contracted services, the procedure for reporting charges the Enrollee receives for contracted services to the Contractor, and circumstances under which an Enrollee might be charged for services.

3.2.4.3 Information about when caregivers and social workers can and cannot be charged for covered services, including prescriptions and medically necessary supplies and transportation;

3.2.4.4 How to obtain hearing and vision hardware;

3.2.4.5 Contact information for the Contractor's Foster Care Unit – toll free line for care givers and social workers and contact info for

24/7 Nurse Advice line. Nurses on the 24/7 Nurse Advice line must have the ability to differentiate between FC issues and others;

3.2.4.6 How to access Non-Emergency Medicaid Transportation Services for appointments and how to access Secured Transport for Enrollees who may be a danger to themselves or others;

3.2.4.7 Information regarding appointment wait-time standards;

3.2.4.8 How timely EPSDT visits can assist the Enrollee in obtaining needed services and supplies, including durable medical equipment, specialty services, and specialty supplies such as metabolic formulas and food assistance provided through the Department of Health;

3.2.4.9 How to access services covered by the FFS system such as dental, Maternity Support Services (MSS) etc.;

3.2.4.10 How to access behavioral health providers;

3.2.4.11 Information on Medicaid behavioral health benefits and services, including where and how to access them and the related authorization requirements;

3.2.4.12 Specialists available to Enrollees, including behavioral health providers, and how to obtain specific information including a list of specialists, their identity, location, languages spoken, qualification, practice restrictions, and availability; and

3.2.4.13 A description of the WISe Program, including how to access additional information and services.

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

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

3.2.7 The Contractor shall include with all written materials a tagline and information on how the Enrollee can request Auxiliary Aids and Services including information in an alternative language and format that is understandable to the Enrollee. If the Enrollee requests the tagline in large print, the Contractor shall provide it to the Enrollee in either paper

form or electronically within five (5) business days.

3.2.8 The Contractor shall submit branding materials developed by the Contractor that specifically mention Medicaid, IFC or the specific benefits provided under this Contract for review and approval. No such materials shall be disseminated to Enrollees, potential Enrollees, providers or other members of the public without HCA's approval.

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

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

3.2.10.1 A description of the benefits of the program:

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

3.2.10.3 Information about how to file grievances and appeals;

3.2.10.4 A statement that a participant has the right to change care coordination providers and the procedure for doing so; and

3.2.10.5 How to obtain more information about the program.

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

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

3.2.12 The Contractor shall communicate changes to state or federal law to Enrollees no more than ninety (90) calendar days after the effective date of the change and Enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the Enrollees' quality of or access to

care, which may include changes to: enrollment rights, grievance and hearing procedures, benefits, authorizations or coverage of emergency services. HCA shall notify the Contractor in writing of any significant change (42 C.F.R. § 438.10(f)(4)).

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

3.2.13.1 Contain information on how to access behavioral health services;

3.2.13.2 Connect to the provider directory that displays a current list of contracted behavioral health agencies specifying those which are contracted to serve children and youth;

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

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

3.2.13.5 Include information about the behavioral health resource line (chapter 74.09 RCW).

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

3.3 Equal Access for Enrollees & Potential Enrollees with Communication Barriers

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

3.3.1 Oral Information

3.3.1.1 The Contractor shall assure that interpreter services are provided for Enrollees and Potential Enrollees with a primary language other than English or who are deaf or hearing impaired, free of charge. This includes oral interpretation, American Sign Language and the use of Auxiliary Aids and Services as defined in this Contract. (42 C.F.R. § 438.10(d)(4)). Interpreter services, provided by certified interpreters, shall be provided for all interactions between such Enrollees or Potential Enrollees and the Contractor or

any of its providers including, but not limited to:

3.3.1.1.1 Customer service,

3.3.1.1.2 All interactions with any provider for any covered service,

3.3.1.1.3 Emergency services, and

3.3.1.1.4 All steps necessary to file Grievances and Appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535 and chapter 284-43 WAC).

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

3.3.1.3 HCA is responsible for payment of interpreter services provided when the interpreter service is requested through, authorized, and provided by the HCA's Interpreter Services program vendor and complies with all program rules.

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

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

3.3.2 Written Information

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

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

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

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

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

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

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

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

3.3.2.1.4.3 Having an interpreter read the material to the Enrollee or potential Enrollee in the Enrollee's preferred language.

3.3.2.1.4.4 Providing the material in another alternative medium.

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

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

3.3.2.2 The Contractor shall ensure that all written information provided to Enrollees or Potential Enrollees is accurate, is not

misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, is written at the sixth grade reading level, is provided in a font size no smaller than 12 point, and fulfills other requirements of the Contract as may be applicable to the materials (42 C.F.R. § 438.10(d)(6)).

3.3.2.3 HCA may make exceptions to the sixth grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the Enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth grade reading level must be in writing.

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

3.3.2.5 Educational materials that are not developed by the Contractor or developed under contract with the Contractor are not required to meet the sixth grade reading level requirement and do not require HCA approval.

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

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

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

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

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

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

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

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

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

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

3.3.3.4 The information is consistent with the content and language requirements of 438.10; and

3.3.3.5 The Enrollee must be informed that the information is available in paper form without charge within five (5) business days of Enrollee request.

3.4 Electronic Outbound calls

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

3.4.1 The Contractor must submit call scripts to HCA no less than thirty (30) calendar days prior to the date the automated calls will begin. Approvable reasons for automated calls include:

3.4.1.1 Recertification of eligibility;

3.4.1.2 Outreach to new Enrollees;

3.4.1.3 Reminders of events such as flu clinics;

3.4.1.4 Initial Health Screening (IHS);

3.4.1.5 Surveys;

3.4.1.6 Appointment reminders/immunizations/well child appointments; and

3.4.1.7 Notification of new programs or assistance offered.

3.4.2 Under no circumstances will the Contractor use automated calls for care coordination activities, behavioral health-related calls or prescription verifications.

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

3.5 Medication Information

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

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

3.5.2 Information must be consistent with content and language requirements.

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

3.6 Conscience Clause

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

3.7 Development of Training Materials for SSS/Social Workers and Caregivers

3.7.1 The Contractor shall coordinate with its HCA Contract Manager and DCYF as necessary in the development of training and informational materials directed towards SSS/Social Workers and Caregivers/Parents of IFC Enrollees.

3.7.2 The Contractor shall submit trainings that are part of its catalog of nationally-developed health education trainings, where no modifications can be made to the HCA Contract Manager and DCYF for an approval or rejection of the complete content.

3.7.3 HCA and DCYF shall review and either approve, reject or, where allowed, return training materials to the Contractor for changes within twenty-one (21) calendar days of submission with the mutual intent to finalize the material within thirty (30) calendar days of initial submission.

3.7.4 Upon approval, the Contractor will send the training as a health education FYI to the HCA managed care mailbox prior to use.

4 ENROLLMENT

4.1 Statewide Coverage

This program is a voluntary statewide program. The Contractor is responsible for provision of covered services described in this Contract to Enrollees in all service areas. The Contractor's policies and procedures related to Enrollment shall ensure compliance with the requirements described in this Section.

4.2 Eligible Client Groups

The HCA shall determine eligibility for enrollment under this Contract. Children and Youth with the Recipient Aid Categories (RACs) listed below are eligible to enroll in Apple Health Integrated Foster Care (IFC) managed care. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract.

4.2.1 Children in Foster care programs with RACs of 1014, 1015, 1019, and 1020. These include licensed, unlicensed, relative, Suitable other, Extended foster care, Interstate Compact on the Placement of Children (ICPC), and Special Immigration Juvenile Status in Foster Care.

4.2.2 Adoption Support Programs with RACs of 1016, 1017, 1021 and 1022, including Adoption Support and Interstate Compact on Adoption and Medical Assistance (ICAMA).

4.2.3 Former Foster Children ages 18-26 (foster care alumni) with RAC of 1196.

4.2.4 American Indian/Alaska Native are eligible for IFC on a voluntary basis and must proactively enroll.

4.3 Client Notification

HCA shall notify eligible clients of their rights and responsibilities as managed care Enrollees at the time of initial eligibility determination, after a break in eligibility greater than six (6) months or at least annually.

4.4 Exemption from Enrollment

A client may request exemption from enrollment without cause at any time. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a termination of enrollment request consistent with the Termination of Enrollment provisions of this Section.

4.4.1 If the Contractor receives an exemption request from an Enrollee or potential Enrollee, the Contractor shall forward the request to the Foster Care Medical Team (FCMT) within two (2) business days of receipt of the request.

4.5 Enrollment Period

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open.

Enrollees described in Subsections 4.2.2 and 4.2.3 above shall have the right to disenroll prospectively, from IFC to FFS, without cause.

4.6 Enrollment Process

HCA shall enroll all Clients eligible for this program with the Contractor unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

4.6.1 Enrollees may disenroll from IFC without cause, at any time. The effective date of the disenrollment shall be consistent with HCA's established enrollment timelines.

4.6.2 The client, the client's representative or responsible parent or guardian must notify the HCA if they want to disenroll from IFC.

4.7 Effective Date of Enrollment

4.7.1 Except for a newborn whose mother is enrolled in IFC, HCA shall enroll all Medicaid eligible clients subject to this Contract into IFC Care effective the first day of the month, if both the date of initial Medicaid eligibility and the managed care enrollment take place in the current month. A newborn whose mother already is enrolled in an Apple Health MCO will be enrolled with that MCO as of the date of birth.

4.7.2 The Contractor is responsible for payment, medical necessity determinations and service authorizations for all services provided on and after the effective date of enrollment except as provided under subsections 4.10.6 and 16.6 of this Contract.

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

4.8 Newborns Effective Date of Enrollment

4.8.1 Newborns shall be enrolled in IFC as described below. Delivery and newborn coverage is provided as described in Subsection 16.11 of this Contract.

4.8.1.1 A newborn whose mother is enrolled in another MCO when the baby is born and the newborn is placed in foster care during the month of birth is enrolled in the mother's MCO for the month of birth. The newborn will be enrolled in IFC effective the first of the month following placement. Subject to the terms in Subsection 16.6, Enrollee in Facility at Enrollment: Medical Conditions, the MCO with which a newborn was enrolled at birth is responsible for hospital costs until the newborn is discharged from the birth hospitalization.

4.8.1.2 A newborn whose mother is receiving services FFS when the baby is born and the newborn is placed in foster care during the month of birth will be enrolled in AHMC and assigned to an MCO according to system rules (Early Enrollment). The

newborn will be enrolled in IFC effective the first of the month that follows the placement.

4.8.1.3 A newborn whose mother is not covered by Apple Health or any comparable coverage, and who is placed in foster care prior to discharge from their initial birth hospitalization shall be enrolled in IFC on the first of the month of placement.

4.8.1.4 If the newborn does not receive a separate client identifier from HCA, the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur, except as provided in Subsection 16.9, Enrollee in Facility at Termination of Enrollment.

4.8.1.5 If the mother is disenrolled before the newborn receives a separate client identifier, the newborn's coverage shall end when the mother's coverage ends except as provided in Subsection 16.9, Enrollee in Facility at Termination of Enrollment.

4.8.1.6 A newborn whose mother is an IFC Enrollee with whom the newborn remains after birth shall be automatically enrolled in the Contractor's Apple Health Managed Care program if it is available in the service area beginning from the newborn's date of birth, or the mother's date of enrollment, whichever is sooner.

4.8.1.7 A newborn whose mother is enrolled in the IFC but who is removed from the mother at birth and placed in foster care shall be enrolled in IFC. The Contractor shall coordinate with the Managed Care Contract Manager to ensure eligibility and enrollment occur in a timely manner.

4.9 Enrollment Data and Requirements for Contractor's Response

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

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

4.9.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 C.F.R. §162.103).

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

4.9.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify the HCA in writing of the refusal of an application for enrollment or any discrepancy regarding the HCA's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the HCA. The effective date of enrollment

specified by the HCA shall be considered accepted by the Contractor and shall be binding if the notice is not timely or the HCA does not agree with the reasons stated in the notice. Subject to the HCA approval, the Contractor may refuse to accept an Enrollee for the following reasons:

4.9.4.1 The HCA has enrolled the Enrollee with the Contractor in a service area the Contractor is not contracted.

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

4.10 Termination of Enrollment

4.10.1 Voluntary Termination of Enrollment

4.10.1.1 Enrollees may request termination of enrollment without cause by submitting a written request to terminate enrollment to the HCA or by calling the HCA toll-free customer service number (42 C.F.R. § 438.56(d)(1)(i)). If the Contractor receives a termination request from an Enrollee, the Contractor shall direct the Enrollee to contact HCA.

4.10.1.2 Termination requests that are approved will be consistent with the provisions outlined in Subsection 4.4, Exemption from Enrollment.

4.10.1.3 Except as provided in chapter 182-538 WAC, the enrollment for Enrollees whose enrollment is terminated will be prospectively ended. The Contractor may not request voluntary termination of enrollment on behalf of an Enrollee.

4.10.2 Involuntary Termination of Enrollment Initiated by the HCA for Ineligibility.

4.10.2.1 The enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for enrollment due to a change in eligibility status.

4.10.3 When an Enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

4.10.3.1 The first (1st) day of the month following the month in which the enrollment termination is processed by the HCA if it is processed on or before the HCA cut-off date for enrollment or the Contractor is informed by the HCA of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the HCA.

4.10.3.2 Effective the first (1st) day of the second month following the month in which the enrollment termination is processed if it is processed after the HCA cut-off date for enrollment and the Contractor is not informed by the HCA of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the HCA.

4.10.4 Involuntary Enrollment Termination Initiated by the HCA for Comparable

Coverage or Duplicate Coverage:

4.10.4.1 The Contractor shall submit to HCA on the 15th of the month following the end of the monthly reporting period a report (Enrollees with Other Health Care Insurance) of Enrollees with any other health care insurance coverage with any carrier, including the Contractor. The Contractor is not responsible for the determination of comparable coverage as defined in this Subsection.

4.10.4.2 The HCA will involuntarily terminate the enrollment of any Enrollee with duplicate coverage or comparable coverage as follows:

4.10.4.2.1 When the Enrollee has comparable coverage which has been verified by HCA, HCA shall terminate enrollment prospectively.

4.10.5 Involuntary Termination Initiated by the Contractor

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

4.10.5.1.1 HCA shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) business days of HCA's receipt of such notice and the documentation required to substantiate the request. HCA shall approve the request for involuntarily termination of the Enrollee when the Contractor has substantiated in writing any of the following (42 C.F.R. § 438.56(b)(1)):

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

4.10.5.1.1.2 The Enrollee engages in intentional misconduct, including

refusing without good cause to provide information to the Contractor about third party insurance coverage; or

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

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

4.10.5.3 HCA will not terminate Enrollment and the Contractor may not request disenrollment of an Enrollee solely due to a request based on an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

4.10.5.4 The Contractor shall have in place, and provide upon HCA's request, written methods by which it assures it does not request disenrollment for reasons other than those permitted under this Contract (42.C.F.R. § 438.56(b)(3)).

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

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

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

4.10.7.2 For the provision of information and assistance to transition

the Enrollee's care with another provider.

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

4.10.8 Regardless of the procedures followed or the reason for termination, when a disenrollment request is granted, or the Enrollee's enrollment is terminated by HCA for one of the reasons described in Subsection 4.10.5 of this Contract, the effective date of the disenrollment will be no later than the first day of the second month following the month the request was made. If HCA fails to disenroll the client within this timeframe, the disenrollment is considered approved.

5 PAYMENT AND SANCTIONS

5.1 Rates/Premiums

Subject to the Sanctions provisions of this Section, HCA shall pay a monthly premium for each Medicaid Enrollee in full consideration of the work to be performed by the Contractor under this Contract. HCA will only pay monthly premium payments for Medicaid Enrollees in the eligible client groups detailed in Subsection 4.2 of this Contract. HCA shall pay the Contractor, on or before the fifteenth (15th) calendar day of the month based on the HCA list of Enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 C.F.R. § 438.726(b) or 42 C.F.R. § 438.730(e).

5.2 Monthly Premium Payment Calculation

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

Premium Payment = (Physical Health Base Rate X Age/Sex Adjustment Factor) + (Behavioral Health Base Rate x Age/Sex Adjustment Factor) X Withhold Factor

Additional premium payments are made for Delivery Case Payment Rates and Wraparound with Intensive Services (WISe), as described in Subsections 5.7 and 5.8 of this Contract.

5.2.1 The Statewide Base Rate is established by HCA.

5.2.2 The Age/Sex Adjustment factors are established by HCA and will be the same for all contractors.

5.2.3 The Withhold Factor is intended to hold back a percentage amount, as identified in Exhibit D, Value-Based Purchasing, of the capitation payments excluding any administrative, WSHIP, PAP, IMD, or FQHC/RHC enhancement funding. A calculated portion of the amount withheld from the monthly premium payment will be released upon demonstrated improvement towards the quality measure benchmarks and physician incentive agreements defined in Exhibit D, Value-Based Purchasing.

5.2.4 HCA shall automatically generate newborn premiums upon enrollment of the newborn. For newborns whose premiums HCA does not automatically generate, the Contractor shall submit a premium payment request to HCA within 365 calendar days of the date of birth. HCA shall pay within sixty (60) calendar days of receipt of the premium payment request.

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

5.2.6 The Contractor shall be responsible for contracted services provided to

the Enrollee in any month for which HCA paid the Contractor for the Enrollee's care under the terms of this Contract.

5.3 Annual Fee on Health Insurance Providers

5.3.1 The Contractor is subject to a fee (the “Annual Fee”) imposed by the federal government under Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (124 Stat. 1029 (2010)) (collectively, “PPACA”), unless specifically exempt under federal law.

5.3.2 If the Contractor is responsible for payment of a percentage of the Annual Fee for all health insurance providers, the Contractor’s obligation is determined by the ratio of the Contractor’s net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Annual Fee for the same year.

5.3.3 The amount of the Annual Fee attributable to the Contractor and attributable specifically to the Contractor’s premiums under this Contract (“Contractor’s Allocated Fee”) could affect the actuarial soundness of the premiums received by the Contractor from HCA for the contract year during which the Annual Fee is assessed.

5.3.4 A dollar amount reflecting the Contractor’s Allocated Fee, which shall also include an adjustment for the impact of non-deductibility of the Annual Fee for federal and state tax purposes, including income and excise taxes (“Contractor’s Adjusted Fee”), shall be payable to the Contractor under this Contract, unless the Contractor is exempt from the Annual Fee under federal law.

5.3.5 HCA shall consult with the Contractor and determine an estimated amount of the Contractor’s Adjusted Fee based on the pro rata share of the preliminary notice of the fee amount, as transmitted by the United States Internal Revenue Service to the Contractor, attributable to the Contractor’s net written premiums under this Contract.

5.3.6 Capitation payments for the period to which the tax applies will be retroactively adjusted to account for this fee. The net aggregate change in capitation payments for the period based on the retroactive rate change will be paid to the Contractor.

5.3.7 HCA shall make a good-faith effort to make the estimated payment to the Contractor thirty (30) calendar days before the deadline for payment by the Contractor.

5.3.8 The adjustment shall be reconciled, no later than ninety (90) calendar days following the receipt of the final notice of the fee from the United States Internal Revenue Service, through a retroactive adjustment to the capitation rates for the applicable period and an additional payment to the Contractor, or a refund from the Contractor, as applicable, once the complete data is available to calculate the Contractor’s Adjusted Fee.

5.3.9 The Contractor agrees to not pursue any legal action whatsoever against HCA or its officers, employees, or agents with respect to the amount of the Contractor's Allocated Fee or Contractor's Adjusted Fee.

5.4 Medical Loss Ratio (MLR) Report

5.4.1 In accordance with 42 C.F.R. § 438.8, MCOs must report a Medical Loss Ratio (MLR) calculation to HCA on an annual basis.

5.4.1.1 Using the instructions provided in Exhibit F, Instructions for MLR Reporting, and in accordance with 42 C.F.R. § 438.8, the Contractor shall complete the MLR reporting template available in MC-Track for the MLR reporting year beginning January 1, 2018, and submit to HCA no later than May 31, 2019.

5.5 Gain Share Program

5.5.1 MCOs must report MLR experience calculated in accordance with 42 C.F.R. § 438.8. Any settlements which result from the gain share program calculation will be limited such that the Contractor's minimum MLR will not be less than 85 percent when the settlement amount is included in the MLR calculation.

5.5.2 HCA will perform gain share calculations on an annual basis for IFC.

5.5.3 The following methods will be used to calculate the Gain Share components:

5.5.3.1 Total Revenue is the sum of all Pre-Tax Capitation Rates, and Delivery Case Rate Payments. Total Revenue also assumes full recovery by the Contractor of Value-Based Purchasing withheld funds, regardless of whether those funds were actually recovered under the capitation withhold arrangement described in Exhibit D. Pre-tax capitation rates means that the AH-PDL payments and Health Insurer Fee related revenue will be excluded from this computation.

5.5.3.2 Revenue for Health Care Expenses is defined as the Total Revenue less an assumed administrative load. [(Revenue) x (1- administrative load)] Actual administrative expenses will not be included in the computation. The assumed administrative load is shown on Exhibit A.

5.5.3.3 Net Health Care Expenses will be based on the actual medical service expenses incurred during the contract year less any reimbursements from third-party reimbursements (including, but not limited to pharmacy rebates, overpayment recoveries from providers, net reinsurance costs or third-party liability offsets) plus direct Medical Management costs as defined by NAIC and GAAP guidelines and excluding any overhead allocations. Upon request by HCA, the Contractor will report its health care expenses for the year with any

adjustments and run out claims as specified in the request from HCA. The template for providing the data and due date for the report will be included in the request from HCA.

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

5.5.3.5 The net gain/loss divided by the Total Revenue will provide a percentage of the gain/loss which will be compared to the gain sharing thresholds established by HCA.

5.5.4 Under the Gain Share Program, HCA will share in a significant excess of the Total Revenue for Health Care Expenses over the Net Health Care Expenses experienced by the Contractor as defined in subsection 5.5.5 of this Contract. Six (6) months following the end of the calendar year, using the financial reports provided by the Contractor, a simple profit and loss statement will be developed for the health services portion for each of the four populations.

5.5.5 If Contractor experiences gain exceeding 3 percent, HCA will share equally in the gain between 3 percent and 5 percent. HCA will recover all gains exceeding five percent (5%). The Contractor will only be required to reimburse HCA if it experiences an actual gain above 3 percent.

5.6 Recoupments

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

5.6.1.1 With duplicate coverage as defined in this Contract.

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

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

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

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

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

5.6.1.7 When an audit determines that payment or enrollment was

made in error.

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

5.6.2.1 Shall void the inaccurate encounters;

5.6.2.2 May recoup payments made to providers.

5.6.2.2.1 If the Contractor recoups said payments:

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

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

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

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

5.7 Delivery Case Rate Payment

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

5.8 WISe Payment

5.8.1 A separate case rate payment will be made monthly for individuals in the WISe Program as defined in this Contract and further described in subsection 17.1.16 of this Contract.

5.9 Provider Access Payment (PAP) Program

5.9.1 The Provider Access Payment (PAP) is a directed payment. On a quarterly basis, HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.

5.9.2 On a one-time basis, PAP payments paid via the pass-through payment methodology from January 1, 2019 through June 30, 2019 will be reconciled with the directed payment methodology and HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.

5.9.3 On a yearly basis, PAP payments for the calendar year will be reconciled with mature encounter data to ensure participating providers PAP payments do not exceed the programs allowable amounts. HCA will calculate and provide to the MCOs, the specific directed payment amounts to be provided to the PAP participating providers.

5.10 Apple Health Preferred Drug List Payment

5.10.1 The cost of all outpatient products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form, including prescription drugs on the AH-PDL described in subsection 17.3.3.1 of this Contract, have been excluded from the Physical Health Base Rates described in subsection 5.2.1 of this Contract.

5.10.2 The Contractor shall continue to administer the outpatient prescription drug program and submit paid encounters for pharmacy products in the National Council for Prescription Drug Programs Batch format as required in subsection 5.12.

5.10.3 HCA shall reimburse the Contractor for the expenditures for outpatient prescription drugs.

5.10.3.1 The Contractor shall be reimbursed for qualifying accepted National Council for Prescription Drug Programs (NCPDP) pharmacy encounters including an administrative fee of $1.50 by generating a Service Based Enhancement (SBE) payment beginning July 1, 2019. During the first full week of each month from February 2018 through July 2018, HCA will extract the encounter data submitted by the Contractor during the prior month with dates of service on or after January 1, 2018, for paid claims for drugs on the AH-PDL. Starting in August 2018, the data extract will include all outpatient pharmacy products included on the National Council for Prescription Drug Programs (NCPDP) Batch submission form with dates of service on or after on or after July 1, 2018. As of July 1, 2019 dates of service, the data extract will only include encounters submitted January 1, 2018 to June 30, 2019. This manual data extract and process will account for encounters that have had a business status change and have not been

paid.

5.10.3.2 The encounter data files will be provided to the Contractor via the HCA Secure File Transfer (SFT) sites for the encounters submitted by the Contractor. HCA will send notification to the Contractor via e-mail when the files have been posted to the SFT sites.

5.10.3.3 The Contractor shall review the data files provided within five business days of the date they receive notification of their availability. If the Contractor identifies any discrepancies between the Contractor's records and the data provided, the discrepancies shall be reported to HCA by the close of business on the fifth day.

5.10.3.4 If adjustments are made to the data files, HCA will provide a final version of the data files to the Contractor within five business days.

5.10.3.5 HCA will initiate payment via ProviderOne Gross Adjustment to the Contractor for the total paid amount in each final version of the encounter plus the administrative fee within five (5) business days of the finalization of the encounter.

5.11 Overpayments or Underpayments of Premium

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

5.12 Encounter Data

5.12.1 For purposes of this Subsection:

5.12.1.1 "Encounter" means a single health care service or a period of examination or treatment.

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

5.12.1.3 "Encounter record" means the number of service lines or products submitted as line items in the standard 837 format or the National Council for Prescription Drug Programs (NCPDP)

Batch format.

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

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

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

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

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

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

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

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

5.12.2.3 These data quality standards are listed within this Contract and incorporated by reference into this Contract. The

Contractor shall make changes or corrections to any systems, processes or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended.

5.12.3 The Contractor must report the paid date, paid unit, and paid amount for each encounter. The "paid amount" data is considered the Contractor's proprietary information and is protected from public disclosure under RCW 42.56.270(11). Paid amount shall not be utilized in the consideration of a Contractor's assignment percentage or in the evaluation of a Contractor's performance.

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

5.12.5 The Contractor must certify the accuracy and completeness of all encounter data concurrently with each file upload (42 C.F.R. § 438.606). The certification must affirm that:

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

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

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

5.12.6 The Contractor shall submit a signed Monthly Certification Letter, a template is available through MC-Track. This letter must include a list of all submitted encounter data files and is due within five business days from the end of each month. The purpose of this letter is to certify that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful in accordance with 42 C.F.R. § 438.606 and this Contract.

5.12.7 The Contractor must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims.

5.12.7.1 Within sixty (60) calendar days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounter data submitted and accepted within required timing in subsection 5.12.2.2 of this Section during that quarter using the Apple Health Quarterly Encounter/General Ledger

Reconciliation (Form D), available through MC-Track, and shall reconcile the cumulative encounter data submitted and accepted for the quarter and Contract year with the general ledger paid claims for the quarter. The Contractor shall provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the Contractor of the decision 120 calendar days of the end of each calendar quarter.

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

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

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

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

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

HCA and incorporated by reference into this Contract:

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

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

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

5.13 Retroactive Premium Payments for Enrollee Categorical Changes

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

5.14 Renegotiation of or Changes in Rates

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

5.15 Reinsurance/Risk Protection

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

5.16 Provider Payment Reform

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

5.17 Experience Data Reporting

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

5.18 **Payments to Hospitals**

5.18.1 The Contractor will pay all hospitals at least the Inpatient and Outpatient at rates published by HCA for its FFS program.

5.18.2 Fourteen-Day Readmission Review Program

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

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

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

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

5.18.2.2.1.2 Completing adequate discharge planning with the prior admission;

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

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

5.18.2.3 The Contractor shall not classify a readmission as avoidable or within the provider's ability to affect, if the readmission is:

5.18.2.3.1 At a Critical Access Hospital (CAH);

5.18.2.3.2 Unrelated to conditions or care from the prior admission;

5.18.2.3.3 A planned readmission or necessary for repetitive treatments such as cancer chemotherapy, transfusions for chronic anemia, burn therapy,

dialysis or other planned inpatient treatment documented in the record or as indicted using patient discharge status “81”-planned readmission;

5.18.2.3.4 A planned therapeutic or procedural admissions following diagnostic admissions, when the therapeutic treatment clinically could not occur during the same case;

5.18.2.3.5 A same-day planned admission to a different hospital unit for continuing care (can include mental health/SUD transfers, rehab transfers, etc. which may be technically coded as discharge/admission for billing reasons);

5.18.2.3.6 An admission for required treatments for cancer including treatment-related toxicities, or care for advanced-stage cancer;

5.18.2.3.7 End of life and hospice care;

5.18.2.3.8 Obstetrical readmissions for birth after an antepartum admission;

5.18.2.3.9 Admissions with a primary diagnosis of mental health or SUD issue;

5.18.2.3.10 Neonatal readmissions;

5.18.2.3.11 Transplant readmissions within 180 days of transplant;

5.18.2.3.12 Readmissions when the index admission occurred in a different hospital system;

5.18.2.3.13 To complete care for an Enrollee who left Against Medical Advice from a prior admission;

5.18.2.3.14 Due to Enrollee non-adherence despite appropriate discharge planning and supports. This also includes cases where the recommended discharge plan was refused by the Enrollee, and a less appropriate alternative plan was made to accommodate Enrollee preferences; this must be clearly documented in the record; or

5.18.2.3.15 Because the Contractor did not fulfill its responsibility for post discharge services that would have prevented the readmission.

5.18.2.4 The Contractor shall work with its providers to assure they understand their role and take the following actions to prevent the occurrence of a readmission within fourteen (14) calendar

days of a prior admission:

5.18.2.4.1 Create a discharge summary including summary of diagnoses, care provided, medication list, and follow up plan;

5.18.2.4.2 Determine the Enrollee's needs to support a safe discharge and write orders accordingly;

5.18.2.4.3 Ensure the discharge summary is sent to the PCP or follow-up provider;

5.18.2.4.4 Provide all required prescriptions and educate the Enrollee about appropriate use of the medication(s);

5.18.2.4.5 Provide written discharge instructions, accompanied by an explanation, to the client and family/guardian;

5.18.2.4.6 Provide appropriate contact telephone numbers to Enrollee or family/guardian to call for discharge related questions, and

5.18.2.4.7 Document clearly in a readable format the content of discussion with the Contractor (call, fax, etc.).

5.18.2.5 The Contractor shall share responsibility with its providers to successfully manage the discharge to prevent a readmission. The Contractor shall coordinate with the provider to remove any barriers the provider may face in implementing the discharge plan and the elements of care.

5.18.2.6 In addition to the services required in the Transitional Services section of this Contract, the Contractor shall:

5.18.2.6.1 Resolve any barriers to implementing ordered services;

5.18.2.6.2 Ensure a follow-up appointment is scheduled according to the discharge instructions (typically seven (7) calendar days);

5.18.2.6.3 Educate the Enrollee about the importance of attending the follow-up appointment, and provide assistance to the Enrollee in getting to the appointment, including helping with transportation arrangements;

5.18.2.6.4 Assure implementation of DME or non-durable supply orders, and the Enrollee is given appropriate education on use;

5.18.2.6.5 Assess the need for and arrange, as indicated, an in-home safety assessment with appropriate follow up as needed;

5.18.2.6.6 Assess and address relevant financial and social needs of the Enrollee;

5.18.2.6.7 Respond timely to implement any changes required in the discharge plan to sustain a successful discharge; and

5.18.2.6.8 Provide case management services, as needed, to prevent readmission.

5.18.2.7 If a readmission occurs because of the Contractor's failure to fulfill its responsibilities, or a component of its shared responsibilities, the Contractor shall not deny payment for the readmission.

5.18.2.8 The Contractor shall use the template letters created with the HCA to support this program.

5.18.2.9 The Contractor must provide a first and second level re-review to the hospital or physician if the Contractor has deemed the provider failed to provide the level of care described above and was responsible for the readmission.

5.18.2.9.1 After exhausting the Contractor's first and second level re-review process, the hospital may request HCA to conduct a review if a dispute between the Contractor and the provider still exists about payment and assignment of responsibility. The Contractor shall appeal to HCA for a "Potentially Preventable" case review when the Contractor and the hospital or attending physician are unable to agree on assignation of responsibility for the readmission and the provider continues to dispute the Contractor's determination.

5.18.2.9.2 The Contractor and the hospital or attending physician will each present a written summary of their position and supporting clinical documentation to HCA. The Contractor shall collect the information and request submitted by the hospital or physician as well as the Contractor's information to HCA within fourteen (14) calendar days of the hospital's request. HCA shall convene an internal panel to review the documents and make a final assignment of responsibility.

5.18.2.10 The Contractor shall respond within fourteen (14) calendar days to any request from HCA for readmission review

information and data required in response to a concern for a pattern of inappropriate adjudication presented to HCA by a hospital.

5.18.2.11 The Contractor shall submit a quarterly report, due thirty (30) days after the end of each quarter (April, July, October) with a comprehensive annual report for the previous year, by January 31 of each year. The report must include:

5.18.2.11.1 Total number of patients readmitted to any hospital within fourteen (14) days of discharge from a prior hospitalization (regardless of preventability);

5.18.2.11.2 Number of readmissions reviewed by the Contractor for determination of Provider Potentially Preventable Readmission (PPPR) status;

5.18.2.11.3 Number of readmissions identified as PPPR with recoupment requested from the hospital;

5.18.2.11.4 For each readmission identified in 5.18.2.11.3 above:

5.18.2.11.4.1 Recouped amount;

5.18.2.11.4.2 Hospital;

5.18.2.11.4.3 Primary and secondary diagnosis of admission; and

5.18.2.11.4.4 Rationale for denial (brief narrative description of what criteria were used to determine that the readmission was preventable and how the case met these criteria).

5.18.2.11.5 Number of cases contested by hospitals, how these were handled, and outcome of dispute; and

5.18.2.11.6 Estimated Contractor staffing time for PPR process.

5.19 Payment for Services by Non-Participating Providers

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

5.19.2 Except as provided herein for Emergency Services, the Contractor shall coordinate with and pay a non-participating provider that provides a

service to Enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the state. For the purposes of this Subsection, "contracts with similar providers in the state" means the Contractor's contracts with similar providers to provide services under the managed care program when the payment is for services received by a managed care Enrollee.

5.19.3 The Contractor shall track and record all payments to participating providers and non-participating providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating providers and non-participating providers separately. The Contractor shall identify the type of providers and subspecialty according to specifications provided by HCA. The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill Enrollees.

5.19.4 The Contractor shall provide annual reports to HCA for the preceding state fiscal year July 1 through June 30. The reports shall indicate the proportion of services provided by the Contractor's participating providers and non-participating providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to HCA no later than August 15 of each year, or as required by HCA.

5.20 Data Certification Requirements

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

5.20.1 Source of certification: The information and/or data shall be certified by one of the following:

5.20.1.1 The Contractor's Chief Executive Officer.

5.20.1.2 The Contractor's Chief Financial Officer.

5.20.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

5.20.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

5.20.3 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

5.20.4 HCA will identify the specific data that requires certification.

5.20.5 Certification applies to Medicaid and file submissions.

5.21 Sanctions

5.21.1 If the Contractor fails to meet one or more of its obligations under the

terms of this Contract or other applicable law, HCA may impose sanctions by withholding from the Contractor up to five percent of its scheduled payments or may suspend or terminate assignments and re-enrollments (defined as connecting an Enrollee who lost eligibility with the Contractor which he or she was enrolled in when he or she lost enrollment).

5.21.2 HCA shall notify the Contractor of any default in writing, and shall allow a cure period of up to thirty (30) calendar days, depending on the nature of the default. If the Contractor does not cure the default within the prescribed period, HCA may withhold payment, assignments, or re-enrollments from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

5.21.2.1 HCA will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in the Disputes provisions of the General Terms and Conditions section of this Contract, if the Contractor disagrees with HCA's position.

5.21.2.2 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with applicable law, including but not limited to 42 C.F.R. § 438.700, 42 C.F.R. § 438.702, 42 C.F.R. § 438.704, 45 C.F.R. § 92.36(i)(1), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210 against the Contractor for:

5.21.2.2.1 Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an Enrollee covered under this Contract.

5.21.2.2.2 Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

5.21.2.2.3 Acting to discriminate against Enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an Enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services.

5.21.2.2.4 Misrepresenting or falsifying information that it furnishes to CMS, HCA, an Enrollee, Potential Enrollee, or any of its subcontractors.

5.21.2.2.5 Failing to comply with the requirements for physician incentive plans.

5.21.2.2.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or materially misleading information.

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

5.21.2.3 HCA may base its determinations regarding Contractor conduct on findings from onsite surveys, Enrollee or other complaints, financial status, or any other source.

5.21.2.4 Except for matters and penalties covered under chapters 74.09 and 74.66 RCW, intermediate sanctions may include:

5.21.2.4.1 Civil monetary sanctions in the following amounts:

5.21.2.4.1.1 A maximum of $25,000 for each determination of failure to provide services; distribution of marketing materials that have not been approved by HCA, or that contain false or misleading information, misrepresentation or false statements to Enrollees, Potential Enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

5.21.2.4.1.2 A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or HCA.

5.21.2.4.1.3 A maximum of $15,000 for each potential Enrollee HCA determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

5.21.2.4.1.4 A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to Enrollees that are not allowed under managed care. HCA will

deduct from the penalty the amount charged and return it to the Enrollee.

5.21.2.4.2 Appointment of temporary management for the Contractor as provided in 42 C.F.R. § 438.706. HCA will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033 or other applicable law.

5.21.2.4.3 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA shall notify current Enrollees of the sanctions and that they may terminate enrollment at any time.

5.21.2.4.4 Suspension of payment for Enrollees enrolled after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.22 Payment to FQHCs/RHCs

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

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

FQHC/RHC and paid to the Contractor for disbursement to the individual FQHC/RHC. The amount due to each FQHC/RHC will be provided to the Contractor by HCA.

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

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

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

5.22.1.2 HCA will provide the Contractor with the monthly enhancement payment funds separately from the monthly premium payments.

5.22.1.2.1 These supplemental payments will include the load for the 2 percent premium tax. The premium tax is retained by the Contractor and is not paid to the FQHC/RHC.

5.22.1.2.2 The enhancement payments will be calculated separately and apart from the risk-based capitation payments made to the Contractor by HCA and at no time will the Contractor be at risk

for or have any claim to the enhancement payments.

5.22.2 The FQHC/RHC is entitled to its specific, full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Section 1902(bb) of the Social Security Act (42 USC § 1396a(bb)). The full encounter rate shall be at least equal to the Prospective Payment System (PPS) rate specific to each FQHC/RHC and applies to FQHC/RHC reimbursed under the Alternative Payment Methodology (APM) rate methodology and to FQHC/RHC reimbursed under the PPS rate methodology. The encounter rates and enhancement rates for each contracted FQHC/RHC will be provided by HCA to the Contractor on a quarterly basis or sooner if any changes or corrections are needed. The rate files will be published to this location (http://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides) according to the following schedule: October 1, January 1, April 1, and July 1. Any changes that occur during the quarter will be included in the next file and will specify the effective date of the change.

5.22.3 To ensure that each FQHC/RHC receives its entire encounter rate for each qualifying encounter, the Contractor shall pay each contracted FQHC/RHC in one (1) of the ways described below:

5.22.3.1 Under the first payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to payment of claims for services made at standard rates paid to the FQHC/RHC by the Contractor. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA.

5.22.3.2 Under the second payment method, the Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to any monthly capitation rates for services. The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA.

5.22.3.3 Within the third payment method, for participating RHCs only, the Contractor shall pay the clinic their full encounter rate for encounter-eligible RHC services. For these RHCs, the Contractor will not pass the enhancement payments through to the clinics. MCOs will use the funds for the sole purpose of paying RHCs their full encounter rate at the time the claim is processed. HCA will notify the Contractor of participating RHC

NPIs.

5.22.3.4 The Contractor must ensure that all encounter-eligible services as defined in HCA's "Rural Health Clinic Billing Guide" are paid at the RHC encounter rates to participating RHCs. RHCs encounter rates are published quarterly and are available at: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides. The Contractor shall make changes or correction to any systems or processes as needed to comply with HCAs guidelines for billing RHC encounter claims.

5.22.4 For all RHCs under the payment method described in subsection 5.22.3.3 HCA will perform an annual reconciliation with the Contractor. Reconciliations will ensure that each participating RHC received its full encounter rate for each qualifying claim and that MCOs are not put at risk for, or have any right to, the enhancement portion of the claim. Reconciliations will be conducted in the second half of the calendar year following the calendar year for which enhancements were made.

5.22.4.1 Claims included in RHC encounter reconciliations between the Contractor and HCA will include:

5.22.4.1.1 An eligible RHC encounter service as outlined in the RHC Billing Guide (found at: https://www.hca.wa.gov/billers-providers/claims-and-billing/professional-rates-and-billing-guides#);

5.22.4.1.2 A T1015 procedure code; and

5.22.4.1.3 A certified RHC Billing NPI (participating NPIs will be shared by HCA with MCOs at least annually).

5.22.4.2 HCA will base reconciliation findings on the Contractor's timely submission of encounter data, as specified in Subsection 5.12 of this Contract. Actual payment amounts will be used for each RHC reconciliation, except for the RHCs that receive payment from the Contractor under a capitated model. Reconciliation for the RHCs that are capitated will utilize a FFS equivalency methodology.

5.22.4.3 For any underpayment in which the Contractor did not receive sufficient monthly supplemental payments in the previous year, HCA shall pay the Contractor the amount due. For any overpayment in which the MCO received more than its sufficient monthly supplemental payment in the previous year, HCA shall recoup the amount due from the Contractor.

5.22.4.4 Following HCA's notification of reconciliation results, the Contractor shall have thirty (30) calendar days to review and respond to the outcome and provide justification for any discrepancies or findings. The Contractor will address any

findings outlined by the HCA including any instances in which an RHC was not paid appropriately. Following the review period, the Contractor shall make these payments to the FQHC/RHC as designated by HCA within the next thirty (30) calendar days.

5.22.5 For RHCs that have arranged to receive the full encounter payment The Contractor shall ensure clinics receive their full encounter payments for global maternity visits.

5.22.6 The Contractor shall ensure it has sufficiently trained staff to handle calls and/or inquiries from providers regarding the reimbursement process and client assignment.

5.23 Payment to FQHCs for Mental Health Encounters

5.23.1 Federally-Qualified Health Centers. The Contractor is required to contract with at least one (1) Federally-Qualified Health Center (FQHC) in each regional service area if the FQHC makes such a request. The Contractor must not pay a FQHC or Rural Health Clinic (RHC) less than the level and amount of payment the Contractor would pay non-FQHC/RHC providers for the same services.

5.24 Nonpayment for Provider Preventable Conditions

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

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

5.25 Billing for Services Provided by Residents

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

5.26 Funding for Enrollees Residing in an Institute for Mental Disease (IMD)

5.26.1 Federal funds may not be used to cover the cost of care for an Enrollee when the Enrollee resides in an IMD for more than fifteen (15) calendar days in a single calendar month.

5.26.2 HCA will take-back each per-member, per-month (PMPM) premium payment for Enrollees who had resided in an IMD for more than fifteen (15) calendar days within one (1) calendar month in the 365-day period preceding the reconciliation period (described below).

5.26.3 On an annual basis, HCA will provide a report to the Contractor for each Enrollee who had an IMD stay of more than fifteen (15) calendar days within one (1) calendar month during the preceding 365-day period. HCA will post the reports to the Contractor's Secure File Transfer (SFT) site during the reconciliation period. Using instructions provided by HCA, the Contractor will have thirty (30) calendar days following the posting date to review and comment on the underlying data provided by HCA. Within ten (10) business days after the Contractor has the opportunity to review and comment on the underlying data, HCA will recover the PMPM premium for identified IMD stays. As of July 1, 2018 this process excludes IMD stays that are attributable to Substance Use Disorders.

5.26.4 The Contractor shall report the total claims paid on behalf of each IMD Enrollee to HCA within thirty (30) calendar days of notification from HCA of the Enrollee's IMD status. Within thirty (30) calendar days of notification, HCA will reimburse the Contractor for the cost of claims paid on behalf of an IMD Enrollee during the calendar month for which the premium was recouped.

5.26.5 When HCA recovers a premium payment for an Enrollee in accordance with this Section, the Contractor must adjust the paid claims and capitated payments made for the affected month of service to reflect that the claims were paid from the IMD funds described in this Section.

5.27 Payment for Supervision of Behavioral Health Providers

5.27.1 The Contractor acknowledges that the capitation rate paid by HCA for BHA services includes funding, as an administrative component, which is intended to reimburse licensed behavioral health practitioners for their time supervising unlicensed practitioners. The Contractor will convey to the providers in their contracts the inclusion of this service.

5.28 Challenge Pool Value-Based Purchasing Incentives

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

5.29 Mental Health Payer

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

5.30 Medicaid Quality Incentive Payments (MQIP) Program

5.30.1 If the HCA implements a Medicaid Quality Incentive Payments (MQIP) program in accordance with 42 C.F.R. § 438.6(b)(2), the Contractor will be eligible to receive MQIP for the achievement of certain detailed

milestones aligned with the HCA's Quality Strategy. MQIP payments will be separate from and in addition to the capitation payments made to Contractor under this Contract and will be specifically identified as the MQIP program in any distribution to the Contractor. MQIP is not premium revenue and will not be considered as such for purposes of calculating Contractor's Medical Loss Ratio or premium tax liability. Eligibility to participate in the MQIP program is not linked to whether Contractor is a public or private entity or whether the Contractor has provided an intergovernmental transfer to the HCA.

5.30.2 The first MQIP deliverable for the current contract year of 2019 is a project proposal, in partnership with public hospitals, that identifies the high-level approach, benefits, and potential challenges associated with implementing the project. This proposal is due October 1, 2019, and will align with the goals and objectives outlined in the HCA Medicaid Quality Strategy.

5.30.3 By August 1 of the contract year, HCA will provide detailed milestones that the Contractor must achieve in order to receive MQIP. All milestones and metrics will be made available online at: https://www.hca.wa.gov/assets/program/mqip-metrics-milestones.pdf and are incorporated by reference into this Contract. The incentive arrangement for the project proposal will be available only for the current contract year of 2019, and the Contractor's total MQIP will be measured based on performance during the current contract year. The MQIP program will not be renewed automatically, but HCA may include the MQIP program or similar arrangements in subsequent contract years. HCA will notify Contractor ninety (90) calendar days prior to the start of the contract year whether the MQIP program will be in effect for that contract year.

5.30.4 In no event will MQIP exceed 5 percent of total capitation revenue that the Contractor receives during the contract year.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate statewide provider network, supported by written agreements, sufficient to provide adequate access to all services covered under the Contract for all Enrollees, including those with limited English proficiency or physical or mental disabilities (42 C.F.R. § 438.206(b)(1)).

6.1.2 On a quarterly basis, no later than the 15th of the month following the last day of the quarter, the Contractor shall provide documentation of its provider network, including the six critical provider types and all contracted specialty providers. This report shall provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.11 of this Section to all Enrollees and shall ensure sufficient choice and number of community health centers (FQHCs/RHCs) and/or private providers to allow Enrollees a choice of service systems or clinics. The report shall include information regarding the Contractor's maintenance, monitoring, and analysis of the network. The quarterly reports shall include a one page narrative describing the contracting activities in border communities and service areas.

6.1.3 The Contractor shall have written policies and procedures for selection and retention of network providers that, at a minimum, meet the requirements of 42 C.F.R. § 438.214.

6.1.4 In addition to the quarterly reports required under this Subsection, the Contractor shall also submit updated provider network information within ten (10) business days when requested by HCA or in the following circumstances:

6.1.4.1 At the time it enters into a Contract with HCA.

6.1.4.2 At any time there has been a change in the Contractor's network or operations that, in the sole judgement of HCA, would materially affect capacity and/or the Contractor's ability to provide services (42 C.F.R. § 438.207(b and c)), including:

6.1.4.2.1 Changes in services, benefits, geographic service area or payments, or;

6.1.4.2.2 Enrollment of a new population in the Contractor.

6.1.5 Provider network information will be reviewed by HCA for:

6.1.5.1 Completeness and accuracy;

6.1.5.2 The need for HCA provision of technical assistance;

6.1.5.3 Removal of providers who no longer contract with the Contractor; and

6.1.5.4 The effect that the change(s) in the provider network will have

on the network's compliance with the requirements of this Section.

6.1.6 The Contractor shall provide contracted services through Non-Participating Providers, at a cost to the Enrollee that is no greater than if the contracted services were provided by Participating Providers, if its network of Participating Providers is insufficient to meet the medical needs of Enrollees in a manner consistent with the Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for Emergency Services.

6.1.7 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure timely access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.

6.1.8 Inaccurate or Incomplete Submissions: For each quarterly network submission that is not submitted in the HCA-developed format as described in the submission Data Definitions that accompany the contract submission documents, HCA may charge the Contractor $5,000 for nonperformance. HCA shall notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.1.8.1 If the submission must be returned to the Contractor for corrections, and the submission contained errors that reflect a material loss of providers in a service area, the Contractor's assignments shall be suspended for that service area. Suspension of assignments shall continue until the quarter in which the Contractor submits an accurate submission for that service area.

6.1.9 Late Submissions: For each quarterly network submission that is not submitted by the due date and does not have written approval from HCA prior to the due date for the late submission, HCA may charge the Contractor $1,000 for the first day, and $100 per day thereafter for non-performance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.1.10 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of providers in any contracted service area including all critical provider types: Primary Care Providers, Hospitals, Pharmacy,

Behavioral Health Providers, Obstetrician/Gynecologist, and Pediatrician and high volume specialties identified by the Contractor, for two consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area.

6.1.11 The Contractor shall conduct continuous network development activities as described in the Contractor's response to HCA Request for Proposals 15-002, Subsection 6.1 Network Capacity and shall submit monthly reports to HCA detailing its progress towards a statewide network.

6.1.11.1 If, in HCA's sole judgment, the Contractor's network is not adequate to meet the requirements of sections 6.11 Provider Network – Distance Standards, the Contractor shall submit in writing, within fourteen (14) calendar days of the Contractor's receipt of the request for information from HCA, a detailed plan describing how the Contractor shall ensure access to IFC Enrollees that meets the Appointment Standards described in Subsection 6.9 of this Contract.

6.1.12 The Contractor shall provide contracted services through non-participating providers, at a cost to the Enrollee that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of Enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.

6.1.13 The Contractor shall maintain an online provider directory that meets the requirements listed below and include information about available interpreter services, communication, and other language assistance services. Information must be provided for each of the provider types covered under this Contract: physicians, including specialists, hospitals, pharmacies, behavioral health providers, and LTSS providers as appropriate. The Contractor shall make all information in the online provider directory available on the Contractor's website in a machine readable file and format as specified by the Secretary. The Contractor shall also make copies of all provider information in the online provider directory available to Enrollees in paper form upon request. The online provider directory must meet the following requirements:

6.1.13.1 Maintain a link on the front page of the Contractor's website that immediately links users to the Contractor's online, searchable provider directory.

6.1.13.2 Include a list of all clinics; and primary and specialty providers, including behavioral health providers for Medicaid, including street addresses, telephone numbers and URLs, as

available.

6.1.13.2.1 For Behavioral Health Providers, must also include: service types, clinic speciality, and areas of expertise.

6.1.13.3 Include any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges, or provider groups with which a provider is a member.

6.1.13.4 Includes a description of each primary and specialty provider's languages spoken, including American Sign Language, and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its members, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili", and whether the provider has completed cultural competence training.

6.1.13.5 Includes information about whether the Contractor's network providers' office/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

6.1.13.6 Indicates whether each primary and specialty provider, including behavioral health providers (BHPs) are accepting new patients. Pediatric BHPs must be listed separately from adult BHPs.

6.1.13.6.1 Search capability to locate providers contracted to provide mental health services to children and youth who are accepting new patients (chapter 74.09 RCW).

6.1.13.7 Include a list of hospitals, pharmacies and DME providers.

6.1.13.8 Include Behavioral Health crisis contacts.

6.1.13.9 Include a specific description of any telemedicine services available from a listed provider and at what facilities.

6.1.13.10 Update the provider directory within thirty (30) calendar days of a change in the Contractor's network that would affect adequate capacity in a service area, or the Contractor receives updated provider information, including providers who are no longer under contract with the Contractor. (42 C.F.R § 438.10(h)(3)).

6.1.13.10.1 If the Contractor chooses to provide paper provider directories, they must be updated monthly.

6.1.13.11 The Contractor shall have in place a process for Enrollees, potential Enrollees and other individuals to identify and report potential inaccurate, incomplete or misleading information in the Contractor's online directory. The Contractor shall provide

a dedicated email address and either a form on the website or a telephone number so that errors can be reported directly through the website. Errors must be corrected within ten (10) business days.

6.1.13.12 Contractor program staff shall provide assistance to enrollees and potential enrollees in conducting provider searches based on office or facility location, provider discipline, provider capacity, and available languages.

6.2 Behavioral Health Network Analysis

6.2.1 The Contractor shall incorporate the following requirements when developing its behavioral health network. The Contractor shall offer and maintain contracts to licensed facilities and entities as listed in subsection 6.2.1.3 as well as individual licensed health care professionals. The Contractor shall:

6.2.1.1 Have sufficient behavioral health providers in its network to allow Enrollees a choice of behavioral health providers.

6.2.1.2 Contract only with licensed behavioral health providers. Licensed behavioral health providers include, but are not limited to, Health Care Professionals, licensed agencies or clinics, or non-licensed professionals operating under an agency-affiliated license.

6.2.1.3 Establish and maintain contracts with providers determined by the HCA to be Essential Behavioral Health Providers (EBHP). The current list of Essential Behavioral Health Providers includes, but is not limited to:

6.2.1.3.1 Certified residential treatment providers;

6.2.1.3.2 Licensed Community MH Agencies;

6.2.1.3.3 Certified SUD provider Agencies;

6.2.1.3.4 DOH-certified medication assisted treatment (e.g. buprenorphrine) providers;

6.2.1.3.5 Certified opiate substitution providers (Methadone Treatment programs);

6.2.1.3.6 Licensed and certified free-standing inpatient, hospitals, or psychiatric inpatient facilities that provide Evaluation and Treatment services;

6.2.1.3.7 Licensed and certified detox facilities (for acute and subacute);

6.2.1.3.8 Licensed and certified residential treatment facility to provide crisis stabilization services; and

6.2.1.3.9 DBHR-Recognized Wraparound and Intensive Services (WISe) provider.

6.2.1.4 Establish and maintain contracts with office-based Opioid treatment qualifying providers that have obtained a waiver under the Drug Addiction Treatment Act of 2000 to practice medication-assisted opioid addiction therapy.

6.2.1.5 Ensure sufficient provider capacity to meet the statewide need for WISe services. Continue work with the independent workforce development collaborative to ensure compliance with the WISe workforce development plan.

6.2.1.6 Provide evaluations and/or medically necessary behavioral health services in the Enrollee's residence, when the Enrollee's health care needs require an onsite service, including Enrollees who have been discharged from a State Hospital or similar treatment facility to a placement such as an adult family home, assisted living facility, or Skilled Nursing Facility.

6.2.1.7 Collaborate with HCA to use data to inform the development of:

6.2.1.7.1 Community-based alternatives for crisis stabilization, such as mobile crisis or crisis residential and respite beds; and

6.2.1.7.2 Community-based, recovery-oriented services and research- and Evidence-based Practices including, but not limited to certified Peer Support specialists.

6.2.1.8 Contract with an adequate number of behavioral health provider agencies that offer urgent and non-urgent same day, evening, and weekend services.

6.2.2 The Contractor shall update and maintain the Contractor's provider manual to include all relevant information regarding behavioral health services and requirements.

6.3 Service Delivery Network

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

6.3.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.

6.3.2 Adequate access to all services covered under this Contract.

6.3.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the population represented by the Contractor's Enrollees and Potential Enrollees.

6.3.4 The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services, including mental health providers by provider type.

6.3.5 The Contractor shall consider expected utilization by children, Transitional Age Youth (TAY), and adults with behavioral health conditions based upon national and State prevalence data.

6.3.6 The number of network providers who are not accepting new Enrollees or who have placed a limit, or given the Contractor notice of the intent to limit their acceptance of Enrollees.

6.3.7 The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees or Potential Enrollees, and whether the location provides physical access for the Contractor's Enrollees with disabilities.

6.3.8 The cultural, racial/ethnic composition and language needs of Enrollees and the ability of network providers to communicate with limited English proficient Enrollees in their preferred language.

6.3.9 The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities.

6.3.10 The availability of triage lines or screening systems, as well as the use of telemedicine, e-visit, and other evolving and innovative technological solutions.

6.3.11 With respect to a behavioral health network, the anticipated needs of special populations including, but not limited to:

6.3.11.1 TAY with behavioral health needs;

6.3.11.2 Children and Youth with Serious Emotional Disturbances;

6.3.11.3 Adults with Serious Mental Illness;

6.3.11.4 Adults and TAY identified with first episode psychosis;

6.3.11.5 Cross-system involved children and Youth;

6.3.11.6 Individuals with co-occurring behavioral health conditions;

6.3.11.7 Individuals with behavioral health/Individuals with Developmental Disabilities in need of behavioral health services;

6.3.11.8 Individuals with a MH condition or a SUD and co-occurring chronic physical health condition;

6.3.11.9 Individuals with a SUD in need of medication-assisted treatment;

6.3.11.10 Homeless individuals;

6.3.11.11 Individuals transitioning from State operated psychiatric facilities and other inpatient and residential settings;

6.3.11.12 Individuals with behavioral health conditions transitioning from

jail/prison/courts;

6.3.11.13 Individuals in permanent supported housing or other types of community housing; and

6.3.11.14 Individuals who self-identify as having specialized cultural, ethnic, linguistic, disability, Pregnant and Parenting Women, or age related needs.

6.4 Timely Access to Care

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

6.4.1 Network providers offer access comparable to that offered to commercial Enrollees or, if the Contractor serves only Medicaid Enrollees, comparable to Medicaid FFS.

6.4.2 Mechanisms are established to ensure compliance by providers.

6.4.3 Providers are monitored regularly to determine compliance.

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

6.5 Unavailable Detention Facilities Records

6.5.1 The Contractor shall collaborate with the Behavioral Health Administrative Service Organization (BH-ASO) when a Designated Crisis Responder (DCR) reports they are unable to find an available bed for an Enrollee who meets detention criteria (RCW 71.05.150, 71.05.153, 71.34.700 or 71.34.710). Collaboration includes:

6.5.1.1 Developing a plan for engaging the Enrollee in appropriate treatment services for which the person is eligible.

6.5.1.2 Reporting to HCA within seven (7) calendar days (of receiving the notification from HCA), the plan and attempts made to engage the person in services, including involuntary treatment.

6.6 Hours of Operation for Network Providers

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

6.7 24/7 Availability

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

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

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

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

6.7.4 The toll-free line staff must be able to make a warm handoff to the regional crisis line.

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

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

6.8 Customer Service

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

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

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

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

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

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

6.8.4 The Contractor shall staff its call center with a sufficient number of trained customer service representatives to answer the phones. Staff shall be able to access information regarding behavioral health service requirements and benefits; facilitate navigation of the eligibility systems to access Medicaid benefits and State only and federal block grant services; refer for needed behavioral health services; distinguish

between a benefit inquiry, third party insurance issue, Appeal or Grievance; and resolve and triage Grievances and Appeals.

6.8.5 The Contractor shall submit its customer services policies and procedures to the HCA for review at least ninety (90) calendar days before implementation. Customer services policies and procedures shall address the following:

6.8.5.1 Information on the array of Medicaid covered benefits behavioral health services including where and how to access them.

6.8.5.2 Authorization requirements.

6.8.5.3 Requirements for responding promptly to family members and supporting linkages to other service systems including, but not limited to: State only and federal block grant funded behavioral health services, law enforcement, criminal justice system, social services.

6.8.5.4 Assisting and triaging Enrollees, who may be in crisis, with access to qualified clinicians, without placing the Enrollee on hold. The qualified clinician shall assess the crisis and warm transfer the call to the BH-ASO or its designated crisis provider(s), call 911, refer the individual for services, refer the individual to his or her provider, or resolve the crisis over the telephone as appropriate.

6.8.6 The Contractor shall train customer services representatives on revised behavioral health policies and procedures. The training shall incorporate the State's vision, mission, system goals, and operating principals for behavioral health Managed Care programs and services.

6.9 Appointment Standards

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

6.9.1 Transitional healthcare services by a primary care provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

6.9.2 Transitional healthcare services by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the Enrollee's primary care provider or as part of the discharge plan.

6.9.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the Enrollee's PCP or another provider within thirty (30) calendar days or as described in subsections6.9.3.1 through 6.9.3.2 below. A non-symptomatic office visit may include, but is not limited to,

well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

6.9.3.1 A child who is already enrolled with IFC and changes placements may receive office visits if the child's SSS/Social Worker, caregiver or CCW care coordinator determines the need for another PCP visit.

6.9.3.2 EPSDT examinations required must be provided within the timeframes required by HCA for children in out of home placement, which follows policy. If a change in placement results in a change of PCP, additional EPSDT exams may be required

6.9.4 Non-urgent, symptomatic (i.e., routine care) office visits, including behavioral health services from a behavioral health provider, shall be available from the Enrollee's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

6.9.5 Urgent, symptomatic office visits shall be available from the Enrollee's PCP or another provider within twenty-four (24) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not emergent.

6.9.6 Specialty appointments shall be available within thirty (30) calendar days, unless the Enrollee's health care needs necessitate an appointment within a shorter timeframe.

6.9.7 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

6.9.8 Second opinion appointments described in subsection 16.4.1 must occur within thirty (30) calendar days of the request, unless the Enrollee requests a postponement of the second opinion to a date later than thirty (30) calendar days.

6.9.9 Failure to meet appointment standards may, at the HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

6.10 Provider Database

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

6.11 Provider Network - Distance and Drive Time Standards

6.11.1 The Contractor's network of providers shall meet the distance and drive time standards in this Subsection in every service area. HCA will

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

6.11.2 Distance Standards

6.11.2.1 PCP

6.11.2.1.1 Urban: 2 within 10 miles.

6.11.2.1.2 Non-urban: 1 within 25 miles.

6.11.2.2 Mental Health Professionals

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

6.11.2.3 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

6.11.2.3.1 Urban: 2 within 10 miles.

6.11.2.3.2 Non-urban: 1 within 25 miles.

6.11.2.4 Obstetrics

6.11.2.4.1 Urban: 2 within 10 miles.

6.11.2.4.2 Non-urban: 1 within 25 miles.

6.11.2.5 Hospital

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

6.11.2.6 Pharmacy

6.11.2.6.1 Urban: 1 within 10 miles.

6.11.2.6.2 Non-urban: 1 within 25 miles.

6.11.3 Drive Time Standards

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

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

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

6.11.3.3 In Large Rural Geographic Areas, a ninety-minute drive from the Enrollee's primary residence to the service site.

These travel standards do not apply under exceptional circumstances (e.g. inclement weather, hazardous road conditions due to accidents or

road construction, public transportation shortages or delayed ferry service).

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

6.12 Distance Standards for High Volume Specialty Care Providers

The Contractor shall establish, analyze and meet measurable distance standards for high volume specialty providers, subject to HCA approval. At a minimum the Contractor shall establish, analyze and meet distance standards for pediatric specialists in the following fields: Allergists, Cardiologists, Dermatologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Endocrinologists, Otolaryngologists, Speech Therapy, Occupational Therapy, Physical Therapy, Mental Health Professionals with prescribing authority and Specialists in Physical Medicine, Rehabilitation.

The Contractor shall analyze performance against standards at minimum, annually, and shall provide a report to HCA upon request detailing the outcomes of this analysis along with the Contractor's analysis of Primary Care Providers.

6.13 Pediatric Specialty Centers

The Contractor shall have the following Pediatric Specialty Centers in its contracted network or shall ensure access to these hospitals as needed for Enrollee continuity of care:

6.13.1 University of Washington Hospitals;

6.13.2 Harborview Medical Center;

6.13.3 Seattle Children's Hospital;

6.13.4 Spokane Providence Sacred Health Medical Center and Children's Hospital;

6.13.5 Doernbecher/Oregon Health Sciences University (OHSU); and

6.13.6 Randall Children's Hospital/Legacy Emanuel

6.14 Contracts with Mental Health Professionals

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

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

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

6.16 Access to Specialty Care

6.16.1 The Contractor shall provide all medically necessary specialty care for Enrollees in a service area. If an Enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, or who is not available to provide the medically necessary services required by the Enrollee within the timeframe described in this Contract, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's provider network, who is willing to see the Enrollee.

6.16.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor's available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

6.17 Enrollees Residing in Rural Areas

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

6.17.1 The Enrollee must have a choice of two Primary Care Providers (42 C.F.R. § 438.52(b)(2)(i));

6.17.2 The Enrollee may seek care from a non-participating provider when the service or type of provider (in terms of training, experience and specialization) is not available within the Contractor's network or when the service or type of provider is available in the Contractor's network, but an appointment with a participating provider cannot be scheduled to provide the service within the timeframes listed in Subsection 6.4 of this Contract (42 C.F.R. § 438.52(b)(2)(ii)(A));

6.17.3 The Enrollee may seek a service from a non-participating provider when Enrollee's primary care provider or other provider determines that the Enrollee needs related services that would subject the individual to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available from a participating provider. (42 C.F.R. § 438.52(b)(2)(ii)(D)); and

6.17.4 The Enrollee may seek a service from a non-participating provider when the state determines that circumstances warrant out-of-network treatment. (42 C.F.R. § 438.52(b)(2)(ii)(E)).

6.18 Order of Acceptance

6.18.1 The Contractor shall provide care to all Enrollees who voluntarily choose the Contractor and all Enrollees assigned by HCA.

6.18.2 Enrollees will be accepted in the order in which they apply.

6.18.3 HCA shall enroll all clients eligible for this program with the Contractor unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

6.18.4 The Contractor shall accept clients who are enrolled by HCA in accord with this Contract and chapter 182-538 WAC.

6.18.5 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or behavioral condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.3(d)).

6.19 Provider Network Changes

6.19.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accord with the Notices provisions of the General Terms and Conditions section of this Contract, of the loss of a material provider. The Contractor, HCA and DSHS shall coordinate to ensure that DCYF Social Service Specialists and Social Workers are aware of network changes.

6.19.2 The Contractor shall make a good faith effort to provide written notification to Enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 C.F.R. § 438.10(f)(5)). Enrollee notices shall have prior approval of HCA. If the Contractor fails to notify affected Enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected Enrollees to continue to receive services from the terminating provider, at the Enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies Enrollees or the Enrollee's effective date of enrollment with another plan.

6.19.3 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material subcontractor from a service area. This reimbursable expense shall be in addition to any other provisions of this Contract.

6.19.4 HCA reserves the right to impose Sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this Section.

6.19.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice

of loss of a material provider.

6.20 Enrollee PCP assignment files

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

6.20.1.1 ProviderOne Client ID number;

6.20.1.2 Primary Care Provider (PCP) name;

6.20.1.3 PCP National Provider Identifier (NPI); and

6.20.1.4 PCP assignment effective date.

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Assessment and Performance Improvement (QAPI) Program

7.1.1 The Contractor shall have and maintain one quality assessment and performance improvement (QAPI) program for all health services it furnishes to its Enrollees that meets the provisions of 42 C.F.R. § 438.330.

7.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.

7.1.1.2 The QAPI program structure shall include the following elements:

7.1.1.2.1 Assessment of the quality of care received by enrollees, as measured by HEDIS® and other quality performance measures;

7.1.1.2.2 Goals and interventions to improve the quality of care received, including primary care and behavioral health bi-directional clinical integration;

7.1.1.2.3 Assessment of health equity, including identification of health disparities;

7.1.1.2.4 Service to a culturally and linguistically diverse membership;

7.1.1.2.5 Service to members with complex health issues and special health care needs;

7.1.1.2.6 Patient safety initiatives and tracking of the critical incident management system;

7.1.1.2.7 Inclusion of Enrollee voice and experience, which may include consumer surveys, grievances, and feedback from Ombuds process;

7.1.1.2.8 Inclusion of provider voice and experience, which may include feedback through involvement in Contractor committees, provider complaints, provider appeals and surveys;

7.1.1.2.9 Involvement of designated physician in the QI program, including involvement of designated behavioral health care provider;

7.1.1.2.10 A quality improvement committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

7.1.1.2.10.1 Include practicing provider participation;

7.1.1.2.10.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data, and performance improvement;

7.1.1.2.10.3 Institute actions to address performance deficiencies, including policy recommendations; and

7.1.1.2.10.4 Ensure appropriate follow-up.

7.1.1.2.11 A written QAPI program description shall include the following:

7.1.1.2.11.1 A listing of all quality-related committee(s);

7.1.1.2.11.2 Descriptions of committee responsibilities and oversight;

7.1.1.2.11.3 Contractor staff and practicing provider committee participant titles;

7.1.1.2.11.4 Meeting frequency;

7.1.1.2.11.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate;

7.1.1.2.11.6 All contractually required elements of the QAPI program structure as outlined above;

7.1.1.2.11.7 Proposed methods to meet the requirements under the Contract to evaluate and report performance measure results in a manner that distinguishes individuals who have indicators of need of mental health and/or Substance Use Disorder treatment;

7.1.1.2.11.8 Processes for monitoring, aggregating, and presenting information regarding physical and behavioral health providers or provider groups with at least 1,000 Enrollees, performance in a

Provider Performance (PPP) format that encourages self-correction and includes, but is not limited to performance relative to:

7.1.1.2.11.8.1 Adherence to applicable EB Practices and practice guidelines;

7.1.1.2.11.8.2 Appointment access standards; and

7.1.1.2.11.8.3 Utilization and quality metrics such as readmissions, average length of stay, and transitional health care services to ambulatory services.

7.1.1.2.11.9 Compliance with all quality management requirements as stipulated by the T.R. v. Quigley and Teeter Settlement Agreement.

7.1.1.2.12 A sufficient number of physical health and behavioral health staff members to completely implement all QAPI program requirements on a timely basis.

7.1.1.2.13 The Contractor shall participate in the single RSA Community Behavioral Health Advisory Board (CBHA) in each region.

7.1.1.2.14 The CBHA shall, at a minimum, advise on the need for establishing a behavioral health Quality Management (QM) sub-committee. If the Community Advisory Board recommends a behavioral health QM subcommittee, the subcommittee shall:

7.1.1.2.14.1 Include, in an advisory capacity, Enrollees, family members, certified peer specialists, and provider representatives.

7.1.1.2.14.2 Maintain records of meetings documenting attendance by Enrollees, family members, and providers, as well as committee's findings, recommendations, and actions.

7.1.1.2.14.3 Include mechanisms to solicit feedback and recommendations from a CBHA and key stakeholders to improve quality of care and Enrollee outcomes.

7.1.1.2.14.4 Provide quality improvement feedback to the CBHA, key stakeholders, and other interested parties defined by HCA. The Contractor shall document the activities and provide to HCA upon request.

7.1.1.2.15 An annual quality work plan is due March 1. The work plan shall contain:

7.1.1.2.15.1 Goals and objectives for the year, including objectives for patient safety, serving a culturally and linguistically diverse membership, individuals with special health care needs, health equity, and health care utilization;

7.1.1.2.15.2 Timeframe to complete each activity;

7.1.1.2.15.3 Identification of a responsible person for each activity;

7.1.1.2.15.4 Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs as defined in HCA's Quality Strategy; and

7.1.1.2.15.5 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.

7.1.1.2.16 An annual quality work plan due June 1, including objectives for service individuals with special

health care needs and Enrollees from diverse communities. The work plan shall contain:

7.1.1.2.16.1 Goals and objectives for the year, including objectives for patient safety, serving a culturally and linguistically diverse membership and individuals with special health care needs;

7.1.1.2.16.2 Timeframe to complete each activity;

7.1.1.2.16.3 Identification of a responsible person for each activity; and

7.1.1.2.16.4 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.

7.1.1.2.17 An annual written QAPI Program Evaluation due June 1, of the overall reporting of the effectiveness of the Contractor's QAPI program. (42 C.F.R. § 438.330(c)(2)(i) and (ii)). The report shall reflect on required QI program structure and activities in the Work Plan and shall include at minimum:

7.1.1.2.17.1 Analysis of and actions taken to improve health equity.

7.1.1.2.17.2 Inclusion of consumer voice.

7.1.1.2.17.3 Contractually required HEDIS® performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid NCQA 90th percentile and Washington State average. Both clinical and non-clinical performance measures must be trended and evaluated in the MCO report.

7.1.1.2.17.4 Accompanying written analysis of performance, including data comparisons to the Medicaid NCQA 90th percentile and Washington State average.

7.1.1.2.17.5 Findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for physical and behavioral health (42 C.F.R. § 438.330(b)(3)). The following minimum measure set shall be reported on in the annual QAPI program evaluation about over and under-utilization:

- 7.1.1.2.17.5.1 Preventable hospitalizations, including readmissions;
- 7.1.1.2.17.5.2 Avoidable emergency department visits;
- 7.1.1.2.17.5.3 EDSDT or well-child care;
- 7.1.1.2.17.5.4 Childhood and adolescent immunizations;
- 7.1.1.2.17.5.5 Mental health treatment penetration;
- 7.1.1.2.17.5.6 Children and Adult Access to Primary Care;
- 7.1.1.2.17.5.7 Prenatal and postpartum care; and
- 7.1.1.2.17.5.8 Comprehensive Diabetes Care.

7.1.1.2.17.6 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.

7.1.1.2.17.7 A written assessment of the success of contractually required performance improvement projects.

7.1.2 Upon request, the Contractor shall make available to providers, Enrollees, or the HCA, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.

7.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

7.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.

7.1.3.2 Evaluation of the delegated organization prior to delegation.

7.1.3.3 An annual evaluation of the delegated entity.

7.1.3.4 Evaluation of regular delegated entity reports.

7.1.3.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

7.2 Performance Improvement Projects

7.2.1 The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. PIPs identified by the Contractor are subject to review and approval of HCA including, but not limited to area of focus, design and implementation and evaluation methodologies. The Contractor shall conduct the following PIPs:

7.2.1.1 The Contractor's Apple Health-required (clinical) PIP, piloting a behavioral health intervention that is evidence-based, research-based or a promising practice recognized by the Washington State Institute for Public Policy (WSIPP). (See current WSIPP Report: Inventory (and Updated Inventory report) of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Behavioral Health http://www.wsipp.wa.gov/Reports);

7.2.1.2 One clinical PIP, conducted in partnership between the Department of Health and the Contractor, which will be a statewide PIP on improving well-child visit rates in infants, young children and adolescents described in this Contract;

7.2.1.3 One additional PIP of the Contractor's choosing; and

7.2.1.4 One non-clinical PIP, developed in partnership between the Contractor, HCA and DSHS.

7.2.2 Each PIP shall be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction and shall include the following elements:

7.2.2.1 Measurement of performance using objective quality indicators.

7.2.2.2 Implementation of interventions to achieve improvement in the

access to and quality of care.

7.2.2.3 Evaluation of the effectiveness of the interventions based on the performance measures.

7.2.2.4 Planning and initiation of activities for increasing or sustaining improvement.

7.2.3 The Contractor shall report the status and results of all required clinical and non-clinical performance improvement projects to HCA. (42 C.F.R. § 438.330(c)(3)).

7.2.3.1 The Contractor must annually submit current year PIP proposals to HCA no later than March 15.

7.2.3.2 Each completed project shall be documented on a PIP Worksheet found in the CMS protocol entitled “Conducting Performance Improvement Projects”.

7.2.4 The Contractor shall collaborate with peer Medicaid managed care organizations, DOH and other entities as appropriate to conduct one clinical statewide PIP to improve well-child visit rates in infants, young children and adolescents. This group shall be called the Well-Child Visit workgroup and shall perform the following work:

7.2.4.1 Appoint a workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating MCOs.

7.2.4.2 Provide adequate funding, resources and staff to plan, execute and evaluate the PIP.

7.2.4.3 Coordinate with existing state efforts such as the DOH Pediatric Transforming Clinical Practice Improvement Initiative to improve well-child visit rates.

7.2.4.4 Set an improvement goal for the next year’s HEDIS® rates for the following well-child visit performance measures:

7.2.4.4.1 Well-Child Visits in the first fifteen (15) months of life (W15);

7.2.4.4.2 Well-Child Visits in the third, fourth, fifth and sixth years of life (W34); and

7.2.4.4.3 Adolescent Well-Care Visits (AWC).

7.2.4.5 Define the target populations and scope of the PIP.

7.2.4.6 Define intervention(s) used in the PIP. Interventions shall be robust and innovative in nature, intended to increase the number of children receiving Well-Child Visits and to educate and assist providers.

7.2.4.7 Evaluate the success of interventions to improve well-child

visit rates by the workgroup set goal in the three child measures using available MCO Well-Child Visit data.

7.2.4.8 Submit quarterly progress reports on the status of Well-Child Visit PIP Workgroup activities. Reports shall be submitted to HCA on the third Friday of the month following the end of the quarter in January, April, July, and October.

7.2.4.9 Submit a PIP Worksheet annually, upon request, to HCA.

7.2.5 CMS, in consultation with HCA and other stakeholders, including the Contractor, may specify performance measures and topics for performance improvement projects to be conducted as part of this Contract and IFC.

7.2.6 Integrated Patient Record/Clinical Data Repository Project

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

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

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

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

7.2.6.1 The Contractor shall appoint a representative to provide input into the CDR project plan, and an evaluation of the project.

7.2.6.2 The Contractor shall pay the operational costs to maintain an integrated health record for each of its Enrollees as billed by the State HIE in two installments each year with estimated due dates of January 31 and July 1.

7.2.6.2.1 If the total AH contract enrollment is less than 1,200,000 covered lives, the Contractor shall pay

the operational costs at the rate of $1.05 per year per Enrollee to maintain an integrated health record for each of its AH Enrollees. If the total covered lives enrolled under the AH contract exceeds 1,200,000, the Contractor shall pay the operational costs at the rate of $1.02 per year per Enrollee to maintain an integrated health record for each of its AH Enrollees, and subsequent semi-annual payments will be adjusted accordingly.

7.2.6.2.2 HCA will use the HIPAA 834 monthly audit files to report the Contractor's total enrollment to the State HIE. The State HIE will bill the Contractor for the maintenance of its Enrollees' integrated health records in two installments each year with estimated due dates of January 31 and July 1.

7.2.6.2.3 The Contractor shall pay the State HIE in full by the due date indicated on the billings.

7.2.6.2.4 If the Contractor fails to pay the State HIE within thirty (30) calendar days of the due date on the billing, HCA will withhold the amount due from the next available scheduled monthly AH premium payment to the Contractor.

7.2.6.2.5 Costs to the Contractor to connect to the HIE to access data are the responsibility of the Contractor.

7.2.6.2.6 Costs to the subcontractors to program EHR systems or connect to the HIE are the responsibility of individual entities.

7.2.6.2.7 The Contractor shall coordinate with HCA and the state HIE efforts to facilitate readiness activities intended to prepare for the secure exchange of high value health information among subcontractors identified by HCA through participation in communication and readiness activities organized by HCA and HIE.

7.2.6.2.8 The Contractor shall reinforce state expectations that subcontracted providers with certified EHR systems begin ongoing submission of automated exports of standard CCD/CCDA from their EHR to the CDR via the HIE each time an Apple Health Managed Care Enrollee is seen. The Contractor will include contract language during the next round of contract activities with subcontractors.

7.2.6.3 The Contractor shall participate in quality measurement activities related to the CDR.

7.2.6.3.1 When a subcontracted provider is required to participate in the CDR per subsection 7.2.6.2.8 above, the Contractor will require a clinical document to be submitted for a minimum of 80 percent of submitted claims.

7.2.6.3.2 The Contractor will provide a report to the HCA on or before July 1, 2019 detailing provider compliance with subsections 7.2.6.2.8 and 7.2.6.3.1 above.

7.2.6.4 The Contractor shall participate in business process improvement activities related to the CDR.

7.2.6.4.1 The Contractor will review prior authorization processes that require subcontracted providers to submit clinical documentation ("chart notes") for the applicability of utilizing CDR data.

7.2.6.4.2 The Contractor will provide a report to the HCA on or before July 1, 2019 detailing the number of prior authorizations which utilized CDR data.

7.3 Performance Measures

7.3.1 The Contractor shall include the IFC population in its annual submission to NCQA of NCQA and HCA required HEDIS® measures according to directions provided by the HCA designated EQRO.

7.3.2 The Contractor shall report IFC required HEDIS® measures using the 2019 HEDIS® Technical Specifications and official corrections published by NCQA, to NCQA and HCA annually, unless directed otherwise in writing by HCA. The Contractor shall use administrative and hybrid data collection methods, specified in the current HEDIS® Technical Specifications and required by HCA (42 C.F.R. § 438.240(b)(2)). Attachment 2, 2019 Performance Measures is the 2019 list of HCA required AHFC HEDIS® performance measures to be submitted to HCA.

7.3.3 Attachment 2, 2019 HEDIS® Performance Measures is the 2019 list of HCA required HEDIS® performance measures to be submitted to NCQA and HCA. If the Contractor does not report by hybrid methodology any HEDIS® measure in Attachment 2 notes as requiring the hybrid method, the Contractor is required to notify HCA within five (5) business days with the reason.

7.3.4 In addition to reporting all required HEDIS® data to NCQA, the Contractor will publically report performance measure data including MCO name through the Quality Compass reporting mechanism, whether public reporting is required or not by NCQA.

7.3.5 No later than the date in June of each year as specified by the audit team, IFC required HEDIS® measures shall be submitted electronically to the HCA contracted EQRO according to instructions provided by HCA or the HCA designated EQRO.

7.3.6 The Contractor shall submit raw HEDIS® data to HCA electronically for all measures, no later than June 30 of each year. The Contractor shall submit the Raw HEDIS®/Member Level Data report according to specifications provided by HCA.

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

7.3.8 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

7.3.8.1 Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the Centers for Medicare and Medicaid Services (CMS) Validating Performance Measures protocol identified by HCA designated EQRO.

7.3.9 The Contractor shall rotate HEDIS® measures only with HCA's advance written approval. The Contractor may request approval to rotate measures by making a written request to the HCA MC Programs mailbox. Any measures rotated by the Contractor without written permission from the HCA shall be subject to the sanctions language described in this Contract.

7.3.10 The following performance measures shall be produced by HCA, in partnership with the DSHS/Research and Data Analysis Division (RDA), and delivered to the Contractor in reporting year 2019; for the data collection period January 1, 2018 through December 31, 2018:

7.3.10.1 Substance use treatment penetration;

7.3.10.2 Substance Use Disorder treatment initiation and engagement (Washington Circle version);

7.3.10.3 Mental Health treatment penetration;

7.3.10.4 Thirty (30) day psychiatric inpatient readmissions;

7.3.10.5 Number of Nulliparous Transverse Singleton Vertex (NTSV) C-Sections (cesarean births);

7.3.10.6 Medication Management for people with Asthma: Medication

Compliant 75 percent (Ages 5-11);

7.3.10.7 Medication Management for people with Asthma: Medication Compliance 75 percent (Ages 12-18);

7.3.10.8 Follow-up Care for Children Prescribed ADHD Medication – Initiation Phase;

7.3.10.9 Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase; and

7.3.10.10 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics – Total.

7.3.11 The Contractor shall create, maintain, and collect separate and unique data fields for Enrollee self-reported demographic data to the Contractor. At minimum, the following data fields shall be maintained by the Contractor: Enrollee name, address, email address, and ethnicity, race, and language markers.

7.3.12 IFC Performance Measures: No later than June 30 of each year, the following IFC-specific measures shall be submitted to HCA. The Contractor shall calculate these additional HEDIS® measures using the administrative method only for all eligible populations enrolled in IFC.

7.3.12.1 Lead Screening in Children (LCS);

7.3.12.2 Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); and

7.3.12.3 Adolescent Well-Care Visits (AWC).

7.3.13 Health Care Disparities Workgroup. The Contractor shall collaborate with peer MCOs and the DOH to form a Health Care Disparities Workgroup aimed at reducing disparities in one performance measure. The Health Care Disparities Workgroup shall consult with community experts and organizations as appropriate to disaggregate data on at least one performance measure and examine the data for racial/ethnic disparities. The Workgroup shall implement interventions aimed at reducing health care disparities in the selected measure. The Health Care Disparities Workgroup shall perform the following work:

7.3.13.1 Appoint a Workgroup coordinator to assist DOH with developing meeting agenda topics, writing quarterly reports, and serving as a managed care subject matter expert. The coordinator position shall be rotated among participating managed care organizations.

7.3.13.2 Collect and examine data on ethnicity, race, and language markers as provided by HCA on all Enrollees and augmented by MCOs.

7.3.13.3 Cooperate with the Department of Health to complete the

analysis of one performance measure no later than June 30th.

7.3.13.4 Define interventions to address observed disparities.

7.3.13.5 Evaluate the effectiveness of interventions to reduce health care disparities.

7.3.13.6 Provide adequate funding, resources, and staff to plan, execute, and evaluate the project.

7.3.13.7 Submit quarterly progress reports providing an update on the status of the Health Care Disparity Workgroup activities. Reports shall be submitted to HCA and quarterly on the third Friday of the month of January, April, July, and October.

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

7.4.1 In 2019, the Contractor shall conduct the CAHPS® Child 5.0H Medicaid with Chronic Conditions survey for IFC Enrollees.

7.4.1.1 The Contractor shall contract with an NCQA-certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the HCA designated EQRO:

7.4.1.1.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name, and CAHPS® primary vendor contact by January 2019.

7.4.1.1.2 Timeline for implementation of vendor tasks upon request.

7.4.1.2 The Contractor shall ensure the survey sample frame consists of all IFC members seventeen (17) years and younger with Washington State addresses. In administering the CAHPS® the Contractor shall:

7.4.1.2.1 Submit the eligible sample frame file(s) for certification by the HCA designated EQRO, a Certified HEDIS® Auditor, by the second Friday in January 2019, or the date otherwise specified by the audit team.

7.4.1.2.2 Receive written notice of the sample frame file(s) compliance audit certification from the HCA designated EQRO by the January deadline listed in the NCQA HEDIS® Audit timeline for 2019.

7.4.1.2.3 HCA EQRO shall review each MCOs questionnaire format, questions, and question placement, using the most recent HEDIS® version of the Medicaid CAHPS® survey (currently 5.0H), plus approved supplemental questions as determined by HCA.

7.4.1.2.4 HCA will add supplemental questions to the Contractor's survey as determined by HCA and approved by NCQA.

7.4.1.2.5 Conduct the mixed methodology (two questionnaires and two reminder postcards with telephone follow-up of at least three telephone attempts) for CAHPS® survey administration.

7.4.1.2.6 Submit a copy of the Washington State Child Medicaid response data set according to 2019 NCQA/CAHPS® standards to the HCA designated EQRO by the date in June each year as specified by HCA or the HCA-designated EQRO.

7.4.1.3 The AHMC/FIMC Child plus Child with Chronic Conditions survey to be conducted by all MCOs will be the survey used for NCQA accreditation and reported through the CAHPS® Database. The AHFC Child plus Child with Chronic Conditions for the AHFC population will be reported to HCA, not NCQA.

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

7.5 NCQA Accreditation

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

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

7.5.3 The Contractor shall notify HCA of the date of its NCQA site visit by January 31, 2019 or within fifteen (15) calendar days of confirmation of the site visit by NCQA. The Contractor shall provide HCA with all written materials submitted to NCQA for purposes of the NCQA audit and allow HCA representative(s) to participate in the NCQA audit activities, including the site visit.

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

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

7.6 External Quality Review

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

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

7.6.2.1 Performance improvement projects.

7.6.2.2 Performance measures.

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

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

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

7.6.5 The Contractor shall submit to annual monitoring reviews by HCA and EQRO. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 C.F.R. § 438.358).

7.6.6 The Contractor shall, during an HCA annual monitoring review of the Contractor's compliance with Contract standards or upon request by HCA or its External Quality Review Organization (EQRO) Contractor(s), provide evidence of how external quality review findings, agency audits and Contract monitoring activities, Enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to Enrollees.

7.6.7 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Annual Report (EQRAR). The EQRAR is a detailed technical report that describes the manner in which

the data from all activities described in External Quality Review provisions of this Section and conducted in accord with 42 C.F.R. § 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.

7.6.8 HCA will provide a copy of the EQRAR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, Enrollees and Potential Enrollees of the Contractor, Enrollee advocacy groups, and members of the general public. HCA must make this information available in alternative formats for persons with sensory impairments, when requested.

7.6.9 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA and Washington State Department of Health (DOH) as needed to reduce duplicated work for both the Contractor and the state.

7.7 Provider Complaints and Appeals

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

7.8 Critical Incident Management System

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

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

7.8.1 Individual Critical Incident Reporting

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

7.8.1.1 Homicide or attempted homicide by an Enrollee;

7.8.1.2 A major injury or major trauma that has the potential to cause prolonged disability or death of an Enrollee that occurs in a

facility licensed by the state of Washington to provide publicly funded behavioral health services.

7.8.1.3 An unexpected death of an Enrollee that occurs in a facility licensed by the state of Washington to provide publicly funded behavioral health services.

7.8.1.4 Abuse, neglect, or exploitation of an Enrollee (not to include child abuse);

7.8.1.5 Violent acts allegedly committed by an Enrollee to include:

7.8.1.5.1 Arson;

7.8.1.5.2 Assault resulting in serious bodily harm;

7.8.1.5.3 Homicide or attempted homicide by abuse;

7.8.1.5.4 Drive-by shooting;

7.8.1.5.5 Extortion;

7.8.1.5.6 Kidnapping;

7.8.1.5.7 Rape, sexual assault, or indecent liberties;

7.8.1.5.8 Robbery; and

7.8.1.5.9 Vehicular homicide.

7.8.1.6 Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions.

7.8.1.7 Any event involving an Enrollee that has attracted or is likely to attract media attention.

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

7.8.2.1 The date the Contractor becomes aware of the incident;

7.8.2.2 The date of the incident;

7.8.2.3 A description of the incident;

7.8.2.4 The name of the facility where the incident occurred, or a description of the incident location;

7.8.2.5 The name(s) and age(s) of Enrollees involved in the incident;

7.8.2.6 The name(s) and title(s) of facility personnel or other staff involved;

7.8.2.7 The name(s) and relationship(s), if known, of other persons

involved and the nature and degree of their involvement;

7.8.2.8 The Enrollee's whereabouts at the time of the report if known (i.e. home, jail, hospital, unknown, etc.) or actions taken by the Contractor to locate the Enrollee;

7.8.2.9 Actions planned or taken by the Contractor to minimize harm resulting from the incident; and

7.8.2.10 Any legally required notifications made by the Contractor.

7.8.3 The Contractor shall report Critical Incidents using the HCA Incident Reporting System (http://fortress.wa.gov/hca/ics. If the system is unavailable, the Contractor shall report Critical Incidents to HCAMCPrograms@hca.wa.gov.

7.8.4 Individual Critical Incident Resolution and Closure

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

7.8.4.1 A summary of any debriefings;

7.8.4.2 Whether the Enrollee is in custody (jail), in the hospital or in the community;

7.8.4.3 Whether the Enrollee is receiving services and include the types of services provided;

7.8.4.4 If the Enrollee cannot be located, the steps the Contractor has taken to locate the Enrollee using available, local resources; and

7.8.4.5 In the case of the death of an Enrollee, verification from official sources that includes the date, name and title of the sources. When official verification cannot be made, the Contractor shall document all attempts to retrieve it.

7.8.5 Population Based Reporting

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

7.8.5.1.1 Incidents identified through the Individual Critical Incidents process;

7.8.5.1.2 A credible threat to Enrollee safety;

7.8.5.1.3 Any allegation of financial exploitation of an enrollee;

7.8.5.1.4 Suicide and attempted suicide; and

7.8.5.1.5 Other incidents as defined in the Contractor's Policies and Procedures.

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

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

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

7.9 Mental Health Evidence-Based Practices (EBPs)

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

7.9.1.1 Participation in planning meetings;

7.9.1.2 Developing methods to collect data; and

7.9.1.3 Reporting of data on the uptake in use of EBPs over time to satisfy HCA requirements and state law.

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

7.9.2.1 The number of children receiving E/RBP services;

7.9.2.2 The number of mental health encounters using these services; and

7.9.2.3 The percentage of mental health encounters using these services.

7.10 Evidence-Based, Research-Based, and Promising Practices

The Contractor will promote the use of research and Evidence-Based Practices, with a particular focus on increasing these practices for children and Youth receiving mental health treatment services as identified through legislative mandates. This includes:

7.10.1 Ensuring that providers participate in DBHR-sponsored training in the

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT/CBT) and CBT-Plus (TF-CBT/CBT+) evidence/Research-Based Practices.

7.10.2 The Contractor is expected to maintain a workforce trained in TF-CBT/CBT+ sufficient to implement the practice within the Contractor's service area.

7.11 Home Health/Private Duty Nursing Services

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

7.11.1 Enrollee name;

7.11.2 Enrollee Date of Birth;

7.11.3 ProviderOne ID;

7.11.4 Type of Service (Private Duty Nursing or Home Health)

7.11.5 Name of Provider;

7.11.6 Provider NPI;

7.11.7 Date request for services received;

7.11.8 Number of units requested, indicated days or 15 minute increments;

7.11.9 Number of units approved;

7.11.10 Number of units paid; and

7.11.11 Date decision made.

7.12 Practice Guidelines

7.12.1 The Contractor shall adopt physical and behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements (42 C.F.R. § 438.236):

7.12.1.1 Are based upon the following:

7.12.1.1.1 Valid and reliable clinical scientific evidence;

7.12.1.1.2 In the absence of scientific evidence, on professional standards; or

7.12.1.1.3 In the absence of both scientific evidence and professional standards, a consensus of health care professionals in the particular field.

7.12.1.2 The Contractor shall develop guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. The Contractor may adopt guidelines developed by recognized sources that develop or promote

evidence-based clinical practice guidelines such as voluntary health organizations, National Institute of Health Centers or the Substance Abuse and Mental Health Services Administration (SAMSHA). If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:

7.12.1.3 Be age-appropriate to address the special needs or considerations that are driven by age.

7.12.1.4 Consider the needs of Enrollees and support client and family involvement in care plans.

7.12.1.5 Be adopted in consultation with contracting health care professionals within the state of Washington or, when applicable, are adopted in consultation with the behavioral health professionals in the Contractor's contracted network.

7.12.1.6 Be reviewed and updated at least every two years and more often if national guidelines change during that time.

7.12.1.7 Be disseminated to all affected providers and, upon request, to HCA, Enrollees and potential Enrollees (42 C.F.R. § 438.236(c)).

7.12.1.8 Be distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers. Be the basis for and consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).

7.12.1.9 Be the basis for and are consistent with decisions for utilization management, Enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).

7.12.2 The Contractor shall develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor shall:

7.12.2.1 Conduct outreach to Enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.

7.12.2.2 Report on preventive care utilization through required performance measure reporting.

7.12.2.3 In collaboration with peer managed care organizations, disaggregate data on at least one preventive care measure

and examine the data for racial/ethnic disparities.

7.12.2.4 In collaboration with peer managed care organizations, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on utilization patterns.

7.12.2.5 Prepare and disseminate all such materials consistently with the requirements of Subsections 3.2 and 3.3.

7.12.3 The Contractor shall include the behavioral health medical director in the evaluation of medications and other emerging technologies for the treatment of behavioral health conditions and related decisions. The Contractor shall also have a child psychiatrist available for consultation related to medications and other emerging technologies for the treatment of behavioral health conditions in children and adolescents.

7.13 Health Information Systems

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

7.13.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility.

7.13.2 Ensure data received from providers is accurate and complete by:

7.13.2.1 Verifying the accuracy and timeliness of reported data;

7.13.2.2 Screening the data for completeness, logic, and consistency; and

7.13.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.13.3 The Contractor shall make all collected data available to HCA and the Center for Medicare and Medicaid Services (CMS) upon request.

7.13.4 Establish and maintain protocols to support timely and accurate data exchange with any subcontractor that will perform any delegated behavioral health function under this Contract.

7.13.5 Establish and maintain web-based portals with appropriate security features that allow referrals, requests for prior authorizations, claims submission and claims status updates for behavioral health services.

7.13.6 Have information systems that enable paperless submission, automated processing and status updates for prior authorization and other UM related requests.

7.13.7 Establish and maintain data driven approaches to monitor requirements, by eligibility group when appropriate, including behavioral health network adequacy, crisis plans, mental health advance directives and behavioral health specific reporting requirements for UM, QM and financial management as well as administrative and clinical performance metrics.

7.13.8 Maintain behavioral health content on a website that meets the following minimum requirements:

7.13.8.1 Public and secure access via multi-level portals (such as providers and Enrollees) for providing web-based training, standard reporting, and data access as needed for the effective management and evaluation of the performance of the contract and the service delivery system as described under this Contract.

7.13.8.2 The Contractor shall organize the website to allow for easy access of information by Enrollees, family members, network providers, stakeholders, and the general public in compliance with the Americans with Disabilities Act. The Contractor shall include on its website, at a minimum, the following information or links:

7.13.8.2.1 Hours of operations for the Contractor.

7.13.8.2.2 How to access behavioral health services, including crisis contact information and toll-free crisis telephone numbers.

7.13.8.2.3 Telecommunications device for the deaf/text telephone numbers.

7.13.8.2.4 Information on the right to choose a qualified behavioral health service provider.

7.13.8.2.5 An overview of the range of behavioral health services being provided.

7.13.8.2.6 Access to behavioral health-medical integration tools and supports to support provider integration initiatives.

7.13.8.2.7 Access to information for Transitional Age Youth.

7.13.8.2.8 A library, for providers and Enrollees, that provides comprehensive information and practical recommendations related to mental illness, Substance Use Disorder and recovery, life events, and daily living skills.

7.13.8.2.9 Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for Enrollees receiving behavioral health services, family members, providers, and stakeholders to become involved.

7.13.8.2.10 Information regarding advocacy organizations, including how Enrollees and other family members may access advocacy services.

7.13.8.2.11 Opportunities, including surveys, for behavioral health Enrollees, family members, network providers, and other stakeholders to provide satisfaction/complaint feedback.

7.14 Clinical Data Repository

7.14.1 HCA shall develop and the Contractor shall publish guidelines for participation in the Clinical Data Repository, along with the contacts and resources to support provider organizations through the readiness activities.

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

7.15 Data Submission to Collective Medical Technologies (CMT)

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

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

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

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

7.16 Required Reporting for Behavioral Health Services

The Contractor's disclosure of individually identifiable information is authorized by law, including 42 C.F.R. § 2.53, authorizing disclosure of patient records for purposes of Medicaid evaluation.

7.17 Technical Assistance

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

7.18 Annual Diabetes Report

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

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

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

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

7.18.2.2.1 Ages less than 18 years of age; and

7.18.2.2.2 Ages 18 to 26 years of age.

7.18.2.3 The gender distribution of Enrollees with Type 1 and Type 2 diabetes.

7.18.2.4 The geographic distribution of Enrollees with Type 1 and Type 2 diabetes using the Enrollee's county of residence, rolled up into the *Healthier Washington* regional map found at: http://www.hca.wa.gov/about-hca/healthier-washington/accountable-communities-health-ach.

7.18.2.5 The total number of Enrollees with a diagnosis of Type 1 and Type 2 diabetes who received a diabetes education encounter.

7.18.2.6 The proportion of Enrollees with a diagnosis of diabetes Type 1 and Type 2 diabetes who received a diabetes education encounter.

7.18.2.7 A narrative description of how:

7.18.2.7.1 Enrollees are referred to diabetes education, and a description of any role that the plan plays in these referrals.

7.18.2.7.2 Diabetes education is promoted to Enrollees including links to Diabetes educational materials.

7.18.2.7.3 Diabetes education providers enroll with the Contractor if interested in joining the Contractor's network of providers.

7.18.2.8 A list of:

7.18.2.8.1 Available Diabetes education providers including, name of diabetes educator, physical address, zip code, county and *Healthier Washington* region.

7.18.2.8.2 Any potential gaps in the network of diabetes educators, and measures the Contractor may take to address gaps in network providers.

7.19 Value-Based Purchasing: Paying for Value Survey

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

8 POLICIES AND PROCEDURES

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

8.1 Contractor's Policies and Procedures

The Contractor's policies and procedures shall:

8.1.1 Direct and guide the Contractor's employees, subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements.

8.1.2 Fully articulate the Contractor's understanding of the requirements.

8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training.

8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training.

8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

8.2 Assessment of Policies and Procedures

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

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

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

9.2 Solvency Requirements for Subcontractors

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

9.3 Provider Nondiscrimination

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

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

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

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

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

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

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

9.4 Required Provisions

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

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

9.4.2 A process for monitoring the subcontractor's performance and a periodic schedule for formally evaluating performance, consistent with industry standards or state managed care laws and regulations.

9.4.3 Procedures and specific criteria for terminating the subcontract and for any other remedies the Contractor provides if HCA or the Contractor determines that the subcontractor has not performed satisfactorily (42 C.F.R. §438.230(c)(1)(iii)).

9.4.4 Identification of the services to be performed and reports to be provided by the subcontractor and which of those services may be subcontracted by the subcontractor. If the Contractor allows the subcontractor to further subcontract, all subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered subcontracts.

9.4.5 Reimbursement rates and procedures for services provided under the subcontract.

9.4.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

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

9.4.8 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring or evaluation identified in subsection 9.4.7. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)).

9.4.9 The requirement to completely and accurately report encounter data, and to certify the accuracy and completeness of all encounter data submitted to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the Contractor to meet the reporting

requirements in the Encounter Data Guide published by HCA.

9.4.10 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.

9.4.11 No assignment of a subcontract shall take effect without HCA's written agreement.

9.4.12 The subcontractor shall comply with the applicable state and federal statutes, rules and regulations including, but not limited to, the laws identified in Subsection 2.4 of this Contract, as set forth in this Contract, including but not limited to 42 U.S.C. § 1396a(a)(43), 42 U.S.C. § 1396d(r), 42 C.F.R. § 438.3(i), and § 438.230(c)(2).

9.4.13 Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract (42 C.F.R. § 438.6).

9.4.14 The Contractor shall provide the following information regarding the Grievance and Appeal System to all subcontractors (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)):

9.4.14.1 The toll-free numbers to file oral grievances and appeals.

9.4.14.2 The availability of assistance in filing a grievance or appeal, including informing the Enrollee about Ombuds services and how to access these services.

9.4.14.3 The Enrollee’s right to request continuation of benefits during an appeal or hearing and, if the Contractor’s Adverse Benefit Determination is upheld, that the Enrollee may be responsible to pay for the cost of the benefits received for the first sixty (60) calendar days after the appeal or hearing request was received. .

9.4.14.4 The Enrollee’s right to file grievances and appeals and their requirements and timeframes for filing.

9.4.14.5 The Enrollee’s right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.4.14.6 The subcontractor may file a grievance or request an adjudicative proceeding on behalf of an Enrollee in accordance with subsection 13.2.1.

9.4.15 The process for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.

9.4.16 A process to identify deficiencies and take corrective action for both the Contractor and subcontractor.

9.4.17 The process whereby the subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the Enrollee’s needs.

9.4.18 Prior to delegation, the Contractor shall evaluate any prospective subcontractor's ability to perform the activities for which that subcontractor is contracting, including the subcontractor's ability to perform delegated activities described in the subcontracting document.

9.4.19 The requirement to refer credible allegations of fraud to HCA and the MFCD as described in Subsection 12.6 of this Contract. (42 C.F.R § 455.23).

9.4.20 The Contractor shall reimburse pharmacies at the actual acquisition cost of a medication. The reimbursement adjustment process must be available online for pharmacies on both the Contractor's website and the PBM's website. The process may require the pharmacy provide an invoice documenting the actual acquisition cost of the medication and reasons why the product was not available for purchase at the reimbursement rate set by the PBM.

9.5 Health Care Provider Subcontracts

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

9.5.1 A quality improvement system consistent with the Contractor's obligations under Subsections 7.1 through 7.3, tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Assessment and Performance Improvement (QAPI) activities required by Section 7 of this Contract.

9.5.3 A means to keep records necessary to adequately document services provided to Enrollees for all delegated activities including QAPI, Utilization Management, Enrollee Rights and Responsibilities, and Credentialing and Recredentialing.

9.5.4 A requirement that the Subcontractor shall comply with chapter 71.32 RCW (Mental Health Advance Directives).

9.5.5 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

9.5.5.1 Assigned responsibilities

9.5.5.2 Delegated activities

9.5.5.3 A mechanism for evaluation

9.5.5.4 Corrective action policy and procedure

9.5.6 Information about Enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and

regulations.

9.5.7 An agreement that applicable Subcontractors will receive payment for the supervision of behavioral health providers whose license or certification restricts them to working under supervision, effective with the next provider contracting period.

9.5.8 The Subcontractor accepts payment from the Contractor as payment in full. The Subcontractor shall not request payment from HCA or any Enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-0160 requirements applicable to providers.

9.5.9 The Subcontractor agrees to hold harmless HCA and its employees, and all Enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The Subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs, and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors (42 C.F.R. § 438.230(b)(2)).

9.5.10 If the subcontract includes physician or behavioral health services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.

9.5.11 If the subcontract includes physician services, provisions that inform the provider of any HCA determined appeal rights to challenge the failure of the Contractor to cover a service. (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)(xi)).

9.5.12 A ninety (90) day termination notice provision.

9.5.13 A specific termination provision for termination with short notice when a Subcontractor is excluded from participation in the Medicaid program.

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

9.5.15 A provision that informs the provider of a reasonably accessible on-line location of the policies and procedures listed in Section 8 of this Contract.

9.5.16 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three (3) years and must identify deficiencies or areas for improvement and provide for corrective action (42 C.F.R. § 438.230(b)).

9.5.16.1 Upon request by HCA, the Contractor will provide a copy of the monitoring policy, process and any results of identified health care providers.

9.5.17 The Contractor shall document and confirm in writing all Single Case Agreements with providers. The agreement shall include:

9.5.17.1 The description of the services;

9.5.17.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.17.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and

9.5.17.4 Any other specifics of the negotiated rate.

9.5.18 The Contractor must supply documentation to the Subcontractor no later than five (5) business days following the signing of the agreement. Updates to the Single Case Agreement, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.19 The Contractor shall maintain a record of the Single Case Agreements for a period of six (6) years.

9.5.20 The Contractor shall provide a copy of the Health Care Provider subcontract template and any contract samples upon request by HCA.

9.6 Health Care Provider Subcontracts Delegating Administrative Functions

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

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

9.6.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to Enrollees and include, but are not limited to, utilization/medical management, claims processing, Enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

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

9.6.1.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 C.F.R. §

438.230(c)(1)(iii)).

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

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

9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of Enrollees assigned or serviced by the delegated entity to the HCA by March 1 of each year applicable to this Contract and upon request by the HCA.

9.7 Behavioral Benefit Administration with Subcontractors and Subsidiaries

9.7.1 Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract, except Behavioral Health Administrative Functions. Essential Behavioral Health Administrative Functions may be subcontracted for a period of time as determined by HCA and the Contractor. The Contractor shall achieve full integration of Essential Behavioral Health Administrative Functions according to a timeline agreed upon with HCA. No Subcontractor shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any Subcontractor.

9.7.2 Required Provisions. Behavioral Health Subcontracts must require Subcontractors to hold all necessary licenses, certifications, and/or permits as required by law for the performance of the activity to be performed under this Contract.

9.7.2.1 Subcontracts must require Subcontractors to notify the Contractor in the event of a change in status of any required license or certification.

9.7.3 GAIN-SS

9.7.3.1 Subcontracts for the provision of behavioral health services must require the use of the GAIN-SS and the assessment process that includes use of the quadrant placement. In addition, the Subcontract must contain terms requiring corrective action if the Integrated Co-Occurring Screening and Assessment process is not implemented and maintained throughout the contact period of performance.

9.7.3.2 If the results of the GAIN-SS are indicative of the presence of a co-occurring disorder, this information must be considered in the development of the treatment plan including appropriate

referrals.

9.8 Health Homes

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

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

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

9.8.1 Federally Qualified Health Centers;

9.8.2 Area Agencies on Aging;

9.8.3 Rural Health Clinics;

9.8.4 Community Mental Health Agencies;

9.8.5 Mental Health clinics or counseling services;

9.8.6 Substance Use Disorder Treatment Agencies or counseling services;

9.8.7 Hospitals;

9.8.8 Behavioral Health Organizations;

9.8.9 Medical or specialty clinics;

9.8.10 Pediatric clinics; and

9.8.11 Social Service organizations.

9.9 Home Health Providers

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

9.10 Physician Incentive Plans

Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section and in federal regulations (42 C.F.R. § 438.6, 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210). The Contractor shall provide written notification to HCA

on an annual basis (due March 1) that its physician incentive plans, if any, comply with federal regulations.

9.10.1 Prohibited Payments: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual Enrollee.

9.10.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by HCA. Prior to entering into, modifying or extending the risk sharing arrangement in a subcontract at any tier, the Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of its subcontractors to HCA:

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

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

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

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

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

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

9.10.3 If the Contractor, or any subcontractor, places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

9.10.3.1 If aggregate stop-loss protection is provided, it must cover 90 percent of the costs of referral services that exceed 25 percent of maximum potential payments under the

subcontract.

9.10.3.2 If stop-loss protection is based on a per-member limit, it must cover 90 percent of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

9.10.3.2.1 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

9.10.3.2.2 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

9.10.3.2.3 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

9.10.3.2.4 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

9.10.3.2.5 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

9.10.3.2.6 25,001 members or more, there is no risk threshold.

9.10.3.3 The Contractor shall provide the following information regarding its Physician Incentive Plans to any Enrollee who requests it:

9.10.3.3.1 Whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;

9.10.3.3.2 The type of incentive arrangement; and

9.10.3.3.3 Whether stop-loss protection is provided.

9.11 Provider Education

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

9.11.1 The Contractor shall keep participating providers informed about:

9.11.1.1 Covered services for Enrollees served under this Contract.

9.11.1.2 Coordination of care requirements.

9.11.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.11.1.4 Health Homes.

9.11.1.5 HCA First Steps Program - Maternity Support Services (MSS). The Contractor shall notify providers about HCA's First Steps program, MSS, using the HCA MSS informational letter template that includes the HCA First Steps Program website and Provider Directory.

9.11.1.6 Interpretation of data from the Quality Improvement program.

9.11.1.7 Practice guidelines as described in the provisions of this Contract.

9.11.1.8 Behavioral health services through the Contractor. The Contractor shall provide a link to the provider directory annually to all Primary Care Providers, including its contracted mental health and children's mental health professionals. The Contractor shall provide the link to its Primary Care Providers no later than January 31.

9.11.1.9 Behavioral Health resource line (chapter 74.09 RCW).

9.11.1.10 The information requirements for UM decision making, procedure coding, and submitting claims. The Contractor shall inform behavioral health network providers in writing regarding these requirements.

9.11.1.11 Contractor care management staff for assistance in care transitions and care management activity.

9.11.1.12 Principles of Trauma Informed Care.

9.11.1.13 Program Integrity requirements.

9.11.1.14 DSHS long-term care services, including availability of home and community based care (chapter 388-106 WAC).

9.11.1.15 DSHS developmental disability services including community-based care (WAC 388-823 to -850).

9.11.1.16 DCYF services for children and families, including, but not limited to, DCYF-contracted home visiting, Early Support for Infants and Toddlers (ESIT), Early Childhood Intervention and Prevention Services (ECLIPSE), and Early Childhood and Education Assistance Program (ECEAP) and Head Start programs using the informational letter template jointly developed by DCYF and HCA.

9.11.1.17 Perinatal Psychiatry Consultation Line (PAL for Moms) offered

through University of Washington Medicine.

9.11.1.18 Partnership Access Line Plus (PAL Plus) program available in Benton and Franklin counties.

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

9.11.2 The Contractor shall develop and deliver ongoing training for network providers. The training objective is to strengthen the knowledge, skill, and expertise of all parties to improve integrated care delivery as it relates to outreach and engagement, screening and assessment, appropriate referral and delivery of person-centered, recovery-oriented care. Training shall go beyond concepts to address how to incorporate guidelines and principles into daily practice. This shall include offering technical assistance and support tools regarding coordinated care practices defined in Section 14 of this Contract. The training program shall meet the following minimum requirements:

9.11.2.1 The application of evidence-based, research-based, Promising Practices related to the assessment and treatment of behavioral health conditions, including those from the Bree Collaborative.

9.11.2.2 Incorporation of recovery and Resilience principles in service provision as well as policies and procedures.

9.11.2.3 Screening, identification and referral for treatment for medical conditions and risk factors commonly occurring in individuals with severe and persistent behavioral health mental illness or chronic SUD. For individuals on medication, screening includes review of Enrollee medical and medication history, and for individuals on psychotropic medication, vital signs, weight, and BMI. Screening tools used with children and Youth shall be developmentally age-appropriate.

9.11.2.4 Subcontracts must require Subcontractors to participate in training when requested by HCA. Requests for HCA to allow an exception to participation in required training must be in writing and include a plan for how the required information will be provided to targeted Subcontractor staff.

9.11.2.5 Annually, all community behavioral health employees who work directly with Enrollees must be provided with training on safety and violence prevention topics described in RCW 49.19.030.

9.11.2.6 The Contractor shall ensure all of its contracted Primary Care

Providers are offered training related to all of the following:

9.11.2.6.1 Screening for behavioral health conditions using developmentally, age appropriate screening tools.

9.11.2.6.2 Brief Intervention and Referral to Treatment for Enrollees aged thirteen (13) years and older.

9.11.2.6.3 The application of evidence-based, research-based and Promising Practices (including those from the Bree Collaborative) for behavioral health conditions commonly occurring in primary care.

9.11.2.6.4 Identification of individuals with First Episode Psychosis (FEP) and referral to appropriate FEP services.

9.11.2.7 Behavioral health and medical providers shall be offered training on effective approaches to managing individuals with co-occurring conditions including individuals with behavioral health and co-occurring medical conditions or co-occurring intellectual and developmental disabilities. Training shall address the following requirements:

9.11.2.7.1 Care Coordination requirements as defined in Section 14, including, but not limited to creating and maintaining a shared care plan;

9.11.2.7.2 Collaborative care or similar research-based models for Care Coordination;

9.11.2.7.3 Discharge planning for Enrollees transitioning from the hospital to the community; and

9.11.2.7.4 Accurate diagnosis and appropriate treatment for individuals with I/DD.

9.11.2.8 Enrollees, family members and other caregivers are involved in the planning, development and delivery of trainings specific to delivery of behavioral health services and behavioral health-medical integration initiatives.

9.11.2.9 Cultural competency shall be incorporated into provider training specific to delivery of behavioral health services and behavioral health-medical integration initiatives.

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

9.12 Claims Payment Standards

9.12.1 The Contractor shall meet the timeliness of payment standards specified for Medicaid FFS in Section 1902(a)(37) of the Social Security Act, 42

C.F.R. § 447.46 and specified for health carriers in WAC 284-170-431. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, 95 percent of clean claims within thirty (30) calendar days of receipt, 95 percent of all claims within sixty (60) calendar days of receipt and 99 percent of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

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

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

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

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

9.12.2 The Contractor shall support both hardcopy and electronic submission of claims and encounters for all claim types (hospital and professional services).

9.12.3 The Contractor must support hardcopy and electronic submission of claim inquiry forms, and adjustment claims and encounters.

9.12.4 The Contractor shall educate and support Behavioral Health Providers about the requirement to submit HIPAA-compliant encounters.

9.12.4.1 The Contractor shall work with BH Providers to resolve encounters or claims not approved on initial submission, identify and resolve errors in encounter submission before they become widespread and systemic, and address other billing issues discovered during the first 180 days of the Contract.

9.12.4.2 The Contractor shall ensure timely payment to BH providers for services delivered to enrollees when a mental health or SUD provider cannot submit HIPAA-compliant encounters or electronic claims.

9.12.4.3 The Contractor shall produce and provide monthly reports to contracted BH providers to assist with claims management that includes numbers of accepted claims or encounters vs. those that are not accepted on initial submission, and error rates by types of errors.

9.12.5 The Contractor shall update its claims and encounter system to support additional behavioral health services, provider types and provider specialties for rendering providers that will be added under the Apple Health Integrated Foster Care program.

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

9.12.7 The Contractor shall produce and submit to HCA a quarterly claims denial analysis report. The report is due the 15th of the month following the end of the quarter. The report shall include the following data:

9.12.7.1 Total number of:

9.12.7.1.1 Approved claims for which there was at least one denied line; and

9.12.7.1.2 Completely denied claims.

9.12.7.2 Total number of claims adjudicated in the reporting claim.

9.12.7.3 Total number of behavioral health claims denied by claim line.

9.12.7.4 Summary by reason and type of claims denied.

9.12.7.5 The total number of denied claims divided by the total number of claims.

9.12.7.6 For each of the five network billing providers with the highest number of total denied claims, the number of total denied claims expressed as a ratio to all claims adjudicated.

9.12.7.7 Total number of:

9.12.7.7.1 Behavioral Health claims received, that were not approved upon initial submission.

9.12.7.7.2 The total number of rejected/non-clean behavioral health claims, divided by the total number of claims submitted.

9.12.7.7.3 The top five reasons for behavioral health claims being rejected upon initial submission.

9.12.8 The report shall include a narrative, including the action steps planned to address:

9.12.8.1 The top five (5) reasons for denial, including provider education to the five network billing providers with the highest number of total denied claims. Provider education must address root causes of denied claims and actions to address them.

9.12.8.2 Claims denied in error by the Contractor.

9.13 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor shall provide HCA with information related to subcontracted Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), as

required by HCA Federally Qualified Health Center and Rural Health Center Billing Guides, published by HCA and incorporated by reference into this Contract.

9.14 Screening and Enrollment of Providers

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

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

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

9.15 Provider Credentialing

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

9.15.1 The Contractor's policies and procedures shall ensure compliance with the following requirements described in this Section.

9.15.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.

9.15.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

9.15.2 The Contractor's credentialing and recredentialing program shall include:

9.15.2.1 Identification of the type of providers credentialed and recredentialed, including but not limited to, acute, primary, behavioral, substance use disorder and LTSS providers, as appropriate (42 C.F.R. § 438.214(b).

9.15.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.

9.15.2.3 A process for provisional credentialing that affirms that:

9.15.2.3.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and

9.15.2.3.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.

9.15.2.3.3 Provisional credentialing shall include an assessment of:

9.15.2.3.3.1 Primary source verification of a current, valid license to practice;

9.15.2.3.3.2 Primary source verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and

9.15.2.3.3.3 A current signed application with attestation.

9.15.2.4 Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.

9.15.2.5 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.

9.15.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.

9.15.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:

9.15.3.1 Review materials.

9.15.3.2 Correct incorrect or erroneous information.

9.15.3.3 Be informed of their credentialing status.

9.15.4 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.

9.15.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.

9.15.6 The Contractor's process to ensure confidentiality.

9.15.7 The Contractor's process to ensure listings in provider directories for Enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

9.15.8 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.

9.15.9 The Contractor's process to ensure that offices of all health care professionals meet office site standards established by the Contractor.

9.15.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.(42 C.F.R. § 455.101).

9.15.11 The Contractor's process and criteria for assessing and reassessing organizational providers.

9.15.12 The criteria used by the Contractor to credential and recredential practitioners shall include (42 C.F.R. § 438.214(b)):

9.15.12.1 Evidence of a current valid license to practice;

9.15.12.2 A valid DEA or CDS certificate if applicable;

9.15.12.3 Evidence of appropriate education and training;

9.15.12.4 Board certification if applicable;

9.15.12.5 Evaluation of work history;

9.15.12.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and

9.15.12.7 A signed, dated attestation statement from the provider that addresses:

9.15.12.7.1 The lack of present illegal drug use;

9.15.12.7.2 A history of loss of license and criminal or felony convictions;

9.15.12.7.3 A history of loss or limitation of privileges or disciplinary activity;

9.15.12.7.4 Current malpractice coverage;

9.15.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and

9.15.12.7.6 Accuracy and completeness of the application.

9.15.12.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.

9.15.13 The Contractor shall ensure that subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled through the Medicare system, which requires a criminal background check as part of the enrollment process. Using https://www.medicare.gov or an enrollment verification letter from Medicare issued after March 23, 2011, the Contractor shall ensure each providers defined as "high categorical risk" are enrolled through the Medicare system. The Contractor shall document use of the Medicare.gov website when using it to verify the

subcontracted provider's status. The contractor shall ensure that contracted providers defined as "high categorical risk" revalidate their Medicare enrollment every five (5) years in compliance with 42 C.F.R. § 424.515.

9.15.13.1 If a "high categorical risk" subcontracted provider is not enrolled in the Medicare system and delivers a service that is not commonly delivered to a Medicare covered subscriber, e.g. someone under twenty-one (21) years of age, the above requirement to submit a letter from Medicare as part of the Contractor's credentialing process is waived. However, the provider must successfully complete the Contractor's credentialing process, which could include a background check.

9.15.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, fraud; integrity; or quality (42 C.F.R. § 455.101).

9.15.15 The Contractor shall notify HCA in accord with the Notices section of this contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, subcontractor or subcontractor employee.

9.15.16 The Contractor shall require providers defined as "high categorical risk" for potential fraud as defined in 42 C.F.R. § 424.518 to be enrolled and screened by Medicare.

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

9.16 Behavioral Health Administrative Service Organization (BH-ASO)

9.16.1 The Contractor shall contract with the HCA's selected Behavioral Health Administrative Services Organization (BH-ASO) for the administration of Crisis and Ombuds Services.

9.16.2 The Contractor shall reimburse the BH-ASO for behavioral health Crisis and Ombuds Services delivered to individuals enrolled in the Contractor's IFC plan. The reimbursement shall be upon receipt of a valid claim per the requirements for timely accurate claims payment under this Contract or a monthly sub-capitation.

9.16.3 In order to ensure the current level of crisis funding for the Regional Service Area is sustained for the initial two (2) years of the contract, the following provisions shall be met:

9.16.3.1 Any sub-capitation arrangement with the BH-ASO shall be reviewed and approved by the HCA.

9.16.3.2 The Contractor shall participate in a semi-annual financial reconciliation process related to predicted versus actual Crisis Services utilization.

9.16.4 The Contractor shall submit complete and accurate encounter data related to the provision of Crisis Services under this Contract in formats prescribed by the HCA.

9.16.5 The Contractor shall enter into a subcontract with the BH-ASO to evaluate and monitor the performance of the crisis system and develop corrective action where needed.

9.16.6 The subcontract with the BH-ASO shall contain the following provisions.

9.16.6.1 Crisis Services shall be available twenty-four (24) hours per day, seven (7) days per week, three hundred sixty five (365) days per year. This shall include availability of a 24/7 regional crisis hotline that provides screening and referral to a network of local providers, and availability of a 24/7 mobile crisis outreach team. Individuals will be able to access Crisis Services without full completion of Intake Evaluations and/or other screening and assessment processes. MCOs shall make it a requirement for behavioral health providers to be the first contact for their assigned member to allow for an attempt at prevention or early intervention strategies to be implemented prior to Crisis Services being contacted.

9.16.6.2 The BH-ASO shall collaborate with the Contractor to develop and implement strategies to coordinate care with community behavioral health providers for individuals with a history of frequent crisis system utilization. Coordination of care strategies will seek to reduce utilization of Crisis Services by promoting relapse/crisis prevention planning and early intervention and outreach that addresses the development and incorporation of wellness recovery action plans and Mental Health Advance Directives in treatment planning consistent with requirements in Section 14 of this Contract.

9.16.6.3 The BH-ASO shall establish information systems to support data exchange consistent with the requirements under this Contract including, but not limited to eligibility interfaces, exchange of claims and encounter data and sharing of care plans and mental health Advance Directive necessary to coordinate service delivery in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

9.16.6.4 The Contractor shall make provisions for the BH-ASO to access the individual service plan on a 24/7 basis for clients

receiving BH services.

9.16.6.5 The BH-ASO shall participate in a semi-annual financial reconciliation process as directed by the HCA.

9.16.7 The Contractor shall either cover Emergency Fills without authorization, or guarantee authorization and payment after the fact for any Emergency Fill dispensed by a contracted pharmacy.

9.16.8 For RSAs where there is no BH-ASO qualified to accept delegation of the full range of Crisis Services:

9.16.8.1 The BHO will maintain administrative responsibility for the 24/7 regional crisis hotline and Ombuds services through a direct contract with HCA.

9.16.8.2 The Contractor shall directly reimburse Crisis Services providers for Crisis Services and 24/7 mobile crisis outreach.

9.16.8.3 The Contractor shall develop and maintain a Memorandum of Understanding (MOU) with the BHO as described in Subsection 14.4 of this Contract. The MOU must address protocols for coordination between the Contractor and the BHO in order to maintain transitional care.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor shall comply with any applicable federal and state laws that pertain to Enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to Enrollees (WAC 182-503-0100; and 42 C.F.R. § 438.100(a)(2)).

10.1.2 The Contractor shall have in place written policies that guarantee each Enrollee the following rights (42 C.F.R. § 438.100(b)(2)):

10.1.2.1 Receive information on Apple Health Managed Care in general and the Contractor's Apple Health program in particular, including information about how to contact the person or entity designated as primarily responsible for coordinating the services accessed by the Enrollee.

10.1.2.2 To be treated with respect and with consideration for their dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)).

10.1.2.3 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's ability to understand (42 C.F.R. § 438.100(b)(2)(iii)).

10.1.2.4 To participate in decisions regarding their health care, including the right to refuse treatment (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.5 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.6 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164 (42 C.F.R. § 438.100(b)(2)(vi)).

10.1.2.7 Each Enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the Enrollee (42 C.F.R. § 438.100(c)).

10.1.2.8 To choose a behavioral health care provider.

10.1.3 The Contractor shall require a criminal history background check through the Washington State Patrol for employees and volunteers of the Contractor who may have unsupervised access to children, people with developmental disabilities, or vulnerable adults.

10.2 Cultural Considerations

10.2.1 The Contractor shall promote access to and delivery of services that are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic

backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

10.2.2 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (42 C.F.R. § 438.206(c)(2)).

10.2.3 At a minimum, the Contractor shall:

10.2.3.1 Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis. (CLAS Standard 4);

10.2.3.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);

10.2.3.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. (CLAS Standard 6);

10.2.3.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided. (CLAS Standard 7);

10.2.3.5 Provide easy–to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);

10.2.3.6 Establish culturally and linguistically appropriate goals. (CLAS Standard 9);

10.2.3.7 Conduct ongoing assessments of the organization's CLAS–related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. (CLAS Standard 10);

10.2.3.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and

10.2.3.9 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).

10.2.4 The Contractor shall make every effort to respect and promote awareness of and sensitivity to the needs of Gay/Lesbian/Bisexual/Transgender/Intersex/Queer/ Questioning (GLBTIQQ) Enrollees, including the increased potential for depression

and suicidal thoughts in these Enrollees.

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

10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this Section.

10.3.2 The Contractor's advance directive policies and procedures shall be disseminated to all affected providers, Enrollees, HCA, and, upon request, potential Enrollees.

10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing Advance Directives.

10.3.2.2 The Contractor's policies and procedures respecting the implementation of advance directives and POLST rights shall be included in the Enrollee handbook at a location designated in its template by HCA, and shall be featured on the Contractor's website in the member/enrollee section.

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

10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

10.3.3.2 Identify the state legal authority permitting such objection.

10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

10.3.4 If an Enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive or received a POLST, the Contractor may give advance directive information to the Enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated Enrollee or to a surrogate or other concerned persons in accord with state law. The Contractor is not relieved of its obligation to provide this information to the Enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

10.3.5 The Contractor must require and ensure that the Enrollee's medical record documents, in a prominent part, whether or not the individual has

executed an advance directive or received a POLST.

10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an Enrollee based on whether or not the Enrollee has executed an advance directive or received a POLST.

10.3.7 The Contractor shall ensure compliance with requirements of state and federal law (whether statutory or recognized by the courts of the State) regarding advance directives or POLSTs.

10.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives or POLSTs.

10.3.9 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable state and federal law concerning advance directives. The Contractor shall document its community education efforts (42 C.F.R. § 438.6(i)(3)).

10.3.10 The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and state law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

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

10.4 Mental Health Advance Directive

10.4.1 The Contractor shall maintain a written Mental Health Advance Directive (MHAD) policy and procedure that respects individuals' Advance Directive for behavioral health care. Policy and procedures must comply with Chapter 71.32 RCW.

10.4.2 The Contractor shall inform all Enrollees who present for mental health services of their right to a Mental Health Advance Directive, and shall provide technical assistance to those who express an interest in developing and maintaining a Mental Health Advance Directive.

10.4.3 The Contractor shall maintain current copies of any Mental Health

Advance Directive in the Enrollee's record.

10.4.4 The Contractor shall inform Enrollees that complaints concerning noncompliance with a MHAD should be referred to the Department of Health by calling 1-360-236-2620.

10.5 Do Not Resuscitate Orders

For Enrollees who are medically fragile and who may have life threatening conditions or episodes, the Contractor shall coordinate with the Enrollee's family, caregivers, Social Workers and providers to develop appropriate documentation regarding Do Not Resuscitate (DNR) and palliative care orders consistent with DCYF policy. The Contractor shall document all contacts with the Enrollee's family, caregivers, Social Workers and providers to ensure all available treatments are explored and that the DNR is the most appropriate decision for the Enrollee.

10.6 Enrollee Choice of PCP/Behavioral Health Provider

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

10.6.2 The Contractor shall allow, to the extent possible and appropriate, each new Enrollee or their caregiver or adoptive parent to choose a participating PCP (42 C.F.R. § 438.3(l)). If the Enrollee has special needs that necessitate selection of a specialist or PCP with special knowledge of the Enrollee's condition, the Contractor shall coordinate with the Enrollee's caregiver or adoptive parent to ensure the appropriate provider is selected.

10.6.3 The Contractor shall offer each Enrollee a choice of providers for medically necessary behavioral health services.

10.6.4 In the case of newborns, either the caregiver or the parent, if the parent is an IFC Enrollee, shall choose the newborn's PCP.

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

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

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

10.6.8 The Contractor shall allow an Enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the Enrollee's request for the change (WAC 182-538-060 and WAC 284-170-360) and shall work with the Enrollee and/or the Enrollee's caregivers or adoptive parents to select the PCP who will best meet the Enrollee's needs.

10.7 Prohibition on Enrollee Charges for Covered Services

10.7.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including non-participating providers, charge Enrollees for covered services as described in the (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 C.F.R. § 438.106(c), 438.6(1), 438.230, 438.204(a) and WAC 182-502-0160).

10.7.2 Prior to authorizing services with non-participating providers, the Contractor shall assure that non-participating providers fully understand and accept the prohibition against balance billing Enrollees.

10.7.3 The Contractor shall require providers to report when an Enrollee/caregiver is charged for services. The Contractor shall maintain a central record of the charged amount, Enrollee/caregiver's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an Enrollee/caregiver is charged for services, whether or not those charges are appropriate.

10.7.4 If an Enrollee/caregiver has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee/caregiver the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee/caregiver fail, the contractor will repay the Enrollee the inappropriately charged amount.

10.7.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees/caregivers from being billed for contracted services.

10.7.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee/caregiver for covered services including other insurer's copayments and coinsurance.

10.8 Provider/Enrollee Communication

The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient, for the following (42 C.F.R. § 438.102(a)(1)(i)):

10.8.1 The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 C.F.R. § 438.102(a)(1)(i)).

10.8.2 Any information the Enrollee's caregiver needs in order to decide among all relevant treatment options (42 C.F.R. § 438.102(a)(1)(ii)).

10.8.3 The risks, benefits, and consequences of treatment or non-treatment (42 C.F.R. § 438.102(a)(1)(iii)).

10.8.4 The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 C.F.R. § 438.102(a)(1)(iv)).

10.9 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from Enrollees, or persons authorized to consent on behalf of an Enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (chapter 70.122 RCW) and state and federal Medicaid rules concerning advance directives (WAC 182-501-0125 and 42 C.F.R. § 438.6(m)); and, when appropriate, inform Enrollees of their right to make anatomical gifts (chapter 68.64 RCW).

10.10 Women's Health Care Services

The Contractor must provide female Enrollees with direct access to a women's health practitioners within the Contractor's network for covered care necessary to provide women's routine and preventive health care services, including prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-170-350 and 42 C.F.R. § 438.206(b)(2). The Contractor shall ensure that Long Acting Reversible Contraceptives (LARC) are readily available to Enrollees without authorization processes that cause unnecessary delays.

10.11 Maternity Newborn Length of Stay

The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

10.12 Enrollment Not Discriminatory

10.12.1 The Contractor will not discriminate against Enrollees due to an adverse change in the Enrollee's health status, the cost of meeting the Enrollee's health care needs, because of the Enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

10.12.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or mental condition, functional impairment or chemical dependency, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

10.12.3 The Contractor will not exclude from participation in any health program or activity, deny benefits to, or discriminate against Enrollees or those eligible to enroll on the basis of race, color, national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any

sensory, mental or physical disability, or the use of a trained guide dog or service animal by a person with a disability (42 C.F.R. § 438.3(d)(4)) and 42 U.S.C. 18116.

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Utilization Management General Requirements

The Contractor shall follow the Utilization Management (UM) requirements described in this Section and educate UM staff in the application of UM protocols, communicating the criteria used in making UM decisions. UM protocols shall recognize and respect the cultural needs of diverse populations.

11.1.1 Drug Utilization Review (DUR) Program

11.1.1.1 The Contractor shall operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Social Security Act and 42 C.F.R. Part 456, Subpart K.

11.1.1.2 The Contractor shall provide a detailed description of its drug utilization review program by December 31 of each calendar year for the prior federal fiscal year (October 1 through September 30). The first report is due no later than December 31, 2019.

11.1.1.3 Contractor must provide a DUR Program to assure that prescriptions are appropriate, Medically Necessary and not likely to result in adverse medical outcomes, and to enhance the quality of patient care by educating prescribers, pharmacists and Enrollees.

11.1.2 Prospective Drug Utilization Review (Pro-DUR)

11.1.2.1 Contractor must provide for a review of drug therapy before each prescription is filled or delivered to a member at the point-of-sale or point-of-distribution. The review shall include screening for potential drug therapy problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, drug-allergy interactions, drug refill too soon and clinical abuse/misuse.

11.1.3 Retrospective Drug Utilization Review (Retro-DUR)

11.1.3.1 Contractor must, through its drug claims processing and information retrieval system, examine claims data and other records to identify patterns of fraud, and abuse such as gross overuse, excessive filling or inappropriate or medically unnecessary care among physicians, pharmacists and members.

11.1.3.2 Contractor shall, on an ongoing basis, assess data on drug use against explicit predetermined standards (using nationally recognized compendia and peer reviewed medical literature) including but not limited to monitoring for therapeutic appropriateness, overutilization and underutilization,

appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse and, as necessary, introduce remedial strategies, in order to improve the quality of care.

11.1.3.3 Contractor shall provide for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems aimed at improving prescribing or dispensing practices.

11.1.4 The Contractor shall demonstrate that all UM staff making service authorization decisions have been trained and are competent in working with the specific area of service for which they have authorization and management responsibility including but not limited to: co-occurring MH and SUDs; co-occurring behavioral health and medical diagnoses; and co-occurring behavioral health and I/DD, and that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health or long-term services and supports needs (42 C.F.R 438.210(b)(3)).

11.1.5 The Contractor's policies and procedures related to UM shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this Section.

11.1.6 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and behavioral services it furnishes its Enrollees. The UMP description shall include:

11.1.6.1 The definition of the Contractor's UMP structure and assignment of responsibility for UMP activities to appropriate individuals.

11.1.6.2 Identification of a designated physician responsible for program implementation, oversight and evaluation, and evidence of the physician's and a behavioral health practitioner's involvement in program development and implementation.

11.1.6.3 Identification of the type of personnel responsible for each level of UM decision–making.

11.1.6.4 The use of board-certified consultants to assist in making medical necessity determinations.

11.1.6.5 Assurance that a physician, doctoral level psychologist, certified addition medicine specialist or pharmacist, as appropriate, reviews any behavioral health denial based on

medical necessity.

11.1.6.6 A written description of all UM-related committee(s)

11.1.6.7 Descriptions of committee responsibilities.

11.1.6.8 Committee participant titles, including UM subcontract, subcontractor representatives and practicing providers.

11.1.6.9 Meeting frequency.

11.1.6.10 Maintenance of signed meeting minutes reflecting decisions made by each committee, as appropriate.

11.1.6.11 Behavioral healthcare benefits to include at a minimum:

11.1.6.11.1 Benefit structure and description;

11.1.6.11.2 Triage and referral procedures and protocols, if any, (i.e., clearly describe how Enrollees access behavioral healthcare services);

11.1.6.11.3 UM activities and staff roles and responsibilities;

11.1.6.11.4 Coordination activities with the behavioral healthcare system, including Ombuds;

11.1.6.11.5 Monitoring and oversight of the behavioral health program; and

11.1.6.11.6 Strategies to foster integration of physical health and behavioral health.

11.1.6.12 Annual evaluation and update of the UMP.

11.1.6.13 By no later than three (3) months after the Contract effective date and annually thereafter, the Contractor shall submit to HCA for approval a UMP description that incorporates and accommodates initiatives requested by HCA when there are changes to the UMP approved by the Contractor and HCA.

11.1.7 The Contractor shall monitor each Enrollee's needs and appropriately refer Enrollees for Care Coordination or Intensive Care Management services consistent with Section 14 of this Contract.

11.1.8 The Contractor shall document use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-2000(2)).

11.1.9 The Contractor shall have written policies for applying UMP decision-making criteria based on individual Enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; and the availability of services in the local delivery system.

11.1.10 The Contractor shall have mechanisms for providers and Enrollees on how they can obtain the UM decision-making criteria upon request,

including UM Adverse Benefit Determination (denial) determination letter template language reflecting the same (WAC 284-43-2000(2)).

11.1.11 The Contractor shall have mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions for both physical and behavioral health.

11.1.12 The Contractor shall maintain a list of all behavioral health services requiring prior authorization by the Contractor and submit to HCA annually on January 31, each year. The Contractor shall also publish this list on their website.

11.1.13 The Contractor shall maintain written job descriptions of all Contractor UM staff. Contractor staff that review denials of care based on medical necessity shall have job descriptions that describe required education, training or professional experience in medical or clinical practice and evidence of a current, non-restricted license, including HIPAA training compliance.

11.1.14 The Contractor shall have mechanisms to verify that claimed services were actually provided.

11.1.15 The Contractor shall require authorization decisions for behavioral health services are made by Washington licensed behavioral health professionals except when there is no Washington resources for specialty review. Contractor staff described in this subsection shall review any behavioral health Adverse Benefit Determination (denial) based on medical necessity, including any decision to authorize a service in an amount, duration, or scope that is less than requested.

11.1.15.1 A physician board-certified or board-eligible in Psychiatry or Child Psychiatry;

11.1.15.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM;

11.1.15.3 A licensed, doctoral level psychologist; or

11.1.15.4 A pharmacist, as appropriate.

11.1.16 The Contractor shall have behavioral health professionals with Utilization Management experience working in a behavioral health Managed Care setting or WA State behavioral health clinical settings on staff. These staff must include individuals who are Certified Chemical Dependency Professionals (CDPs) or have three (3) years of experience in a Substance Use Disorder setting.

11.1.17 The Contractor must designate at least one (1) Children's Care Manager who oversees behavioral health services requested for Enrollees under age twenty-one (21) that is a Children's Mental Health Specialist or who is supervised by a Children's Mental Health Specialist.

11.1.18 The Contractor shall have Utilization Management staff who have experience and expertise in working with one (1) or more of the following

populations:

11.1.18.1 Children, Transitional Age Youth, and adults with behavioral health needs;

11.1.18.2 High risk groups such as individuals with behavioral health conditions with or without co-occurring SUD;

11.1.18.3 Co-occurring behavioral health and chronic medical conditions or I/DD;

11.1.18.4 Individuals involved with multiple service systems;

11.1.18.5 Individuals with a SUD in need of medication-assisted treatment;

11.1.18.6 High risk groups, such as individuals involved in the juvenile justice and criminal justice systems; and

11.1.18.7 Individuals who are homeless.

11.1.19 The Contractor shall have a sufficient number of behavioral health clinical peer reviewers available to conduct denial and appeal reviews or to provide clinical consultation on psychological testing, complex case review and other treatment needs.

11.1.20 The Contractor shall ensure that any physical or behavioral health clinical peer reviewer who is subcontracted or works in a service center other than the Contractor's Washington State service center shall be subject to the same supervisory oversight and quality monitoring as staff located in the Washington State service center, to include participation in initial orientation and at least annual training on Washington State specific benefits, protocols and initiatives.

11.1.21 The Contractor shall ensure that any behavioral health Adverse Benefit Determinations must be peer-to-peer — that is, the credential of the licensed clinician making the decision to authorize service in an amount, duration or scope that is less than requested must be at least equal to that of the recommending clinician. In addition:

11.1.21.1 A physician board-certified or board-eligible in Psychiatry must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations and reductions) for psychiatric treatment.

11.1.21.2 A physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM, must review all inpatient level of care Adverse Benefit Determinations (full or partial denials, terminations, and reductions) for SUD treatment.

11.1.22 The Contractor shall ensure documentation of timelines for Appeals shall be in accordance with the Appeal Process provisions of the Grievance and Appeal System Section of this Contract.

11.1.23 The Contractor shall implement the coverage decisions of the Health

Technology Clinical Committee (HTCC) (chapter 182-55 WAC) as directed by HCA (See Health Technology Assessment (HTA) resources: http://www.hca.wa.gov/about-hca/health-technology-assessment).

11.1.24 Prior Authorization Administrative Simplification Workgroup. The Contractor shall participate in the statewide Prior Authorization Administrative Simplification Workgroup convened by the OIC (RCW 48.165.030). The Contractor will abide by best practice recommendations agreed to by the Prior Authorization Administrative Simplification Workgroup unless otherwise directed by HCA.

11.1.25 Opioid Crisis Engagement. The Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to collaborate on approaches to the opioid crisis. Contractor activities developed in collaboration with peer managed care organizations and the HCA medical directors to address this health and safety concern may include, but are not limited to: Identification and management of Enrollees taking high-dose opioids for non-cancer pain; prescriber and Enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, use of naloxone, requesting second opinions from a pain management specialist, preauthorization of opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or substance use disorder programs for assessment.

11.1.26 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee (42 C.F.R. § 438.210(e)).

11.1.27 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of Participating Provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service.

11.1.28 The Contractor shall develop and implement UM protocols, including policies and procedures and Level of Care Guidelines for behavioral health services that are specific to Washington State Levels of Care, consistent with the HCA's medical necessity criteria and comply with federal and state parity requirements.

11.1.29 The Contractor shall establish criteria for, and document and monitor consistent application of Medical Necessity criteria and Level of Care Guidelines to include:

11.1.29.1 UM protocols and guidelines as well as any subsequent modifications to the protocols and guidelines for behavioral health levels of care shall be submitted to the HCA for prior review and approval.

11.1.29.2 The Contractor's Level of Care Guidelines must include

criteria for authorization of inpatient behavioral health care at a community hospital and extensions to community hospital episodes of care.

11.1.29.3 The Contractor shall establish protocols for discharge planning during initial and continued stay reviews that addresses:

11.1.29.3.1 Treatment availability and community supports necessary for recovery including, but not limited to: housing, financial support, medical care, transportation, employment and/or educational concerns, and social supports.

11.1.29.3.2 Barriers to access to and/or engagement with post-discharge ambulatory appointments, including Medication Management and other interventions.

11.1.29.3.3 Procedures for Concurrent Review, if applicable for Enrollees requiring extended inpatient care due to poor response to treatment and/or placement limitations.

11.1.29.3.4 Corrective action expectations for ambulatory providers who do not follow-up on Enrollees discharged from inpatient settings as per the transitional health care services timeframes defined in Section 14 of this Contract.

11.2 Prescription Drug Authorization Decisions and Timeframes

11.2.1 Contractor must include in its written policies and procedures an assurance that all requirements and conditions governing coverage and payment for Covered Outpatient Drugs, such as, but not limited to, prior authorization (including step therapy), medical necessity guidelines, age edits, drug rebate encounter submission, reporting, notices of decision, etc. will, apply, regardless of whether the Covered Outpatient Drug is provided as an outpatient drug benefit or as a “medical benefit” incident to a medical service and billed by the prescribing Provider using codes such as the Healthcare Common Procedure Coding System (HCPCS).

11.2.2 Contractor must respond to a prior authorization request for a covered outpatient drug or over-the-counter drug by telephone or other telecommunication device within twenty-four (24) hours of the request. Authorization Determinations for Covered Out Patient Drugs or Over-the-Counter Drugs: Consistent with Section 1927(d)(5) of the Social Security Act, all authorization determinations for prescriptions or over-the-counter drugs must be made no later than the following business day after receipt of the request for service unless additional information is required. Any additional information needed must be requested by the close of business on the first day following the initial request for authorization and

determinations must be made no later than close of business on the first business day after receipt of the additional information. If the provider does not respond to the Contractor's request for additional information within three (3) business days of the request the Contractor must make a decision based on the information at hand.

11.2.3 Contractor shall have in place a mechanism to allow automated approval of prior authorization criteria based on situation specific codes or values submitted via point-of-sale by the dispensing pharmacy. Overrides of prior authorization criteria may be based on values submitted in either the prior authorization or diagnosis fields.

11.2.4 Contractor shall have a process for providing an emergency drug supply to Enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the Enrollee's health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

11.2.5 Contractor shall have a process for authorization after the fact of an emergency fill as defined in this Contract when an emergency fill of a medication is dispensed according to the professional judgment of the dispensing pharmacist not to exceed thirty (30) calendar days' supply. The authorization for the prescription must match the drug quantity and days supplied as dispensed by the pharmacist.

11.3 Medical Necessity Determination

The Contractor shall collect all information necessary to make medical necessity determinations. (42 C.F.R § 456.111 and 456.211). The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding appeals, hearings and independent review.

11.4 Authorization of Services

11.4.1 The Contractor shall follow the authorization of services requirements described in this Section. The Contractor shall not have or implement authorization policies that inhibit Enrollees from obtaining medically necessary contracted services and supplies. For example, inpatient admissions for deliveries or home births should not require prior authorization because there is not a question of medical necessity associated with a delivery. It is reasonable to require notification of admissions for delivery or of a home delivery to support concurrent review activities or case management.

11.4.2 Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for chronic conditions.

11.4.3 The Contractor's policies and procedures related to authorization and post-service review of services shall include compliance with 42 C.F.R. § 438.210, WAC 284-43-2000(6)(b), chapters 182-538 and 182-550 WAC, WAC 182-501-0160 and -0169, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this Section, and shall include a definition of "service authorization" that includes an Enrollee's request for services.

11.4.4 The Contractor shall provide education and ongoing guidance to Enrollees and providers about its UM protocols and level of care guidelines, including admission, continued stay and discharge criteria.

11.4.5 The Contractor shall consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(2)(ii)).

11.4.6 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in addressing the Enrollee's medical or behavioral health condition or long-term services and supports (42 C.F.R. § 438.210(b)(3)).

11.4.6.1 In denying services, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the FFS program. For services that are excluded from this Contract, but are covered by HCA, the Contractor's denial will include directions to the Enrollee about how to obtain the services through HCA and will direct the Enrollee to those services and coordinate receipt of those services.

11.5 Timeframes for Authorization Decisions

11.5.1 The Contractor shall provide for the following timeframes for authorization decisions and notices:

11.5.1.1 Denial of Payment that may result in Payment Liability. The authorization decision and notice is provided for the Enrollee, at the time of any Adverse Benefit Determination affecting the claim.

11.5.1.2 Termination, Suspension, or Reduction of Previously Authorized Services. The authorization decision and notice is provided ten (10) calendar days prior to such termination, suspension, or reduction, except in the following circumstances:

11.5.1.2.1 The Enrollee dies;

11.5.1.2.2 The Contractor has a signed written Enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that

termination, reduction, or suspension of services is the result of supplying this information);

11.5.1.2.3 The Enrollee is admitted to an institution where he or she is ineligible for services;

11.5.1.2.4 The Enrollee's address is unknown and mail directed to him or her has no forwarding address;

11.5.1.2.5 The Enrollee has moved out of the Contractor's service area past the end of the month for which a premium was paid;

11.5.1.2.6 The Enrollee's PCP prescribes the change in the level of medical care;

11.5.1.2.7 An adverse determination regarding the preadmission screening for nursing facility was made; or

11.5.1.2.8 The safety or health of individuals in the nursing facility would be endangered, the Enrollee's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Enrollee's urgent medical needs, or an Enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to Adverse Benefit Determinations for nursing facility transfers).

11.5.1.3 Standard authorizations for Health Care Services determinations: The authorization decisions are to be made and notices are to be provided as expeditiously as the Enrollee's health condition requires (42 C.F.R. § 438.210(d)(1)). The Contractor must make a decision to approve, deny, or request additional information from the provider within five (5) calendar days of the original receipt of the request. If additional information is required and requested, the Contractor must give the provider five (5) calendar days to submit the information and then approve or deny the request within four (4) calendar days of the receipt of the additional information (WAC 284-43-2050).

11.5.1.3.1 A possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances (42 C.F.R. § 438.210(d)(1)):

11.5.1.3.1.1 The Enrollee or the provider requests an extension; or

11.5.1.3.1.2 The Contractor justifies and documents a need for additional

information and how the extension is in the Enrollee's interest.

11.5.1.3.2 If the Contractor extends the timeframe past fourteen (14) calendar days of the receipt of the request for service:

11.5.1.3.2.1 The Contractor shall provide the Enrollee written notice within three (3) business days of the Contractor's decision to extend the timeframe. The notice shall include the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision.

11.5.1.3.2.2 The Contractor shall issue and carry out its determination as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires (42 C.F.R. § 438.404(c)(4)).

11.5.1.3.3 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).

11.5.1.4 Expedited Authorization Decisions: For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires.

11.5.1.4.1 The Contractor will make the decision within two (2) calendar days if the information provided is sufficient; or request additional information within one (1) calendar day, if the information provided is not sufficient to approve or deny the request. The Contractor must give the provider two (2)

calendar days to submit the requested information and then approve or deny the request within two (2) calendar days of the receipt of the additional information.

11.5.1.4.2 The Contractor may extend the expedited time period by up to ten (10) calendar days under the following circumstances (42 C.F.R. § 438.210(d)(2)(ii):

11.5.1.4.2.1 The Enrollee requests the extension; or

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

11.5.1.5 Concurrent Review Authorizations: The Contractor must make its determination within one (1) business day of receipt of the request for authorization.

11.5.1.5.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) business days of the request of the authorization, if the Contractor has made at least one (1) attempt to obtain needed clinical information within the initial one (1) business day after the request for authorization of additional days or services.

11.5.1.5.2 Notification of the Concurrent Review determination shall be made within one (1) business day of the Contractor’s decision.

11.5.1.5.3 Expedited appeal timeframes apply to Concurrent Review requests.

11.5.1.6 Post-service Authorizations: For post-service authorizations, including pharmacy post-service authorizations, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.

11.5.1.6.1 The Contractor shall notify the Enrollee in writing and the requesting provider either orally or in writing within three (3) business days of the Contractor’s determination.

11.5.1.6.2 Standard appeal timeframes apply to post-service denials.

11.5.1.6.3 When post-service authorizations are approved, they become effective the date the service was first administered.

11.5.1.7 Verified Enrollee Fraud: The Contractor shall give notice at least five (5) calendar days before the effective date when the Adverse Benefit Determination is a termination, suspension, or reduction of previously authorized Medicaid-Covered Services when Enrollee Fraud has been verified.

11.5.1.8 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an Adverse Benefit Determination), authorization decisions are to be made and Notices of Adverse Benefit Determinations are to be provided no later than the date that the timeframes expire (42 C.F.R. § 438.404(c)(5)).

11.5.1.9 Extenuating Circumstances: When extenuating circumstances are identified, consistent with *Best Practice Recommendation for Extenuating Circumstances around Pre-Authorization and Admission Notification*, and the provider is not able to request a pre-authorization prior to treating the Enrollee or provide timely notification to the Contractor of the Enrollee's admission, the Contractor shall allow claims and related appeals to process as if a pre-authorization had been requested or admission notification had been submitted within the time period (WAC 284-43-2060).

11.6 **Notification of Coverage and Authorization Determinations:**

11.6.1 For all Adverse Benefit Determinations, the Contractor must notify the Enrollee in writing and the requesting provider or facility orally or in writing. The Contractor must notify the parties, other than the Enrollee, in advance whether it will provide notification by phone, mail, fax, or other means. The Contractor must use an HCA-developed template for Skilled Nursing-related Adverse Benefit Determinations.

11.6.1.1 Adverse Benefit Determinations Involving Expedited Authorization: The Contractor must notify the Enrollee in writing of the decision. The Contractor may initially provide notice orally to the Enrollee or the requesting provider within seventy-two (72) hours of the request. The Contractor shall send the written notice no later than seventy-two (72) hours after receipt of the request for service.

11.6.1.2 Adverse Authorization Decisions involving a WISe screening. The Contractor must notify the Enrollee in writing of the decision to deny WISe services if a Children and Adolescent Needs and Strengths screen is provided and WISe services

are not offered.

11.6.1.3 The Contractor shall notify the requesting provider and give the Enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements (42 C.F.R. § 438.210(c) and 438.404):

11.6.1.3.1 The notice to the Enrollee shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.

11.6.1.3.2 For all authorization decisions, the notice shall be mailed as expeditiously as the Enrollee's health condition requires and within three (3) business days of the Contractor's decision.

11.6.1.3.3 The notice to the Enrollee and provider shall explain the following (42 C.F.R. § 438.404(b)(1-3)(5-7)):

11.6.1.3.3.1 The Adverse Benefit Determination the Contractor has taken or intends to take.

11.6.1.3.3.2 The reasons for the Adverse Benefit Determination, in easily understood language, including citation to the Washington Administrative Code rules or any Contractor guidelines, protocols, or other criteria that were the basis of the decision.

11.6.1.3.3.3 If applicable the notice must include information about alternative covered services/treatment which may be seen as a viable treatment option in lieu of denied services.

11.6.1.3.3.4 The Enrollee and providers right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision.

11.6.1.3.3.5 A statement whether or not an Enrollee has any liability for payment.

11.6.1.3.3.6 A toll-free telephone number to call if the Enrollee is billed for services.

11.6.1.3.3.7 The Enrollee's or the provider’s right to file an appeal and any deadlines applicable to the process.

11.6.1.3.3.8 If services are denied as non-covered, inform Enrollees how to access the Exception to Rule (ETR) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an ETR to obtain the services that are the subject of the appeal, and that requesting an ETR does not affect any deadlines applicable to the appeal process.

11.6.1.3.3.9 If services are denied or authorized in a more limited scope, amount or duration than requested because they would exceed the established limit on the scope, amount or duration of the requested service, inform Enrollees how to access the Limitation Extension (LE) process including, but not limited to, the fact that an Enrollee may appeal an Adverse Benefit Determination affecting his or her services and simultaneously request an LE to obtain the services that are the subject of the appeal, and that requesting an LE does not affect any deadlines applicable to the appeal process.

11.6.1.3.3.10 The procedures for exercising the Enrollee’s rights.

11.6.1.3.3.11 The circumstances under which expedited resolution is available and how to request it.

11.6.1.3.3.12 The Enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the Enrollee may be required to pay for these services.

11.6.1.3.3.13 The Enrollee's right to receive the Contractor's or regional Ombuds' assistance with filing the appeal.

11.6.1.3.3.14 The Enrollee's right to equal access to services for Enrollees and potential Enrollees with communications barriers and disabilities.

11.6.1.4 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an Adverse Benefit Determination. The Contractor shall issue a formal Notice of Adverse Benefit Determination to the Enrollee, including the Enrollee's right to an appeal. See 42 C.F.R. § 438.404(c)(5).

11.6.1.5 UM Authorization Turnaround Time Compliance Report: The Contractor will send a quarterly report to HCA by the last day of the month following the quarter that shall include:

11.6.1.5.1 Monthly UM authorization determination data that demonstrates timeliness compliance rates separated into Standard, Pharmacy, Expedited, Concurrent Review, and Post-service timelines, including:

11.6.1.5.1.1 Percentage compliance, including those in which the timeline is extended appropriately;

11.6.1.5.1.2 Specific numbers of authorization determinations meeting contractual timeframes and the numbers of those that did not; and

11.6.1.5.1.3 For those authorization determinations that did not meet contractual timeframes, the range of time to complete the authorization determinations.

11.6.1.5.2 If UM authorization turnaround time compliance is below 90 percent in any month during the quarter for any of the authorization categories specified in this Contract, the report shall also include a narrative description of the Contractor's efforts before and after notification to HCA to address the problem.

11.7 Experimental and Investigational Services for Managed Care Enrollees

11.7.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual Enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its FFS program described in WAC 182-501-0165, including the option to approve an investigational or experimental service when there is:

11.7.1.1 A humanitarian device exemption for the requested service or device from the Food and Drug Administration (FDA); or

11.7.1.2 A local institutional review board (IRB) protocol addressing issues of efficacy and safety of the requested service that satisfies both the HCA and the requesting provider.

11.7.2 Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual Enrollee based on that Enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.

11.7.3 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid Enrollees than that applied to any other members.

11.7.4 An Adverse Benefit Determination made by the Contractor shall be subject to appeal through the Contractor's appeal process, hearing, and independent review process in accordance with the Grievance and Appeal System section of this Contract.

11.8 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with Federal regulations. Where it is necessary to harmonize federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

11.9 Institutes of Mental Disease

The Contractor may provide services in lieu of those described in the Medicaid State Plan and allowed under Medicaid. The services must meet all DOH licensing

and certification standards and be medically necessary. The Contractor is not required to provide these services in lieu of Medicaid State Plan services. All costs and encounter reporting requirements are the same for any provided in lieu of services.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents and subcontractors to comply with the requirements of this Section. (42 C.F.R. § 438.608).

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.

12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed below:

12.1.3.1 Section 1902(a)(68) of the Social Security Act;

12.1.3.2 42 C.F.R. § 438;

12.1.3.3 42 C.F.R. § 455;

12.1.3.4 42 C.F.R. § 1000 through 1008;

12.1.3.5 Chapter 182-502A WAC; and

12.1.3.6 Chapters 74.09 and 74.66 RCW.

12.1.4 The Contractor shall ensure compliance with the program integrity provisions of this Contract, including proper payments to providers or subcontractors and methods for detection and prevention of Fraud, Waste, and Abuse.

12.1.5 The Contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues, and with MFCD on fraud or abuse investigation issues. This will include the following:

12.1.5.1 Participation in MCO-specific, quarterly program integrity meetings with HCA following the submission of the quarterly allegation log defined in Subsection 12.9, Reporting, of this Contract. Discussion at these meetings shall include but not be limited to case development and monitoring.

12.1.5.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.

12.1.5.3 Quality control and review of encounter data submitted to HCA.

12.1.5.4 Participation in meetings with MFCD, as determined by MFCD and the Contractor.

12.1.6 The Contractor shall have adequate staffing and resources dedicated to Washington State to perform fraud, waste and abuse analysis of its

authorization, utilization, claims, provider's billing patterns, encounter data to detect improper payments, and shall perform audits and investigations of subcontractors, providers, and provider entities that provide services to Washington State Medicaid Enrollees.

12.1.6.1 When the Contractor or the state identifies an Overpayment, pursuant to Section 1128J(d), the funds must be recovered by and returned to the state or the Contractor. For the purposes of this subsection, "overpayment" means a payment from the Contractor to a provider or subcontractor to which the provider or subcontractor is not legally entitled.

12.1.6.2 To maintain compliance with Section 1128J(d) of the Social Security Act, Overpayments that are not recovered by or returned to the Contractor within sixty (60) calendar days from the date they were identified and known by the provider or subcontractor and the Contractor, may be recovered by HCA.

12.2 Disclosure by Managed Care Organization: Information on Ownership and Control

12.2.1 The Contractor must provide to HCA the following disclosures (42 C.F.R. § 455.103, 42 C.F.R § 455.104, SSA §§ 1903(m)(2)(A)(viii), 1124(a)(2)(A)):

12.2.2 The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of 5 percent or more of the Contractor's equity (or, in the case of a subcontractor's disclosure, 5 percent or more of the subcontractor's equity);

12.2.3 The identification of any person or corporation with an ownership interest of 5 percent or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least 5 percent of the value of the Contractor's assets (or, in the case of a subcontractor's disclosure, a corresponding obligation secured by the subcontractor equal to 5 percent of the subcontractor's assets);

12.2.4 The name, address, date of birth, and Social Security Number of any managing employee of the Managed Care Organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

12.2.5 The disclosures must include the following:

12.2.5.1 The name, address, and financial statement(s) of any person (individual or corporation) that has 5 percent or more ownership or control interest in the Contractor.

12.2.5.2 The name and address of any person (individual or

corporation) that has 5 percent or more ownership or control interest in any of the Contractor's subcontractors.

12.2.5.3 Indicate whether the individual/entity with an ownership or control interest is related to any other Contractor's employee such as a spouse, parent, child, or siblings; or is related to one of the Contractor's officers, directors or other owners.

12.2.5.4 Indicate whether the individual/entity with an ownership or control interest owns 5 percent or greater in any other organizations.

12.2.5.5 The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

12.2.5.6 Date of birth and Social Security Number (in the case of an individual).

12.2.5.7 Other tax identification number (in the case of a corporation) with an ownership or control interest in the managed care organization or its subcontractor.

12.2.6 The Contractor must terminate or deny network participation if a provider, or any person with 5 percent or greater direct or indirect ownership interest , fails to submit sets of fingerprints in a form and manner to be determined by HCA, within thirty (30) calendar days when requested by HCA or any authorized federal agency.

12.2.7 Disclosures from the Contractor are due to HCA at any of the following times:

12.2.7.1 When the Contractor submits a proposal in accordance with an HCA procurement process.

12.2.7.2 When the Contractor executes the Contract with HCA.

12.2.7.3 Upon renewal or extension of the Contract.

12.2.7.4 Within thirty-five (35) calendar days after any change in ownership of the Contractor. The Contractor shall report the change on the HCA Medicaid Provider Disclosure Statement Form HCA-09-048.

12.2.7.5 Upon request by HCA.

12.3 Disclosure by Managed Care Organization: Information on Ownership and Control, Subcontractors and Providers

12.3.1 The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

12.3.1.1 Requiring the subcontractor or provider to disclose to the MCO upon contract execution [42 C.F.R. § 455.104(c)(1)(ii)], upon request during the re-validation of enrollment process

under 42 C.F.R. § 455.414 [42 C.F.R. § 455.104(c)(1)(iii)], and within thirty-five (35) business days after any change in ownership of the subcontractor or provider 42 C.F.R. § 455.104(c)(1)(iv).

12.3.1.2 The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(1)(i).

12.3.1.3 If the subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address. 42 C.F.R. § 455.104(b)(1)(i).

12.3.1.4 If the subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s). 42 C.F.R. § 455.104(b)(1)(iii).

12.3.1.5 If the subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. § 455.104(b)(1)(ii).

12.3.1.6 If the subcontractor or provider has a 5 percent ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s). 42 C.F.R. § 455.104(b)(1)(iii).

12.3.1.7 Whether any person with an ownership or control interest in the subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor/provider. 42 C.F.R. § 455.104(b)(2).

12.3.1.8 If the subcontractor or provider has a 5 percent ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.104(b)(43).

12.3.1.9 Whether any person with an ownership or control interest in the subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider or in any managed care entity. 42 C.F.R. § 455.104(b)(4).

12.3.2 Upon request, the Contractor and the Contractor's subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

12.3.2.1 The ownership of any subcontractor with whom the Contractor or subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date

of the request (42 C.F.R § 455.105(b)(1)).

12.3.2.2 Any significant business transactions between the Contractor or subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request (42 C.F.R § 455.105(b)(2)).

12.3.3 Upon request, the Contractor and the Contractor's subcontractors shall furnish to the Washington Secretary of State, the Secretary of the US Department of Health and Human Services, the Inspector General of the US Department of Health and Human Services, the Washington State Auditor, the Comptroller of the Currency, and HCA a description of the transaction identified under 42 C.F.R § 455.105 between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions 42 C.F.R. § 438.50(c)(1):

12.3.3.1 A description of transactions between the Contractor and a party in interest (as defined in Section 1318(b) of the Public Health Service Act), including the following:

12.3.3.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.

12.3.3.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.

12.3.3.1.3 Any lending of money or other extension of credit between the Contractor and such a party. (1903(m)(4)(B); 42 C.F.R. § 438.50(c)(1)).

12.4 Information on Persons Convicted of Crimes

The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

12.4.1 Requiring the subcontractor/provider to investigate and disclose to the MCO, at contract execution or renewal, and upon request by the MCO of the identified person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is [42 C.F.R. § 455.106(a)]:

12.4.1.1 A person who has an ownership or control interest in the subcontractor or provider. 42 C.F.R. § 455.106(a)(1).

12.4.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or provider. 42

C.F.R. § 455.101; 42 C.F.R. 455.106(a)(1).

12.4.1.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the subcontractor or provider. 42 C.F.R. § 455.101; 42 C.F.R. § 455.106(a)(2).

12.5 Fraud, Waste and Abuse (FWA)

12.5.1 The Contractor, or the Contractor's subcontractor delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between HCA and the Contractor, shall implement and maintain administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse. (42 C.F.R. § 438.608(a)). The arrangements or procedures must include the following:

12.5.1.1 A compliance program that includes, at a minimum, all of the following elements:

12.5.1.1.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state requirements.

12.5.1.1.2 Designation of a Compliance Officer who is accountable for developing and implementing policies and procedures, and practices designed to ensure compliance with the requirements of the contract and who directly reports to the Chief Executive Officer (CEO) and the Board of Directors.

12.5.1.1.3 Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.

12.5.1.1.4 System for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under this Contract.

12.5.1.1.5 Effective lines of communication between the Compliance Officer and the Contractor's staff and subcontractors.

12.5.1.1.6 Enforcement of standards through well-publicized disciplinary guidelines.

12.5.1.1.7 Establishment and implementation of procedures and a system with dedicated staff of routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract.

12.5.1.2 Provision for prompt reporting of all overpayments identified and recovered, specifying the overpayments due to potential fraud, to HCA. (42 C.F.R § 438.608(a)(2)).

12.5.1.3 Provision for notification to HCA when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. (42 C.F.R § 438.608(a)(4)).

12.5.1.4 Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis. (42 C.F.R § 438.608(a)(5)).

12.5.1.4.1 The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of Enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20).

12.5.1.4.2 Results of the verification and any action(s) taken must be available upon HCA's request.

12.5.1.5 Written policies for all employees of the Contractor that provide detailed information about the False Claims Act, including protections for whistleblowers, as described in Section 1902(a)(68) of the Social Security Act; 42 C.F.R § 438.608(a)(6), and the Washington false claims statutes, chapters 74.66 RCW and RCW 74.09.210, including information about rights of employees to be protected as whistleblowers, and the criminal statutes found in chapter

74.09.230-.280 RCW.

12.5.1.6 Provision for prompt referral of any potential fraud, waste, or abuse the Contractor identifies to HCA Program Integrity and potential fraud to the MFCD pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(7)).

12.5.1.7 Provision for the Contractor's suspension of payments to a network provider for which HCA determines there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 and pursuant to Subsection 12.6. (42 C.F.R § 438.608(a)(8)).

12.5.1.8 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.5.1.9 Provision for notification of the Contractor's program integrity activities when requested by HCA or MFCD to prevent duplication of activities.

12.5.2 The Contractor and its subcontractors shall:

12.5.2.1 Provide written disclosure of any prohibited affiliation in accordance with 42 C.F.R. § 438.610; 42 C.F.R. § 455.106; and 42 C.F.R § 438.608(c)(1) to HCA;

12.5.2.2 Provide written disclosures of information on ownership and control required under 42 C.F.R. § 455.104; 42 C.F.R. § 455.105; and 42 C.F.R § 438.608(c)(2); and

12.5.2.3 Report to HCA within sixty (60) calendar days when it has identified capitation payments or other payment amounts received are in excess to the amounts specified in this Contract. (42 C.F.R. § 438.608(c)(3)).

12.5.3 Treatment of recoveries made by the Contractor of overpayments to the providers. (42 C.F.R. § 438.608(d)).

12.5.3.1 The Contractor and its subcontractors shall have:

12.5.3.1.1 Have internal policies and procedures for the documentation, retention and recovery of all overpayments, specifically for the recovery of overpayments due to fraud, waste, or abuse.

12.5.3.1.2 Report the identification and recovery of all overpayments as required in subsection 12.9.

12.5.3.2 This subsection of the contract does not apply to any amount of a recovery to be retained under False Claim Act cases or through other investigations.

12.5.3.3 The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment within sixty (60) calendar days, and to notify the Contractor in writing of the

reason for the overpayment.

12.5.3.4 The Contractor shall report at least annually to HCA, or as required in the Contract, on their recoveries of overpayments. See Subsection 12.9, Reporting.

12.5.4 In accordance with RCW 74.09.195, when the Contractor conducts an audit of a Contractor's provider or subcontractor, the Contractor must:

12.5.4.1 Provide a thirty (30) day notice to a provider or subcontractor prior to an onsite audit, unless there is evidence of danger to public health and safety or fraudulent activities.

12.5.4.2 Avoid auditing a provider or subcontractor claim that is or has already undergone an audit, review or investigation by the Contractor, HCA, MFCD, or another governmental or law enforcement entity.

12.5.4.3 Allow a provider or subcontractor, at their request, to submit records requested as a result of an audit in electronic format, including compact disc, digital versatile disc, or other electronic formats deemed appropriate by the Contractor, or by facsimile transmission.

12.5.4.4 Extrapolate only when there is a sustained high level of payment error or when documented provider or subcontractor educational intervention has failed to correct the level of payment error.

12.5.4.5 Issue draft or preliminary findings within one-hundred twenty (120) calendar days from receipt of all provider or subcontractor information required to conduct the audit.

12.5.4.6 Provide a detailed explanation in writing to a provider or subcontractor for any adverse determination that would result in partial or full recoupment of a payment to the provider or subcontractor. The written notification shall, at a minimum, include the following:

12.5.4.6.1 The reason for the adverse determination;

12.5.4.6.2 The specific criteria on which the adverse determination was based;

12.5.4.6.3 An explanation of the provider's appeal rights; and

12.5.4.6.4 If applicable, the appropriate procedure to submit a claim adjustment.

12.5.4.7 Ensure all informal and formal appeal processes are completed before recouping overpayments.

12.5.4.8 Offer a provider or subcontractor with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve

months.

12.5.4.9 In any appeal by a health care provider, employ or contract with a medical or dental professional who practices within the same specialty, is board-certified, and experienced in the treatment, billing, and coding procedures used by the provider being audited to make findings and determinations.

12.5.4.10 Provide educational and training programs annually for providers. The training topics must include a summary of audit results, a description of common issues, problems and mistakes identified through audits and reviews, and opportunities for improvement.

12.5.4.11 In the event of an audit of a provider or subcontractor who is no longer in the Contractor's network, include a description of the claim with patient name, date of service and procedure.

12.5.4.12 Consistent with the requirements in 42 C.F.R. § 438.4, HCA will utilize the information and documentation collected in subsections 12.5.3 and 12.5.4 of this Contract for setting actuarially sound capitation rates for each Contractor.

12.5.5 The Contractor must provide HCA a detailed list of current and past program integrity activities initiated and completed by the Contractor upon HCA's or MFCD's request.

12.5.6 Notification and treatment of potential provider and subcontractor improper payments made by the Contractor and identified by HCA.

12.5.6.1 HCA will notify the Contractor to conduct an audit or review when potential provider or subcontractor improper payment(s) are identified by HCA, see chapter 182-502A WAC. The Contractor shall:

12.5.6.1.1 Initiate an audit or review of the potential improper payment(s) within thirty (30) calendar days of HCA's notification;

12.5.6.1.2 Report to HCA when initiation of the audit or review occurs; and

12.5.6.1.3 Report to HCA the outcome of the Contractor's audit or review.

12.5.6.2 If the Contractor confirms an improper payment was made to the provider or subcontractor, the Contractor shall follow the requirements found in RCW 74.09.195, and:

12.5.6.2.1 Following any applicable appeal process, recoup overpayments from the provider or subcontractor, as appropriate;

12.5.6.2.2 Work with the provider or subcontractor to void or adjust improperly paid claim(s);

12.5.6.2.3 Submit an adjustment to or void the encounter record submitted to HCA to reflect the recoupment of the overpayment or provider/subcontractor adjusted or voided; and

12.5.6.2.4 Record all fraud, waste and abuse program integrity activities, in progress and completed in the monthly Program Integrity Report.

12.6 Referrals of Credible Allegations of Fraud and Provider Payment Suspensions

The Contractor shall establish policies and procedures for referring all identified allegations of potential fraud to HCA and MFCD, and for provider payment suspensions. When HCA notifies the Contractor that a credible allegation of fraud exists, the Contractor shall follow the provisions for payment suspension contained in this Section. (42 C.F.R § 455.23).

12.6.1 When the Contractor has concluded that an allegation of potential fraud exists, the Contractor shall make a Fraud referral to MFCD and HCA within five (5) business days of the determination. The referral must be submitted to HCA through MC-Track and emailed to MFCUreferrals@atg.wa.gov.. The Contractor shall report using the WA Fraud Referral Reporting Form.

12.6.2 When HCA determines the Contractor's referral of potential fraud is a credible allegation of fraud, HCA shall notify the Contractor's compliance officers.

12.6.2.1 To suspend provider payments, in full, in part, or if a good cause exception exists to not suspend. (42 C.F.R § 438.608(a)(8)).

12.6.2.1.1 Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral.

12.6.2.2 Whether MFCD, or other law enforcement agency, accepts or declines the referral.

12.6.2.2.1 If HCA, MFCD, or other law enforcement agencies decline to investigate the fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in this Subsection 12.6.

12.6.3 Upon receipt of payment suspension notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within five (5) calendar days of HCA's notification to suspend payment, unless the MCFD or other law enforcement agency requests a temporary withhold of the notice.

12.6.4 The notice of payment suspension must include or address all of the

following (42 C.F.R. § 455.23(2)):

12.6.4.1 State that payments are being suspended in accordance with this provision;

12.6.4.2 Set forth the general allegations identified by HCA. The notice should not disclose any specific information concerning an ongoing investigation;

12.6.4.3 State that the suspension is for a temporary period and cite suspension will be lifted when notified by HCA that it is no longer in place;

12.6.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

12.6.4.5 Where applicable and appropriate, inform the provider of any Appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.

12.6.5 All suspension of payment actions under this Section will be temporary and will not continue after either of the following:

12.6.5.1 The Contractor is notified by HCA, MFCD, or other law enforcement agency that there is insufficient evidence of Fraud by the provider; or

12.6.5.2 The Contractor is notified by HCA, MFCD, or other law enforcement agency that the legal proceedings related to the provider's alleged Fraud are completed.

12.6.6 The Contractor must document in writing the termination of a payment suspension and issue a notice of the termination to the provider and send a copy to HCA.

12.6.7 HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a Credible Allegation of Fraud if any of the following are applicable:

12.6.7.1 MFCD or other law enforcement agency have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

12.6.7.2 Other available remedies are available to the Contractor, after HCA approves the remedies as more effective or timely to protect Medicaid funds.

12.6.7.3 HCA determines, based upon the submission of written evidence by the Contractor, individual or entity that is the subject of the payment suspension, there is no longer a Credible Allegation of Fraud and that the suspension should be removed. HCA shall review evidence submitted by the

Contractor or provider. The Contractor may include a recommendation to HCA. HCA shall direct the Contractor to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence.

12.6.7.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:

12.6.7.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

12.6.7.4.2 The individual or entity serves a large number of Enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

12.6.7.5 MFCD or law enforcement agency declines to certify that a matter continues to be under investigation.

12.6.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.

12.6.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

12.6.8.1 Details of payment suspensions that were imposed in whole or in part; and

12.6.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

12.6.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a Credible Allegation of Fraud without good cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accordance with the Sanctions Subsection of this Contract.

12.6.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity or individual, the entirety of such monetary recovery belongs exclusively to the state of Washington and the Contractor and any involved subcontractor have no claim to any portion of such recovery.

12.6.11 Furthermore, the Contractor is fully subrogated, and shall require its Subcontractors to agree to subrogate, to the state of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity or individual that directly or indirectly receives funds under this Contract including, but not limited to, any Health Care Provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design,

manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.

12.6.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

12.6.13 For the purposes of this Section, “subrogation” means the right of any state of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party.

12.7 Investigations

12.7.1 The Contractor shall cooperate with all state and federal agencies that investigate fraud, waste and abuse.

12.7.2 The Contractor shall suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable state or federal agency.

12.7.3 The Contractor shall maintain all records, documents and claim or encounter data for Enrollees, providers and subcontractors who are under investigation by any state or federal agency in accordance with retention rules or until the investigation is complete and the case is closed by the investigating state or federal agency.

12.7.4 The Contractor shall comply with directives resulting from state or federal agency investigations.

12.7.5 The Contractor shall request a refund from a third-party payor, provider or subcontractor when an investigation indicates that such a refund is due. These refunds must be reported to HCA as overpayments.

12.8 Excluded Individuals and Entities

The Contractor and its subcontractors are prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person. The Contractor shall notify the suppliers of the excluded individual and allow the suppliers a fifteen (15) day grace period from the notification to stop all prescription fills. (Social Security Act (SSA) Section 1903(i)(2); 42 C.F.R. § 455.104, § 455.106, and § 1001.1901(b)).

12.8.1 The Contractor shall monitor for excluded individuals and entities by:

12.8.1.1 Screening Contractor and subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.

12.8.1.2 Screening individuals during the initial provider application,

credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.

12.8.1.3 Screening the LEIE and SAM lists monthly by the 15th of each month for all Contractor and subcontractor individuals and entities with an ownership or control interest, and individuals defined as affiliates in the Federal Acquisition Regulation, of an individual that is debarred, suspended, or otherwise excluded from participating in procurement activities, and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities. 42 C.F.R. § 438.610(a) and (b), SMD letter 2/20/98).

12.8.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

12.8.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within five (5) business days of discovery.

12.8.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to Enrollees. (SSA Section 1128A(a)(6) and 42 C.F.R. § 1003.102(a)(2)).

12.8.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA Section 1126(b), and 42 C.F.R. § 455.104(a).

12.8.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).

12.8.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.9 **Reporting**

12.9.1 All Program Integrity notification and reporting to HCA shall be in accordance with the provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.

12.9.2 All Program Integrity notification and reports shall be submitted through the MC-Track application unless otherwise instructed in this Section and/or within the notification form or report templates. See table below of listing of notification forms and reports and their respective due dates:

DELIVERABLES	FREQUENCY	DUE DATE
Annual Program Integrity Plan for WA State	Annual	March 1 of each calendar year.
Records	On Request, or while On-site	By the date specified in HCA's record request or while onsite.
Program Integrity Report	Monthly	Thirty (30) calendar days after the end of the reporting month.
PIR001 – Annual Program Integrity Report for WA State	Annual	March 1 of each calendar year.
HCA Medicaid Provider Disclosure Statement Form HCA-09-048	Ad Hoc	Within thirty five (35) calendar days of an owner change
WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) business days from the date of discovery.
WA Fraud Referral Form	Ad Hoc	Within five (5) business days from the date of determining a credible allegation of fraud exists.

12.9.3 On a monthly basis, the Contractor shall use the Program Integrity Form to report the following:

12.9.3.1 Allegations of provider and subcontractor fraud received and reviewed by the contractor.

12.9.3.2 Program Integrity Activities and all required notifications found in Subsection 12.5.

12.9.3.3 Provider Termination Report to include but not limited to:

12.9.3.3.1 Termination for convenience;

12.9.3.3.2 Provider self-termination;

12.9.3.3.3 Terminations due to:

12.9.3.3.3.1 Sanction;

12.9.3.3.3.2 Invalid Licenses;

12.9.3.3.3.3 Services or Billing Errors;

12.9.3.3.3.4 Re-credentialing Errors;

12.9.3.3.3.5 Data Mining;

12.9.3.3.3.6 Investigation; or

12.9.3.3.3.7 Any other related program integrity involuntary terminations.

12.9.4 A completed HCA PIR001 – WA Annual Program Integrity Report for WA State. See subsection 12.9.2 for the specific due date.

12.9.4.1 A completed Annual Program Integrity Report containing details of the improper payments identified, overpayments recovered, and costs avoided for the program integrity activities conducted by the Contractor for the preceding year. The report shall include a report of all provider and service-specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations, authorization denials, payment edits and audits, provider credentialing outcomes and terminations, and COB/TPL identification outcomes.

12.9.5 The Contractor is responsible for investigating Enrollee fraud, waste, and abuse. If the Contractor suspects client/member/enrollee fraud:

12.9.5.1 The Contractor shall notify and submit all associated information of any alleged or investigated cases in which the Contractor believes there is a serious likelihood of Enrollee fraud to the HCA Office of Medicaid Eligibility and Policy (OMEP) by:

12.9.5.1.1 Sending an email to WAHeligibilityfraud@hcwa.wa.gov; or

12.9.5.1.2 Calling the Office of Medicaid Eligibility and Policy at 360-725-0934 and leave a detailed voice mail message; or

12.9.5.1.3 Mailing a written referral to:

Health Care Authority
Attention: OMEP
P.O. Box 45534
Olympia, WA 98504-5534

Or

12.9.5.1.4 Faxing the written complaint to Attention Washington Apple Health Eligibility Fraud at360-725-1158;

12.9.6 Any excluded individuals and entities discovered in the screening described in the Fraud, Waste and Abuse subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within five (5) business days of discovery. The identified excluded individual/entities shall be reported using the WA Excluded Individual Reporting Form.

12.9.7 The Contractor shall investigate and disclose to HCA, within five (5) calendar days of Contractor's discovery or upon request from HCA, the identity of any person who has been convicted of a criminal offense

related to that person's involvement in any program under Medicare, Medicaid, or the Children's Health Insurance Program (CHIP) services program since the inception of those programs and:

12.9.7.1 Who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor; or

12.9.7.2 Any person entering into a provider or subcontractor agreement with the Contractor, or

12.9.7.3 Any person who has ownership or control interest in a provider or subcontractor, or

12.9.7.4 Is an agent or managing employee of the provider or subcontractor.

12.9.8 The Contractor and any person entering into a provider or subcontractor agreement, or a person who has ownership or control interest in a provider or subcontractor, or is an agent or managing employee of the provider or subcontractor shall, on a monthly basis, check the LEIE and SAM database to identify any excluded individuals/entities. Documentation shall be kept validating the review of the databases and provided to HCA upon request.

12.9.9 The Contractor shall submit to HCA via MC-Track or ProviderOne help ticket all payment and enrollment inquiries to include but not limited to Newborn retro-enrollment, Service Base Enhancement (DCR, WISe, etc.), regular premium payments and other demographic changes that may impact eligibility (DOD, Address, etc.) Please refer to the Payment Assistant Request section of the Encounter Data Reporting Guide.

12.9.10 The Contractor shall submit an Annual Program Integrity Plan of activities the Contractor plans for the upcoming year. The Plan shall include all provider, service and subcontractor specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations planned, services requiring authorization, prepayment services or providers, payment edits and audits, provider credentialing, and COB/TPL identification.

12.10 Access to Records, On-site Inspections and Periodic Audits

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

12.10.2 The Contractor and its subcontractors shall forthwith produce all records, documents, or other data requested as part of such inspection, review,

audit, investigation, monitoring or evaluation identified in subsection 12.10.1. If the requesting agency requests copies of records, documents, or other data, the Contractor and its subcontractors shall make copies of records and shall deliver them to the requestor, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. Copies of records and documents shall be made at no cost to the requesting agency. (42 C.F.R. § 455.21(a)(2); 42 C.F.R. § 431.107(b)(2)). The right for the parties named above to audit, access and inspect under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later, or any other timeframe authorized by law. (42 C.F.R. § 438.3(h)). A record, in this section, includes but is not limited to:

12.10.2.1 Medical records;

12.10.2.2 Billing records;

12.10.2.3 Financial records;

12.10.2.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;

12.10.2.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

12.10.2.6 Any record of a Contractor-paid claim or encounter, or a Contractor-denied claim or encounter.

12.10.3 Upon request, the Contractor, its provider or subcontractor shall provide and make staff available to assist in such inspection, review, audit, investigation, monitoring or evaluation, including the provision of adequate space on the premises to reasonably accommodate HCA, MFCD or other state or federal agency.

12.10.4 HCA will conduct, or contract for the conduct of, periodic audits of the Contractor no less frequently than once every three (3) years of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, each Contractor. (42 C.F.R. § 438.602(e)).

12.11 **Affiliations with Debarred or Suspended Persons**

Pursuant to Section 1932(d)(1)(A) of the SSA (42 U.S.C. § 1396u-2(d)(1)(A)):

12.11.1 The Contractor shall not knowingly have a director, officer, partner, or person with beneficial ownership of more than 5 percent of the Contractor's equity who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.11.2 The Contractor shall not knowingly have a director, officer, partner, or

person with beneficial ownership of more than 5 percent of the Contractor's equity who is affiliated with another person who has been debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order.

12.11.3 The Contractor shall not have an employment, consulting, or any other contractual agreement with a debarred or suspended person or entity for the provision of items or services that are significant and material to this Contract.

12.11.4 The Contractor shall agree and certify it does not employ or contract, directly or indirectly, with:

12.11.4.1 Any individual or entity excluded from Medicaid or other federal health care program participation under Sections 1128 (42 U.S.C. § 1320a-7) or 1128A (42 U.S.C. § 1320a) of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual;

12.11.4.2 Any individual or entity discharged or suspended from doing business with the HCA; or

12.11.4.3 Any entity that has a contractual relationship (direct or indirect) with an individual convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act.

12.12 **Transparency**

12.12.1 HCA shall post on its website, as required by 42 C.F.R. § 438.10(c)(3), the following documents and reports:

12.12.1.1 The Contract;

12.12.1.2 The data at 42 C.F.R. § 438.604(a)(5) which HCA certifies that the Contractor has complied with the Contract requirements for availability and accessibility of services, including adequacy of the provider network, as set forth in 42 C.F.R. § 438.206;

12.12.1.3 The name and title of individuals included in 42 C.F.R. § 438.604(a)(6) to confirm ownership and control of the Contractor, described in 42 C.F.R. § 455.104, and subcontractors as governed by 42 C.F.R. § 438.230; and

12.12.1.4 The results of any audits, under 42 C.F.R. § 438.602(e), of the accuracy, truthfulness, and completeness of the encounter and financial data submitted and certified by the Contractor.

12.12.2 In accordance with RCW 74.09.195, HCA will post performance metrics

and outcomes on its website.

13 GRIEVANCE AND APPEAL SYSTEM

13.1 General Requirements

The Contractor shall have a Grievance and Appeal System which complies with the requirements of 42 C.F.R. § 438 Subpart F and chapters 182-538, 182-526, and 284-43 WAC, insofar as those WACs are not in conflict with 42 C.F.R. § 438 Subpart F. The Grievance and Appeal System includes a Grievance process, access to the state's administrative hearing process, and access to independent review through the Contractor. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor shall have policies and procedures addressing the Grievance and Appeal System, which comply with the requirements of this Contract. HCA must approve, in writing, all Grievance and Appeal System policies and procedures and related notices to Enrollees regarding the Grievance and Appeal System.

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

13.1.3 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-4020(2)(h)).

13.1.4 The Contractor shall inform Enrollees about Behavioral Health Ombuds services including how to access these services, and provide Enrollees any reasonable assistance necessary in completing forms and other procedural steps for grievances and appeals (42 C.F.R. § 438.406(a)(1) and WAC 284-43-4020(2)(d)). Enrollees may also use the free and confidential regional Ombuds services for assistance with Grievances and Appeals.

13.1.5 The Contractor shall cooperate with any representative authorized in writing by the Enrollee (WAC 284-43-4020(2)(e)).

13.1.6 The Contractor shall consider all information submitted by the Enrollee or representative (WAC 284-43-4020(2)(f)).

13.1.7 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within two (2) business days.

13.1.8 The Contractor shall acknowledge in writing the receipt of each appeal. The Contractor shall provide the written notice to both the Enrollee and requesting provider within five (5) calendar days of receipt of the appeal. (42 C.F.R. § 438.406(a)(2)).

13.1.9 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making , nor were they a subordinate or direct report of any such individual (42 C.F.R. § 438.406(a)(3)(i)).

13.1.10 A physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral

health appeal of care based on medical necessity.

13.1.11 Decisions regarding grievances and appeals shall be made by individuals with clinical expertise in treating the Enrollee's condition or disease if any of the following apply (42 C.F.R. § 438.406(a)(3)(ii)):

13.1.11.1 If the Enrollee is appealing an Adverse Benefit Determination concerning medical necessity, including any decision to not authorize the service in an amount, duration or scope less than requested.

13.1.11.2 If an Enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.11.3 If the grievance or appeal involves any clinical issues.

13.1.12 For the grievance process, a foster care Enrollee's authorized representative includes the SSS/social worker, caregiver, Fostering Well-Being Care Coordination Unit staff member, or otherwise court-ordered representative.

13.1.13 With respect to any decisions described in subsection 13.1.10 that involve behavioral health, the Contractor shall ensure that the individuals making such decisions:

13.1.13.1 Have clinical expertise in treating the Enrollee's condition or disease that is age appropriate and when clinically indicated (e.g., a pediatric psychiatrist for a child Enrollee).

13.1.13.2 Are physician board-certified or board-eligible in Psychiatry or Child Psychiatry if the Grievance or Appeal is related to inpatient level of care denials for psychiatric treatment.

13.1.13.3 Are physician board-certified or board-eligible in Addiction Medicine, a Sub-specialty in Addiction Psychiatry or by ASAM, if the Grievance or Appeal is related to inpatient level of care denials for SUD treatment.

13.1.13.4 Are one (1) or more of the following, as appropriate, if a clinical Grievance or Appeal is not related to inpatient level of care denials for psychiatric or SUD treatment:

13.1.13.4.1 Physicians board-certified or board-eligible in Psychiatry, Addiction Medicine or a sub-specialty in Addiction Psychiatry or by ASAM;

13.1.13.4.2 Licensed, doctoral level psychologists; or

13.1.13.4.3 Pharmacists.

13.2 **Grievance Process**

The following requirements are specific to the grievance process:

13.2.1 An Enrollee or the Enrollee's authorized representative may file a Grievance with the Contractor at any time. Only an Enrollee or the

Enrollee's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of an Enrollee (42 C.F.R. § 438.402(b)(3)) unless the provider is acting on behalf of the Enrollee and with the Enrollee's written consent.

13.2.2 Enrollee Grievances must be filed with the Contractor, not with HCA. HCA will forward any grievance received by HCA to the Contractor for resolution.

13.2.3 The Contractor shall accept, document, record, and process Grievances forwarded by HCA or DSHS.

13.2.4 The Contractor shall provide a written response to HCA within three (3) business days to any constituent grievance, unless HCA requests an expedited response. For the purpose of this Subsection, "constituent grievance" means a complaint or request for information from any state or federal elected official or any state or federal agency director or designee.

13.2.5 The Contractor shall investigate and resolve all Grievances whether received orally or in writing (WAC 284-43-4020(g)). The Contractor shall not require an Enrollee or his/her authorized representative to provide written follow-up for a grievance the Contractor received orally.

13.2.6 The Contractor shall complete the resolution of a Grievance and notice to the affected parties as expeditiously as the Enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the Grievance. The Contractor may extend the timeframe for processing a Grievance by up to fourteen (14) calendar days if the Enrollee requests the extension. For any extension not requested by an Enrollee, the Contractor must document that there is need for additional information and that the delay is in the Enrollee's best interest and give the Enrollee prompt oral notice of the delay.

13.2.6.1 If the Contractor extends the timeline for a Grievance not at the request of the Enrollee, it must give the Enrollee written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if he or she disagrees with that decision. 42 C.F.R. § 438.408(c)(2)(ii); and 42 C.F.R. § 438.408(b)(1).

13.2.7 The Contractor must notify Enrollees of the resolution of Grievances within five (5) business days of determination. The notification may be orally or in writing for Grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing, must be easily understood and meet all Enrollee communications requirements in Subsection 3.2.

13.2.8 Enrollees do not have the right to a hearing in regard to the resolution of a Grievance.

13.3 **Appeal Process**

The following requirements are specific to the appeal process:

13.3.1 An Enrollee, the Enrollee's authorized representative, or a provider acting on behalf of the Enrollee and with the Enrollee's written consent, may appeal a Contractor Adverse Benefit Determination (42 C.F.R. § 438.402(b)(1)(ii)).

13.3.1.1 If a provider has requested an appeal on behalf of an Enrollee, but without the Enrollee's written consent, the Contractor shall not dismiss the appeal without first contacting the Enrollee within five (5) calendar days of receipt of the provider's request, informing the Enrollee that an appeal has been made on the Enrollee's behalf, and then asking if the Enrollee would like to continue the appeal. The Contractor shall have made at least three (3) attempts to contact the Enrollee on three (3) different business days, at three (3) different times during the day, without success, prior to dismissing the provider-initiated appeal request.

13.3.1.2 If the Enrollee wants to continue the Appeal, the MCO shall obtain from the Enrollee a written consent for the Appeal. If the Enrollee does not wish to continue the Appeal, the MCO shall formally dismiss the Appeal, in writing, with appropriate Enrollee Appeal rights and by delivering a copy of the dismissal to the provider as well as the Enrollee.

13.3.1.3 For expedited appeals, the Contractor may bypass the requirement for Enrollee written consent and obtain Enrollee oral consent. The Enrollee's oral consent shall be documented in the Contractor's UMP records.

13.3.2 If HCA receives a request to appeal an Adverse Benefit Determination of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the Enrollee.

13.3.3 For Appeals of standard service authorization decisions, an Enrollee, or a provider acting on behalf of the Enrollee, must file an appeal, either orally or in writing, within sixty (60) calendar days of the date on the Contractor's Notice of Advance Benefit Determination. This also applies to an Enrollee's request for an expedited appeal (42 C.F.R. § 438.402(b)(2) and WAC 182-538-110).

13.3.4 For Appeals for termination, suspension, or reduction of previously authorized services when the Enrollee requests continuation of such services, an Enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the Notice of Adverse Benefit Determination. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 C.F.R. § 438.420 and WAC 182-538-110).

13.3.5 The Enrollee may request an appeal either orally or in writing. An oral appeal must be followed by a written, signed, appeal unless the Enrollee requests an expedited resolution or the Contractor determines the timeframe for standard appeal decisions could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function (42 C.F.R. § 438.402(c)(3)(ii). The Contractor shall outreach and coordinate as needed to assist the Enrollee in submitting a written, signed appeal.

13.3.5.1 If the Enrollee does not provide a written, signed appeal within ten (10) calendar days of a standard oral appeal request, the Contractor shall notify the Enrollee, in writing, of the need for the written appeal, unless the Enrollee's sixty (60) day timeline to file an appeal has expired. The notification shall include an HCA-produced template for written appeals; a pre-stamped and addressed return envelope; and the Enrollee's appeal rights, which allow the Enrollee to appeal until sixty (60) calendar days from the date on the Contractor's Notice of Adverse Benefit Determination.

13.3.5.2 During the appeal process, the Contractor shall proactively engage the Enrollee offering alternative treatment or pathway of care steps, care coordination, or explaining the continuation of benefits to support meeting medically necessary care.

13.3.6 The Appeal process shall provide the Enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the Enrollee of the limited time available for this sufficiently in advance of the resolution timeframe for appeals in the case of expedited resolution (42 C.F.R. § 438.406(b)(5) and § 438.408(b) and (c)).

13.3.7 The appeal process shall provide the Enrollee and the Enrollee's representative copies of the Enrollee's case file, including medical records, other documents and records relied on, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information must be provided upon request by either the Enrollee or the Enrollee's representative and free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. §438.308(b) and (c). (42 C.F.R. § 438.406(b)(3)).

13.3.8 The Appeal process shall include as parties to the appeal, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate (42 C.F.R. § 438.406(b)(4)).

13.3.9 In any Appeal of an Adverse Benefit Determination by a subcontractor, the Contractor or its subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.10 The Contractor shall resolve each Appeal and provide notice, as

expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):

13.3.10.1 For standard resolution of Appeals and for Appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the appeal, unless the Contractor notifies the Enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for appeal. For any extension not requested by an Enrollee, the Contractor shall resolve the appeal as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

13.3.10.2 The Enrollee may request an extension in the timeframe for processing an appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay.

13.3.10.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

13.3.11 The Contractor shall provide notice of resolution of the appeal in a language and format which may be understood by the Enrollee. The notice of the resolution of the appeal shall:

13.3.11.1 Be in writing and sent to the Enrollee and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice (42 C.F.R. § 438.408(d)).

13.3.11.2 Include the date completed and reasons for the determination in easily understood language (42 C.F.R. § 438.408(e)).

13.3.11.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or Enrollee may obtain the UMP clinical review or decision-making criteria.

13.3.11.4 For Appeals not resolved wholly in favor of the Enrollee (42 C.F.R. § 438.408(e)(2)):

13.3.11.4.1 Include information on the Enrollee's right to request a hearing and independent review and how to do so.

13.3.11.4.2 Include information on the Enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.11.4.3 Inform the Enrollee that the Enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's Adverse Benefit Determination.

13.4 Expedited Appeal Process

13.4.1 The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).

13.4.2 The Enrollee may file an expedited appeal either orally or in writing. No additional Enrollee follow-up is required.

13.4.3 The Contractor shall resolve each appeal and provide notice, as expeditiously as the Enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):

13.4.3.1 For expedited resolution of appeals or appeals of mental health drug authorization decisions, including notice to the affected parties, the Contractor shall make a decision within seventy-two (72) hours after the Contractor receives the appeal. The Contractor shall also make reasonable efforts to provide oral notice of the decision.

13.4.3.2 The Enrollee may request an extension in the timeframe for processing an appeal for up to fourteen (14) calendar days. For any extension not requested by an Enrollee, the Contractor must document how the delay is in the Enrollee's best interest and make reasonable efforts to provide oral notice of the delay. If the Contractor extends the timeline for processing an expedited appeal not at the request of the enrollee, it must resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

13.4.3.2.1 The Contractor must follow up the oral notification within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

13.4.4 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an Enrollee's appeal (42 C.F.R. § 438.410(b)).

13.4.5 If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard resolution of appeals timeframe in this Contract, and make reasonable efforts to give the Enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice of denial (42 C.F.R. § 438.410(c)).

13.4.5.1 The Enrollee has a right to file a grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor must inform the Enrollee of their right to file a grievance in the notice of denial.

13.5 Administrative Hearing

13.5.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an Enrollee.

13.5.2 If an Enrollee does not agree with the Contractor's resolution of the appeal, the Enrollee may file a request for a hearing within the following time frames (See WAC 182-526-0200):

13.5.2.1 For hearings regarding a standard service, within one hundred twenty (120) calendar days of the date of the notice of the resolution of the appeal (42 C.F.R. § 438.402(b)(2)).

13.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the Enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the Enrollee is notified in a timely manner and the Enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

13.5.3 If the Enrollee requests a hearing, the Contractor shall provide to HCA and the Enrollee, upon request, and within three (3) business days, and for expedited appeals, within one (1) business day, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4 When medical necessity is an issue, the Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals and the outcome of any independent review.

13.5.5 The Enrollee must exhaust appeal rights prior to filing a request for a hearing with HCA. If the Contractor fails to adhere to the appeal notice and timing requirements, the Enrollee is deemed to have exhausted the appeal process and may initiate a hearing (42 C.F.R § 438.408(c)(3)).

13.5.6 The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final

order shall not be the basis for termination of enrollment by the Contractor.

13.5.7 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.8 The hearings process shall include as parties to the hearing, the Contractor, the Enrollee and the Enrollee's representative, or the legal representative of the deceased Enrollee's estate and HCA.

13.6 Independent Review

After exhausting both the Contractor's Appeal process and the Administrative Hearing, the Enrollee has the right to request an independent review in accordance with RCW 48.43.535 and chapter 182-538 WAC.

The MCO will advise the HCA Appeals Administrator at P.O. Box 45504, Olympia, WA 98504-5504 when an Enrollee requests an independent review as soon as the MCO becomes aware of the request. The MCO will forward a copy of the decision made by the Independent Review Organization to the Appeals Administrator as soon as the MCO receives the decision.

13.7 Petition for Review

Any party may appeal the initial order from the administrative hearing to HCA Board of Appeals in accord with chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the administrative hearing.

13.8 Continuation of Services

13.8.1 The Contractor shall continue the Enrollee's services if all of the following apply (42 C.F.R. § 438.420):

13.8.1.1 An Appeal, hearing, or independent review, is requested on or before the later of the following:

13.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of Adverse Benefit Determination, which for Adverse Benefit Determinations involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

13.8.1.1.2 The intended effective date of the Contractor's proposed Adverse Benefit Determination.

13.8.1.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

13.8.1.3 The original period covered by the original authorization has

not expired.

13.8.1.4 The Enrollee requests an extension of services.

13.8.2 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's services while the appeal, hearing, or independent review, is pending, the services shall be continued until one of the following occurs (42 C.F.R. § 438.420 and WAC 182-526-0200 and WAC 182-538-110):

13.8.2.1 The Enrollee withdraws the appeal, hearing, or independent review request.

13.8.2.2 The Enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days after the Contractor mailed the notice of resolution of the appeal.

13.8.2.3 When the Office of Administrative Hearings issues a decision adverse to the Enrollee.

13.8.3 If the final resolution of the appeal upholds the Contractor's Adverse Benefit Determination, the Contractor may recover from the Enrollee the amount paid for the services provided to the Enrollee for the first sixty (60) calendar days during which the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

13.9 Effect of Reversed Resolutions of Appeals and Hearings

13.9.1 If the Contractor, or an independent review (IR) decision by an independent review organization (IRO), or a final order from the Office of Administrative Hearings (OAH) or Board of Appeals (BOA), reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires , but no later than 72 hours from the date the Contractor receives notice reversing the determination (42 C.F.R. § 438.424(a)).

13.9.2 If the final order of OAH, or the HCA Board of Appeals, or an IRO reverses a decision to deny authorization of services and the Enrollee received the disputed services while the Appeal was pending, the Contractor shall pay for those services. (42 C.F.R. § 438.424(b)).

13.10 Recording and Reporting Adverse Benefit Determinations, Grievances, Appeals and Independent Reviews

The Contractor shall maintain records of all adverse benefit determinations, grievances, appeals and independent reviews.

13.10.1 The records shall include Adverse Benefit Determinations, grievances and appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such adverse benefit determinations, grievances, appeals, and independent

reviews.

13.10.2 The Contractor shall provide a report of all adverse benefit determinations, grievances, appeals and independent reviews to HCA in accord with the Grievance and Appeal System Reporting Requirements published by HCA.

13.10.2.1 The Contractor will separately track, trend, and report behavioral health Adverse Benefit Determinations, Grievances, and Appeals and independent reviews.

13.10.2.2 The Contractor will separately track, trend, and report Grievances, Appeals, and independent reviews for children/youth referred to WISe.

13.10.3 Delegated Adverse Benefit Determinations, Grievances, and Appeals are to be integrated into the Contractor's report.

13.10.4 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance and Appeal System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within thirty (30) calendar days.

13.10.5 The report medium shall be specified by HCA and shall be in accord with the Grievance and Appeal System Reporting Requirements published by HCA.

13.10.6 Reporting of adverse benefit determination shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the Enrollee is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.

13.10.7 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.

13.10.8 Reporting of grievances shall include all expressions of Enrollee dissatisfaction not related to an adverse benefit determination. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

14 HEALTH CARE COORDINATION

The Contractor shall provide the services described in this Section for all Enrollees, regardless of acuity level, if the Enrollee is determined by the initial health screening to need health care coordination, or if the Enrollee or his/her caregiver, parent or SSS/Social Worker requests assistance in accessing or coordinating services. The Contractor shall offer new Enrollees the choice of Health Home services or intensive care management if the Enrollee meets criteria for these services.

14.1 Continuity of Care

The Contractor shall ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute physical or behavioral health condition, including children receiving WISe services and TAY who have a current care plan. The Contractor shall ensure medically necessary care for Enrollees is not interrupted and transitions from one setting or level of care to another are promoted for six months after the implementation of this Contract. The Contractor shall honor service authorizations made by other systems, such as BHOs, FFS, and Apple Health Managed Care Organizations (42 C.F.R. § 438.208). After the initial six (6) months of the Contract, the continuity of care period shall be no less than ninety (90) days for all new Enrollees.

14.1.1 The Contractor shall coordinate with the DCYF, caregivers, and providers to ensure continuity of care when the new Enrollee moves from another Apple Health MCO to IFC or from FFS to IFC.

14.1.1.1 Where preservation of provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's physical and behavioral health condition requires.

14.1.2 When changes occur in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions found in the Access to Care and Provider Network section of this Contract, and shall work with DCYF and HCA staff to ensure Enrollees and their caregivers are notified of the change and have the opportunity to select a new provider.

14.1.3 The Contractor shall have in place policies and procedures that allow the SSS/Social Worker, caregivers, or Enrollees to obtain needed medications on an emergency basis for Enrollees who do not have access to their medications and shall ensure that pharmacy providers understand the need to fill prescriptions as necessary to ensure continuity for the Enrollee.

14.1.4 The Contractor shall make a good faith effort to preserve Enrollee-Provider relationships, including relationships through transitions.

14.1.5 Where preservation of Provider relationships is not possible and reasonable, the Contractor shall assist the Enrollee to transition to a

Provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's physical and behavioral health condition requires.

14.1.6 The Contractor shall allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has documented established relationships. The Contractor shall take the following steps:

14.1.6.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

14.1.6.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

14.1.6.3 If the non-participating provider or the Enrollee will not cooperate with a necessary transition, the Contractor may transfer the Enrollee's care to a participating provider within ninety (90) calendar days of the Enrollee's enrollment effective date.

14.1.6.4 Pay the non-participating provider indefinitely if it chooses when the non-participating provider accepts payment rates the Contractor has established.

14.1.6.5 Apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.

14.1.7 Unless required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new Enrollees to fill prescriptions written prior to enrollment until the first of the following occurs:

14.1.7.1 The Enrollee's prescription expires. If the Enrollee's prescription expires before evaluation by a participating provider, the Contractor shall facilitate a primary care visit and shall not deny the prescription. For the purposes of this subsection, a prescription expires when the date by which a prescribed refills for the prescription passes or when the last fill on the prescription has been made by a pharmacy and the Enrollee has used the medications for that fill.

14.1.7.2 A participating provider examines the Enrollee to evaluate the continued need for the prescription, and if necessary, oversees medically appropriate changes that do not threaten the health of the Enrollee.

14.1.7.2.1 If the Enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the Enrollee's safety and the safety of others is considered in the decision. The Contractor shall document in

writing the information and factors it considered in refusing the fill the prescription.

14.1.7.3 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.

14.1.8 The Contractor shall provide for the smooth transition of care for Enrollees who lose Medicaid eligibility while hospitalized in behavioral health inpatient or residential treatment facilities or while incarcerated or in homeless shelters. The Contractor shall include protocols for coordination with the BH-ASO and the BHO in other RSAs to facilitate referral for state funded or federal block grant services, when such funds are available, in order to maintain Continuity of Care.

14.1.9 The Contractor shall provide Care Coordination for children participating in WISe.

14.1.9.1 The Contractor must have policies and procedures consistent with the WISe Manual and ensure that subcontractors providing WISe services adhere to the most current version of the WISe Manual and participate in all WISe-related quality activities.

14.1.9.2 WISe subcontractors must participate in a review of WISe services conducted using the WISe Quality Improvement Review Tool (QIRT) at least once during the contract period.

14.1.9.3 The Contractor shall ensure that subcontracted WISe agency staff conduct Child Adolescent Needs and Strengths (CANS) screenings for children and youth referred for WISe services.

14.1.9.4 The Contractor shall:

14.1.9.4.1 Follow WISe policies and procedures to screen, identify, and engage children, youth, and caretakers who are eligible to receive the services under WISe.

14.1.9.4.2 Participate in the planning and implementation of a standardized screening and assessment process and uniform reporting of service level for children and youth with intensive behavioral health needs with the Enrollee consent and according to the timelines and guidelines published by DSHS to the extent they are not inconsistent with this Contract or federal regulations.

14.1.9.4.3 Report on actions taken in response to WISe Quality Management Plan reports and associated outcomes.

14.1.9.5 Develop and implement a plan to achieve and maintain a network of WISe providers adequate to meet monthly caseload targets as determined by the HCA and the DSHS Research and Data Analytics Division (RDA). The Contractor's plan must take into account the need to meet a demand for service that exceed the caseload targets. The Contractor shall meet monthly caseload enrollment targets for the number of children and youth served in each of the Contractor's Regional Service Areas.

14.1.9.6 The Contractor shall submit a monthly progress report, no later than the 15th of the month, following the month of service that includes the following:

14.1.9.6.1 The current WISe service capacity for the region and the number of the Contractor's Enrollees served in WISe.

14.1.9.6.2 The increase or decrease of number of children/youth served compared to the previous month's progress report.

14.1.9.6.2.1 If the Contractor has an action plan from a previous progress report, the Contractor shall identify what progress has been made to meet WISe caseload targets.

14.1.9.6.2.2 If the Contractor has deficiencies in the number served for three consecutive months, HCA may consider imposing sanctions as described in the Payment and Sanctions section of this Contract.

14.1.9.7 The Contractor shall identify challenges in meeting their service capacity targets and develop strategies to address those challenges.

14.1.10 Continuity and Care Coordination for TAY

14.1.10.1 The Contractor shall develop a comprehensive transition plan in collaboration with other systems and providers, including agencies contracted to provide services to Youth, that identifies the Enrollee's goals, objectives, and strategies to achieve goals. The transition plan shall take into account the following:

14.1.10.1.1 Individual behavioral and physical health needs, which may include continued services in the adult behavioral or physical health systems. The transition plan shall address the need for

continuity and coordination of services and supports for the Enrollee and the Enrollee's family and identify developmentally and culturally appropriate adult services.

14.1.10.1.2 Connections with supportive housing and supported employment services through the Foundational Community Supports program, post-secondary education, technical training, housing community support, natural supports, and cross-system coordination as needed to attain the Enrollee's goals.

14.2 Population Health Management: Plan

The Contractor shall develop a plan to address Enrollee needs across the continuum of care, and ensure services are coordinated for all Enrollees. The plan shall be reviewed by HCA during the annual monitoring review. The Population Health Management plan shall include at a minimum the following focus areas:

14.2.1 Keeping Enrollees healthy;

14.2.2 Managing Enrollees with emerging risk;

14.2.3 Enrollee safety and outcomes across settings; and

14.2.4 Managing multiple chronic conditions.

The Contractor's Population Health Management plan shall establish methods to identify targeted populations for each focus area and includes interventions that meet the requirements of NCQA and the subsections below. The Contractor shall take into account available data and analytic infrastructure, and HIT and HIE system needs, capabilities, and resources to support population health management activities.

14.3 Population Health Management: Identification and Triage

14.3.1 Initial Health Screen.

14.3.2 The Contractor shall conduct a brief Initial Health Screen containing behavioral, developmental, physical and oral health questions within sixty (60) calendar days of enrollment for all new Enrollees, including Family Connects and reconnects, beginning the first (1st) of the month after the month of enrollment (42 C.F.R. § 438.208(b)(3)).

14.3.2.1 The Contractor shall use evidence-based screening tools appropriate to the age of the Enrollee, which shall include but is not limited to:

14.3.2.1.1 Tobacco use assessment; and

14.3.2.1.2 Housing and housing instability assessment.

14.3.2.2 If the Social worker, caregiver or parent, Enrollee or an Enrollee's provider calls the Contractor with a specific need,

the Enrollee will be assessed within five business days of the call;

14.3.2.3 The standard for completion of the IHS is within thirty (30) calendar days of notification of enrollment for new Enrollees who are in adoption support or who are alumni of the foster care program.

14.3.3 The Contractor shall conduct a welcome call in lieu of the Contractor's Initial Health Screening process for newly eligible foster children who have not yet received a CHET screening. During this call, the Contractor shall describe program benefits, notify the caregiver or Enrollee that there will be a call from the CHET screener if the parent or caregiver has not already been contacted, and shall gather information about current health care needs, with emphasis on whether the Enrollee has a PCP or needs one, has scheduled or needed appointments, or has medication or DME needs that must be addressed prior to the CHET screening process.

14.3.4 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an Enrollee or his/her caregiver or parent to complete the Initial Health Screen or welcome call and document these attempts for Enrollees who are not referred for Health Home services. The requirements described in Exhibit C apply to Enrollees who are referred for Health Home services. If the Contractor is unable to contact the Enrollee or his/her caregiver after the three attempts, the Contractor shall work with the Enrollee's DCYF SSS/Social Worker or FCMT to get accurate contact information for the Enrollee and conduct the Initial Health Screen or welcome call.

14.3.5 If the Contractor is unable to contact the Enrollee or his/her caregiver because accurate or verifiable contact information was not provided to the Contractor for that Enrollee, the Contractor shall notify HCA of the incorrect information. HCA and DCYF shall collaborate to obtain the most accurate information and provide it to the Contractor. The Contractor shall have sixty (60) calendar days from the date the Contractor receives the correct contact information to contact the Enrollee and conduct the Initial Health Screen.

14.3.6 Initial Health Assessment (IHA): To assess identified Individuals who need Long Term Supports and Services (LTSS) or those with Special Health Care Needs who are not eligible for Health Home services, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs, or Initial Health Screen that indicates the need for Care Coordination. The assessment shall determine ongoing need for Care Coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.

14.3.6.1 The assessment shall include, at minimum, an evaluation of the Enrollee's physical, behavioral, and oral health status,

health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.

14.3.6.2 The Contractor shall require the Enrollee's primary care provider and care coordinator to ensure arrangements are made for the Enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community- based social services and LTSS.

14.3.6.3 The IHA shall be maintained in the Enrollees' medical record and in the Contractor's Care Coordination file and available during subsequent preventive health visits.

14.3.7 The Contractor shall track enrollment of foster children, including those receiving adoption support or in relative care, to ensure adequate coordination of care with the Enrollee's providers and foster parents or guardians. If the child's placement changes and the child must move to a new geographic area, the Contractor shall ensure assignment of a new PCP within seventy-two (72) hours of receiving notification of the new placement, and shall arrange for care sooner if the child has needs that must be addressed within the seventy-two (72) hour timeframe.

14.3.8 The Contractor will use other data sources to identify enrollees who need Care Coordination and care management services, including but not limited to:

14.3.8.1 Enrollees that have had contact with crisis services;

14.3.8.2 Review of administrative data sets, such as PRISM;

14.3.8.3 Children with elevated blood lead screen levels;

14.3.8.4 Indicators of potential for high risk pregnancy;

14.3.8.5 Enrollees with unmet care needs or evidence of being underserved;

14.3.8.6 Claims or encounter data;

14.3.8.7 Pharmacy data;

14.3.8.8 Laboratory data;

14.3.8.9 Electronic health records;

14.3.8.10 Results of Contractor-specific algorithms; or

14.3.8.11 SSS/Social worker referral or caregiver/parent request.

14.3.9 The Contractor will risk stratify the population to determine the level of intervention enrollees require.

14.4 Population Health Management: Interventions

14.4.1 The Contractor shall work with providers to achieve population health management goals, and shall provide PCPs with clinical information about their patients to improve their care.

14.4.1.1 The Contractor shall make clinical decision support tools available to providers for use at the point of care that follow evidence based guidelines for:

14.4.1.1.1 Behavioral health conditions.

14.4.1.1.2 Chronic medical conditions.

14.4.1.1.3 Acute conditions.

14.4.1.1.4 Unhealthy behaviors.

14.4.1.1.5 Wellness.

14.4.1.1.6 Overuse/appropriateness issues.

14.5 Bi-Directional Behavioral and Physical Health Integration

14.5.1 The Contractor shall promote bi-directional behavioral-physical health integration through education, training, financial, and nonfinancial incentives consistent with Section 14 of this Contract, recommendations of the Bree Collaborative, and other network initiatives to promote integrated care including, but not limited to:

14.5.1.1 Increased screening, identification, and referral for behavioral health conditions that commonly occur in primary care settings;

14.5.1.2 Increased access to routine physical health services by individuals with serious mental illness and Substance Use Disorders;

14.5.1.3 Development of collaborative care models and co-location of primary care and behavioral health providers;

14.5.1.4 Development of data analytic tools to identify Enrollees with behavioral health conditions who are in need of physical health care or Enrollees with physical health conditions in need of behavioral health care;

14.5.1.5 Improved Care Coordination consistent with requirements in Section 14 of the Contract including, but not limited to, use of required screening tools and use of Research- and Evidence-based Practices; and

14.5.1.6 Use of electronic records, decision support tools, client registries, data sharing, Care Coordination, wellness initiatives targeting high-risk behavioral health populations, or other similar program innovations.

14.5.2 The Contractor shall submit a quarterly report on Bi-directional

Behavioral and Physical Health Integration to HCA through MC-Track. The report shall include the factors listed in subsection 14.5.1 above, using the Bi-directional Behavioral and Physical Health Integration report template available through MC-Track. The quarterly reports are due to HCA no later than the 30th the month beginning October of 2019. (July, October, January and April).

14.6 Care Coordination Services (CCS) General Requirements

The Contractor shall implement the following activities:

14.6.1 The Contractor shall offer Wellness and Prevention services to all Enrollees according to the benefits outlined in this Contract.

14.6.1.1 Refer individuals identified in the Initial Health Screen as having a need for Care Coordination services to the Enrollee's PCP, Mental Health Professional or SUD provider or to DSHS/Home and Community Services (HCS) for follow-up care and needed services within thirty (30) calendar days of screening and identification.

14.6.1.2 Ensure the PCP has assessed and/or examined the Enrollee according to wellness assessment requirements and appointment scheduling standards (42 C.F.R. § 438.208(c)(2)).

14.6.1.3 Ensure the Enrollee has received appropriate follow-up health care services, including preventive care, care for Chronic Conditions, and referrals to LTSS, social services and community-based organizations.

14.6.2 Care Coordination services are provided by the Contractor, clinic-based Care Coordinator staff, or community based organizations, and delivered to Enrollees who have short-term, or intermittent needs for coordination of care, such as those identified as Enrollees with Emerging Risk. Care Coordination services may be provided by non-licensed staff and include but are not limited to:

14.6.2.1 Coordinating authorization of services such as Contractor timely approval of durable medical equipment, pharmacy, and medical supplies;

14.6.2.2 Ensuring access to medically necessary mental health, or physical health services and coordination with entities that provide mental health, SUD services, and oral health services; or

14.6.2.3 Ensuring access to community-based services, such as home care or long-term services and supports.

14.6.3 The Care Coordinator and affiliated staff shall work with Enrollees, caregivers and parents to promote the following:

14.6.3.1 Improved clinical outcomes;

14.6.3.2 Enrollee participation in care;

14.6.3.3 Continuity of Care;

14.6.3.4 Increased self-management skills;

14.6.3.5 Improved adherence to prescribed treatment; and

14.6.3.6 Improved access to care or to services that address social needs.

14.6.4 The Care Coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting health and health care choices.

14.6.5 The Care Coordinator shall deliver services in a culturally competent manner that addresses health disparities by interacting directly and in-person with the Enrollee and his or her family in the Enrollee's primary language; with appropriate consideration of literacy and cultural preference.

14.6.6 The Care Coordinator is responsible for:

14.6.6.1 Conducting IHS or collecting IHS data from providers, to assess Enrollees for unmet health care or social service needs;

14.6.6.2 Communicating utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action;

14.6.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs;

14.6.6.4 Ensuring referrals are made and services are delivered, including any follow-up action;

14.6.6.5 Ensuring the deployment of standardized screening tools as outlined in this Contract; and

14.6.6.6 Ensuring collaboration with the regional Behavioral Health Administrative Services Organization (BH-ASO), including developing processes to ensure an Enrollee is followed up with within seven (7) calendar days when of the Enrollee has received crisis services.

14.6.7 The Contractor shall develop policies and procedures for Care Coordination services that include:

14.6.7.1 Identification of gaps in care through Initial Health Screen or analysis of claims and encounter data for Enrollee patterns of under- or overutilization.

14.6.7.2 Referral of Enrollees identified through self-referral or the

Initial Health Screen as having a gap in behavioral, developmental, physical or oral health services to the Enrollee's PCP and as appropriate, to a Mental Health Professional or SUD provider for services follow-up care within thirty (30) calendar days of screening and identification.

14.6.7.3 Communication with the PCP and other providers regarding:

14.6.7.3.1 The Contractor's medical necessity decisions to authorize care and services.

14.6.7.3.2 Shared care plans and transitional services between the Care Coordinator and jails, crisis service system, prisons, acute withdrawal management and sobering centers, homeless service providers, and the PCP.

14.6.7.3.3 Enrollee over-use of emergency department, preventable hospitalizations and re-hospitalizations, crisis service, and opioid use.

14.6.8 If an Enrollee's reunification with their family changes their enrollment to an AH MCO, the Contractor shall coordinate transition of the Enrollee to the new MCO's Care Coordination system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure Enrollee confidentiality and Enrollee rights are protected (42 C.F.R § 438.206(b)(6)).

14.6.9 Care Coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.

14.6.10 The Contractor shall provide a toll free line for PCPs and specialists who seek technical and referral assistance when any condition, including behavioral health conditions, requires treatment or developmental delays are suspected or identified.

14.6.10.1 Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals and referrals to LTSS when appropriate. Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to providers.

14.6.11 The Contractor shall implement policies and procedures to ensure completion of Advance Directives (physical health and mental health).

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

14.6.13 The Contractor shall support practice change activities including the deployment of evidence-based and Promising Practices, preventive

screening of Enrollees and models of service delivery that optimize health care service delivery, Enrollee social support and coordinated health care and social services.

14.6.14 The Contractor shall require and ensure that PCPs and health care coordinators employed by the Contractor or in the Contractor's provider network are trained on standardized, validated screening tools used in the conduct of an IHA and an age appropriate evaluation, to evaluate at a minimum:

14.6.14.1 Delays in child development;

14.6.14.2 Behavioral health conditions including SUD; and

14.6.14.3 Adverse Childhood Experiences.

14.6.15 The Contractor shall ensure that all Enrollees with a history of deliberate self-harm or previous suicide attempts shall be assessed quarterly for suicide risk and the results of this assessment are incorporated into the Enrollee's care plan.

14.6.16 The Contractor shall secure an appropriate signed Release of Information for an Enrollee over the age of 13 in order to share protected health information, including the sharing of reproductive or behavioral health information with the Enrollee's caregiver and assigned SSS/social worker.

14.7 **Care Management Services**

The Contractor shall implement activities for Enrollees identified as requiring Complex Case Management (CCM), or those with multiple chronic conditions:

14.7.1 Support of a person-centered approach to care in which Enrollee's needs, strengths, and preferences play a central role in the development and implementation of the care plan by:

14.7.1.1 Ensuring the clinical appropriateness of care;

14.7.1.2 Addressing gaps in care, including appropriate use of culturally appropriate, evidence- or research-based practices;

14.7.1.3 Promoting recovery using Certified Peer Counselors, Community Health Workers and community and natural supports;

14.7.1.4 Requesting modifications to treatment plans to address unmet service needs that limit progress;

14.7.1.5 Assisting Enrollees in relapse/crisis prevention planning that goes beyond crisis intervention and includes development and incorporation of recovery action plans and Advance Directives for individuals with a history of frequent mental health readmissions or crisis system utilization; and

14.7.1.6 Assuring coordination of assessments and evaluations with

mental health, SUD and other providers.

14.7.2 Individuals identified by HCA as Health Home eligible shall receive Health Home Services, as described in Exhibit C if the Enrollee consents to participate.

14.7.3 Individuals identified by the Contractor as requiring CCM shall receive services in accordance with NCQA Standards and interventions as described elsewhere in Section 14.

14.7.4 Complete or verify the PCP completion of an Enrollee care plan. The care plan shall be developed in partnership with the Enrollee and in consultation with specialists and social service providers serving the Enrollee, updated at minimum annually and maintained in the Enrollee's health record (42 C.F.R. § 438.208(c)(3)); 42 C.F.R. § (438.208(c)(3)(i)). The care plan shall include all of the following:

14.7.4.1 Presenting diagnosis(es) and health problems;

14.7.4.2 An action plan, including agreed-upon health goals;

14.7.4.3 Documentation of behavioral health, social service, and community resource interventions that promote child development, healthy behaviors, and early referral and treatment for mental health and SUD conditions, including recovery-based programs; and

14.7.4.4 Documentation of Advance Directives (physical health and mental health).

14.7.5 The Contractor shall respond to EPSDT referrals from primary medical care providers with a written notice that must at a minimum include date of intake and diagnosis.

14.7.6 The Contractor shall provide information on how to obtain a provider for children/Youth who do not have a PCP.

14.7.7 For Enrollees with Special Health Care Needs, the Contractor will develop the Enrollee's care plan in accordance with the requirements described throughout Section 14 and will ensure the plan is reviewed and revised upon reassessment, at least every twelve (12) months or when the Enrollee's circumstances or needs change, or when the Enrollee requests an update.

14.7.7.1 For Enrollees determined to have LTSS needs, the Contractor shall coordinate with staff of Home and Community Services (HCS) to ensure the Enrollee has access to and appropriate evaluation and LTSS services.

14.8 **Data Exchange Protocols**

14.8.1 The Contractor shall develop data exchange protocols, including consent to release, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including sharing of claims and pharmacy data, treatment

plans or care plans and Advance Directives necessary to coordinate service delivery, and care management for each Enrollee in accordance with applicable privacy laws, including HIPAA and 42 C.F.R. Part 2.

14.9 Allied System Coordination

14.9.1 Allied System Coordination Plan: For each RSA in which the Contractor participates, the Contractor shall develop a written Allied Systems Coordination Plan that describes how the Contractor will coordinate and collaborate with healthcare and other allied systems that serve Contractor Enrollees. The Contractor shall collaborate with ACH representatives and representatives of the entities listed in Subsection 14.15 to develop and update this plan as needed. The plan must describe how the Contractor will address the elements below and how the Contractor will interact with any Allied System that chooses not to participate in the jointly developed coordination plan and include the following elements:

14.9.1.1 Clearly defined roles and responsibilities of the allied systems in helping Enrollees served by more than one system. For children this includes EPSDT coordination for any child serving agency and a process for participation by the agency in the development of a cross-system ISP when indicated under EPSDT.

14.9.1.2 Identification of needed local resources, including initiatives to address those needs.

14.9.1.3 A process for facilitation of community reintegration from out-of-home placements (e.g., State hospitals and other facilities that provide care for individuals with 90 and 180-day civil commitments, Children's Long- term Inpatient facilities, Juvenile Rehabilitation Administration facilities, foster care, nursing facilities, and acute inpatient settings) for Enrollees of all ages.

14.9.1.4 A process for working with ACH, the BH-ASO managing crisis services, and first responders, evaluate the need to develop procedures to engage and collaborate with first responders that address:

14.9.1.4.1 Education about Behavioral Health resources and crisis intervention to de-escalate volatile situations and prevent the use of lethal force.

14.9.1.4.2 Strengthening relationships between first responders and Behavioral Health providers to improve access to timely crisis response services or to improve engagement in Behavioral Health treatment.

14.9.1.4.3 Ensuring support to PCPs, emergency department, and local emergency management

(fire, police) when Behavioral Health emergencies and urgent problems are encountered.

14.9.1.4.4 Jail diversion response for TAY and adults with Serious and Persistent Mental Illness (SMI) or Co-Occurring Disorders (COD).

14.9.1.4.5 Transition of incarcerated adults and TAY with SMI for the continuation of prescribed medications and other Behavioral Health services prior to re-entry to the community.

14.9.1.4.6 Prevention and treatment of overdose.

14.9.1.5 Facilitating linkages with social services and criminal justice/courts and providers under contract with the county or state.

14.9.1.6 A procedure for Contractor representatives attending relevant stakeholder, planning, and advocacy meetings and communicating/coordinating with other entities to ensure the Contractor is aligned with state and local Behavioral Health initiatives.

14.9.2 The Contractor's Allied Coordination Plan shall include the following:

14.9.2.1 Processes for the sharing of information related to eligibility, access and authorization;

14.9.2.2 A process for sharing system issues;

14.9.2.3 Procedures to identify and address joint training needs; and

14.9.2.4 A process or format to address disputes related to service or payment responsibility, including attribution for hospital-related claims.

14.10 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

14.10.1 The Contractor shall work with the caregiver, CHET screener, or SSS/Social worker to ensure that each Enrollee receives an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) examination within thirty (30) calendar days of the Enrollee's entrance into out-of-home care in order to identify special needs, or when the Initial Health Screen indicates the need for intensive health Care Coordination. The EPSDT shall determine ongoing need for health Care Coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.

14.10.1.1 The Contractor shall ensure that the recommendations of the EPSDT, including exams related to behavioral health, developmental and substance abuse, dental, vision and hearing are provided for program Enrollees.

14.10.1.2 The Contractor shall respond to EPSDT referrals from PCPs

with at least a written notice that must, at a minimum, include date of intake and diagnosis.

14.10.1.3 The care coordinator shall work with the PCP to ensure that referrals from the CHET report for follow up services that reflect the EPSDT findings such as referrals for mental health and/or SUD assessments are made and that the Enrollee and his/her caregiver understand the importance of going to the follow up appointment.

14.10.1.4 Documentation of the EPSDT shall be maintained in the Enrollee's medical record and in the Contractor's health Care Coordination file.

14.10.2 For Enrollees at high risk of re-hospitalization and/or relapse after SUD treatment, or challenges following the plan of care for mental health conditions, the Contractor shall ensure the Enrollee has a documented, individual behavioral health care plan for interventions to promote recovery and resiliency and to mitigate risk. For the purposes of this Subsection, "mental health care plan" means a plan that describes the clinical and social supports needed by an Enrollee.

14.10.3 The Contractor shall develop policies and procedures to govern coordination of assessments and evaluations with mental health, SUD and other providers, and if an Enrollee chooses to disenroll from AHFC, the Contractor's care management staff will coordinate transition of the Enrollee's care to the FFS system, and to any care managers who are involved in the Enrollee's care, to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure that Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208 (b)(6)).

14.11 Continuity of Care for Enrollees Who Transition From IFC

Within the limitations of information provided by HCA and DCYF, the Contractor shall continue to provide health care coordination and other services as needed to ensure that an Enrollee who is returning to his or her biological family, has been adopted or has ended enrollment in IFC is able to smoothly transition to another health care setting.

The Contractor shall work with DCYF SSS/Social Workers, the child's caregiver, and health care providers as necessary to ensure coordination and continuity of care while the child is transitioning to the new setting.

14.11.1 The Contractor shall ensure that:

14.11.1.1 The Enrollee stays with his/her PCP if possible. If the Enrollee is moving to a different service area, the Contractor shall ensure that the Enrollee has a new PCP and that the PCP has access to the Enrollee's health care information to ensure continuity of care;

14.11.1.2 If a change in eligibility causes an IFC Enrollee to change

MCOs or default to FFS health care, the Contractor shall work with the new MCO, or the Enrollee's health care provider(s) to ensure there is no break in health care services.

14.11.1.3 If an Enrollee chooses to disenroll from IFC, the Contractor's care management staff will coordinate transition of the Enrollee's care to the FFS system, and to any care managers who are involved in the Enrollee's care, to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure that Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208(b)(6)).

14.11.1.4 Mental health services are coordinated to ensure there is no break in services to the Enrollee during the reunification period; and

14.11.1.5 The Enrollee has access to needed medications and supplies during the transition, as described in subsection 14.1.7 of this Contract.

14.12 Coordination with Behavioral Health Organizations

14.12.1 The Contractor shall have an operational agreement with all Behavioral Health Organizations (BHOs). In addition to Transitional Care, the agreement must comprehensively address the day-to-day operational requirements to coordinate physical and behavioral health care services and fully recognize the shared responsibility for their mutual Enrollees' health care.

14.12.2 The operational agreement shall address the following areas:

14.12.2.1 Exchange of Enrollee health information, with Enrollee consent to include:

14.12.2.1.1 Diagnosis;

14.12.2.1.2 Treatment, including treatment plan;

14.12.2.1.3 Medications;

14.12.2.1.4 Labs/Testing; and

14.12.2.1.5 Treating providers, with contact information.

14.12.2.2 Transitions in care between the Contractor and BHOs, and BHOs and the Contractor; and

14.12.2.3 Procedure for Enrollee evaluation or referral to BHO for intake to determine whether the Enrollee meets Access to Care Standards (ACS).

14.12.3 The Contractor shall require providers to coordinate with BHO providers and provide all required information to facilitate such coordination, and shall provide written instructions to its primary care and mental health professionals on how to access mental health services for Enrollees. Instructions shall include information on when an Enrollee should be

referred to the BHO for evaluation and when the Enrollee should receive services from a provider contracted with the Contractor for mental health services.

14.13 Coordination with Wraparound and Intensive Services (WISe) Program

The Contractor must offer WISe services to all youth in Foster Care who have screened eligible by January 30, 2019, and starting in October 2019 all youth entering Behavioral Rehabilitation Services (BRS) who screen eligible. The Contractor shall coordinate with WISe providers, including, but not limited to the development of policies and procedures consistent with the Washington Children's Mental Health Principles and WISe. The Contractor shall collaborate and coordinate delivery of care with WISe providers to improve the effectiveness of services and outcomes for Enrollees, their families and caregivers who are mutually served by WISe and the Contractor.

14.13.1 The Contractor shall participate, upon invitation, in Child and Family Teams (or care planning teams) for Enrollees participating in WISe and shall ensure the following:

14.13.1.1 Participation in the development of one cross system care plan for each Enrollee who participates in WISe;

14.13.1.2 Provision of medically necessary services and supports through contracts with BHOs;

14.13.1.3 Collaborative work with the WISe team to assess the effectiveness of the care plan and make adjustments as necessary;

14.13.1.4 Inclusion of the caregiver or biological parent in the WISe team as appropriate; and

14.13.1.5 Ensure all WISe services are provided by state approved WISe providers, paid the same case rate as that paid by the state, and meet the same level of fidelity as all other Medicaid youth receive.

14.14 Collaboration with the Division of Behavioral Health and Recovery (DBHR)

The Contractor shall work in collaboration with DBHR to ensure all current legal mandates set forth by the T.R. v Quigley and Teeter Settlement Agreement are followed, and will comply with any future legal mandates resulting from the Settlement Agreement.

14.15 Health Information Technology (HIT) Tools for Integrated Care

14.15.1 The Contractor shall support the use by contracted providers, of Health Information Technology (HIT)/Health Information exchange (HIE) tools and services such as:

14.15.1.1 Certified EHR Technology (CEHRT);

14.15.1.2 Emergency Department Information Exchange (EDIE);

14.15.1.3 Pre-Manage tools (including use by behavioral health providers);

14.15.1.4 Services offered by OneHealthPort (OHP), (such as the Clinical Data Repository); and

14.15.1.5 Other HIT/HIE tools and services to support the integration, coordination and continuity of care.

14.15.2 The Contractor shall consider how HIT/HIE can be used to support data exchange protocols and tools to support provider integration of behavioral health and medical services, transitional services, care coordination oversight and transitional planning for incarcerated individuals, and coordinate with the state to advance the use of statewide HIT/HIE tools/services and engage in the implementation of the HIT Operational Plan.

14.15.3 The Contractor shall develop policies and procedures for Care Coordination and Care Management Services that encourage and support the use of HIT and HIE technologies (Certified EHRs, existing statewide HIE and HIT, and other technology solutions) to coordinate care across the care continuum, including physical health, behavioral health, social service, and other community-based organizations.

14.16 Coordination Between the Contractor and External Entities

14.16.1 The Contractor shall coordinate with the Enrollee's SSS/social worker, caregiver or parent, when making or recommending referrals for the Enrollee to, health care and social services/programs including but not limited to:

14.16.1.1 BHOs for coordination of mental health services, including Licensed Substance Use Disorder providers and Community Mental Health Agencies;

14.16.1.2 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Apple Health MCOs;

14.16.1.3 County-managed treatment and social service programs (e.g. Access to Recovery, Criminal Justice Treatment Account Services);

14.16.1.4 Ombuds services;

14.16.1.5 Oral Health services, including the promotion of oral health screening and prevention;

14.16.1.5.1 Contractors operating in counties served by the Oral Health Connections Pilot Project shall identify and refer Enrollees eligible for the pilot

project services, in coordination with the Arcora Foundation through Arcora's referral portal.

14.16.1.6 Department of Health (DOH) and Local Health Jurisdiction (LHJ) services, including Title V services for Children with Special Health Care Needs;

14.16.1.7 The Department of Social and Health Services:

14.16.1.7.1 Aging and Long-Term Support Administration (ALTSA) including Home and Community Services (HCS);

14.16.1.7.2 Contracted skilled nursing facilities and community-based residential programs;

14.16.1.7.3 Behavioral Health Administration;

14.16.1.7.4 Developmental Disabilities Administration;

14.16.1.7.5 Division of Vocational Rehabilitation; and

14.16.1.7.6 Juvenile Justice and Rehabilitation Administration (JJ&RA).

14.16.1.8 Department of Children, Youth and Families: Early childhood and family support services including home visiting, ESIT, ECLIPSE, ECEAP/Head Start;

14.16.1.9 Department of Corrections;

14.16.1.10 Criminal Justice Systems (courts, jails, law enforcement, public defenders);

14.16.1.11 State hospitals;

14.16.1.12 Community hospitals/Evaluation and Treatment centers that provide care for individuals with 90 and 180-day civil commitments;

14.16.1.13 Children's Long-term Inpatient facilities;

14.16.1.14 Community Health Clinics, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Apple Health Managed Care Organizations;

14.16.1.15 Educational Service Districts (ESDs);

14.16.1.16 DSHS/ALTSA's Fostering Well Being;

14.16.1.17 HCA First Steps Program - Maternity Support Services (MSS);

14.16.1.18 Supported Housing and Employment programs;

14.16.1.19 State and/or federal agencies and local partners that manage

access to housing;

14.16.1.20 Tribal entities;

14.16.1.21 Non-Emergency Medicaid Transportation services;

14.16.1.22 Interpreter Services;

14.16.1.23 Chronic Disease Self-Management Education;

14.16.1.24 Foster Care advocacy groups such as Passion2Action and the Mockingbird Society;

14.16.1.25 Women, Infants, and Children (WIC) providers and programs;

14.16.1.26 HCA's contracted Third Party Administrator for supportive housing and supported employment;

14.16.1.27 BHOs and BH-ASOs regarding state only, federal block grant, Ombuds, crisis services, and any other areas where information sharing would improve the services of either system; and

14.16.1.28 Any Offender Re-entry Community Safety Program (ORCSP) within the boundaries of the Contractor that is not a Subcontractor of the Contractor.

14.16.2 The Contractor shall participate with, cooperate with and coordinate with regional health alliances, such as the Southwest Washington Regional Health Alliance, Eastern Washington Regional Health Alliance, and CHOICE Regional Health Network.

14.16.3 The Contractor shall participate in the management or discussions held at the Bree Collaborative, or with the Foundation for Health Care Quality in their work on COAP, OB COAP, and SCOAP programs as well as coordinate with other organizations engaged in quality improvement in Washington State.

14.16.4 The Contractor shall join and pay a fee to be a member of the Washington Health Alliance (WHA) no later than February 15 of each calendar year.

14.16.4.1 The Contractor shall actively cooperate and participate with the WHA in efforts to improve the quality and efficiency of health care services.

14.16.4.2 The Contractor shall submit data to the WHA for the purpose of producing results for the Community Checkup, the Washington State Common Measure Set on Health Care Quality and Cost, and all other health care measurement and reporting completed by WHA, according to the terms and schedule defined by the WHA.

14.16.4.2.1 As part of routine data submissions provided to the WHA as required under this subsection, the Contractor must include claim-line level financial

information (e.g. Billed, Allowed, and Paid dollar amounts) as defined by the WHA.

14.16.5 The Contractor shall coordinate Enrollee information, including initial assessments, relevant SON reviews and care plans, with other managed care entities as needed when an Enrollee changes from one MCO to another, changes from one Health Home lead to another or receives services through a BHO, to reduce duplication of services and unnecessary delays in service provision for Enrollees.

14.16.6 For Enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC Enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the Enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.

14.16.7 The Contractor shall participate in the local Accountable Communities of Health (ACH) in each Regional Service Area in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies but must participate as follows:

14.16.7.1 Serve in a leadership or other supportive capacity;

14.16.7.2 Participate in the design and implementation of transformation projects;

14.16.7.3 Collaborate with provider networks to implement Value Based Purchasing Models; and

14.16.7.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

14.17 **Children's Long-Term Care Inpatient Program (CLIP)**

14.17.1 The Contractor will designate a single person within each region to be their "CLIP Liaison" who will participate in the monthly Regional CLIP Committee that acts as the referral mechanism for Enrollees seeking voluntary CLIP treatment and will coordinate with the ASO to facilitate the CLIP Committee's review of all the region's Voluntary applications. Each IMC Contractor is responsible for coordinating the CLIP Committee's review with the ASO's Regional CLIP Committee Coordinator within thirty (30) calendar days.

14.17.2 The Contractor will collaborate with the BH-ASO and other MCOs operating in the RSA to develop a written Regional CLIP Committee Agreement that includes all the Managed Care Entities operating within the RSA and outlines roles and responsibilities for the operation of the region's monthly CLIP Committee meeting. The Region's ASO will be responsible for submitting the CLIP Committee Agreement to the CLIP

Administration Office for approval by HCA's CLIP Administrator and CLIP Coordinator within thirty (30) calendar days of the start date of the contract.

14.17.2.1 Contractor's CLIP Committee Roles and Responsibilities:

14.17.2.1.1 The Regional CLIP Committee determines whether appropriate, less restrictive services are available to the Enrollee, and when requested, must offer a plan of less restrictive alternatives to CLIP when an Enrollee is hospitalized involuntarily.

14.17.3 Upon request, the Contractor must collaborate on any Juvenile Rehabilitation (JR) transfers of youth court ordered for Forensic services on a 10.77 Evaluation and Restoration Order, and Parent Initiated Treatment (PIT) voluntary applicants. The Contractor must integrate resources for all children and youth applying, awaiting admission, or admitted to CLIP.

14.17.4 CLIP Committee determination to "recommend" or "not recommend" CLIP:

14.17.4.1 For all Voluntary CLIP applicants, within thirty (30) calendar days, the regional CLIP Committee will make a determination of whether CLIP treatment is recommended based on medical necessity criteria, whether CLIP treatment is the most appropriate level of treatment to address the needs of the client, or whether there are less restrictive services available that meet the Enrollee's needs. CLIP is not intended to be utilized as a placement resource.

14.17.5 Contractor CLIP Liaison Role:

14.17.5.1 The Contractor will designate a single person who is familiar with local resources and services to act as the Contractor's local "CLIP Liaison" and who attends the Region's monthly CLIP Committee. The CLIP Liaison provides guidance and support in preparing the Enrollee's CLIP applications, presents the Enrollee's application for CLIP consideration at the regional CLIP Committee meetings, and participates on a regular basis in care coordination activities, which may include preadmission meetings, facility admissions when necessary, treatment team meetings while the Enrollee is in CLIP treatment, and coordination with the CLIP Administration Office.

14.17.5.2 CLIP Liaison Role on Region's CLIP Committee:

14.17.5.2.1 The Contractor's designated CLIP Liaison is responsible for presenting all of the relevant facts, including clinical profile and treatment needs of the Enrollee to the CLIP Committee, as well as

presenting any less restrictive services that have been attempted prior to consideration of CLIP treatment. The Contractor's CLIP Liaison may request that the CLIP Committee review an Enrollee's case *prior* to the CLIP application being complete. Before a CLIP Application is considered complete, the CLIP Liaison must submit the application and all required application materials to the CLIP Administration office.

14.17.6 Requirements for a Voluntary CLIP Application: The Contractor or CLIP Liaison must ensure that the completed CLIP Application Form includes the following:

14.17.6.1 A signed Youth Agreement to CLIP Treatment signature page attesting that the Enrollee agrees to the CLIP admission;

14.17.6.2 The Enrollee's identifying information;

14.17.6.3 A current psychiatric evaluation completed within the last six months;

14.17.6.4 Contact information for the youth/family team and case manager responsible for coordination if/when the Enrollee is admitted to a CLIP Program;

14.17.6.5 Challenges and/or behavioral issues that lead to the request for CLIP treatment;

14.17.6.6 Enrollee's treatment needs to be addressed while in CLIP treatment;

14.17.6.7 Strengths and interests of the Enrollee and their family; and

14.17.6.8 A detailed continuity of care plan and post-discharge plan that outlines community-based behavioral health care services and involvement of other agencies and support services that may be needed post-discharge.

14.17.7 Contractor Notification of a Completed Voluntary CLIP Application:

14.17.7.1 The Contractor must notify the family within three (3) business days of receipt of a completed CLIP application. The regional CLIP Committee will convene within thirty (30) calendar days to review the application and make a final determination whether CLIP is recommended. The Contractor's CLIP Liaison may request the CLIP Committee review an Enrollee's application prior to having a completed application when the CLIP Liaison can demonstrate the following conditions have been met:

14.17.7.1.1 The Enrollee has a severe psychiatric illness that warrants intensive inpatient treatment;

14.17.7.1.2 The Enrollee has consented by signature attesting that the Enrollee is in agreement to CLIP treatment; and

14.17.7.1.3 A psychiatric evaluation has been completed within the last six months by a Psychiatrist or a Psychiatric ARNP, and less restrictive services available in the community have not been able to meet the Enrollee's needs.

14.17.7.2 If the CLIP Committee makes the determination that CLIP "is recommended," the Contractor's CLIP Liaison is responsible to ensure that all required materials are submitted to the CLIP Administration for the application to be deemed "complete".

14.17.8 CLIP IS Recommended: If the regional CLIP Committee recommends CLIP treatment, a written response will be provided to the legal guardian and Enrollee outlining suggestions for stabilizing the child or youth while the CLIP application is processed by the CLIP Administration. The Contractor's designated CLIP Liaison must ensure that all medically necessary services continue for the Enrollee and family to ensure intensive community services and plan of care continue while the youth awaits admission to a CLIP facility.

14.17.9 CLIP Is Not Recommended: The Contractor must provide the legal guardian and Enrollee aged thirteen (13) years and over with a written copy of the Appeal Process at the time the Contractor makes a determination to "not recommend" a voluntary application for CLIP services. If CLIP is not recommended by the regional CLIP Committee, this is considered an adverse benefit determination and a written response will be provided to the legal guardian and Enrollee specifying the reasons for not recommending CLIP and an outline of recommendations for alternative less restrictive services for the child or youth, along with the Enrollee's appeal rights.

14.17.10 180-day ITA Court Orders:

14.17.10.1 When an Enrollee under age eighteen (18) years is committed on an Involuntary Treatment Act (ITA) court order for up to180 calendar days under RCW 71.34, the Contractor's CLIP Liaison must be available to consult and assess the Enrollee's needs prior to CLIP admission. This includes consideration of less restrictive treatment options that may meet the needs of the youth and that are acceptable to the court.

14.17.10.2 The Contractor's CLIP Liaison must collaborate with the CLIP Administration for children subject to court-ordered involuntary treatment and provide care coordination and assistance in the development of a less restrictive community plan when appropriate. The Contractor's CLIP Liaison will share the community and/or Family recommendations with the CLIP Administration Office for purposes of CLIP program

assignment of committed youth.

14.17.11 Reasonable Efforts for Less Restrictive Orders and Services: The Contractor must collaborate and consult with the CLIP Administration Office and the CLIP facility regarding the behavioral health needs of Enrollees being transferred for evaluation purposes to the Child Study and Treatment Center under the requirements of RCW 10.77 or by the Rehabilitation Administration-Juvenile Rehabilitation (RA-JR) to a Juvenile Rehabilitation Facility. The CLIP Liaison will remain available to collaborate and consult with the CLIP facility and the CLIP Administration Office when the Enrollee returns to the community.

14.17.12 Child and Adolescent Needs and Strengths (CANS) Screening Requirements: The Contractor must ensure that a CANS screen is completed within the ninety (90) calendar days prior to the actual admission date to a CLIP facility and provide a full CANS within thirty (30) calendar days post-discharge from a CLIP facility for all Medicaid or Medicaid-eligible voluntary Enrollees.

14.17.13 Initial Contact with CLIP Facility Post-Admission: The Contractor's CLIP Liaison must ensure that initial contact with CLIP facility treatment staff occurs within three (3) business days of a CLIP admission.

14.17.14 Prioritizing WISe For Youth Discharging From CLIP: The Contractor must prioritize access to WISe services for all youth qualified to receive WISe services that are discharging from CLIP.

14.17.15 Rehabilitation Case Management (RCM): The Contractor must provide Rehabilitation Case Management (RCM) throughout the entirety of the CLIP treatment from preadmission through discharge. RCM includes a range of activities conducted in or with a facility for the direct benefit of the admitted youth to improve treatment gains and plan for successful discharges from CLIP. Activities include:

14.17.15.1 Assessment for discharge from the CLIP facility or admission to community behavioral health care;

14.17.15.2 Integrated behavioral health treatment planning;

14.17.15.3 Identification of appropriate resources;

14.17.15.4 Involvement of WISe team members while an enrollee is receiving CLIP treatment;

14.17.15.5 Linkage to behavioral health rehabilitative services; and

14.17.15.6 Collaborative development of individualized services that promote continuity of behavioral health care. These specialized coordination activities promote discharge from CLIP, maximize the benefits of treatment, minimize the risk of readmission, and increase likelihood that the Enrollee can remain in the community.

14.17.16 Coordination with The CLIP Administration Office: The Contractor's CLIP Liaison must coordinate with the CLIP Administration to ensure the

Contractor follows the CLIP Policies and Procedures Manual, January 2016, or its successors. The Contractor's CLIP Liaison must provide the CLIP Administration any relevant information regarding the individual's treatment history that can assist in guiding CLIP program assignment, CLIP treatment, and/or Discharge planning.

14.17.17 CLIP Recertification of Need for Continued Stay in CLIP: If a recertification for continued stay by the CLIP Administration is required, the Contractor's CLIP Liaison will provide input in a recommendation for continued CLIP treatment. If there is a not consensus about the need for recertification, the Contractor will provide documentation to the CLIP Facility and the CLIP Administration outlining a plan of care and services available to support discharge back to the community. The proposed community plan will be considered in the final recertification made decision by the CLIP Administration.

14.17.18 CLIP Transfers to Short-Term/Acute Care: If a CLIP facility requests the transfer of an Enrollee from a CLIP facility to an acute care hospital setting, the Contractor's CLIP Liaison will collaborate with the CLIP Administration Office and the CLIP Program to decide if authorization is needed for transfer to short-term/acute hospitalization.

14.17.19 Tribal CLIP Services: The Contractor's Tribal Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services.

14.18 Children's Health Care Coordination

14.18.1 The Contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under age 21 from receiving any other care coordination activity described in this Contract.

14.18.2 In accordance with chapter 74.09.337 RCW, when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor will, as necessary:

14.18.2.1 Coordinate mental health treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider;

14.18.2.2 Follow-up to ensure an appointment has been secured; and

14.18.2.3 Coordinate with the PCP regarding development of a

treatment plan, including medications management.

14.18.3 The Contractor will submit a report to HCA of children who have been identified as needing mental health care and appointment status. The quarterly Children's Mental Health report is due on the last business day of October, January, April, and July.

14.18.4 The Contractor will collaborate with Seattle Children's to receive Washington's Mental Health Referral Service for Children and Teens consultation letters. When Enrollee consultation letters are received, the Contractor will contact the Enrollee to ensure the Enrollee's needs are met and follow the provisions in this subsection as indicated.

14.19 Transitional Services

14.19.1 The Contractor shall ensure transitional services described in this Section are provided to all Enrollees who are transferring from one care setting to another, or one level of care to another.

14.19.2 The Contractor shall provide Transitional Care services to Enrollees who participate in Health Home services in accordance with Exhibit C, Health homes. When a Health Home Enrollee moves from one coverage area to another, the Contractor in the new coverage area shall provide Care Management Coordination services or other services to ensure the care plan established by the Health Home Care Coordinator in the previous county of residence continues for the Enrollee. If Health Home services were not available in the previous county of residence, the Contractor must ensure a Health Home-eligible Enrollee receives Health Home services in the new coverage area consistent with Exhibit C of this Contract.

14.19.3 The Contractor shall work with appropriate staff at any hospital, including a CPE facility, to implement a safe, comprehensive discharge plan that assures continued access to medically necessary covered services which will support the client's recovery and prevent readmission. The Contractor shall have in place operational agreements or shall incorporate transitional language into existing subcontracts with the Contractor's contracted state and community physical and Behavioral Health hospitals, residential treatment facilities and long-term care facilities, and with BHOs, to ensure Enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

14.19.3.1 The Contractor must complete the Uniform Discharge Tool reporting template for every individual discharging from a mental health inpatient setting hospital stay. The template, developed collaboratively with contracted MCOs and HCA, will be finalized by the end of the first quarter of 2019 and submitted afterward as described below:

14.19.3.2 On a semi-annual basis, the Contractor must compile and submit a summary of aggregate scores derived from the

Uniform Discharge Tool to HCA. The report is due on the fifteenth of July for the reporting period of January 1 through June 30 and the fifteenth of January for the reporting period of July 1 through December 31.

14.19.3.2.1 HCA may request a copy of the Uniform Discharge Tool for an individual and the Contractor must provide the tool within one (1) business day of the request.

14.19.3.3 Development of an individual Enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

14.19.3.3.1 Information that supports discharge care needs, Medication Management, interventions to ensure follow-up appointments are attended, and follow-up for self-management of the Enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Caregivers of AHFC Enrollees under age 13 will be included in this process. Formal or informal caregivers shall be included in this process when requested by the Enrollee if the Enrollee is over age 13;

14.19.3.3.2 A written discharge plan, including scheduled follow-up appointments, provided to both the Enrollee if the Enrollee is over age 13, the Enrollee's caregiver if the Enrollee is under age 13,and all treating providers at Enrollee discharge;

14.19.3.3.3 Systematic follow-up protocol to ensure timely access to follow-up care post-discharge and to identify and re-engage Enrollees who do not receive post-discharge care;

14.19.3.3.4 Organized post-discharge services, such as home care services, after-treatment services, and occupational and physical therapy services;

14.19.3.3.5 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following Enrollee discharge;

14.19.3.3.6 Information on what to do if a problem arises following discharge;

14.19.3.3.7 For Enrollees at high risk of re-hospitalization, a visit by the PCP or Care Coordinator at the Facility before discharge to coordinate transition;

14.19.3.3.8 For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage of the Enrollee to appropriate referrals;

14.19.3.3.9 Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge;

14.19.3.3.10 Follow-up to ensure the Enrollee saw his/her provider; and

14.19.3.3.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.

14.19.4 For the purposes of this Contract, transitional care may include movement between placements – from home to foster care, foster care to independent living, changes in legal status from foster care to adoption, return of a foster child to his or her birth home or youths aging out of foster care. The Contractor is not expected to take the lead in assisting Enrollees in placement changes; however, the Contractor shall provide assistance to DCYF staff, care givers and parents to ensure continuity of care for these Enrollees, as described in this Contract.

14.19.5 The Contractor shall obtain consent to share health care information from Enrollees or their caregiver/social worker to share information with clinical and non-clinical providers to facilitate care transitions. Consent to share information must be obtained from an Enrollee who is age 13 years of age or older.

14.19.5.1 If the Enrollee, caregiver or parent is unwilling to consent to share information and sharing the information is necessary to ensure ongoing health and well-being of the Enrollee, consent may be obtained via a court order with assistance from the Enrollee's SSS/Social Worker. Consent to share information about an Enrollee under age 13 may be obtained from the parent (biological or adopted) or, for a dependent child, the Enrollee's SSS/Social Worker.

14.19.6 The Contractor shall also work with SSS/Social Workers and caregivers, and the Enrollee's providers to ensure that children enrolled in the AHFC program who transition from one placement to another maintain

continuity of care to the extent possible, especially when an Enrollee moves from one geographical area to another.

14.19.6.1 The Contractor, in collaboration with all hospitals including state hospitals and other facilities that provide care for individuals with 90 and 180-day civil commitments, shall develop discharge planning policies and procedures.

14.19.6.1.1 The Contractor shall process hospital prior authorization request for all clinic services required by the Enrollee within two (2) business days. Such services shall include authorizations for any therapies, home care services, equipment, or pharmaceuticals.

14.19.6.1.2 The Contractor shall educate state hospitals, other facilities providing care for individuals with 90 and 180-day civil commitments, and discharge planning staff on clinical services requiring pre-authorization to facilitate timely discharge from these settings.

14.19.6.1.3 The Contractor shall not delay discharge from a hospital because of Contractor authorization procedures that unnecessarily delay such discharges.

14.19.6.1.4 The Contractor must accept the 'honor authorization' for SUD residential admission when services are authorized by the Enrollee's previous MCO, in cases where an incarcerated Enrollee is authorized by one MCO but changes to another MCO upon release. This includes, but is not limited to:

14.19.6.1.4.1 Enrollee selects a different MCO upon release than they were enrolled in at incarceration;

14.19.6.1.4.2 The MCO that the Enrollee was enrolled in at incarceration is no longer being offered in the service area that the Enrollee was released in; or

14.19.6.1.4.3 The Enrollee becomes associated with a household that has selected a different MCO than the Enrollee had prior to incarceration.

14.19.7 Care coordination and transitions between levels of care – Inpatient Treatment Agencies.

14.19.7.1 The Contractor must require that behavioral health treatment agencies develop policies and procedures that enhance care coordination, including transitions between all levels of care, by July 1, 2019. Any new policies or procedures must take effect on or before October 1, 2019.

14.19.7.2 The Contractor must work with behavioral health treatment agencies to ensure there is adequate coordination for Enrollees transitioning between various levels of treatment services to ensure continuity of care. As used in this section, "continuity of care" means the situation under which an Enrollee who is receiving services from an individual provider is entitled to receive timely and applicable follow-up services from ancillary referral agencies with the goal of providing immediate follow-up to address the holistic needs of the Enrollee. This will include, at a minimum, the following:

14.19.7.3 The Contractor must work with the Subcontractor to ensure that discharge plans and facilitation to post-discharge services are documented in the Enrollee's electronic health record. The following must occur when the Enrollee is discharged or transitioned to a lower or higher level of care:

14.19.7.3.1 Appropriate referrals are made to a behavioral health provider and coordination with the Enrollee's MCO.

14.19.7.3.2 Follow up appointments must be scheduled to occur within seven calendar days of Enrollee discharge and documented as such in the Enrollee's electronic health record. Documentation must include:

14.19.7.3.2.1 Release of Information between behavioral health treatment agencies for the Enrollee; date and time of appointment; any current medications; and

14.19.7.3.2.2 If applicable, sufficient supply and compliance plan for prescribed medications is documented as part of the discharge process.

14.19.7.3.3 Enrollee's counselor or a designated outreach coordinator at the facility, will follow up via telephone, text message, or email with the Enrollee within one week post-discharge.

14.19.7.4 The Contractor must ensure continuity of Medication Assisted Treatment (MAT) services for an Enrollee who transfers out of their region if that Enrollee was inducted or continued on FDA approved medications for all substance use disorders during

the course of their treatment. For those receiving FDA approved medications for substance use disorder, the following must occur:

14.19.7.4.1 The Contractor must ensure an intake appointment takes place within seven (7) calendar days of discharge from previous treatment facility.

14.19.7.4.2 Upon Enrollee discharge, the subcontractor must ensure medication management to include sufficient medication until the Enrollee's scheduled appointment with community provider or behavioral health treatment agency.

14.19.7.4.3 The Contractor must have enough subcontractors that provide MAT services to allow for potential referrals from Enrollees who transfer from other regions.

14.19.8 Transition from Inpatient SUD Behavioral Health Agency. The Contractor must coordinate with Subcontractors who provide inpatient treatment to ensure referrals of Enrollees to outpatient services post-discharge from their facility. This includes the following:

14.19.8.1 Inpatient Treatment Provider must have Policies in place for prompt exchange of Enrollee information between behavioral health treatment agencies to facilitate continuity of care.

14.19.8.2 Warm Hand-off: When an Enrollee completes or is discharged from an Inpatient Behavioral Health Agency, the subcontracting agency will have policies and practices in place to:

14.19.8.2.1 Provide scheduled immediate appointments with community health care providers, to include, but not be limited to the following:

14.19.8.2.1.1 Intensive Outpatient/Outpatient Services. Documentation of and appointment referral for next level of treatment upon completion of residential services.

14.19.8.2.1.2 MAT. If the Enrollee was inducted or continued on FDA approved medications for substance use disorder during their stay in an Inpatient Behavioral Health facility, the agency will coordinate a same day appointment with an outpatient provider to coincide

with the individual's discharge date.

14.19.8.2.1.3 Peer Support and Recovery Based Services. The Inpatient Behavioral Health facility will document and provide the Enrollee with addresses and phone numbers at discharge for community based Peer Support and Recovery Support resources.

14.19.8.2.1.4 Housing. Enrollee's housing status must be verified through the Enrollee or authorized representative and documented within the electronic health record system. When necessary, the Behavioral Health facility will refer Enrollee to housing and community support services; documentation of any referrals must be placed in the electronic health record. When the Enrollee is prescribed FDA approved medications for SUD, the provider must document efforts to obtain housing to fit the individual's needs.

14.19.8.2.1.5 Transportation- Arrange for transportation for the individual, as needed, to scheduled appointments and recovery-based housing.

14.19.8.3 If the Enrollee discontinues services, the Subcontractor will document as such and attempt to facilitate transition back into the community.

14.19.8.4 If a behavioral health treatment agency discontinues treatment of an Enrollee, the agency must meet all discharge requirements noted in subsections 14.19.7.2 and 14.19.8 above.

14.20 **Skilled Nursing Facility Coordination**

14.20.1 Skilled Nursing Care is care provided by trained individuals (RN, PT, OT, ST, or RT) that typically follows an acute hospital stay, or is provided as an alternative to skilled care in an acute care facility. It may be necessary for acute medical conditions (for example, rehab) or due to chronic medical conditions or disabilities. Skilled care is:

14.20.1.1 Rehabilitative: Care provided for or post an acute illness or injury with the intent of restoring or improving skills and/or function that was lost or impaired; or

14.20.1.2 Skilled Medical: Care provided daily and including, but not limited to, IV therapy, IM injections, indwelling and subrapubic catheters, tube feeding, TPN, respiratory therapy, or wound care.

14.20.2 The Contractor is responsible for medically necessary Skilled Nursing care in a SNF or Nursing Facility (NF) when the Contractor determines that NF care is more appropriate than acute hospital care. The Contractor shall coordinate with the hospital or other acute care facility discharge planners and NF Care Managers or social workers, as described in the Coordination Between the Contractor and External Entities subsection of this Contract to ensure a smooth transition of the Enrollee to or from a SNF or NF.

14.20.3 The Contractor shall coordinate with the SNF or NF to provide Care Coordination and transitional care services and shall ensure coverage of all Medically Necessary Services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.

14.20.3.1 If the Contractor, in coordination with the NF or SNF, anticipates the Enrollee will be in the Facility for additional days after an Enrollee no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Contractor shall coordinate with the DSHS/ALTSA/HCS to:

14.20.3.1.1 Determine functional, financial and institutional eligibility, if necessary; and

14.20.3.1.2 Assist the Enrollee to explore all options available for care, including whether the Enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for Long Term Services and Supports (LTSS).

14.20.3.2 If the Enrollee is discharged home or to a community residential setting the Enrollee remains enrolled in IFC. The Contractor shall coordinate with SNF/NF and HCS staff to ensure the Enrollee is discharged to a safe location and shall ensure Medically Necessary Services are available to the Enrollee including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the Enrollee's recovery. The Contractor shall also ensure follow-up care is provided consistent with the

Transitional Care Coordination requirements of this Contract.

14.20.4 If the Enrollee remains in the SNF/NF, the Enrollee remains enrolled in IFC and ALTSA is responsible for payment of SNF/NF room and board beginning on the date it is determined the Enrollee does not meet or no longer meets criteria for the rehabilitative or skilled benefit. The Contractor continues to be responsible for all Medically Necessary Services, prescriptions, and equipment not included in the ALTSA NF rate. The Contractor shall continue to monitor the Enrollee's status and assist in coordination of transitions back to the community.

14.20.5 Issuance of an award letter by ALTSA does not constitute a guarantee or promise of payment for nursing home care.

14.20.6 The Contractor must provide written notice to the Facility, including dates of service and the date coverage will end, if the Enrollee:

14.20.6.1 Is admitted under the rehabilitative or skilled benefit;

14.20.6.2 Does not meet rehabilitative or skilled nursing criteria; or

14.20.6.3 If a previously authorized stay is being reduced.

14.20.7 For purposes of this Section, "nursing facility level of care" means ongoing support services provided in a SNF/NF for Enrollees that do not meet the criteria for rehabilitative or skilled nursing services.

14.21 Health Care Coordination Oversight

14.21.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Health Care Coordination requirements and the quality and appropriateness of care furnished to Individuals with Special Health Care Needs. (42 C.F.R. § 438.240 (b)(4)).

14.21.2 Quality assurance reviews of documented health care coordination activities provided by the Care Coordinator shall include assessment of:

14.21.2.1 Case identification and assessment according to established risk identification and assessment systems and timeframes;

14.21.2.2 Documented Health care coordination plans with evidence of periodic revision as appropriate to the Enrollee's emerging needs;

14.21.2.3 Effective Enrollee monitoring, including management of barriers;

14.21.2.4 Referral management;

14.21.2.5 Effective coordination of care, including coordination of services that the Enrollee receives through the FFS system; and

14.21.2.6 Identification of appropriate actions for the care coordinator to take in support of the Enrollee, and the Care Coordinator's

follow-through in performing the identified tasks.

14.21.3 The Contractor shall conduct quality assurance reviews, at a minimum, on a quarterly basis.

14.22 Direct Access to Specialists for Individuals with Special Health Care Needs

When the required treatment plan of Individuals with Special Health Care Needs, Children with Special Health Care Needs, or Enrollees meeting Level 2 eligibility indicates the need for frequent utilization of a course of treatment with or regular monitoring by a specialist, the Contractor shall allow these Individuals to retain the specialist as a PCP, or alternatively, be allowed direct access to specialists for needed care (42 C.F.R. § 438.208(c)(4) and 438.6(m)).

14.23 Transitional Planning for Incarcerated Enrollees

For the purposes of this subsection, “correctional facility” includes city and county jails, Department of Corrections (DOC) facilities, and Juvenile Rehabilitation facilities.

14.23.1 In accordance with SSB 6430 (Laws of 2016, chapter 154), the Contractor shall coordinate care for Enrollees as they transition into a correctional facility or upon release from a correctional facility. The Contractor shall initiate development of and make progress toward obtaining data sharing agreements with correctional facilities to enable the Contractor and these facilities to share health information about the Enrollees. Transitional care coordination shall be provided for up to the first thirty (30) calendar days of incarceration or as needed and upon the Enrollee’s release, including honoring another MCOs prior authorization for admission to SUD residential facility. When correctional facilities opt out of this activity the Contractor is not required to pursue these facilities.

14.23.2 The Contractor shall:

14.23.2.1 Provide transitional Care Coordination services to Enrollees when they enter a correctional facility, including:

14.23.2.1.1 Working with the facility to define the responsible party at the facility who will provide Care Coordination activities in the facility;

14.23.2.1.2 Ensuring the facility is aware of the Enrollee’s special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions, and is aware of medications and supplies the enrollee needs; and

14.23.2.1.3 Providing information to enable the facility to maintain the Enrollee’s medication regimen while the Enrollee is incarcerated.

14.23.2.2 Provide services and Care Coordination for Enrollees upon release from a correctional facility, or other facilities that provide care for individuals with 90 and 180-day civil

commitments, including:

14.23.2.2.1 Coordinating with the facility to get copies of the Enrollee's medical records at the time of discharge;

14.23.2.2.2 Requesting the Enrollee sign a Release of Information to allow exchange of health care information between systems;

14.23.2.2.3 Using an evidence based approach to care coordination as the Enrollee transitions from incarceration to the community;

14.23.2.2.4 Ensuring expedited prior authorization for medications or supplies prescribed while the Enrollee was incarcerated, and for admissions to SUD residential treatment facilities when previously authorized by another MCO during the client's incarceration period;

14.23.2.2.5 Prioritize Care Coordination for Enrollees with special needs, such as a PRISM score of 1 or higher, SUD, mental health needs, or chronic health conditions;

14.23.2.2.6 Providing the Enrollee with an overview of benefits for which the Enrollee is eligible through the Contractor;

14.23.2.2.7 Discuss with the Enrollee how to access a PCP, notify the Enrollee who their PCP is or help the Enrollee to find a PCP; and

14.23.2.2.8 Assist the Enrollee to access the following services:

14.23.2.2.8.1 Transportation to Medicaid appointments;

14.23.2.2.8.2 Follow-up appointments for Behavioral Health or medical services;

14.23.2.2.8.3 Housing and employment assistance; and

14.23.2.2.8.4 Other support services the Enrollee may need.

14.23.3 HCA shall provide:

14.23.3.1 Information to the Contractor about the Enrollee's incarceration status when the information is available to HCA.

14.23.4 When possible, HCA shall coordinate with the Contractor to re-enroll the

Enrollee with the IFC program after the Enrollee's release from a correctional facility, even when the incarceration was longer than six months.

14.24 Transitioning Health Care Coordination through Fostering Well Being

14.24.1 Within the limits of available information, the Contractor shall coordinate with FWB Program Manager and RN Clinical Consultant upon enrollment of children who were receiving services through the DSHS Fostering Well Being (FWB) program prior to enrollment in the IFC program to ensure a smooth transition of health care coordination services.

14.24.2 HCA, DSHS and the Contractor shall coordinate to transition a child who returns to the FFS system back to FWB for care coordination;

14.24.3 FWB Care Coordination Unit (CCU) shall provide technical assistance to the Contractor in the following circumstances:

14.24.3.1 The Contractor is unable to identify or contact the Enrollee's SSS/Social Worker; or

14.24.3.2 The Contractor requests information about an Enrollee previously managed by FWB CCU.

14.24.4 FWB shall assist in expediting and coordinating a State Administrative hearing or Independent Review when a grievance or appeal cannot be resolved through the Contractor's Grievance and Appeals process.

14.24.5 Eligibility for FWB Care Coordination Services: Children and youth are eligible for FWB care coordination services if they are:

14.24.5.1 Under age 18;

14.24.5.2 In out-of-home placement through tribal or state dependency (adoptions are not eligible);

14.24.5.3 Not enrolled in IFC;

14.24.5.4 Medicaid eligible; or

14.24.5.5 Under age 21 and participating in the Extended Foster Care Program.

14.24.6 Upon request by HCA, FWB shall provide assistance to HCA Medicaid Monitoring staff in conducting annual monitoring visits, as well as coordinating with monitoring staff to conduct quarterly file reviews for program Enrollees.

14.25 Children's Mental Health Care Coordination

14.25.1 The Contractor shall ensure coordination for all Enrollees under age 21 in accordance with EPSDT requirements. The Contractor shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services needed to treat health problems and conditions when the Contractor becomes aware of an unmet need. This requirement does not preclude Enrollees under age 21 from receiving any other care

coordination activity described in this Contract.

14.25.2 In accordance with chapter 74.09.337 RCW, when the Contractor receives notification or identifies children requiring mental health treatment, including behavioral intervention to treat autism, the Contractor shall, as necessary:

14.25.2.1 Coordinate treatment and care based on the child's assessed needs, regardless of referral source, whether the referral occurred through primary care, school-based services, or another provider;

14.25.2.2 Follow-up to ensure an appointment has been secured; and

14.25.2.3 Coordinate with the PCP regarding development of a treatment plan, including medications management. (chapter 74.09 RCW).

14.25.3 The Contractor will submit a report to HCA of children who have been identified as needing mental health care and appointment status. The quarterly Children's Mental Health report is due on the last business day of October, January, April, and July.

14.26 American Indian/Alaska Natives

14.26.1 The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs).

14.26.2 The Contractor must provide for training of its tribal liaison, conducted by one (1) or more IHCPs and/or the American Indian Health Commission for Washington State and/or the DSHS Indian Policy Advisory Committee, on AI/AN health disparities and needs, the Indian health care delivery system, the government-to-government relationship between the state of Washington and the federally recognized tribes, applicable federal and state laws and regulations, applicable provisions in this Contract, and matters specific to IHCPs.

14.26.3 The Contractor must ensure its employees and agents receive training in cultural humility, including training on how to communicate with AI/AN Enrollees and IHCP staff, and in the history, culture, and services of IHCPs within the RSAs under the Contract. Training shall be obtained in collaboration with the tribes and IHCPs in such RSAs.

14.26.4 The Contractor must notify and coordinate care and transitions with any IHCP when the Contractor becomes aware an Enrollee is AI/AN or is receiving care from an IHCP and the Enrollee consents to such notification. To meet this requirement, the Contractor must develop and maintain a process for asking whether an Enrollee is a member of a federally recognized tribe or is receiving care from an IHCP and, if applicable, whether the Enrollee consents to the Contractor notifying such IHCP or federally recognized tribe.

14.26.5 With respect to voluntary psychiatric hospitalization authorization, the Contractor shall:

14.26.5.1 Develop and maintain policies and procedures that explain how IHCP request voluntary psychiatric hospitalization authorizations for Enrollees.

14.26.5.2 Obtain the approval of HCA's tribal liaison for such policies and procedures before they are implemented; and

14.26.5.3 Make available to IHCPs information on how to request voluntary psychiatric hospitalization authorizations for Enrollees, including policies and procedures, and how to submit appeals and expedited appeals.

14.26.6 The Contractor's Tribal Liaison, DCYF Liaison and the Enrollee's Indian Health Care Provider shall participate in treatment and discharge planning, including continuity of care in the nearest clinically appropriate setting for all AI/AN Enrollees (including BHSO) admitted for voluntary inpatient psychiatric and/or residential substance use disorder services.

14.26.7 With respect to voluntary psychiatric hospitalization authorization, the Contractor shall:

14.26.7.1 Develop and maintain policies and procedures that explain how IHCP request voluntary psychiatric hospitalization authorizations for Enrollees.

14.26.7.2 Obtain the approval of HCA's tribal liaison for such policies and procedures before they are implemented; and

14.26.7.3 Make available to IHCPs information on how to request voluntary psychiatric hospitalization authorizations for Enrollees, including policies and procedures, and how to submit appeals and expedited appeals.

14.27 **Mental Health Parity**

14.27.1 The Contractor shall not impose Non-Quantitative Treatment Limits (NQTL) for mental health or substance use disorder benefits in any classification (inpatient, outpatient, emergency care, or prescription drugs) unless, under the Contractor's policies and procedures as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 C.F.R. § 438.910(d)).

14.27.2 The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

14.27.3 The Contractor may cover, in addition to services covered under the

state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 C.F.R. part 438, subpart K, and the contract identifies the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either the state or the Contractor. (42 C.F.R. § 438.3(e)(1)(ii)).

14.27.4 If Enrollees are provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided to the Enrollee in every classification in which medical/surgical benefits are provided. (42 C.F.R. § 438.910(b)(2)).

14.27.5 The Contractor's prior authorization requirements shall comply with the requirements for parity in mental health and substance use disorder benefits in (42 C.F.R § 438.910(d)).

14.27.6 The Contractor must provide all necessary documentation and reporting to HCA to establish and demonstrate compliance with 42 C.F.R. part 438, subpart K regarding parity in mental health and substance use disorder benefits.

14.27.7 The Contractor shall make the criteria for medical necessity determinations made by the Contractor for mental health or substance abuse disorder benefits available to any enrollee, potential enrollee, or contracting provider upon request.

14.27.8 The Contractor shall not impose aggregate lifetime, annual dollar limits or any other financial limitations on Enrollees for mental health, substance use disorder benefits regardless of whether the services are covered by the Contractor or a Behavioral Health Organization.

14.28 Private Duty Nursing Coordination

If private duty nursing is denied for a child placed in a pediatric group home, the Contractor shall notify the HCA and DCYF within two (2) business days of the Contractor's decision. The Contractor will coordinate with the SSS/Social worker regarding the change in the child's care plan.

15 SPECIAL PROVISIONS FOR IHCPs AND AMERICAN INDIAN/ALASKA NATIVE ENROLLEES

15.1 Special Provisions for Subcontracts with Indian Health Care Providers (IHCPs)

15.1.1 If, at any time during the term of this Contract, an IHCP submits a written request to the Contractor at the mailing address set forth on the cover page of this Contract indicating such IHCP's intent to enter into a subcontract with the Contractor, the Contractor must negotiate in good faith with the IHCP.

15.1.1.1 Any such subcontract must include the Special Terms and Conditions set forth in the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Addendum for Indian Health Care Providers (the IHCP Addendum) issued by the Centers for Medicare and Medicaid Services (CMS). To the extent that any provision set forth in the subcontract between the Contractor and the IHCP conflicts with the provisions set forth in the IHCP Addendum, the provisions of the IHCP Addendum shall prevail.

15.1.1.2 Such subcontract may include additional Special Terms and Conditions that are approved by the IHCP and the Contractor. Each party must provide the HCA Tribal Liaison with a complete copy of such Additional Special Terms and Conditions, in the format specified by the HCA, and a written statement that both parties have agreed to such Additional Special Terms and Conditions.

15.1.2 Any subcontracts with IHCPs must be consistent with the laws and regulations that are applicable to the IHCP. The Contractor must work with each IHCP to prevent the Contractor's business operations from placing requirements on the IHCP that are not consistent with applicable law or any of the special terms and conditions in the subcontract between the Contractor and the IHCP.

15.1.3 The Contractor may seek technical assistance from the HCA Tribal Affairs Office to understand the legal protections applicable to IHCPs and American Indian/Alaska Native Medicaid recipients.

15.1.4 In the event that (a) the Contractor and the IHCP fail to reach an agreement on a subcontract within ninety (90) calendar days from the date of the IHCP's written request (as described in subsection 15.1.1) and (b) the IHCP submits a written request to HCA for a meeting to discuss the subcontract, the Contractor and the IHCP shall meet in person with HCA in Olympia, Washington or at an alternate location agreed upon by the parties involved within thirty (30) calendar days from the date of the IHCP's written consultation request in an effort to resolve differences and come to an agreement. Executive leadership of the Contractor must attend this meeting in person and be permitted to have legal counsel present.

15.2 IHCP Engagement

15.2.1 No later than April 30 of each year, the Contractor shall submit to the HCA Tribal Affairs Office a report that includes:

15.2.1.1 A plan that describes the outreach activities the Contractor will undertake during the upcoming year to work with IHCPs in developing and implementing various services, financing models and other activities for the Contractor to:

15.2.1.1.1 Support and enhance the care coordination services provided by IHCPs for Enrollees, both American Indian/Alaska Native and non-American Indian/Alaska Native, including coordination with non-IHCP; and

15.2.1.1.2 Improve access for American Indian/Alaska Native Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed care.

15.2.1.1.3 A summary of the progress made during the previous year in building relationships, contractual and otherwise, with IHCPs.

15.2.2 No later than the 15th calendar day after the end of each calendar quarter, the Contractor shall submit to the HCA Tribal Affairs Office a quarterly report that briefly describes:

15.2.2.1 IHCPs the Contractor has worked with during the previous quarter;

15.2.2.2 IHCPs with whom the Contractor successfully negotiated collaborative or contractual arrangements during the previous quarter; and

15.2.2.3 IHCPs to whom the Contractor will reach out during the coming quarter.

15.3 Special Provisions for American Indians and Alaska Natives

15.3.1 If an American Indian/Alaska Native Enrollee indicates to the Contractor that he or she wishes to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an in-network PCP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor.

15.3.2 The Contractor must honor the referral of an out-of-network IHCP who refers an AI/AN Enrollee to a network provider. (42 C.F.R. § 438.14(b)(6)).

15.3.3 In accordance with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating IHCPs for contracted services provided

to AI/AN Enrollees at a rate equal to the rate negotiated between the Contractor and the IHCP. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an IHCP.

15.3.4 Facilities of the Indian Health Service and facilities operated by a tribe or tribal organization and funded by Title I or III of the Indian Self Determination and Education Assistance Act, whether designated with the Medicaid program as a Tribal 638 Clinic or a Federally Qualified Health Center (a Tribal FQHC), must be reimbursed the specific full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Federal Guidance.

15.3.5 The encounter rates for each contracted Indian Health Service facility, Tribal 638 Clinic, and Tribal FQHC will be provided by HCA to the Contractor with each accepted qualified claim. The rate files will be consistent with federal guidance found at https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules under Tribal Health Program or Tribal FQHC, and updated annually.

15.3.5.1 Tribal 638 Clinic and Tribal FQHC designation with the Medicaid program may be verified by contacting tribalaffairs@hca.wa.gov.

15.3.5.2 Claims paid to Indian Health Service facilities, Tribal 638 Clinics, and Tribal FQHCs and included in the encounter submission by the Contractor to HCA will include:

15.3.5.2.1 An encounter service as outlined in the Tribal Health Program Billing Guide or Tribal FQHC Billing Guide;

15.3.5.2.2 A T1015 procedure code; and

15.3.5.2.3 An NPI of an Indian Health Service facility, Tribal 638 Clinic, or Tribal FQHC (participating NPIs will be shared by HCA with Contractors on the HCA Tribal affairs website found at https://www.hca.wa.gov/assets/program/tribal-managed-care-plan-resources-npi-classifications.pdf or by contacting tribalaffairs@hca.wa.gov).

15.3.5.3 HCA will reimburse the Contractor for paid clean claims through ProviderOne for qualifying encounters as outlined in the ProviderOne Billing Guides and the Encounter Data Reporting Guide.

15.3.6 The Contractor shall ensure it has sufficiently trained staff to handle calls or inquiries from providers regarding the reimbursement process and how to ensure that services to AI/AN Enrollees are correctly processed.

15.3.7 The Contractor will submit the Indian Health Service Facility report

quarterly to HCA of services provided to Tribal facilities. The report shall be submitted through MC-Track. The reports are due to HCA no later than the fifteenth of the month following the end of the quarter in January, April, July and October.

15.3.7.1 The report shall include:

15.3.7.1.1 A list of all facilities by name and NPI contracted by:

15.3.7.1.1.1 IHS Facility;

15.3.7.1.1.2 Tribal 638 Facility; and

15.3.7.1.1.3 Tribal FQHC.

15.3.7.1.2 Total number of unique clients by facility and by AI/AN or non-AI/AN status, and

15.3.7.1.3 Total number of claims paid for each facility.

16 BENEFITS

16.1 Scope of Services

16.1.1 Medically Necessary Services: The Contractor is responsible for covering medically necessary services to Enrollees sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished (42 C.F.R. § 438.210(a)(3)(ii). The Contractor shall cover services that address the following (42 C.F.R. § 438.210(a)(4); and WAC 182-501-0060):

16.1.1.1 The prevention, diagnosis, and treatment of an Enrollee's disease, condition, health impairment, and/or disorder that results in health impairments and/or disability 42 C.F.R. § 438.210(a)(5)(ii)(A).

16.1.1.2 The ability for an Enrollee to achieve age-appropriate growth and development.

16.1.1.3 The ability for an Enrollee to attain, maintain, or regain functional capacity.

16.1.2 Integrated behavioral health services that support a bi-directional delivery of care model. The Contractor shall implement coverage of designated services collaboratively with HCA to support an integrated model of care that has no barriers by provider type or place of service, except as driven by scope of licensure, CPT or correct coding initiatives. This will include coverage of selected codes, including those classified as collaborative care codes, behavioral health integration codes and primary care codes.

16.1.3 Except as otherwise specifically provided in this Contract, the Contractor must provide the same amount, duration and scope of services as described in the Medicaid State Plan (42 C.F.R. § 438.210(a)(1 & 2) unless a service is specifically excluded from the Contract. Covered services that are not excluded are Contracted Services. For specific Contracted Services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the HCA under its FFS program, but shall rather be construed to require the Contractor to provide the same scope of services. The Contractor is allowed to have guidelines, developed and overseen by appropriate Health Care Professionals, for approving services. All denials of Contracted Services are to be individual medical necessity decisions made by a Health Care Professional without being limited by such guidelines.

16.1.4 The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual Enrollee's healthcare needs by a health care professional with expertise appropriate to the Enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision.

16.1.4.1 The amount and duration of contracted services that are

medically necessary depends on the Enrollee's condition (42 C.F.R. § 438.210(a)(3)(i)).

16.1.4.2 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the Enrollee's diagnosis, type of illness or condition (42 C.F.R. § 438.210(a)(3)(ii)).

16.1.5 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to Enrollees nor unduly burden providers or Enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid FFS program (42 C.F.R. § 438.210(a)(4)(ii)).

16.1.6 If the Contractor objects on moral or religious grounds to providing a counseling or referral service that it would otherwise be required to provide, reimburse for, or provide coverage for, the Contractor is not required to do so. The Contractor must document the grounds on which it objects to providing this service.

16.1.7 The Contractor shall ensure that utilization control measures imposed on family planning services are imposed in such a manner that the enrollee's right to choose the method of family planning to be used is protected.

16.1.8 For services that the HCA determines are non-covered that are not specifically excluded by this Contract, excluded from coverage under federal regulation or excluded from coverage by HCA, the Contractor shall have policies and procedures consistent with WAC 182-501-0160, Exception to Rule (ETR). The Contractor shall cover a service when the criteria in this WAC are met.

16.1.9 For services that are covered, but with limits in scope, amount or duration the Contractor will have policies and procedures consistent with WAC 182-501-0169 Limitation Extension (LE) to determine medical necessity of services outside or more than the limit. The Contractor is responsible for covering a service when the criteria in this WAC are met and results in an approval of services outside or more than the limitation.

16.1.10 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 C.F.R. §438.3). Services provided outside the scoped of Contracted Services shall be reported separately to HCA and shall not be included in the rates development process.

16.1.11 The Contractor may limit the provision of contracted services to Participating Providers except for the following:

16.1.11.1 Emergency services;

16.1.11.2 Services Provided outside the Service Areas as necessary to provide medically necessary services;

16.1.11.3 Coordination of Benefits, when an Enrollee has other primary comparable medical coverage as necessary to coordinate benefits; and

16.1.11.4 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment section of this Contract, the Contractor shall cover Enrollees for all medically necessary services.

16.1.12 Outside the Service Area:

16.1.12.1 For Enrollees who are temporarily outside the service area or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

16.1.12.1.1 Emergency and post-stabilization services.

16.1.12.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the, Appointment Standards provisions of the Access to Care and Provider Network section of this Contract, are not exceeded.

16.1.12.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access to Care and Provider Network section of this Contract are not exceeded.

16.2 Special Provision for Substance Use Disorder Benefits

All Enrollees are entitled to an assessment of need for SUD services. The Contractor shall ensure use of ASAM Level of Care Guidelines to make prior authorization and continuing care decisions for all SUD services.

16.3 Special Provisions Regarding Behavioral Health Benefits

The Contractor's administration of behavioral health benefits also shall comply with the following provisions:

16.3.1 Unless otherwise agreed upon, Essential Behavioral Health Functions and required behavioral health personnel shall be located in Washington State and available during business hours.

16.3.2 Outside of business hours, information, crisis triage, referral services and prior authorization may be conducted out-of-state. Any Contractor staff that work outside of Washington State must be trained and have knowledge of Washington State-specific behavioral health Covered Services, Managed Care rules, UM protocols and Level of Care Guidelines.

16.3.3 The Contractor must maintain an adequate complement of qualified and trained staff located in Washington State to accomplish AH-IFC program goals and to meet the needs of individuals with serious emotional disturbance, serious mental illness and SUDs. The Contractor shall have behavioral health resources sufficient to meet all contract requirements and performance standards and shall require that all staff have the required education, experience, credentials, orientation and training to perform assigned job duties.

16.3.4 The Contractor shall designate employees who fulfil the following behavioral health functions:

16.3.4.1 A Behavioral Health Medical Director.

16.3.4.2 A Behavioral Health Clinical Director.

16.3.5 The Contractor shall designate managerial positions with the following behavioral health responsibilities:

16.3.5.1 A behavioral health Children's System Administrator.

16.3.5.2 An Addictions Administrator.

16.3.5.3 A behavioral health Utilization/Care Management Administrator.

16.3.5.4 A behavioral health network development manager.

16.3.5.5 A behavioral health provider relations manager.

16.3.6 In addition to the key and managerial staff, the Contractor shall have a sufficient number of qualified operational staff to meet its responsibilities under this Contract.

16.3.6.1 The Contractor shall locate a sufficient number of Provider Relations staff within the state to meet requirements under this Contract for provider education and training, provider profiling, and provider performance improvement or problem resolution.

16.3.6.2 The Contractor shall ensure that one (1) or more Data Management and Reporting Specialists shall have experience and expertise in Medicaid data analytics and behavioral health data systems to oversee all data interfaces and support the behavioral health specific reporting requirements under

this Contract. This position can be located outside of Washington State.

16.3.6.3 The Contractor shall designate one (1) or more Community Liaisons to work within Washington State, county behavioral health leadership, and ACHs within its service area. This shall include a liaison to Enrollee and family organizations for children, youth and families and a liaison to other member-serving systems including, but not limited to State and local criminal and juvenile justice agencies, foster care agencies, housing administrators/homeless services and vocational administration. Contractor shall participate and coordinate with the designated regional ACH and actively participate in at least one (1) health improvement strategy identified by the ACH.

16.3.6.4 The Contractor shall ensure a sufficient number of qualified staff to meet both new contract requirements and increased volume including the following functions: administrative and support, member services, Grievance and Appeal, claims, encounter processing, data analysts, and financial reporting analysts.

16.3.6.5 The Contractor may administer claims out of state. If claims are administered in another location, physical and behavioral health provider relations staff shall have access to the claims payment and reporting platform during Business Hours.

16.3.7 The Contractor shall develop and maintain a human resources and staffing plan that describes how the Contractor will maintain adequate staffing:

16.3.7.1 The Contractor shall hire employees for the key and required behavioral health functions specified in the Contract. Consultants must be prior approved by the state.

16.3.7.2 The Contractor may propose a staffing plan, with prior approval by the State, which combines positions and functions with other positions.

16.3.7.3 The Contractor shall develop and implement staff training plans that address how all staff will be trained on the requirements of this Contract.

16.3.7.4 The Contractor must ensure development and implementation of training programs for network providers that deliver, coordinate, or oversee Behavioral Health services to Enrollees. The individual(s) responsible for Behavioral Health training must have at least two (2) years experience and expertise in developing training programs related to behavioral health systems comparable to those under the

Contract.

16.4 Second Opinions

16.4.1 The Contractor must authorize a second opinion regarding the Enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the Enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for an independent and impartial qualified health care professional. The appointment for a second opinion must occur within thirty (30) calendar days of the request unless the Enrollee requests a delay for the second opinion to a date later than thirty (30) calendar days.

16.4.2 If the Contractor refuses to authorize a second opinion, or a second opinion from a provider of the Enrollee's choice, the refusal is an Adverse Benefit Determination, which shall be subject to appeal under the provisions of the Grievance and Appeal System section of this Contract.

16.4.3 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider.

16.5 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 C.F.R. § 441 Subpart F, and that a Consent for Sterilization form (HHS-687) is used. A hysterectomy requires the Hysterectomy Consent and Patient Information form (HCA 13-365). These forms can be accessed using the link provided in the HCA Sterilization Supplemental Billing Guide.

16.6 Enrollee in Facility at Enrollment: Medical Conditions

16.6.1 If an Enrollee was admitted to a hospital the same month that enrollment occurs, the Contractor is responsible for the admission and all related services unless:

16.6.1.1 The Enrollee is SSI Blind/Disabled and admitted to a CPE hospital. In this case, HCA is responsible for the inpatient claim and the Contractor is responsible for professional services and management of the authorization requirements.

16.6.2 HCA is responsible for payment of all hospital and professional services provided from the date of admission until the date the Enrollee is discharged from the acute hospital inpatient stay when:

16.6.2.1 The client was admitted to the hospital in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or

16.6.2.2 The client was on FFS before the admission and is enrolled in

AHMC during the admission; or

16.6.2.3 The client's eligibility is retroactive to a month prior to the current month, the client is hospitalized, and enrollment is completed during the admission.

16.6.3 If an Enrollee was admitted to a skilled nursing or nursing facility the same month that enrollment occurs, the Contractor is responsible for the admission and all related services, until the Enrollee no longer meets rehabilitation or skilled level of care criteria.

16.6.4 DSHS is responsible for payment of any nursing facility admissions including when the Enrollee meets rehabilitation or skilled level of care criteria, provided from the date of admission until the date the Enrollee is discharged from the nursing facility when:

16.6.4.1 The client was admitted to the nursing facility in the same month Medicaid eligibility is established but enrollment is not completed until the following month; or

16.6.4.2 The client was on FFS before the admission and is enrolled in IFC during the admission; or

16.6.4.3 The client's eligibility is retroactive to a month prior to the current month, the client is admitted, and enrollment is completed during the admission.

16.6.5 If the Enrollee's admission to a nursing facility is the responsibility of DSHS, under the provisions of subsection 16.5.4, the Contractor is responsible for all other services as described in this Contract, except for the room and board for the nursing facility, that are medically necessary and required to meet the client's needs, including professional services, specialty beds, specialty wheelchairs, etc. The Contractor is responsible for management of the authorization requirements for these services.

16.6.6 The Contractor is responsible for actively planning from either a hospital or a nursing facility when that admission is the responsibility of HCA or DSHS, respectively. The Contractor is also responsible for coordinating the delivery of care pursuant to this Contract once discharge has occurred, including any subsequent care: hospital inpatient, rehabilitation, outpatient, outpatient observation, any professional services, and any subsequent nursing facility placements that meet rehabilitative or skilled stay nursing level of care criteria.

16.6.6.1 If the Enrollee is admitted to a hospital or a nursing facility after the first of the month in which enrollment occurred, the Contractor may conduct retrospective review to establish medical necessity of the admission.

16.6.7 If an Enrollee changes AH MCOs and the change becomes effective during an inpatient admission, the AH MCO that the Enrollee was enrolled with on the date of admission is responsible for payment of all covered inpatient facility and professional services. This responsibility continues from the date of admission until the date the Enrollee no longer

meets criteria for the rehabilitative or skilled benefit, or is discharged from a facility to home or a community residential setting or readmitted to an inpatient or observation hospital stay, consistent with the Skilled Nursing Facility Coordination subsection of this Contract. The AH MCO that is receiving the Enrollee is responsible for completing the responsibilities described in subsection 16.6.6 above.

16.6.7.1 The party responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

16.7 Enrollee in Hospice at Enrollment

16.7.1 If an Enrollee changes AH MCOs and the change becomes effective while the Enrollee is receiving hospice services, the AH MCO that the Enrollee was enrolled with on the date of hospice admission is responsible for payment of all covered hospice services regardless of place of service. This responsibility continues from the date of admission until the date the Enrollee no longer meets criteria for hospice or is discharged from hospice. The AH MCO that is receiving the Enrollee is responsible for coordinating discharge and ensuring continuity of services for the Enrollee.

16.8 Enrollee in Facility at Enrollment: Behavioral Health

16.8.1 For Enrollees receiving inpatient or residential services through the Medicaid FFS system or BHO that were admitted prior to January 1, 2019, the Contractor shall be responsible for payment of all facility service costs beginning with the date of enrollment into IFC.

16.9 Enrollee in Facility at Termination of Enrollment

If an Enrollee is in a facility at the time of termination of enrollment and the Enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

16.9.1 The Enrollee is discharged from a facility to home or a community residential setting.

16.9.2 The Enrollee's eligibility to receive Medicaid services ends. The Contractor's obligation for payment ends at the end of the month the Enrollees Medicaid eligibility ends.

16.9.3 The Enrollee no longer meets the Contractor's rehabilitative or skilled criteria.

16.10 Services Provided in Lieu of

16.10.1 The Contractor may not provide services or settings that are in lieu of services or settings covered by the State Plan without prior written approval from HCA as follows:

16.10.1.1 At the request of the Contractor, HCA shall determine whether the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State Plan and provide the Contractor with written approval or denial of the request within no more than thirty (30) calendar days or as expeditiously as the Enrollees health condition requires the response;

16.10.1.2 The Enrollee is not required to use the alternative service or setting;

16.10.1.3 The approved in lieu of services are authorized and identified in this Contract and may be offered to the Enrollee at the Contractor's discretion; and

16.10.1.4 The utilization of the lieu of services is reported in the Contractor's encounter data submission.

16.11 Deliveries and Newborn Coverage

16.11.1 For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the enrolled newborn is discharged from the acute care hospital.

16.11.2 If the HCA is responsible for payment of labor and delivery services provided to a mother, the HCA shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions section of this Contract.

16.11.3 For covered deliveries in a birthing center, the Contractor shall pay for all covered services, including facility costs and professional services provided to the mother and the newborn until the date the enrolled mother and newborn are discharged from the birthing center.

16.11.4 For home deliveries, the Contractor shall pay for all costs associated with the home delivery, including professional services provided to the mother and newborn.

17 General Description of Contracted Services

17.1 Contract Services

The Contractor shall provide the following services, as medically necessary, to Enrollees:

17.1.1 The Contractor shall provide a wellness exam to each Enrollee that documents the Enrollee's baseline health status and allows the Enrollee's PCP to monitor health improvements and outcome measures.

17.1.2 When an Enrollee has a substance use disorder (SUD) and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the Enrollee is also receiving SUD and/or mental health treatment.

17.1.3 The Contractor is responsible for providing integrated medical and behavioral health services as directed by Section 14.

17.1.4 Inpatient Services:

17.1.4.1 Provided by acute care hospitals, including CPE hospitals and behavioral health inpatient facilities. Authorization and payment for services provided at CPE hospitals shall be made in accordance with the Payments to Hospitals section of this Contract.

17.1.4.2 Provided by a Nursing Facility, Skilled Nursing Facility or other acute care setting, when services are determined medically necessary and nursing facility services are not covered by DSHS' Aging and Long Term Supports Administration.

17.1.4.3 Consultations with specialty providers, including psychiatric or psychology consultations, are covered during medical hospital stays or those admissions described in subsection 17.1.4.4.

17.1.4.4 Inpatient professional mental health services associated with an IFC behavioral health approved ITA or voluntary inpatient psychiatric admission, including the admissions covered by HCA in the Long Term Inpatient Mental Health Program stated in the Exclusions section of this Contract.

17.1.4.5 Inpatient psychiatric mental health services except when the Enrollee is approved for placement in a state hospital or HCA-contracted long-term mental health bed located in a community hospital or Evaluation and Treatment, as stated in the Exclusions section of this Contract.

17.1.4.6 Covered services provided during an inpatient admission for medical detoxification services.

17.1.5 Outpatient Hospital Services: Provided by acute care hospitals, including surgeries, labs, diagnostics and emergency room.

17.1.6 Emergency Services:

17.1.6.1 The Contractor will provide all inpatient and outpatient Emergency Services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider, is a participating provider, in accordance with the requirements of 42 C.F.R. § 438.114 as follows:

17.1.6.1.1 An Enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 C.F.R. § 438.114(c)(1)(ii)(A)).

17.1.6.1.2 A participating provider or other Contractor representative instructs the Enrollee to seek emergency services (42 C.F.R. § 438.114(c)(1)(ii)(B)).

17.1.6.1.3 When the Enrollee presents at the emergency room with a psychiatric diagnosis:

17.1.6.1.3.1 but is not admitted for inpatient treatment; or

17.1.6.1.3.2 if the Enrollee was transferred for a BHO approved mental health admission to a different facility. The Contractor is responsible for all covered psychotropic medications prescribed as a part of the emergency room visit.

17.1.6.2 The Contractor shall ensure that an Enrollee who has an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient (42 C.F.R. § 438.114(d)(2)).

17.1.6.3 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollee's Primary Care Provider or the Contractor of the Enrollee's screening and treatment within ten (10) calendar days of presentation for emergency services (42 C.F.R. § 438.114 (d)(1)(ii)).

17.1.6.3.1 The only exclusions to the Contractor’s coverage of Emergency Services are:

17.1.6.3.1.1 Dental services if provided by a dentist or an oral surgeon to treat

a dental diagnosis, covered under HCA's FFS program.

17.1.6.4 Emergency services shall be provided without requiring prior authorization.

17.1.6.5 What constitutes an Emergency Medical Condition may not be limited on the basis of lists of diagnoses or symptoms (42 C.F.R. § 438.114(d)(1)(i)).

17.1.6.6 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an un-stabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the Enrollee at the treating Facility prevails and is binding on the Contractor (42 C.F.R. § 438.114(d)(3)).

17.1.7 Post-stabilization Services:

17.1.7.1 The Contractor will provide all inpatient and outpatient post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating provider, in accordance with the requirements of 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

17.1.7.2 The Contractor shall cover post-stabilization services under the following circumstances (42 C.F.R. § 438.114 (e) and 42 C.F.R. § 438.113(c)(2)(iii)):

17.1.7.2.1 The services are pre-approved by a participating provider or other Contractor representative.

17.1.7.2.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the Enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

17.1.7.2.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the Enrollee's stabilized condition and the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(1)(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the Enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor

shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the Enrollee until a Contractor physician is reached or one of the criteria identified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3) is met.

17.1.7.2.3.1 The Contractor's responsibility for post-stabilization services it has not pre-approved ends when (42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.113(c)(3)):

17.1.7.2.3.1.1 A participating provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

17.1.7.2.3.1.2 A participating provider assumes responsibility for the Enrollee's care through transfer;

17.1.7.2.3.1.3 A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or

17.1.7.2.3.1.4 The Enrollee is discharged.

17.1.8 Ambulatory Surgery Center: Services provided at ambulatory centers.

17.1.9 Early, Intensive Behavioral Intervention for Autism Spectrum Disorder and other related disorders (WAC 182-531A-0100 to -1200).

17.1.9.1 Initial Clinical Evaluation by a Center of Excellence (COE) for children under twenty (21) years of age, with a diagnosis, or suspected diagnosis, of autism spectrum disorder, or other developmental delay conditions, for evaluation of the appropriateness of Applied Behavioral Analysis (ABA) as part

of the child's plan of care.

17.1.9.2 ABA treatment services.

17.1.9.3 Care Coordination activities for children with a diagnosis or suspected diagnosis of autism spectrum disorder, when the Contractor becomes aware of a need for services, in accordance with EPSDT requirements.

17.1.10 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy, or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, Mental Health Professionals, chemical dependency specialists, certified dietitians, and interns and residents under the supervision of a teaching physician.

17.1.10.1 Medical examinations and mental health evaluations, including wellness exams for adults and EPSDT screenings for children, and referrals for further mental health assessment, as needed.

17.1.10.2 Annual depression screening for youth ages twelve (12) to eighteen (18), and up to age twenty (20) per EPSDT requirements.

17.1.10.3 Depression screening for mothers/caregivers of children up to six months old.

17.1.10.4 Immunizations.

17.1.10.5 Pregnant and postpartum Enrollees receive coverage for TDAP vaccine given in any setting (pharmacy, obstetrical provider, etc.) whether or not ordered by PCP.

17.1.10.6 Family planning services provided or by referral from a Participating Provider or practitioner.

17.1.10.7 Performing and/or reading diagnostic tests.

17.1.10.8 Medically intensive children's private duty nursing services for children age seventeen (17) and younger, in home and group home settings. The Contractor shall conduct a mortality review for any Enrollee who expires while authorized for these services. The mortality review shall include identification and analysis of trends or patterns and result in implementation of needed training, policy change, or other related action.

17.1.10.9 Surgical services.

17.1.10.10 Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction.

17.1.10.11 Telemedicine services, provided in accordance with

Substitute Senate Bill 6519 (Chapter 68, Laws of 2016).

17.1.10.12 Anesthesia.

17.1.10.13 Administering pharmaceutical products.

17.1.10.14 Fitting prosthetic and orthotic devices.

17.1.10.15 Physical Medicine Rehabilitation services.

17.1.10.16 Enrollee health education.

17.1.10.17 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia.

17.1.10.18 Bio-feedback training when determined medically necessary.

17.1.10.19 Genetic testing for all Enrollees. Genetic counseling for children and non-pregnant adults.

17.1.10.20 Palliative care for adults and children.

17.1.10.21 Hormone therapy for any transgender Enrollees and puberty-blocking treatment for transgender adolescents consistent with HCA's gender dysphoria treatment benefit.

17.1.10.22 Medication Assisted Treatment, including buprenorphine/suboxone treatment provided by an SUD clinic.

17.1.11 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell. The MCO shall use the same standards respecting coverage and delivery of the services as the state uses.

17.1.12 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

17.1.13 Vision Care: Eye examinations once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). (WAC 182-531-1000. These limitations do not apply to additional services needed for medical conditions.

17.1.14 Inpatient Behavioral Health Services. The Contractor shall provide the following Inpatient Behavioral Health Services:

17.1.14.1 Inpatient Withdrawal Management (Alcohol and Drug acute withdrawal management) Services required for the care and/or treatment of individuals intoxicated or incapacitated by alcohol or other drugs while the person recovers from the transitory effects of acute or chronic intoxication or withdrawal from alcohol or other drugs. Services are provided in facilities with sixteen (16) beds or less and exclude room and board.

Services include:

17.1.14.1.1 Screening and acute withdrawal management; and

17.1.14.1.2 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 chemically dependent persons to other appropriate chemical dependency services providers.

17.1.14.2 Inpatient/Residential Substance Abuse Treatment Services: Rehabilitative services including diagnostic evaluation and face-to-face individual or group counseling using therapeutic techniques directed toward Enrollees who are harmfully affected by the use of mood-altering chemicals or have been diagnosed with 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.

17.1.14.3 Court-ordered behavioral health Involuntary Treatment Act (ITA) commitment inpatient admission, except as stated in the Exclusions section of this Contract.

17.1.15 Outpatient Behavioral Health Services. The Contractor shall provide the following Outpatient Behavioral Health Services:

17.1.15.1 Brief Intervention Treatment;

17.1.15.2 Day Support;

17.1.15.3 Family Treatment;

17.1.15.4 Freestanding Evaluation and Treatment;

17.1.15.5 Mental health Group Treatment Services;

17.1.15.6 High Intensity Treatment;

17.1.15.7 Individual Treatment Services;

17.1.15.8 Intake Evaluation;

17.1.15.9 Medication Management;

17.1.15.10 Medication Monitoring;

17.1.15.11 Peer Support Services;

17.1.15.12 Psychological Assessment;

17.1.15.13 Rehabilitation Case Management;

17.1.15.14 Residential Mental Health Services;

17.1.15.15 Stabilization Services;

17.1.15.16 Special Population Evaluation;

17.1.15.17 Therapeutic Psychoeducation;

17.1.15.18 Chemical Dependency Case Management;

17.1.15.19 Chemical Dependency Outpatient Services;

17.1.15.20 Opiate Substitution Treatment; and

17.1.15.21 The Contractor shall ensure Medication Management:

17.1.15.21.1 Provided by the PCP; or

17.1.15.21.2 Provided in conjunction with a Mental Health Professional or CDP contracted with the Contractor; or

17.1.15.21.3 Provided by an appropriate behavioral health specialist; and

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

17.1.16 WISe Services and Monitoring

17.1.16.1 The Contractor shall provide intensive home and community-based services to help children receive behavioral health treatment and connect with natural supports in their homes, schools, and communities consistent with the requirements of the WISe program and requirements of the T.R. v. Birch and Strange Settlement Agreement (See https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Mental%20Health/WISe%20Manual%20v%201.5-FINAL.pdf). The Contractor must maintain a monthly average of 10.5 service hours for children and youth participating in WISe.

17.1.16.2 Wraparound with Intensive Services (WISe) provides a combination of the services identified in the current Mental Health State Plan. Provision of the WISe services must include, at a minimum, access to:

17.1.16.2.1 Intake Evaluation;

17.1.16.2.2 Intensive Care Coordination;

17.1.16.2.3 Intensive Services;

17.1.16.2.4 24/7 Crisis Intervention and Stabilization Services; and

17.1.16.2.5 Peer Support.

17.1.16.3 Provision of WISe services must also include any of the following services as determined medically necessary. The delivery of services must be focused on needs and strengths of the Enrollee and driven by youth and family voice and choice:

17.1.16.3.1 Crisis Services;

17.1.16.3.2 Family Treatment;

17.1.16.3.3 Group Treatment Services;

17.1.16.3.4 Individual Treatment Services;

17.1.16.3.5 Medication Management;

17.1.16.3.6 Medication Monitoring;

17.1.16.3.7 Peer Support;

17.1.16.3.8 Psychological Assessment;

17.1.16.3.9 Rehabilitation Case Management;

17.1.16.3.10 Special Population Evaluation; and

17.1.16.3.11 Therapeutic Psychoeducation.

17.1.16.4 Evaluation of WISe service includes:

17.1.16.4.1 Semi-annual review of Service Encounters.

17.1.16.4.2 Individual chart review – quarterly by supervisors, annually by state.

17.1.16.4.3 Feedback on service effectiveness to meet desired goals from youth/families through annual interviews.

17.1.16.4.4 Quarterly review of Notices of Adverse Benefit Determinations that reflect an adverse decision.

17.1.16.4.5 Quarterly review of Grievances and Appeals related to WISe.

17.1.16.4.6 Annual Quality Improvement Review findings, based on outcomes from the Quality Improvement Review tool.

17.1.16.4.7 Additional elements as detailed in the AIM of the WISe Quality Management Plan.

17.1.17 Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an Enrollee’s illness, disability, condition or injury, or for the amelioration of

the effects of a developmental disability.

17.1.17.1 The Contractor shall contract with Department of Health (DOH) recognized neurodevelopmental centers, recognizing them as a COE) for treating children with significant health care needs. The Contractor will not impose prior authorization requirements for physical, occupational or speech therapy services to ensure no delay in access to services, and shall enroll all qualified providers employed at the COE to ensure timely access to services and continuity of care. The Contractor may use concurrent review and retrospective review to ensure therapy services are medically necessary. The Contractor may contract with these providers for therapy services described above, but may also choose to contract for any other services the COE offers to children.

17.1.18 Non-pharmaceutical birth control products, including:

17.1.18.1 ParaGard® (T 380A);

17.1.18.2 Fertility awareness-based methods, such as cycle beads, basal body temperature thermometers, and charts; and

17.1.18.3 Essure© sterilization method.

17.1.19 Enteral nutrition products, including the following:

17.1.19.1 Parenteral nutritional supplements and supplies for all clients.

17.1.19.2 Enteral nutrition products and supplies for tube-feeding are covered for all clients.

17.1.19.3 Medically necessary oral enteral nutrition products, including prescribed infant formulas not covered by WIC or additional quantities beyond amounts allowed by WIC, for clients 20 years of age and under.

17.1.20 Home Health Services: Home health services, including palliative care, through state-licensed agencies.

17.1.21 Durable Medical Equipment (DME) and Supplies and any applicable sales tax including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for Enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the Enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax.

17.1.22 Respiratory Care: Equipment, services and supplies.

17.1.23 Palliative Care and Care Coordination: Provision of skilled care services and care coordination to Enrollees with a life-limiting medical condition under a palliative care model. Services can be provided in the following settings, but not limited to, hospice care centers, hospitals, clinics, and

the Enrollee's home.

17.1.24 Hospice Services: Includes services for adults and children and provided in Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the Enrollee's home. Hospice services include:

17.1.24.1 Pediatric Concurrent Care -Treatment, including diagnostics, that is related to an Enrollee's terminal condition for an Enrollee aged twenty and younger who voluntarily elects hospice care. Pediatric concurrent care preserves the Enrollee's rights to hospice care without waiving any rights to services that the Enrollee is entitled to under Title XIX Medicaid and Title XXI CHIP. (WAC 182-551-1860).

17.1.25 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

17.1.26 Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

17.1.27 Smoking Cessation Services with or without primary care provider referral or Contractor prior authorization. The Contractor shall submit a quarterly report to HCA. The report shall include the number of Enrollees that have accessed the Contractor's Quit Line in the previous quarter. The quarterly reports are due to HCA no later than the fifteenth of the month of January. April, July and October.

17.1.28 Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health and shall contract with the DOH lab and cover all newborn screening by midwives for home births and other birthing scenarios in which the screening is not billed as part of the inpatient claim. These screenings shall be billed separately by the DOH lab.

17.1.29 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):

17.1.29.1 The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and HCA WAC 182-534-0100.

17.1.29.1.1 Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health, developmental and substance use disorder conditions, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory guidance for both the

child and caregiver, and screenings for: vision, dental, substance use conditions, mental health and hearing.

17.1.29.1.2 The Contractor shall conduct outreach efforts with Enrollees to promote completion of EPSDT services and coordinate EPSDT screening services both at established times and as requested (https://www.hca.wa.gov/assets/billers-and-providers/EPSDT-bi-20180101.pdf). The Contractor may implement Enrollee and primary care provider incentives to ensure that Enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at other times, when medically necessary (42 U.S.C. § 1396(r)(1)).

17.1.29.1.3 Diagnostic and treatment services include vision, dental and hearing services, and developmental screenings for all children at 9 and 18 months of age, one (1) screening between 24 and 36 months of age, and autism screenings for all children at 18 and 24 months of age, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a physician, ARNP, or PA acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5)).

17.1.29.1.4 When the Contractor becomes aware of a need for an EPSDT diagnostic or treatment service, the Contractor shall ensure coordination of such service and shall follow-up to ensure children receive the physical, mental, vision, hearing, and dental services they need to treat health problems and conditions.

17.1.29.1.5 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary during the EPSDT exam. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to screening, diagnostic, and treatment services identified during an EPSDT examination.

17.1.29.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a non-covered service to determine the medical necessity of the service, including evaluating the safety and effectiveness of the requested service and to establish it is not experimental. If a healthcare service is determined to be medically necessary under the EPSDT benefit, the Contractor will provide the service, whether or not it is a contracted service, unless it is specifically excluded by this Contract or prohibited by federal rules. ETR and LE rules shall apply in these circumstances.

17.1.29.2.1 If any EPSDT service exceeds the “soft” limit placed on the scope, amount or duration of a service, the Contractor shall use LE procedures in accordance with WAC 182-501-0169 to determine medical necessity of the requested services and authorize the additional services as indicated.

17.1.29.3 If a child with special health care needs is assigned to a specialist for primary care, the assigned specialist is responsible for ensuring the child receives EPSDT services.

17.1.29.4 The Contractor may enter into contractual agreements with school-based health centers and family planning clinics to promote delivery of EPSDT services to children and youth accessing such services. Such contracts shall:

17.1.29.4.1 Require providers to follow EPSDT requirements;

17.1.29.4.2 Coordinate identified needs for specialty care, such as referrals for vision or mental health evaluation and treatment services with the Primary Care Provider;

17.1.29.4.3 Not deny payment for EPSDT services delivered by more than one provider (primary care provider, school-based provider or family planning clinic) within a calendar year;

17.1.29.4.4 Ensure the policies and procedures for accessing such services by contracting school-based health centers and family planning clinics are compliant with applicable federal and state statutes; and

17.1.29.4.5 The Contractor shall coordinate with school-based health centers and other appropriate entities to assure activities performed by the Contractor are not duplicated.

17.1.29.5 The Contractor shall follow the guidelines found at the following website:

https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

17.1.30 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair.

17.1.31 Bilateral Cochlear Implants, including implants, including parts, accessories, batteries, chargers, and repairs: For Enrollees age 20 and younger.

17.1.32 Bone-Anchored Hearing Aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries: For Enrollees age 20 and younger.

17.1.33 Services to Inmates of City and County Jail Facilities: The Contractor shall provide inpatient hospital services to Enrollees who are inmates of a city or county jail facility when an inpatient admission occurs during the first month of the incarceration period and HCA has paid a premium for that month to the Contractor. The Contractor's existing policies about establishing medical necessity for the inpatient admission and procedure(s) may be applied, even retrospectively, to determine payment. The Contractor shall provide transitional care coordination services to inmates upon release from jail in accordance with Subsection 14.24 of this Contract.

17.1.33.1 HCA may recoup a premium payment and retroactively terminate enrollment for an inmate if the inpatient hospital services occur after the first (1st) month of incarceration period and HCA has paid a premium for the full month of enrollment.

17.1.34 Habilitative Services: Limited to Enrollees in the Medicaid expansion population that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME benefit.

17.1.34.1 For Children: No limitation.

17.1.34.2 For Adults: Twenty-four (24) units each for physical and occupational therapy and six (6) units of speech therapy, subject to limitation extensions as determined medically necessary.

17.1.34.3 Habilitative services do not include:

17.1.34.3.1 Day habilitation services designed to provide training, structured activities and specialized services to adults;

17.1.34.3.2 Chore services to assist with basic needs;

17.1.34.3.3 Vocational services;

17.1.34.3.4 Custodial services;

17.1.34.3.5 Respite care;

17.1.34.3.6 Recreational care;

17.1.34.3.7 Residential treatment;

17.1.34.3.8 Social services; and

17.1.34.3.9 Educational services.

17.1.35 Screening, Brief Intervention and Referral to Treatment (SBIRT) services for adolescents and adults who are at high risk for substance abuse, to include alcohol and drugs with or without anxiety or depression. The Contractor is not required to pay for SBIRT screening above and beyond the evaluation/management visits when there is no intervention or referral during the visit. Screening conducted without brief intervention and referral to treatment is not reimbursable. SBIRT activities for identifying and reducing risk in individuals with drug or alcohol use concerns shall be one of the screening tools/interventions selected. Included as part of this effort are screens for depression and anxiety.

17.1.36 Comprehensive Medication Therapy Management Services.

17.1.37 Bariatric Surgery for weight loss or reduction consistent with WAC 182-531-1600 and WAC 182-550-2301.

17.1.38 Early, elective inductions (before 39 weeks) that meet medically necessary indicators set by the Joint Commission. Because the Joint Commission's criteria do not capture all situations in which an early delivery is medically indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet that criteria, but which the hospital and delivering provider believe were medically necessary.

17.1.39 Services identified in this Section that are medically necessary to treat complications resulting from a non-covered or an excluded service (e.g. antibiotics to treat infection that occurs post operatively of a non-covered surgery or an excluded voluntary termination of pregnancy procedure).

17.1.40 Residential treatment facilities to offer MAT on-site or facilitate access off-site. The Contractor must require that residential and inpatient treatment agencies develop policies and procedures to offer MAT on-site or facilitate access off-site on July 1, 2019. Any new policies or procedures must take effect on or before January 1, 2020.

17.1.40.1 The Contractor must only subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders will not be denied services.

17.1.40.2 The Contractor must assure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any

level of ASAM SUD treatment.

17.1.40.3 The Contractor may not subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any substance use disorder as a condition of Enrollees receiving treatment or continuing to receive behavioral health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing provider.

17.1.40.4 The Contractor must subcontract with licensed inpatient SUD behavioral health treatment agencies that have policies and procedures allowing Enrollees to seek FDA-approved medication for any substance use disorder at any point in their course of treatment and ensuring the agency will provide or facilitate the induction of any prescribed FDA approved medications for any SUD.

17.1.40.4.1 This may be done by:

17.1.40.4.1.1 Having an appropriately credentialed prescriber on-site or available through telemedicine who is able to prescribe FDA approved medications for SUD; or

17.1.40.4.1.2 Facilitating off-site transportation of Enrollees to medical or behavioral health treatment agencies that offer medications for SUD.

17.1.40.5 The Contractor may only subcontract with licensed inpatient SUD behavioral health treatment agencies that have policies and procedures ensuring they will provide or facilitate the continuation of any prescribed FDA approved medications for any substance use disorder. Decisions concerning medication adjustment must be based on medical necessity and in concert with the prescribing provider.

17.1.40.5.1 This may be done by:

17.1.40.5.1.1 Facilitating off-site transportation of Enrollees to medical or behavioral health treatment agencies that offer medications for substance use disorder; or

17.1.40.5.1.2 Allowing Enrollees currently on medications for substance use disorders to continue to take their medications as prescribed and

provide a safe storage space for said medication during their course of treatment.

17.1.41 Outpatient treatment facilities. The Contractor must require that outpatient treatment agencies develop policies and procedures to facilitate treatment access to Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders by July 1, 2019. Any new policies or procedures must take effect on or before January 1, 2020.

17.1.41.1 The Contractor must only subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place to ensure Enrollees who are prescribed any of the Federal Drug Administration (FDA) approved medications to treat all substance use disorders will not be denied services.

17.1.41.2 The Contractor must ensure there is enough network capacity that Enrollees with an SUD receiving or desiring medication to treat SUD are able to have it prescribed while engaged in any level of ASAM SUD treatment.

17.1.41.3 The Contractor may not subcontract with licensed SUD behavioral health treatment agencies that have policies and procedures in place that mandate titration of any prescribed FDA approved medications to treat any substance use disorder as a condition of Enrollees receiving treatment and/or continuing to receive behavioral health treatment. Decisions concerning medication adjustment are based on medical necessity and in coordination with the prescribing provider.

17.1.41.4 The Contractor shall begin development of policies and procedures related to contracting with SUD Peer Supports.

17.2 Enrollee Self-Referral

17.2.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the state of Washington.

17.2.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

17.2.3 The Enrollees also may choose to receive such services from the Contractor.

17.2.4 The Contractor shall ensure that Enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the Enrollee's choice of where to receive the services. If the Contractor in any manner prejudices, directs, or influences Enrollees' free choice to receive services through the Contractor, the Contractor shall pay the

local health department or family planning facility for services provided to Enrollees up to the limits described herein.

17.2.5 The Contractor shall make a reasonable effort to subcontract with all local health departments, school-based health centers, family planning agencies contracted with HCA, and Indian Health Service, Indian Tribe, Tribal Organization, UIHP, and IHCP providers.

17.2.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or Indian Health Service, Indian Tribe, Tribal Organization, UIHP, and IHCP providers as participating providers or refers Enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.

17.2.7 The services to which an Enrollee may self-refer are:

17.2.7.1 Family planning services and supplies and sexually-transmitted disease screening and treatment services provided at participating or nonparticipating providers, including but not limited to family planning agencies, such as Planned Parenthood.

17.2.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department.

17.2.7.3 Immunizations, sexually transmitted disease screening, family planning and mental health services through and if provided by a school-based health center.

17.2.7.4 All services received by American Indian or Alaska Native Enrollees under the Special Provisions for American Indians and Alaska Natives Subsection of this Contract.

17.2.7.5 Crisis Response Services, including crisis intervention; crisis respite; investigation and detention services; and evaluation and treatment services. Self-referrals can also be made for assessment and intake for behavioral health services.

17.3 Pharmacy Benefits and Services

17.3.1 Contractor’s with a subcontracted pharmacy benefit manager (PBM)

17.3.1.1 On or before January 1, 2020, Contractors using a PBM shall require in their contract with the PBM that the PBM only seek reimbursement from the Contractor for the reimbursement amount paid to the participating pharmacy for an individual prescription claim dispensed to an Enrollee.

17.3.1.2 On or before January 1, 2020, Contractor’s PBM may not retroactively deny or reduce a payment made to a participating pharmacy for services after adjudication of the

claim including direct and indirect remuneration, unless the original claim payment is adjusted by the MCO or the original claim was determined to be an improper payment described in Subsection 12.5 of this Contract.

17.3.1.3 On or before January 1, 2020, Contractor's contract with a PBM must require that they pass all retroactive adjustments in payments made to participating pharmacies for services after adjudication of the claim back to the Contractor within thirty (30) calendar days, including all forms of direct and indirect remuneration.

17.3.1.4 HCA will audit this requirement through ad hoc Network Pharmacy Reimbursement Reconciliation reports. HCA may impose sanctions if the Contractor is out of compliance with this section.

17.3.2 General Requirements

17.3.2.1 The Contractor shall ensure that the amount, duration, and scope of covered outpatient drugs provided under this Contract is consistent with coverage under the FFS program. The Contractor shall cover all covered outpatient drugs when determined to be Medically Necessary, unless otherwise excluded from coverage. This includes brand name and generic drugs, and over-the-counter drugs (OTCs), prescribed by licensed providers and sold or distributed by drug manufacturers that participate in the Medicaid Drug Rebate Program.

17.3.2.2 The Contractor shall provide coverage for all medically accepted indications, as described in Section 1927(k)(6) of the Social Security Act, 42 U.S.C. 1396r-8(k)(6). This includes any use which is approved under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C.A. 301 et seq. or whose use is supported by the nationally recognized pharmacy compendia, or peer-reviewed medical literature, unless otherwise directed by HCA.

17.3.2.3 The Contractor must cover all prescription drugs produced by rebate eligible manufacturers, with the exception of those excluded under this Contract or those eligible for exclusion under 42 U.S.C. §1396r–8(d)(2) which HCA has not specifically instructed the Contractor to cover.

17.3.2.4 The Contractor shall ensure that prescription drugs produced by non-rebate eligible manufacturers are not covered, regardless of the general status of the drug on the HCA defined formulary.

17.3.2.5 The Contractor shall have in place a mechanism to deny

prescriptions:

17.3.2.5.1 Written by excluded providers

17.3.2.5.2 Prescribed for non-medically accepted indications.

17.3.2.6 The Contractor shall allow up to a ninety (90) day supply as an early prescription refill for prescriptions that are lost, stolen, or destroyed once per prescription per 6-month period. Exceptions to the 6-month period may be granted for extreme circumstances (e.g. fire, flood, natural disaster, etc.) at the MCOs discretion.

17.3.2.7 The Contractor shall allow, once every 6 months, up to a ninety (90) day supply as an early prescription refill for a vacation for each prescription due during the vacation period.

17.3.3 Apple Health Preferred Drug List and Plan Formularies

17.3.3.1 Apple Health Preferred Drug List (AH PDL)

17.3.3.1.1 The Contractor must use the AH-PDL as its primary preferred drug list. HCA has final authority on the status of products included on the AH-PDL. HCA will provide the Contractor with opportunities to offer feedback on the preferred status of products on the AH-PDL. Contractor's representatives may attend the Drug Utilization Review (DUR) Board and provide feedback directly to the DUR Board at the meeting.

17.3.3.1.2 The Contractor will follow the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions recommended by the DUR Board or approved by HCA, unless otherwise directed by HCA. The HCA will provide Contractor with final authorization criteria and step therapy protocols in the HCA clinical policy template ninety (90) calendar days prior to implementation.

17.3.3.1.3 HCA will notify the Contractor of major changes to the preferred status, authorization criteria, quantity limits, step therapy protocol, or other restrictions for products on the AH-PDL at least ninety (90) calendar days prior to implementation of the changes. The Contractor has ten (10) business days to review the file and submit questions or requests for changes to the HCA. The HCA will respond and provide final determination no later than sixty (60) calendar days prior to implementation.

17.3.3.1.4 HCA shall provide the Contractor with comprehensive files detailing the preferred status, authorization criteria, quantity limits, step therapy protocols, and other restrictions for products included in the AH-PDL. The file will also contain product specific information such as product identification number, active pharmaceutical ingredient, dosage form, route of administration, strength, and specific National Drug Code (NDC).

17.3.3.1.4.1 HCA will provide the AH-PDL file through secure file transfer protocol posted on the HCA website. The file will be submitted in a format and at a frequency mutually agreed upon by all participating Apple Health Managed Care Contractors and HCA.

17.3.3.1.4.2 For new products to market the Contractor will adjudicate claims using the AH-PDL file within five (5) business days of notification the file is available.

17.3.3.1.4.3 For changes to criteria for existing products on the AH-PDL which are not the result of DUR Board recommendations, the Contractor will adjudicate claims using the AH-PDL file within ten (10) business days of notification the file is available. If the Contractor determines any change is too complex to implement within the required timeframe, the Contractor must request an extension by close of business on the second business day after receiving the file. HCA will review the request and notify Contractor whether an extension is granted on the next business day.

17.3.3.1.5 The Contractor shall place new drugs to market within a class included on AH-PDL in a non-preferred status until otherwise directed by HCA.

17.3.3.1.6 The Contractor must achieve a threshold of at least 90 percent of the number of prescriptions

written for preferred versus non-preferred products on the AH-PDL per calendar quarter, excluding drugs that were given permanent grandfathering status. For drugs that were grandfathered for three or six months, this provision applies to the first quarter after grandfathering expired. The Contractor shall provide data to HCA forty-five (45) calendar days after the end of each calendar quarter in a format determined by HCA. The first quarter AH-PDL Compliance report is due May 15.

17.3.3.1.7 The HCA may require a corrective action for any AH-PDL non-compliance. HCA may impose sanctions if corrective actions fail to improve AH-PDL compliance.

17.3.3.1.8 The Contractor shall maintain individual product coverage and exceptions to coverage according to this Section.

17.3.4 Wrap-around Drug Formulary Requirements for drugs not on the AH-PDL

17.3.4.1 The Contractor must develop and maintain a wrap-around formulary for drugs not included within a class on the AH-PDL.

17.3.4.2 The Contractor's wrap-around formulary shall cover the following products and supplies unless specifically detailed in the AH-PDL:

17.3.4.2.1 Antigens and allergens;

17.3.4.2.2 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

17.3.4.2.3 Psychotropic medications according to the Contractor's approved formulary when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice.

17.3.4.2.4 Hemophiliac Blood Product – Blood factors VII, VIII, and IX and the anti-inhibitor provided to Enrollees with a diagnosis of hemophilia or von Willebrand disease when the Enrollee is receiving services in an inpatient setting.

17.3.4.2.5 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion

by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:

17.3.4.2.5.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over the counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

17.3.4.2.5.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.

17.3.4.2.5.3 Dispensing of twelve (12) months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than twelve (12) months.

17.3.4.2.5.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the Enrollee requests a smaller supply.

17.3.4.2.5.5 Promotion of appropriate prescribing and dispensing practices in accordance with clinical guidelines to ensure the health of the Enrollee while maximizing access to effective birth control methods or contraceptive drugs.

17.3.4.2.6 All drugs FDA labeled or prescribed as Medication Assisted Treatment (MAT) or maintenance therapy for substance use disorders, with the exception of methadone dispensed directly by opiate substitution treatment programs. The Contractor will cover all MAT according to detailed guidelines and requirements determined by HCA.

17.3.4.2.7 The term “Formulary” as used in this subsection includes lists of products and their formulary status, preferred status, authorization requirements and coverage limitations available through retail specialty, and mail order pharmacies, and drugs paid by the Contractor under the medical benefits.

17.3.4.2.8 HCA may require changes to the formulary at any time, upon sixty (60) calendar days’ written notice of the change. Required formulary changes may include any aspect of drug coverage, including, but not limited to: formulary status, limitations, prior authorization requirements, approval criteria, use of automated overrides, or determination of the benefit under which a product will be available. Failure to make requested changes by the date specified in HCA’s notice may result in sanctions as described in the Sanctions subsection of this Contract.

17.3.4.2.9 If HCA determines the Contractor’s online formulary does not accurately reflect coverage requirements, or the Contractor is not providing coverage as previously required by HCA, the Contractor shall make the necessary changes in coverage and update its online formulary and related materials as required by HCA within five (5) business days of the request.

17.3.4.2.10 The Contractor shall have a process in place to allow access to all non-formulary drugs, other than those excluded from coverage by the HCA, when determined to be Medically Necessary.

17.3.4.2.11 The Contractor shall submit its drug formulary and related material to HCA for review and approval no later than September 1 of each contract year. The submission shall be in an electronic format according to HCA specifications for the following benefit year.

17.3.4.2.11.1 HCA shall notify the Contractor of either the approval of or required changes to the formulary and related materials, no later than October 1, of each contract year.

17.3.4.2.11.2 If HCA notifies the Contractor of required changes, all such changes shall be completed and resubmitted to HCA no later than December 1, of each contract year.

17.3.4.2.11.3 Once approved, any change to the formulary must be approved in writing by HCA before publication. Any proposed changes to the formulary and utilization management programs, such as prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, etc. after January 1, must be submitted to the HCA for review and approval prior to implementation, at least ninety (90) calendar days prior to implementing any changes.

17.3.4.2.12 The Contractor shall provide prominent public online access to the AH-PDL, the plan formulary and coverage criteria shall include information on how to request authorization for covered drugs, non-preferred drugs, and non-formulary drugs. The online formulary shall be easy to access and the website in which it is situated will be designed to use easily understandable language.

17.3.5 Second Opinion for Children Prescribed Mental Health Medications.

17.3.5.1 The Contractor shall require a medication consultation by an HCA-approved Second Opinion Network (SON) provider before authorizing coverage of any psychotropic medication or medication regimens for children under eighteen (18) years of age that exceed the medication review thresholds established by HCA unless otherwise specified below.

17.3.5.1.1 For Enrollees who have previously filled prescriptions for the same drug at the same daily dosage, the Contractor shall authorize continuation of psychotropic medications exceeding these review thresholds until receipt of

written report containing treatment recommendations from the SON.

17.3.5.1.2 For Enrollees who have NOT previously filled prescriptions at the same daily dosage, the Contractor shall deny authorization of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON or otherwise directed by HCA.

17.3.5.2 HCA will provide the Contractor with a list of products and definitions of review thresholds for certain psychotropic medications which require a second opinion. Changes to the medication review thresholds established by HCA will be communicated to the Contractor no less than ninety (90) calendar days before any required implementation date.

17.3.5.3 The Contractor must identify all psychotropic medication prescriptions that require a second opinion. HCA may require corrective action or apply sanctions if the Contractor incorrectly authorizes or fails to identify psychotropic medications requiring consultation.

17.3.5.4 For the defined list of psychotropic medications, the Contractor is prohibited from applying any clinically or therapeutically based claim rejections or authorization requirements which have not been reviewed and approved by HCA.

17.3.5.4.1 No later than two (2) business days after an Enrollee is determined to exceed review thresholds, the Contractor shall contact the prescriber to request relevant clinical information and chart notes detailing the need for the requested medication(s). In the event that multiple prescribers are prescribing mental health medications for the same Enrollee, the Contractor shall request relevant documentation from each prescriber.

17.3.5.4.2 If a prescriber fails to provide documentation to support a prescription which exceeds HCA defined review thresholds within ten (10) business days the Contractor shall deny all medications exceeding thresholds within two (2) business days.

17.3.5.4.3 No later than close of business of the first business day after obtaining all relevant documentation, the Contractor shall send notification of required authorization to

applehealthpharmacypolicy@hca.wa.gov. Documentation received after close of business is considered received on the next business day. Notification shall include Enrollee's name, date of birth, ProviderOne client ID, National Drug Code of the drug denied, prescribed quantity and days' supply, National Provider Identifier of prescriber, name of prescriber, fax or phone number for prescriber, National Provider Identifier of dispensing pharmacy, name of dispensing pharmacy, fax or phone number of dispensing pharmacy, date of denial by plan, and reason for denial.

17.3.5.4.4 Upon receipt of a written report from HCA, the Contractor shall approve or deny medications according to the recommendations of the SON within five (5) business days.

17.3.5.4.5 The Contractor shall have processes in place to accurately follow up with SON recommendations for future care, such as gradual tapering of medications, or required re-review based on other medication trials.

17.3.5.4.6 The Contractor shall provide case management to assist and facilitate the provision of any psychosocial recommendations made by SON.

17.3.5.4.6.1 If the Contractor is unable to contact the Enrollee to provide case management, the Contractor shall inform the prescriber that participated in the SON review.

17.3.5.4.7 Upon notification by HCA that a prescriber has failed to participate in an SON consultation, the Contractor shall deny all medications exceeding thresholds within five (5) business days.

17.3.5.4.8 Changes to medications or medication regimens which exceed HCA review thresholds and which are not addressed in an existing SON report require the initiation of a new SON review by the Contractor. Reduction of medication doses or discontinuation of medications in a psychotropic polypharmacy regimen do not require a new SON.

17.3.5.4.9 If the provider submits a SON report or Partnership Access Line (PAL) consultation letter that addresses the requested medication

regimen, the Contractor shall approve or deny medications according to the recommendations in the SON report or PAL consultation letter.

17.3.5.4.10 Payment to the SON provider for required reviews are the responsibility of HCA according to the provisions of HCA's contract with the SON provider.

17.3.5.4.11 The Contractor is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.

17.3.5.4.12 To assist prescribers in meeting the needs of Enrollees who are children with a mental health diagnosis, and in order to minimize the need for required medication reviews, the Contractor shall inform network prescribers that HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL). The Contractor is not required to provide payment to prescribers for voluntarily accessing the PAL.

17.3.6 Provider and Enrollee Notification

17.3.6.1 The Contractor shall have policies and procedures for notifying Providers and Enrollees of changes to the Contractor's Formulary or AH-PDL, and any changes to Prior Authorization requirements.

17.3.6.1.1 The Contractor shall provide:

17.3.6.1.1.1 Written notification for changes to the Formulary or AH-PDL and Prior Authorization requirements to all affected Providers and Enrollees at least thirty (30) days prior to the effective date of the change.

17.3.6.1.1.2 Written information about changes to the Formulary or AH-PDL and Prior Authorization requirements upon request by Providers or Enrollees.

17.3.6.1.1.3 Provide information about Formulary, AH-PDL, and Prior Authorization changes through Member and Provider newsletters, its web site, or other regularly published media of general distribution.

17.3.7 Medication Therapy Management

17.3.7.1 The Contractor shall ensure its provider contracts include provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington State to provide chronic care management including comprehensive medication management services to individuals, consistent with the goals established in RCW 74.09.522.

17.3.8 Rebates

17.3.8.1 The Contractor or the Contractor's pharmacy benefit manager (PBM) is prohibited from negotiating and collecting rebates for utilization by Apple Health enrollees with drug companies for preferred or non-preferred pharmaceutical products included on the AH-PDL. If the Contractor or its Subcontractor has an existing rebate agreement with a manufacturer for a product on the AH-PDL, all Medicaid outpatient drug claims, including provider-administered drugs, must be exempt from such rebate agreements.

17.3.8.2 The Contractor or the Contractor's PBM, is authorized to negotiate and collect rebates with drug manufacturers for any product that is not included in a class on the AH-PDL.

17.3.8.3 Section 2501 (c) of the Patient Protection and Affordable Care Act (ACA) expanded the drug rebate requirement to include drugs dispensed to Enrollees. Covered outpatient drugs dispensed by the Contractor to Enrollees, including those administered by physicians in their offices, are subject to the same manufacturer rebate requirements as HCA's FFS outpatient drugs.

17.3.8.4 The Contractor is subject to requirements for rebate agreements as defined in Section 1927 of the Social Security Act found at: http://www.ssa.gov/OP_Home/ssact/title19/1927.htm

17.3.8.5 The Contractor shall ensure that:

17.3.8.5.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer as defined in this Contract. A list of eligible manufacturers can be found at: https://www.hca.wa.gov/assets/billers-and-providers/rebate_customer_list.xls;

17.3.8.5.2 Bulk chemicals used in the compounding of medications are exempt from the federal rebate requirements.

17.3.8.5.3 Drug rebate records are kept in accordance with the Records section of this Contact and are made available to HCA upon request.

17.3.8.6 The Contractor will have processes in place to ensure the validity of medical claim data for rebate collection purposes, including but not limited to:

17.3.8.6.1 Validating the association between submitted HCPC codes and their corresponding National Drug Code (NDC) using sources other than the CMS NDC - HCPCS Crosswalk for Medicare Part B Drugs. Validation must include processes for correctly paying claims with previously unknown NDC-HCPC associations as well as denying claims for invalid associations.

17.3.8.6.2 Denying claims for products that come in unbreakable package sizes such as single-dose vials when the number of units billed is not a multiple of the number of units included in the unbreakable package.

17.3.8.7 HCA retains all funds collected from pharmaceutical manufacturers from rebates under the federal Medicaid Drug Rebate Program based on drug utilization by the Contractor's Enrollees.

17.3.8.8 HCA retains all funds collected from pharmaceutical manufacturers from rebates negotiated by the HCA under its supplemental rebate program for utilization of drugs by the Contractor's Enrollees that are listed on the AH-PDL.

17.3.8.9 The Contractor retains all funds from rebates or discounts negotiated by the contractor with pharmaceutical manufacturers for drugs not included in the AH-PDL, and must report those to HCA as an offset to the costs of providing healthcare.

17.3.9 Reports

17.3.9.1 Prior Authorization

17.3.9.1.1 The Contractor shall submit a report of all prescription drug authorizations forty-five (45) calendar days after the end of the calendar quarter in a format determined by HCA. Detail must be provided by drug label name, number of requests, number denied, and number approved. The first quarter Prescription Drug Authorization report is due May 15.

17.3.9.2 Drug Utilization Review (DUR)

17.3.9.2.1 The Contractor shall submit an Annual Drug Utilization Review report on the CMS-approved template by the specific due dates stated in subsection 11.1.1.2. The report will include a description of the nature and scope of the prospective and retrospective drug use review programs, a summary of the interventions used, an assessment of the impact of these educational interventions on quality of care, and an estimate of the cost savings generated as a result of the DUR program.

17.3.9.3 Rebates and Pharmacy Reimbursement

17.3.9.3.1 The Contractor shall provide a Network Pharmacy Reimbursement Reconciliation report detailing the actual ingredient cost and dispensing fee paid to network pharmacies by the Contractor or by the Contractor's PBM for all paid claims as well as total amount paid to the PBM for the same claims that Contractor reported to HCA through submission of encounter data. The Network Pharmacy Reimbursement Reconciliation report is due on an ad hoc basis.

17.3.9.3.2 The Contractor shall provide a quarterly Drug Rebate report no later than forty-five (45) calendar days following the end of the calendar quarter estimating the amounts of rebates or discounts negotiated with drug manufacturers that will be invoiced to manufacturers for drug utilization by managed care Enrollees in the preceding calendar quarter. The reports shall be in a format determined by HCA and will, include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected. The first quarter Drug Rebate report is due May 15.

17.3.9.3.3 The Contractor shall provide an annual Drug Rebate report, no later than June 30, of any actual savings collected from manufacturers for rebates or discounts negotiated by the Contractor with drug manufacturers for utilization in the previous calendar year. The reports shall be in a format determined by HCA and will include, at a minimum, detail by NDC of units invoiced, rebate amounts per unit, and total rebate projected or collected.

17.3.9.4 Historical Reports

17.3.9.4.1 The Contractor shall provide a report by April 30th of all rebates or discounts received from drug manufacturers for drug utilization by Enrollees for each calendar quarter January 1, 2019 through December 31, 2020. The report shall be in a format determined by HCA and will include, at a minimum, manufacturer, drug name, rebate amounts invoiced and collected per drug, and total rebate projected or collected. The Historical Drug Rebate report shall be submitted as one document but broken down by calendar quarters that span 2019 and 2020. For example: January through March, 2015, April through June, 2015, etc.

17.3.9.5 Confidentiality of Proprietary Rebate Information

17.3.9.5.1 The Contractor shall identify any confidential or proprietary information contained within reports. Failure to label such materials or failure to respond timely after notice of request for public disclosure has been given shall be deemed a waiver by the Contractor of any claim that information contained in the submitted reports is confidential, proprietary or trade secrets.

17.4 **Exclusions**

The following services and supplies are excluded from coverage under this Contract.

17.4.1 Unless otherwise required by this Contract, Ancillary Services resulting solely from or ordered in the course of receiving non-contracted or excluded services are also non-covered or an excluded service (e.g. dressing supplies as a non-durable medical supply to care for an incision related to a cosmetic abdominoplasty).

17.4.2 The Contractor shall not provide or pay for services that violate the Assisted Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).

17.4.3 The Contractor is not responsible for coverage of any services when an Enrollee is outside the United States of America and its territories and possessions.

17.4.4 Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by the Joint Commission.

17.4.5 The following Covered Services are provided by the state and are not contracted services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or

Contractor publications.

17.4.5.1 Inpatient Hospital charges at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by the HCA.

17.4.5.2 School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan who have a disability, developmental delay or are diagnosed with a physical or mental condition;

17.4.5.3 Eyeglass frames, lenses, and fabrication services covered under the HCA's selective contract for these services for children under age twenty-one (21), and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for adult Enrollees if not offered by the Contractor as a value added benefit;

17.4.5.4 Voluntary Termination of Pregnancy;

17.4.5.5 Court-ordered transportation services, including ambulance services;

17.4.5.6 Long Term Inpatient Psych Program covered by the HCA: Per diem bed rate for court-ordered mental health Involuntary Treatment Act (ITA) commitment starting the date the ninety (90) to one hundred eighty (180) day court order is issued, where the individual is approved for placement in a state hospital or HCA-contracted long-term mental health community hospital bed or E&T.

17.4.5.7 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation, and common carriers;

17.4.5.8 Ambulance services, including air and ground ambulance transportation services;

17.4.5.9 Professional services provided by a dentist, dental surgeon, dental hygienist, denturist, dental anesthesiologist, endodontist, periodontist, or other dental specialist for care and treatment of a dental condition, including anesthesia;

17.4.5.10 Orthodontics;

17.4.5.11 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;

17.4.5.12 Sterilizations for Enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R.

§ 441 Subpart F);

17.4.5.13 Services provided by a health department when an Enrollee self-refers for care if the health department is not contracted with the Contractor;

17.4.5.14 HIV Case Management;

17.4.5.15 Prenatal Genetic Counseling;

17.4.5.16 Hemophiliac Products – Blood factors VII, VIII, and IX, anti-inhibitor, and all FDA approved products labeled with an indication for use in treatment of hemophilia and von Willebrand disease when distributed for administration in the Enrollee's home or other outpatient setting;

17.4.5.17 Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C;

17.4.5.18 The exclusion of the following drugs does not apply to any other services related to the treatment or diagnosis of conditions for which the drug may be prescribed. No services will be considered ancillary to this exclusion under subsection 17.4.1, including the treatment of complications from or adverse reactions to treatment with the drugs. The Contractor shall cover all new drugs regardless of cost, unless HCA notifies Contractor that the drug will be excluded.

17.4.5.18.1 AVXS-101 as marketed under the brand name Zolgensma®;

17.4.5.18.2 axicabtagene ciloleucel, as marketed under the brand name Yescarta®;

17.4.5.18.3 burosumab-twza, as marketed under the brand name Crysvita®;

17.4.5.18.4 cerliponase alfa, as marketed under the brand name Brineura™;

17.4.5.18.5 edaravone, as marketed under the brand name Radicava™;

17.4.5.18.6 elapegademase-lvlr as marketed under the brand name Revcovi ™;

17.4.5.18.7 emapalumab as marketed under the brand name Gamifant ™;

17.4.5.18.8 eteplirsen, as marketed under the brand name Exondys 51™;

17.4.5.18.9 lutetium Lu 177 dotatate as marketed under the brand name Lutathera®;

17.4.5.18.10 nusinersen, as marketed under the brand name Spinraza®;

17.4.5.18.11 pegvaliase-pqpz, as marketed under the brand name Palynziq ™;

17.4.5.18.12 tisagenlecleucel-t, as marketed under the brand name Kymriah ™; and

17.4.5.18.13 voretigene neparvovec-rzyl, as marketed under the brand name Luxturna ™.

17.4.5.19 Sexual reassignment surgery as described in WAC 182-531-1675(6)(d) and (e) as well as hospitalizations, physician, and Ancillary Services required to treat postoperative complications of these procedures;

17.4.5.20 Chemical-Using Pregnant (CUP) Women program as described in WAC 182-533-0730 when provided by an HCA-approved CUP provider; and

17.4.5.21 "Treat and Refer", or treatment with no transport when provided by eligible providers defined as fire departments pursuant to a community assistance referral and education services program (CARES) as described in RCW 35.21.930.

17.4.6 The following services are covered by other state agencies and are not Contracted Services. The Contractor is responsible for coordinating and referring Enrollees to these services through all means possible, e.g., Adverse Benefit Determination notifications, call center communication or Contractor publications.

17.4.6.1 Long-term private duty nursing for Enrollees ages 18 and over. These services are covered by DSHS, Aging and Long-Term Support Administration;

17.4.6.2 Community-based services (e.g., COPES, CFC and Personal Care Services) covered through the Aging and Long-Term Support Administration (ALTSA);

17.4.6.3 Nursing facility stays that do not meet rehabilitative or skilled criteria are covered through the Aging and Long-Term Support Administration (ALTSA);

17.4.6.4 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;

17.4.6.5 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health;

17.4.6.6 Any service provided to an Enrollee while incarcerated with the Washington State Department of Corrections (DOC); and

17.4.6.7 Early Childhood services (e.g., home visiting, ESIT, ECLIPSE, ECEAP/Head Start) covered by DCYF.

18 Third Party Liability

18.1 Subrogation of Rights of Third Party Liability

18.1.1 Subrogation Rights of Third-Party Liability:

18.1.1.1 “Injured person” means an Enrollee covered by this Contract who sustains bodily injury.

18.1.1.2 “Contractor's health care expense” means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's FFS schedule.

18.1.1.3 If an Enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

18.1.1.4 The HCA specifically assigns to the Contractor the HCA’s rights to such third party payments for medical care provided to an Enrollee on behalf of the HCA, which the Enrollee assigned to the HCA as provided in WAC 182-503-0540.

18.1.1.5 The HCA also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor shall be subrogated to the HCA’s rights and remedies under RCW 74.09.180 and RCW 41.05A.050-.080 with respect to medical benefits provided to Enrollees on behalf of the HCA under chapter 74.09 RCW.

18.1.1.6 The Contractor may obtain a signed agreement from the Enrollee in which the Enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

18.1.1.7 The Contractor shall notify the HCA of the name, address, and other identifying information of any Enrollee and the Enrollee's attorney:

18.1.1.7.1 who settles a claim without protecting the Contractor's interest in contravention of RCW 41.05A.060; or

18.1.1.7.2 when a claim has been identified as having potential Third Party Liability.

18.2 Good Cause Exemption from Billing Third Party Insurance

18.2.1 The Contractor must have a policy to allow Enrollees the right to be

exempt from billing third party insurance due to good cause. This includes a procedure that allows for the good cause process to apply on an individual claim basis and a means to flag the Enrollee's account so that the need for additional privacy and precaution can be easily seen. "Good cause" means that the use of the third-party coverage would violate an Enrollee's confidentiality because the third party:

18.2.1.1 Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;

18.2.1.2 Requires the Enrollee to use a primary care provider who is likely to report the Enrollee's request for family planning services to the subscriber;

18.2.1.3 The Enrollee has a reasonable belief that cooperating with the Contractor in identifying TPL coverage could result in serious physical or emotional harm to the Enrollee, a child in his or her care, or a child related to him or her; or

18.2.1.4 The Enrollee is incapacitated without the ability to cooperate with the Contractor.

18.2.2 A description of this process, including any steps the Enrollee must take to seek exemption based on good cause, must be included in every notice the Contractor provides to Enrollees regarding Third Party billing or seeking cooperation with such billing. The notices must include that reasons such as fear of domestic violence or other harm are included in good cause. The Contractor's policy must include a procedure that allows for the good cause process to apply on an individual claim basis. Any denial of good cause is an adverse benefit determination. Any communications or billing must be suspended pending a good cause request or appeal of a request denial.

19 BUSINESS CONTINUITY AND DISASTER RECOVERY

19.1 Primary and Back-up Systems

19.1.1 The Contractor shall have in place a primary and back-up system for electronic submission of data requested by HCA. This must include the use of the Inter-Governmental Network (IGN); state of Washington, Washington Technology Solutions (WaTech) approved secured Virtual Private Network (VPN) or other WaTech approved dial-up.

19.1.1.1 In the event these methods of transmission are unavailable and immediate data transmission is necessary, an alternate method of submission will be considered based on HCA Enterprise Technology Service's (ETS) review and approval.

19.2 Business Continuity and Disaster Recovery Plan

19.2.1 The Contractor shall develop and maintain a business continuity and disaster recovery plan that ensures timely reestablishment of the Enrollee information system following total loss of the primary system or a substantial loss of functionality.

19.2.1.1 The Contractor shall submit an annual statement by January 1 of each Contract year, certifying that there is an up-to-date business continuity disaster plan in place for both the Contractor and Subcontractors. The certification must indicate that the system, data backup and recovery procedures have been tested, and that copies of the Contractor and Subcontractor plans are available for HCA to review and audit. The disaster plan must include the following:

19.2.1.1.1 A mission or scope statement.

19.2.1.1.2 Identification of the information services disaster recovery staff.

19.2.1.1.3 Provisions for back up of key personnel, identified emergency procedures and visibly listed emergency telephone numbers.

19.2.1.1.4 Procedures for allowing effective communication, applications inventory and business recovery priority and hardware and software vendor list.

19.2.1.1.5 Confirmation of updated system and operations documentation and process for frequent back up of systems and data.

19.2.1.1.6 Description and location of off -site storage of system and data back-ups and ability to recover data and systems from back up files.

19.2.1.1.7 Designated recovery options which may include use of a hot or cold site.

19.2.1.1.8 Documentation that disaster recovery tests or drills have been performed.

EXHIBIT A – RATES

Integrated Foster Care

The rate exhibit is not included in this online version of the contract.

EXHIBIT B

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Exhibit C

Designation of Behavioral Health Providers

State Licensure and Certification and Providers Restricted to Working under Supervision and/or in Affiliation with an Approved Agency:

All Behavioral Health Providers listed below may provide behavioral health services. They are licensed or certified by the Washington Department of Health. Providers licensed or certified by the Department of Health, Independent Contractors and those working under supervision, consultation, or in an employee status are designated below.

#	Behavioral Health Providers	Licensed or Certified by the Washington Department of Health	Independent versus Supervised Clinical Practice		Practice in a HCA-DBHR Licensed Behavioral Health Agency **Only**
			Independent Practitioner	Under Supervision, Consultation or Employee Status	
1	Advanced registered nurse practitioner including psychiatric advanced registered nurse practitioner and psychiatric mental health and board-certified nurse practitioners	X	X		
2	Agency affiliated counselor	X		X	X
3	Certified adviser	X		X	
4	Certified counselor	X		X	
5	Chemical dependency professional	X		X	X *A CDP that also holds a DOH license may practice in settings outside of a DBHR licensed agency [RCW 18.205.040(2)]
6	Chemical dependency professional - trainee (CDPT)	X		X	X
7	Hypnotherapist	X		X	
8	Licensed marriage and family therapist	X	X		
9	Licensed marriage and family therapist – associate (LMFTA)	X		X	

Exhibit C

Designation of Behavioral Health Providers

#	Behavioral Health Providers	Licensed or Certified by the Washington Department of Health	Independent versus Supervised Clinical Practice		Practice in a HCA-DBHR Licensed Behavioral Health Agency **Only**
			Independent Practitioner	Under Supervision, Consultation or Employee Status	
10	Licensed mental health counselor	X	X		
11	Licensed mental health counselor – associate (LMHCA)	X		X	
12	Licensed practical nurse (LPN)	X		X	
13	Physician (MD)	X	X		
14	Physician Assistant (PA)	X		X	
15	Registered Nurse (RN)	X		X	
16	Psychiatrist (MD)	X	X		
17	Psychologist (PhD)	X	X		
18	Licensed social worker associate, advanced (LSWAA)	X		X	
19	Licensed social worker associate, independent clinical (LSWAIC)	X		X	
20	Licensed social worker, advanced (LASW)	X		X	
21	Licensed, Independent Clinical Social worker (LICSW)	X	X		
22	Sex offender Treatment Provider	X	X		
23	Affiliate sex offender treatment provider	X		X	
24	DBHR-Certified Peer Counselor	X		X	X

Notes:

1. Agency-affiliated counselors, chemical dependency professional trainees and HCA-certified peer counselors are restricted to working in a recognized DOH agency also licensed as a behavioral health agency by HCA-DBHR.
2. Agency affiliated counselors must notify HCA within thirty calendar days if they are no longer employed by the agency identified on their application, are now employed with another agency, or both. Agency affiliated counselors may not practice counseling unless they are employed by an agency.

Exhibit D-1
Integrated Foster Care
Value-Based Purchasing

1. Quality Improvement – 1.5 percent Withhold

1.1. HCA will withhold one and one half percent (1.5 percent) of the Capitation Payments, as defined under section 1.3 of this Exhibit, paid by HCA under this Contract. The Contractor will be eligible to earn back part or all of the withhold ("Withhold") as set out in this Exhibit.

1.2. The time periods covered by the Withhold and the applicable percentage amount of the Withhold for each time period are set out in Table 1. Each Performance Year and Improvement Baseline Year identified in Table 1 shall encompass services provided in the defined time period and payments for those services.

Table 1
Performance Years, Time Periods and Thresholds

Year	Performance Year Time Period	Withhold Percent	Provider Incentives Threshold*	VBP Payments Threshold*	Improvement Baseline Year Time Period**
1	Jan. 1, 2018 – Dec. 31, 2018	1.5%	1%	50%	Jan. 1, 2017 – Dec. 31, 2017
2	Jan. 1, 2019 – Dec. 31, 2019	1.5%	1%	75%	Jan. 1, 2018 – Dec. 31, 2018
3	Jan. 1, 2020 – Dec. 31, 2020	TBD	TBD	TBD	Jan. 1, 2019 – Dec. 31, 2019

*The limited Evaluation Period, Provider Incentives Threshold and VBP Payments Threshold applies only as set out in sections 2 and 3 of this Exhibit.

**The Improvement Baseline Year applies only as set out in section 4 of this Exhibit.

1.3. Following each Performance Year, HCA will determine the total amount of the Withhold for the Performance Year and the amount of such Withhold that the Contractor is eligible to earn back. The Contractor will be eligible to earn back part or all of the Withhold ("Withhold") based on performance measures in the following three areas:

1.3.1. Up to 12.5 percent of the Withhold may be earned back by implementing qualifying Provider Incentives tied to quality and financial attainment as described in Section 2 of this Exhibit (the "Provider Incentives Portion" of the Withhold);

1.3.2. Up to 12.5 percent of the Withhold may be earned through Value-Based Purchasing arrangements as described in section 3 of this Exhibit (the "VBP Payments Portion" of the Withhold); and

1.3.3. Up to 75 percent of the Withhold may be earned by achieving quality improvement and attainment targets as described in Section 4 of this Exhibit

(the “QIS Portion” of the Withhold).

1.4. No later than November 30 following each Performance Year, HCA will notify the Contractor of the amount of the Withhold that the Contractor has earned back for the Performance Year. HCA will schedule payment to the Contractor based on the calculated method defined above and as described in section 5 of this Exhibit. HCA will also provide the Contractor with a copy of Value-Based Purchasing Withhold Calculation Summary Form, Attachment C to this Exhibit, signed by the HCA Chief Financial Officer, outlining the percent withhold recovered through provider incentive payments, Value Based Purchasing arrangements, and the Quality improvement Score Achieved.

1.5. Capitation Payments subject to the 1.5 percent Withhold are defined in Section 5 of this Contract and include all Capitation Payments excluding any administrative, WHSIP, SNAF, PAP, IMD or FQHC/RHC enhancement funding.

1.6. For sections 2 and 3 of this Exhibit, “Assessed Payments” shall refer to all contractor payments made to providers using funds that were subject to the Withhold as defined under section 1.3 of this Exhibit, with the exception of any case payments for delivery and low birth weight, administrative dollars, or other payments funded through Washington State Health Insurance Pool (WSHIP), premium tax, or Institutions for Mental Disease (IMD) funding.

1.7. For purposes of this Exhibit, a “Value-Based Payment Arrangement” means a payment arrangement that meets the definition of Category 2C or higher of the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated 1/12/2016, attached as Attachment A (“Whitepaper”). For Performance Year 1, for the Contractor to be eligible for reimbursement of all or a portion of the Withhold under this Exhibit, contracts that include Value-Based Payment Arrangements must be signed no later than September 30, 2018, with an effective date of October 1, 2018, or earlier.

1.8. For purposes of reporting regional data, each regional service area is defined as follows:

1.8.1. Better Health Together (BHT) includes Ferry, Stevens, Pend Oreille, Spokane, Lincoln, and Adams Counties.

1.8.2. Cascade Pacific Action Alliance (Cascade) includes Grays Harbor, Mason, Thurston, Pacific, Lewis, Cowlitz, and Wahkiakum Counties.

1.8.3. Greater Columbia (GC) includes Kittitas, Yakima, Benton, Franklin, Walla Walla, Columbia, Garfield, Whitman, and Asotin Counties.

1.8.4. King includes King County.

1.8.5. North Central (NC) includes Chelan, Douglas, Grant, and Okanogan Counties.

1.8.6. North Sound (NS) includes Whatcom, Skagit, San Juan, Island, and Snohomish Counties.

1.8.7. Olympic includes Clallam, Jefferson, and Kitsap Counties.

1.8.8. Pierce includes Pierce County.

1.8.9. South West Washington Regional Health Alliance (SW WA) includes Clark, Skamania, and Klickitat Counties.

2. Qualifying Provider Incentives

2.1. For purposes of this section, the term "Provider Incentives" means Payment Incentives and Payment Disincentives that apply to base payments that are Assessed Payments in a Value-Based Payment Arrangement.

2.2. For purposes of this section, the term "Payment Incentives" means the portion of contractor rates that are paid to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include retrospective bonus payments made on top of a provider's existing reimbursement structure (i.e. upside only), savings achieved by a provider under a shared-savings arrangement whereby the provider's portion of the savings is tied to quality reporting and/or performance, or prospective care management incentive or payment, on top of a provider's existing reimbursement structure, that is tied to quality reporting and/or performance.

2.3. For purposes of this section, the term "Payment Disincentives" means the portion of contractor rates that are charged to providers in a Value-Based Payment Arrangement conditioned on the quality of services provided. Examples include downside risk arrangements whereby providers make payments to contracted payer(s) from their existing reimbursement structure based on quality reporting and/or performance, deficit payments made by a provider to contracted payer(s) based on quality reporting and/or performance, or withheld payments from existing provider reimbursement structures based on quality reporting and/or performance.

2.4. The Provider Incentives Portion of the Withhold shall be 12.5 percent of the total Withhold. The Provider Incentives Portion may be earned back in whole or in part by establishing Payment Incentives and Payment Disincentives tied to quality and financial attainment, and by satisfying the additional requirements set out in this section. The formula under which all or part of the Provider Incentives Portion of the Withhold may be earned back is set out in this section.

2.5. During the Performance Year, the Contractor at its discretion can seek feedback from HCA on whether provider payment arrangements qualify as Provider Incentives.

2.6. On or before August 1 following each Performance Year, the Contractor shall report to HCA the total statewide and regional Assessed Payments that the

contractor made to providers for the Performance Year, and the amount of statewide and regional Payment Incentives and Payment Disincentives for the Performance Year. Failure to provide the report by the deadline may result in loss of the amount withheld under subsection 1.1 of this Exhibit.

2.6.1. Provider Incentives will be assigned to each region based on the location of the Provider.

2.6.2. Assessed Payments will be considered to have been made when the services have been provided.

2.7. The Contractor shall report the data outlined in subsection 2.6 of this Exhibit, and provide examples of the types of Payment Incentives and Payment Disincentives implemented in each region, in the format set out in Table 2.

Table 2
Statewide and Regional Qualifying Incentives

Region	Assessed Payments	Payment Incentives		Payment Disincentives	
		Total Amount	Describe*	Total Amount	Describe*
BHT					
Cascade					
GC					
King					
NC					
NS					
Olympic					
Pierce					
SW WA					
Statewide total					

**For example: "Downside risk arrangement whereby providers make payments to contracted payers from an existing reimbursement structure based on quality reporting and performance."*

2.8. A third-party contractor to HCA will validate the Contractor's reported actual Payment Incentives and Payment Disincentives to network providers.

2.9. Provider Incentives should be reported in the period in which they are paid or accrue in the Contractor's financial statements. The method of reporting should be consistent to ensure that amounts are not double-counted from year to year.

2.10. HCA will use the data supplied by the contractor to calculate the total Provider Incentives for the Performance Year as a percent of total Assessed Payments for the contractor for the Performance Year.

2.11. For the Contractor to earn back the Provider Incentives Portion of the Withhold in full, the total Provider Incentives for the Performance Year must equal at least Provider Incentives Threshold percent of Assessed Payments made during the Performance Year.

2.12. If for the Performance Year the percent calculated under subsection 2.10 of this Exhibit is equal to less than 1 percent, then the percentage calculated under subsection 2.10 of this Exhibit will be recalculated as a percentage of 1 percent. The resulting Provider Incentives "Partial Earn-Back Percentage" will then be the percentage of the Provider Incentives Portion of the Withhold that the contractor is eligible to earn back.

2.13. The results of the calculations made in subsections 2.10 and 2.12 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

3. Qualifying Value-Based Payments

3.1 For purposes of this section, "Payments in a Value-Based Payment Arrangement" means Assessed Payments in a Value-Based Payment Arrangement.

3.2 For purposes of this section, "Hybrid Payment Models" means payment arrangements that incorporate multiple APMs. Payments in Hybrid Payment Model shall assign Total Payments to the most dominant APM Category. The dominant APM Category is defined as the APM Category under which a plurality of payments are made.

3.3 For purposes of this section, "Integrated Primary Care Payment and Delivery Systems" are systems whereby a primary care provider is held accountable for the total cost of care for their patient population. Assessed Payments that are Integrated Primary Care Payment and Delivery Systems shall be included in APM Category 3A (for an upside only, shared savings arrangement) or Category 3B (for a two-sided, shared savings and downside risk arrangement).

3.4 The VBP Payments Portion of the Withhold shall be 12.5 percent of the total Withhold. The VBP Payments Portion of the Withhold may be earned back in whole or in part by ensuring that Assessed Payments are tied to Value-Based Payment Arrangements. The formula under which all or part of the VBP Payments Portion of the Withhold may be earned back is set out in this Section.

3.5 On or before August 1 following the Performance Year, the Contractor shall report to HCA the total regional and statewide Assessed Payments in each HCP-LAN Category as defined under subsection 1.5 of this Exhibit. In addition, the Contractor shall report to HCA the total regional and statewide Assessed Payments made by the Contractor in MACRA A-APM payment models certified through the Centers for Medicare and Medicaid Services (CMS). Failure to provide the report by the deadline may result in loss of the amount withheld. Payments will be assigned to each region based on the location of the Provider,

3.6 The Contractor shall report the data outlined in subsection 3.5 of this Exhibit in the format laid out in Table 3.

Table 3
Statewide and Regional Payments by HCP-LAN Category

Medicaid Total Assessed Payments by APM Category													
Category			**Region: Accountable Communities of Health**										
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WA	Out of State	All
1 FFS - No Link to Quality	1	Fee-for-Service											
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
	2D	Rewards and Penalties for Performance											
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
4 Population-Based Payment	4A	Condition-Specific Population-Based Payment											
	4B	Comprehensive Population-Based Payment											
Total Annual Payments													
Payments in MACRA A-APMs (all payments entered here should ALSO be entered under categories 1-4 above)													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

3.7 The Contractor shall report the total annual covered lives in each HCP-LAN category at a statewide and regional level as described in Table 4. Covered lives shall be reported for Enrollee member months as defined in this Contract.

3.8 Where an enrollee receives services that are funded under multiple payment models, the enrollee shall be reported under the dominant category of payment model either by month or over the total reporting period so long as a consistent method is used. The dominant category for this purpose shall be the payment category with the greatest assessed payments for the enrollee.

Table 4
Statewide and Regional Covered Lives by HCP-LAN Category

Medicaid Total Statewide Covered Lives by APM Category													
Category			**Region: Accountable Communities of Health**										
APM Category	APM Sub-category	Strategy	Better Health Together	Cascade	Greater Columbia	King	North Central	North Sound	Olympic	Pierce	SW WA	Out of State	All
1 FFS - No Link to Quality	1	Fee-for-Service											
2 FFS - Link to Quality	2A	Foundational Payments for Infrastructure & Operations											
	2B	Pay for Reporting											
	2C	Rewards for Performance											
	2D	Rewards and Penalties for Performance											
3 APMs built on FFS Architecture	3A	APMs with Upside Gainsharing											
	3B	APMs with Upside Gainsharing and Downside Risk											
4 Population -Based Payment	4A	Condition-Specific Population-Based Payment											
	4B	Comprehensive Population-Based Payment											
Total Covered Lives													
Covered Lives in MACRA A-APMs (all covered lives entered here should ALSO be entered under categories 1-4 above)													
For additional details on APM Categories, see HCP-LAN Alternative Payment Models (APM) Framework													

3.9 A third party contractor to HCA shall validate the Contractor's reporting of the total amounts and categorization of the reported Payments in a Value-Based Payment Arrangement.

3.10 HCA will use the data supplied by the contractor to calculate the total Payments in a Value-Based Payment Arrangement as a percent of total Assessed Payments for the contractor for the Performance Year.

3.11 For the Contractor to earn back the VBP Payments Portion of the Withhold in full, the total Payments in a Value-Based Payment Arrangement for the Performance Year must equal at least the VBP Payments Threshold Percent of Assessed Payments made during the Performance Year. The VBP Payments Threshold for Each Performance Year is set out in Table 1.

3.12 If for the Performance Year the percentage calculated under subsection 3.10 of this Exhibit is less than the VBP Payments Threshold for the Performance Year, then the percentage calculated under subsection 3.10 of this Exhibit will be recalculated as a percentage of the VBP Payments Threshold for the Performance Year. The resulting VBP Payments "Partial Earn-Back Percentage" will then be the percentage of the VBP Payments Portion of the Withhold that the contractor is eligible to earn back.

3.13 The results of the calculation made in subsections 3.10 and 3.12 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

4. Overall Quality Improvement Score Calculation

4.1 The QIS Portion of the Withhold shall be 75 percent of the total Withhold. The QIS Portion may be earned back in whole or in part by achieving quality improvement and attainment targets on the basis of Healthcare Effectiveness Data and Information Set HEDIS® scores that the Contractor will report to HCA, and by satisfying the additional requirements set out in this Section.

4.2 In accordance with Section 7 of this Contract, the Contractor shall report HEDIS® measures electronically to the HCA contracted External Quality Review Organization no later than the date in June of each year as specified by the audit team. Specific measures will be evaluated to determine the share of the QIS Portion of the Withhold that the Contractor is eligible to earn back and are identified in Table 5. Failure to provide the report by the deadline may result in loss of the amount withheld.

4.3 If the value for one or more measures in the Improvement Baseline Year is missing or not available, the HCA Chief Medical Officer (CMO), in his or her sole discretion, will determine the values to be used in place of the missing values using publicly available sources. If the value using publicly available sources is missing or not available, the HCA CMO will either determine an alternative measure or exclude the measure from the calculation.

4.4 HCA will use the data supplied by the Contractor to calculate a single Quality Improvement Score for the Contractor for the Performance Year. The total Quality Improvement Score will reflect a weighted average of individual composite scores (the "Measure Composite Score") that assess annual improvement (the "Measure Improvement Score") and objective attainment (the "Measure Quality Score") on each Quality Measure.

4.5 The Measure Improvement Score and Measure Quality Score for each Quality Measure will measure the HEDIS® scores provided by the Contractor and non-HEDIS® scores against Target Measure Score and Mean Measure Score values shown in Table 5.

4.5.1 The Target Measure Score values referenced in Table 5 that are identified as HEDIS® scores are derived from NCQA Quality Compass Medicaid HMO 90th percentile values for the year immediately preceding the Performance Year. The Target Measure Score values referenced in Table 5 that are identified as non-HEDIS scores will be one percentage point above the Mean Measure Score for the year immediately proceeding the Performance Year.

4.5.2 The Mean Measure Score values referenced in Table 5 are equal to the Contractor's Improvement Baseline Year measure score.

Table 5
Measure Weights, Target Measure Scores and Mean Measure Scores

	Quality Measures Description	HEDIS®	Measure Weight	Target Measure Score	Mean Measure Score
Physical Health	Well-child visits in the 3rd, 4th, 5th and 6th years of life	Yes	Full	Improvement Baseline Year measure score (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 5-11)	Yes	Half	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Medication Management for people with Asthma: Medication Compliance 75% (Ages 12-18)	Yes	Half	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Adolescent Well-Care Visits	Yes	Full	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Follow Up Care for Children Prescribed ADHD Medication - Continuation & Maintenance Phase	Yes	Half	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase	Yes	Half	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
	Lead Screening in Children	Yes	Full	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score

	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - Total	Yes	Full	Improvement Baseline Year measure score × (Quality Compass 90th Percentile / Quality Compass Mean)	Improvement Baseline Year measure score
Behavioral Health	Alcohol and Drug Treatment (Service) Penetration	No	Full*	Improvement Baseline Year measure score + 1 percentage point	Improvement Baseline Year measure score
	Mental Health Treatment (Service) Penetration	No	Full*	Improvement Baseline Year measure score + 1 percentage point	Improvement Baseline Year measure score

* These measures are initially given zero weight as specified in section 4.12 of this Exhibit.

4.6 The Measure Quality Score QS(i) for a given measure will reflect the Contractor's attainment beyond the Mean Measure Score in terms of the total distance between the Mean Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure QS Ratio where Measure QS Ratio = (Performance Year Measure Score - Mean Measure Score) / (Target Measure Score - Mean Measure Score).

4.6.1 The Measure QS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

4.6.2 The Measure QS Ratio will be transformed into a curved distribution using a lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be a QS Table Lookup Value.

4.6.3 For a given measure, the QS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Performance Year Measure Score - Mean Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score - Mean Measure Score). However, if the Performance Year Measure Score is less than the Mean Measure Score, then the QS Table Lookup Value shall be considered to be zero.

4.7 The Measure Improvement Score IS(i) for a given measure will reflect the Contractor's improvement from the Improvement Baseline Year Measure Score in terms of the total distance between the Improvement Baseline Year Measure Score and the Target Measure Score. This relationship is initially calculated as the Measure IS Ratio where Measure IS Ratio = (Performance Year Measure Score - Improvement Baseline Year Measure Score) / (Target Measure Score – Improvement Baseline Year Measure Score).

4.7.1 The Measure IS Ratio is rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the

hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

4.7.2 The Measure IS Ratio will be transformed into a curved distribution using the lookup table provided in Attachment B of this Exhibit, QIS Lookup Table. The result of the lookup transformation will be an IS Table Lookup Value.

4.7.3 For a given measure, the IS Table Lookup Value is the value where the horizontal axis that equals the absolute value of the (Performance Year Measure Score - Improvement Baseline Year Measure Score) intersects with the vertical axis that equals the absolute value of the (Target Measure Score – Improvement Baseline Year Measure Score). However, if the Performance Year Measure Score is less than the Improvement Baseline Year Measure Score, then the IS Table Lookup Value shall be considered to be zero.

4.8 The Measure Q-I Weighting Factor z(i) for a given measure will determine the respective weight given to the Measure Quality Score and the Measure Improvement Score in calculating the Measure Composite Score. The Measure Q-I Weighting Factor shall range from .25 to 1, dependent on the Measure QS Ratio (not the QS Table Lookup Value) as follows:

4.8.1 If the Measure QS Ratio is equal to or less than .25, then the Measure Q-I Weighting Factor shall equal .25.

4.8.2 If the Measure QS Ratio is more than .25 and less than 1 then the Measure Q-I Weighting Factor shall equal the Measure QS Ratio.

4.8.3 If the Measure QS Ratio is equal to or greater than 1, then the Measure Q-I Weighting Factor shall equal 1.

4.9 The Measure Quality Score QS(i) for a given measure shall equal the QS Table Lookup Value multiplied by the Measure Q-I Weighting Factor.

4.10 The Measure Improvement Score IS(i) for a given measure shall equal the IS Table Lookup Value multiplied by a value equal to one minus the Measure Q-I Weighting Factor.

4.11 The Measure Composite Score QIS(i) for a given measure shall equal the sum of the Measure Improvement Score IS(i) and the Measure Quality Score QS(i).

4.12 The overall Quality Improvement Score, QIS, is the weighted average of all the individual Measure Composite Scores, QIS(i), where the Measure Weight for each measure is specified in Table 5. In the Contractor's first year of operation under this Contract for Fully Integrated Managed Care, the Behavioral Health Measures shall be given a weight of zero. The resulting QIS (e.g. 0.14) is converted to a percentage (e.g. 14 percent).

4.13 For the Contractor to earn back the QIS Portion of the Withhold in full, the overall Quality Improvement Score, QIS, for the Performance Year must equal at least 20 percent.

4.14 If for the Performance Year the Quality Improvement Score for the Performance Year is equal to less than 20 percent, then the Quality Improvement Score will be recalculated as a percentage of 20 percent. The resulting QIS "Partial Earn-Back Percentage" will then be the percentage of the QIS Portion of the Withhold that the contractor is eligible to earn back.

4.15 The results of the calculation made in subsections 4.12 and 4.14 of this Exhibit are rounded to the nearest hundredth value. If the thousandths place of a decimal is four or less, it is dropped and does not change. If the thousandths place of a decimal is five or higher, the hundredth value increases by one. For example, rounding 0.667 to the nearest hundredth would give 0.67, or 67 percent.

5. Payment

5.1 On or before October 30 of the year following the Performance Year, HCA will provide the Contractor with a completed Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C to notify the Contractor in writing of its percentage of Withhold earned back based on the calculations described in this Exhibit.

5.2 The Contractor will have 20 calendar days from the date the Contractor is notified of its percentage Withhold earned back to review and sign the Value-Based Purchasing Withhold Calculation Summary Form provided in Attachment C and return to HCA, in writing, any alleged discrepancies with the calculations.

5.3 If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.

5.4 HCA will schedule payment for the percentage of the Withhold earned back no later than November 30 of the year following the Performance Year.

Exhibit D-1, Attachment C
Value-Based Purchasing Withhold Calculation Summary Form

Contractor/Vendor Name: _____

Contract No: _____

Performance Period: _____ to _____

Percent of qualifying Provider incentive payments tied to quality: _____

Percent of payments in a qualifying Value Based Purchasing Arrangements: _____

Quality Improvement Score: _____

The Contractor earned back _____% of the Value-Based Purchasing Withhold described in Exhibit D.

Washington State Health Care Authority Chief Financial Officer Signature:

_____

Signature Date

_____

Print Name & Title

Email Address: _____

Contractor hereby agrees to the accuracy of this Value-Based Purchasing Withhold Calculation Summary and the underlying calculations.

Contractor Authorized Agent Signature

_____

Signature Date

_____

Print Name & Title

Email Address: _____

HCP LAN
Health Care Payment Learning & Action Network

ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

Written by:

Alternative Payment Model Framework
and Progress Tracking (APM FPT) Work Group

For Public Release
Version Date: 1/12/2016

Table of Contents

Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

To advance this goal, the Alternative Payment Models Framework and Progress Tracking Work Group ("the Work Group") was charged with creating an alternative payment model (APM) Framework ("the APM Framework") that could be used to track progress towards payment reform. Composed of diverse health care stakeholders, the Work Group has deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care.

Although the Work Group was not charged with developing a working definition of person centered care, it thought that it was important to do so because it views payment reform as one means for accomplishing the larger goal of person centered care. The Work Group believes that person centered care rests on three pillars: quality, cost effectiveness, and patient engagement. For the purposes of the White Paper, the term is nominally defined as follows: *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. In addition, it should be noted that the opinions expressed within the White Paper are those of the Work Group Members and not of the organizations of which they are affiliated.

The Work Group is committed to the notion that transitioning the U.S. health care system away from fee for service (FFS) and towards shared risk and population based payment is necessary, though not sufficient in its own right, to a value based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person centered care because it does not reward high quality, cost effective care. By contrast, population based payments (including bundled payments for clinical episodes of care) offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the Work Group and the LAN as a whole believe that the health care system should transition towards shared risk and population based payments. The Work Group hopes the Framework will be useful in this context to establish a common nomenclature upon which progress can be discussed and measured.

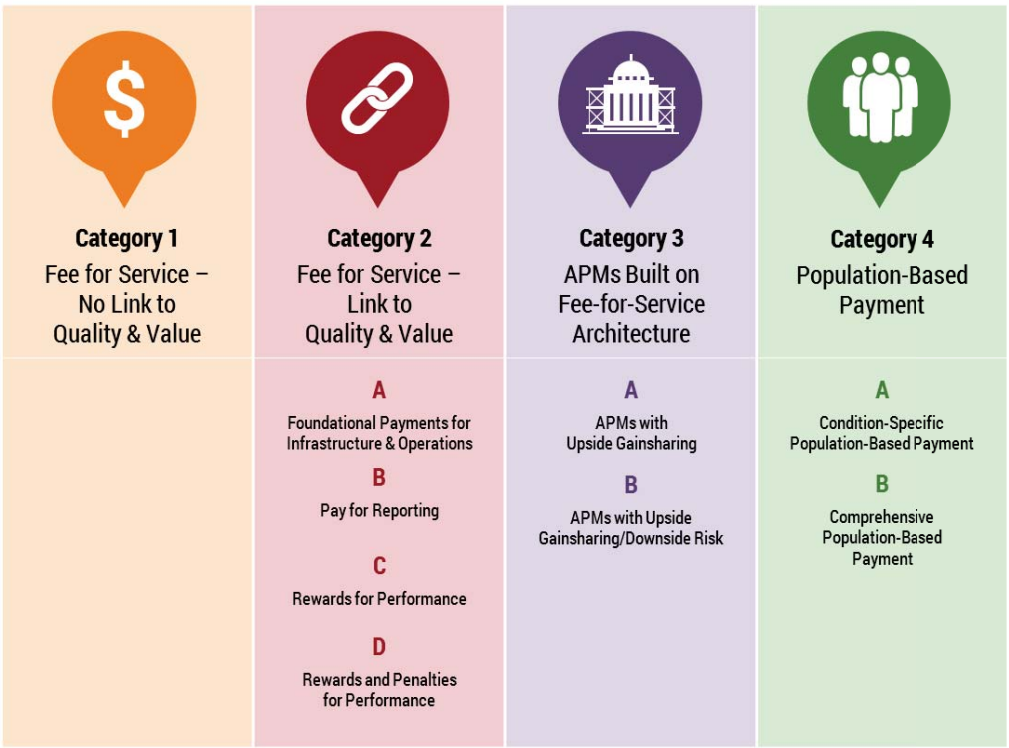
The APM Framework rests on seven principles, which can be summarized as follows:

1. Changing providers' financial incentives is not sufficient to achieve person centered care, so it will be essential to empower patients to be partners in health care transformation.
2. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. Centers of excellence, accountable care organizations, and patient centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by the Centers for Medicare & Medicaid Services (CMS), and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated below:

Figure 1. APM Framework (At-A-Glance)



Overview

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

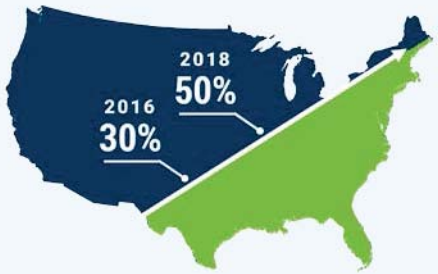
The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the "Work Group") and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the "APM Framework"). The Work Group brought together public and private stakeholders to assess APMs in use across the nation and to define terms and concepts essential for understanding, categorizing, and measuring APMs. (A roster of Work Group members, representing the diverse constituencies convened by the LAN, is provided in Appendix A. Please note that opinions expressed within the White Paper are those of the Work Group Members not of the organizations of which they are affiliated.) The aim of the Work Group is to create a clear and understandable APM Framework, to provide a deeper understanding of payment models and how those models can enhance health and health care, and to provide examples of how public and private payment models are organized within the APM Framework.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Work Group is hopeful that this White Paper will help CMS consider some of the issues involved in implementing MACRA, but stresses that providing formal recommendations on how to do so is explicitly not part of the Work Group's charge. Although the Work Group is no longer soliciting comments on the White Paper, formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS.

Health Care Payment Learning & Action Network (LAN)

To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. To enable these reforms, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

U.S. Health Care Payments in APMs



The Case for Reforming the Health Care Payment System

The LAN and the Work Group are unanimous in their desire to drive payment approaches that improve the quality and safety of care and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides person centered care. Recognizing that the Work Group was not charged with developing a comprehensive definition of the term or its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands person centered care to mean *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. The Work Group believes that person centered care, so defined, rests upon three pillars:

- **Quality**: This term indicates that patients receive appropriate and timely care that not only is consistent with evidence based guidelines and patient goals, but also results in optimal patient outcomes and patient experience. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process, outcome, patient reported outcome, and patient experience measures that both provide an accurate and comprehensive assessment of clinical and behavioral health, and that report results that can be meaningfully accessed, understood, and used by patients and consumers.
- **Cost Effectiveness**: This term indicates a level of severity adjusted total costs (and, when relevant, unit prices) that reflect benchmarked best achievable results, and that are consistent with robust and competitive health insurance marketplaces as characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial, and government programs sectors. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Conversely, care that is costly but that results in dramatic improvements in patient outcomes could be considered cost effective. Affordable health care services are vital to ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health.
- **Patient Engagement**: This term encompasses the important aspects of care that improve patient experience, enhance shared decision making, and ensure that patients and consumers achieve their health goals. Patient engagement should occur at all levels of care delivery, with patients and caregivers serving as partners when setting treatment plans and goals at the point of care; when designing and redesigning delivery and payment models; on governance boards and decision making bodies; and when identifying and establishing connections to social support services. Engaged patients and consumers are informed of their health status and share in their own care; they are easily able to access appointments and clinical opinions; they seek care at the appropriate site; they possess the information they need to identify high value providers and to tailor treatment plans to individual health goals; they provide ongoing feedback that providers can use to improve patient experience; they are able to obtain transparent price information about services and their value for patients and consumers; and they can move seamlessly among providers that are engaged in different aspects of their care. Routine communication with family caregivers and other support members is also a critical part of comprehensive, person centered care.

As evidenced by the creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders in the health care system that efforts to deliver person centered care have been stymied, in large part, by a payment system that is oriented largely towards volume, as opposed to value for patients and caregivers. These stakeholders and the

Work Group believe that by reconfiguring payments to incentivize value, and by ensuring that valuable activities (e.g., care coordination) are compensated appropriately, providers will be able to invest in care delivery systems that are optimized for the provision of care that is more focused on patient needs. In other words, changes in payment are necessary (though insufficient on their own) to change provider behavior and drive delivery system transformations, thereby ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group believes that shifting from traditional fee for service (FFS) payments to person focused payments (in which all or much of a person's overall care or care for related conditions is encompassed within a single payment) is a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Such payments should thus include accountability for the quality of care at the population level, rather than for the volume of particular services. Although it is not yet possible to reach a definitive, evidence based conclusion about the impact of population based payments on patient care, there is a belief that these types of payment models are designed in a way that holds substantial promise. This is because person focused, population based payments give providers more flexibility to coordinate and manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and increased incentives to provide services that are currently undervalued in FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

At present, FFS payments are ill suited for initiating investments and sustaining population health management innovations, such as information technology, clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., payments for telehealth, home visits, and additional office hours). This is because FFS incentivizes providers to optimize volume. As a result, FFS may at times discourage the perspective that patients require individualized and highly coordinated care. Population based payments may enable providers to develop more innovative approaches to person centered health care delivery because they reward providers that successfully manage all or much of an individual's care. Provided that safeguards are put in place to ensure that quality and patient engagement are not sacrificed to reduce costs, and that the care delivered is state of the art and takes advantage of valuable advances in science and technology, these innovative approaches to health care delivery stand to benefit patients and society alike. Patients may come to expect a more coordinated, more accessible, and more effective health care system, and the nation would benefit from reductions in national health care expenditures, and a healthier, more productive workforce.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care, and that the transition away from FFS may be costly and administratively difficult. The Work Group also recognizes that participation in shared risk and population based payment models involves financial risk for providers, that not all provider organizations possess the capacity to successfully operate in these payment models, and that providers will need assistance to develop additional capabilities. In order to smooth and accelerate this transition, the Work Group believes that a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a population based health system that delivers the best health care possible. If providers were able to participate in APMs that were consistently deployed across multiple payer networks, this would reduce the administrative burden of making the transition and allow investments to be applied to all patient populations, independent of payer. Aligned payments from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long term. The Work Group

expects that the adoption and diffusion of these innovative delivery systems should ultimately improve the quality, efficiency, safety, and experience of patient care, while becoming sustainable business models for providers that are eager to take a more comprehensive and coordinated approach to medical practice.

The Work Group believes that a shift to person focused, population based payments will, in concert with other reforms, result in an expansion of high value care in the United States. The Work Group recognizes the possibility that shifts in payment can result in unintended and unanticipated consequences, such as cost increases owing to provider consolidation, reduced provider willingness to exchange data, and a potential reduction in costly but effective medical services. The Work Group believes that it is therefore absolutely essential to monitor the impact of population based payment systems on patient outcomes, health care costs, and other indicators of significance to patients and other stakeholders in the health care system. The Work Group envisions the shift to person focused, population based payment as a course correcting feedback loop between innovation, implementation, and evaluation; it also anticipates that its forthcoming effort to measure progress will help accelerate this process. The Work Group is hopeful this, the first in a series of LAN publications, will help align stakeholders in the public and private sectors and support the implementation of payment systems that promote person centered care.

Purpose of the White Paper

In order to accelerate the transformations described above, the Guiding Committee charged the Work Group with creating an APM Framework through which progress towards payment reform can be described and measured. In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a shared set of conventions that can facilitate discussions among stakeholders and expedite the generation of evidence based knowledge about the capabilities and results of APMs.

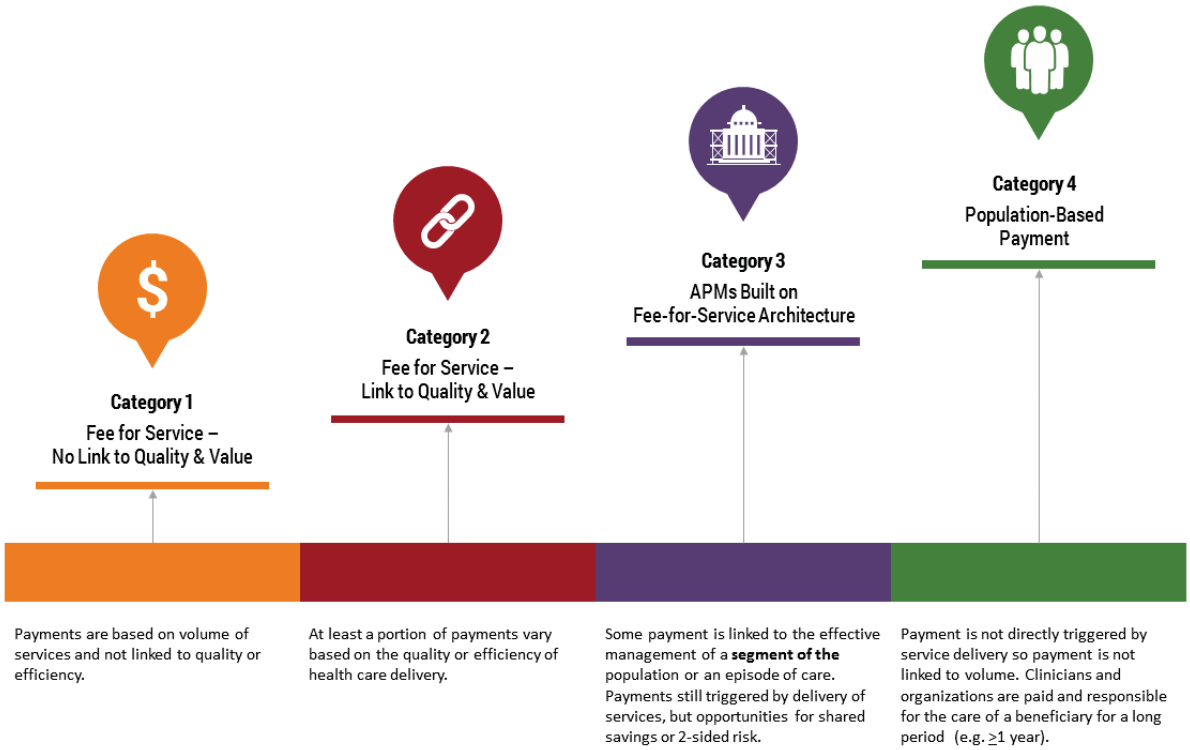
The White Paper begins by describing the approach that the Work Group used to develop the APM Framework, and then describes the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates the Categories within the APM Framework by explaining how the Categories are defined and where their boundaries lie. The White Paper concludes with a summary of the Work Group's key findings and recommendations, as well as recommendations for how various stakeholders can use the Framework to accelerate payment reform. To further clarify the classification of individual APMs, the Work Group has separately released a collection of APMs that are currently in use.

Approach

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,[1] and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from plans to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and total cost of care, with a greater focus on population health management (as opposed to payment for specific services).

[1] Rajkumar R, Conway PH, Tavenner M. CMS: Engaging multiple payers in payment reform. JAMA. 2014 May 21: 311(19):1967 8.

Figure 2. CMS Payment Framework



The Work Group added to and refined the CMS model by: 1) articulating key principles to explain what the APM Framework does and does not mean to convey; 2) introducing four new Categories to account for payment models that are not considered progress towards payment reform; 3) introducing eight subcategories to account for nuanced but important distinctions between APMs within a single Category; 4) delineating explicit decision rules that can be used to place a specific APM within a specific subcategory; and 5) compiling, with the help of the LAN, examples of APMs that illustrate key characteristics of each of the subcategories.

Key Principles for the APM Framework

The Work Group's Framework is predicated on several key principles. To provide context for understanding the APM Framework and the Work Group's recommendations, these principles are delineated and explained below.

***Principle 1**: Changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of person centered care. In the future, it will be important to monitor progress in initiatives that empower patients to have a voice in model design, to seek care from high value providers (via performance metrics, financial incentives, and other means), and to become active participants in shared decision making.*

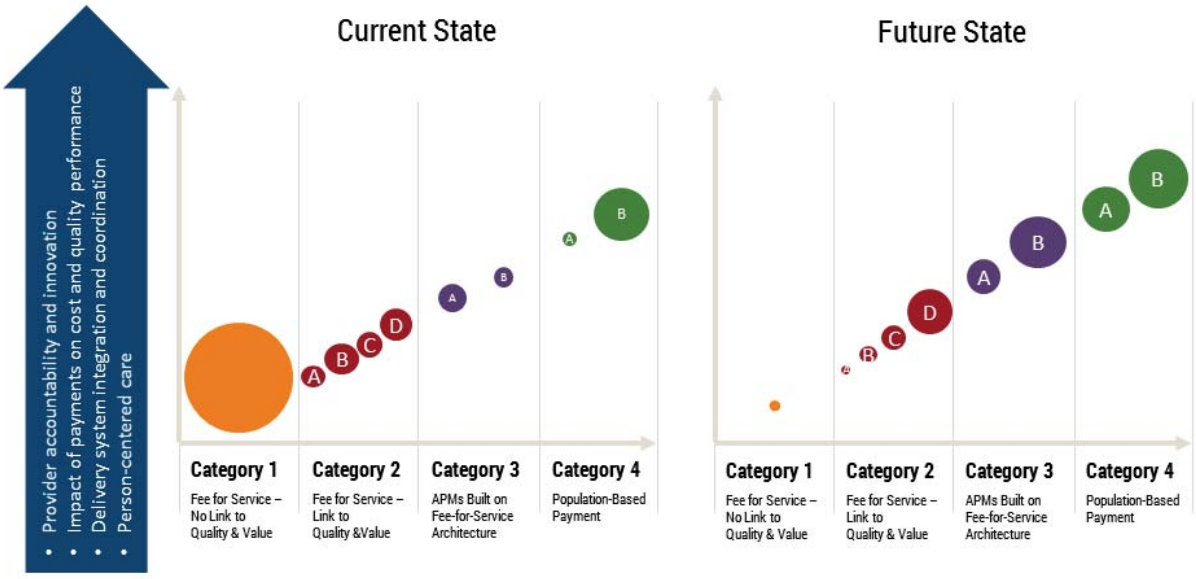
Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a high value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, the Work Group expects all stakeholders to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. Such approaches may include strategies to clearly and meaningfully communicate, to patients and consumers, information about provider and health plan performance on clinical and patient experience measures; financial rewards for patients and consumers to select high value providers and to successfully manage chronic diseases; and efforts to enlist patients and caregivers as partners in the setting of health goals and the development of treatment plans. In order to avoid unintended consequences associated with APMs, the Work Group also believes it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or a greater need for social support, and that patients and consumers will be informed of providers' financial incentives in APMs. Additional activities and monitoring will also be needed to ensure that the expansion of population based payments does not lead to disparities in health outcomes or to a decline in access to care.

***Principle 2**: As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.*

The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional FFS payment. Consistent with this objective, the Work Group recommends that over time, the U.S. health care system should move concertedly towards APMs in Categories 3 and 4. Nevertheless, the Work Group strongly believes that providers should clearly understand the requirements for financial and clinical participation in APMs, as well as that participation in APMs should be voluntary and that providers should not take on risk that they are not prepared to accept. The Work Group also recognizes that market forces have led to different levels of delivery system organization and integration, and investment in infrastructure and management will be required to build the capabilities that will ensure greater success of more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market, for every clinical domain (e.g., dental care), or for every patient population. Furthermore, the Work Group anticipates that some regional markets may be slower to make the transition to these Categories. In particular, the Work Group expects participation in Category 3 and 4 APMs to be more limited for rural providers and for certain small or solo practices. Additionally, the transition may be more challenging for safety net providers, given the broad array of other services needed by their patient populations that are not integrated into health care, unless such services can be better integrated into payment reform.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 3.

Figure 3. The Work Group's Goals for Health Care Reform



** Note: The values presented in the above "current state" graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent the Work Group's belief of how the health care system should change, and it takes into account the likely impact of Medicare's Merit Based Incentive Payment System. The Work Group cautions that values displayed in the graphic are not precise, nor are they intended to lay out specific targets for health care reform.*

In Figure 3, the size of the various circles represents spending across various types of payment models. As Figure 3 illustrates, payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally, the Work Group expects that, over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value based care.

***Principle 3**: To the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care.*

Based on the experience of members of the Work Group, payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for providers that are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop mechanisms that drive person centered, well-coordinated, and high value care that ultimately lead to better outcomes. For example, an accountable care organization (ACO) that is at risk for cost and quality would ideally design financial incentives for individual physicians and hospitals in a way that aligns with the ACO's incentives as an organization. The Work Group recognizes that it may not always be possible to measure accurately the degree to which incentive payments reach individual practitioners. Nevertheless, the Work Group considers this a best practice and affirms that all delivery systems participating in Category 3 and 4 APMs should commit to

this principle. The Work Group believes that making population based payments to provider organizations that, in turn, pay individual providers on an FFS basis will not harness the full potential of the incentives in the APM.

***Principle 4**: Payment models that do not take quality and value into account will be classified within the appropriate category with a designation that distinguishes them as a payment model that is not value based. They will not be considered APMs for the purposes of tracking progress towards payment reform.*

As illustrated in Figure 4, the APM Framework represents a continuum of payment approaches across four Categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 are organized according to the degree to which they advance beyond traditional FFS payment. The Work Group believes strongly that there is limited merit in moving toward population based payments if the resulting payment models do not include incentives to deliver quality health care based on current clinical knowledge. Although the Work Group was not charged with making specific recommendations about what constitutes meaningful quality measurement, it believes that APMs should use harmonized measure sets that include process, clinical outcome, patient reported outcome, and patient experience of care measures. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Payment models that represent some movement away from traditional FFS, but that do not take quality (and therefore value) into account, will be placed under the appropriate payment category and marked with an "N" to indicate "No Quality" considerations (e.g., population based payments not linked to value will fall into Category 4N). Accordingly, such models will not be considered to represent progress toward true payment reform, and the Work Group will not track them as part of measuring the achievement of the LAN's goals.

***Principle 5**: In order to reach the LAN's goals for health care reform, value based incentives should be intense enough for providers to invest in and implement delivery reforms, and they should increase over time. However, the strength of incentives does not affect the classification of APMs in the APM Framework.*

The Work Group believes that APMs can be effective stimuli for delivery system change if providers are given meaningful incentives to develop and sustain innovative approaches to care delivery, and it acknowledges that shifting to person focused, population based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value based incentives be large enough to motivate providers to invest in and adopt new approaches to care delivery, and—over time—to outweigh profits that could be generated by increasing FFS billing. For example, the Work Group believes that a two sided incentive of plus or minus 10% is likely to promote change to a greater extent than a plus or minus 2% incentive. To accelerate and sustain progress throughout the entire health care system, the Work Group also believes that the size of this incentive should grow over time, as providers obtain greater experience in advancing quality while managing costs. A similar principle

applies to the setting of cost and quality benchmarks, in the sense that higher expectations for quality improvements and cost reductions are more effective at stimulating innovative approaches to care delivery.

At this time the Work Group classifies APMs without considering the intensity of the associated incentive payments because it believes that doing so would unnecessarily complicate the APM Framework. Using the example above, an episode based payment with a 10% financial risk/reward is classified the same as an episode based payment with a 2% financial risk/reward. The Work Group believes that more experience and analysis will be needed to determine what the "right" risk/reward level is to promote progress, while also recognizing that it may be different for hospitals and health systems than for physician organizations and health professionals. Nevertheless, the Work Group believes that a minimal threshold of risk and reward should be 5%, but likely greater.

***Principle 6**: For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count towards the category of the most dominant APM. This will avoid double counting payments through APMs.*

The Work Group recognizes that a particular payment model may utilize several APMs concurrently, especially as the model is evolving. For example, an ACO may utilize a shared savings model in years one and two along with nominal pay for performance incentives, and then transition to a shared risk model in year three. For the purpose of tracking progress in such hybrid cases, the entire payment model will be placed in the category that best captures the "dominant" APM (in this case, shared savings for years one and two, and shared risk in year three). It is also possible that bundled payments may be used within gainsharing, shared risk, and population health models, and that a patient centered medical home may be supported by FFS based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count towards the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed.

***Principle 7**: Centers of excellence, patient centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them.*

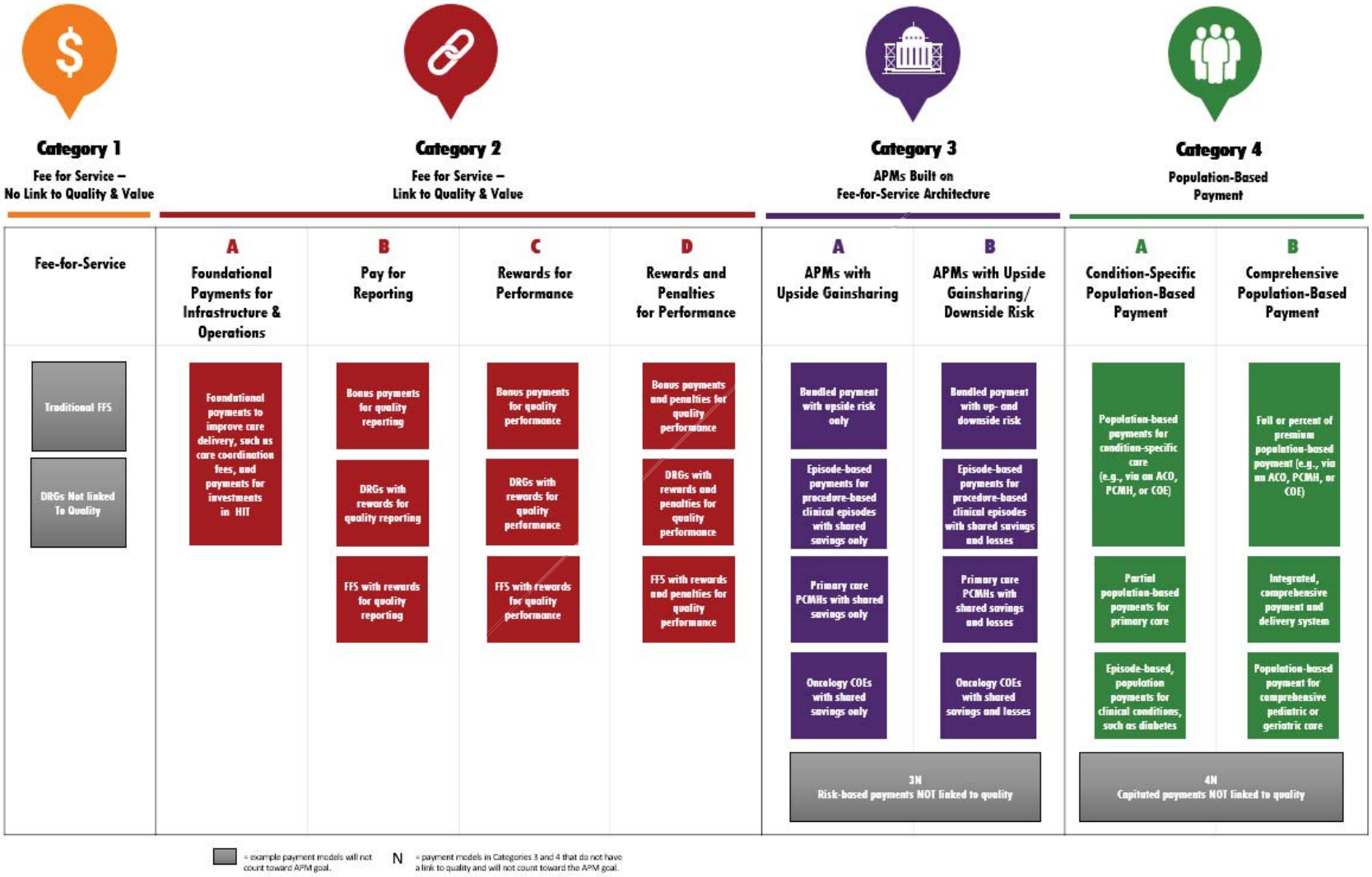
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they will be listed according to their underlying payment arrangement when they appear in the APM Framework. For example, a PCMH that participates in a shared savings/risk model will be classified in Category 3, but a PCMH that receives population based payments linked to value will be classified in Category 4. The Work Group recognizes that PCMHs and ACOs are commonly understood to be associated with risk sharing payment models. Nevertheless, the Work Group strongly

recommends maintaining a clear distinction between concepts that describe payment models and those that describe delivery models. At the same time, the Work Group believes these delivery models have been developed with the goal of driving care coordination and delivery improvements, and will enable more advanced payment models while at the same time requiring more advanced payment models to succeed. In recognition of their dramatic potential to improve the delivery of high quality and efficient health care, the Work Group elected to represent ACOs, PCMHs, and COEs in multiple categories, where corresponding APMs exist today and, likely, in the future.

The APM Framework

The Work Group's APM Framework is depicted in Figure 4. The Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The following discussion identifies the organizing principles that serve as the foundation for each Category, explains how the Categories are differentiated, and highlights examples of APMs in each Category. Please note that the examples in Figure 4 are not meant to be exhaustive, but are rather intended to give a sense of possible arrangements in each of the subcategories.

Figure 4. APM Framework



❶ *Fee for Service with No Link to Quality & Value (Category 1):*

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments are made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor for provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1. This is because the Work Group has determined that DRGs are used to reimburse a group of services delivered within a hospitalization, and while DRGs drive efficiencies in inpatient care, hospitals typically bill DRGs in much the same way that physicians bill services that are paid on a fee schedule. In both instances, the provider's incentive may be to bill for additional services because they are paid more for more volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter incentivizes infrastructure investments and/or involves some method of reporting or assessing the quality of the care delivered. Unlike payments made in Category 1, payments made in Category 2 are influenced by whether a provider invests in infrastructure, reports quality data, or achieves quality targets.

❷ *Fee for Service Linked to Quality & Value (Category 2):*

Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments that are made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well they perform on cost and quality metrics.

The Work Group has split Category 2 into subcategories A, B, C, and D as outlined below:

- Payments placed into **Category 2A** involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, the Work Group considers these types of FFS or per member per month (PMPM) payments an important—though preliminary—step toward payment reform.
- Payments placed into **Category 2B** provide positive or negative incentives to report quality data to the health plan and—preferably—to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay for reporting program therefore gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan’s reporting system. Because pay for reporting does not link payment to quality performance, the Work Group maintains that participation in Category 2B payment models should be time limited and that participation in Category 2B payment models will often evolve into subsequent categories.
- Payments are placed into **Category 2C** if they provide rewards for high performance on clinical quality measures. Much like pay for reporting programs, pay for performance programs that only reward high performance on quality metrics give providers an opportunity to acclimate themselves to the applicable reporting systems and measures before they are subject to penalties for low performance. In some instances, these programs have an extensive set of performance measures

that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in a hospital acquired infections.

- Payments placed into **Category 2D** reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive lower updates to their FFS baseline or may receive a percent reduction on all claims paid if they do not meet quality goals. (Please note that payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may take into account performance on a more limited set of cost measures.)

In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT). Although the Work Group was not tasked with developing specific recommendations on HIT and data sharing, it believes that providers should invest in interoperable systems; that administrative reporting requirements should be minimized as much as possible; that patients and caregivers should have free and ready access to patient records; and that HIT should be used to maintain patient registries and contribute to the development of clinical measures and guidelines.

As indicated in the discussion above, the Work Group expects that providers receiving Category 2A and 2B payments are investing in the HIT and other infrastructure needed to assess and improve quality performance, and that payments in these categories will be an "on ramp" to participation in subsequent categories. In other words, the Work Group expects that under most circumstances, providers and provider groups will transition quickly into Categories 2C and 2D, though they may do so in different ways. In the private sector, few payment plans support pay for reporting arrangements, and providers often move directly into pay for performance models. By contrast, Medicare pay for reporting programs typically precede and serve as the foundation for pay for performance programs in the same facility setting. Because data from the former determine payment adjustments in the latter, providers paid under that Medicare arrangement are typically eligible to receive both Category 2B and Category 2D payment adjustments. The Work Group stresses that the payment models in Categories 2A through 2C will prepare providers to take on the additional accountability and financial risk associated with APMs in Categories 3 and 4. This concept of Categories 2A and 2B as an "on ramp" for subsequent categories will be assessed as the Work Group measures and tracks progress towards adoption of APMs.

Payments that fall under Category 2 are distinguished from those that fall under Category 3 in two respects. First, Category 2 payments do not involve arrangements in which providers assume either shared savings or shared losses based on established cost targets. Second, FFS based payments in Category 3 reflect, to a greater degree, care that is provided longitudinally, such that multiple providers are responsible for the cost and quality associated with a particular set of procedures or services. By contrast, Category 2 payments are limited to specific providers.

❸ *APMs Built on Fee for Service Architecture (Category 3):*

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. In addition to taking quality considerations into account (as in Category 2), Category 3 payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. For APMs in Category 3, providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures, such as hip replacement or back surgery.

The Work Group has split Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. If a provider participating in a Category 3A APM meets quality targets but does not meet cost targets, then the provider is not held financially responsible for excess spending.
- Payments in **Category 3B** involve both upside gainsharing (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments) based on performance on cost measures.

Most ACO arrangements today can be placed into either Category 3A (most often) or Category 3B, depending on whether the underlying risk arrangement includes only upside gainsharing or both upside gainsharing and downside risk for providers. The Work Group believes payments in Category 3 will advance clinical integration and affordability to a greater extent than payments in Category 2 because risk sharing arrangements provide stronger incentives to manage health care costs and reward care coordination across the span of care.

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single payment that encompasses a broad array of services, whereas providers participating in Category 3 models are eligible for only a portion of the losses and/or savings they generate. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population. By contrast, even if they are fully capitated, payments that cover a more limited set of specialty services (including primary care) would be classified in Category 3. For example, a Category 4 model for pediatric care would have to cover a wide range of medical, preventive, and developmental services, whereas a population based payment model for primary care would fall under Category 3 if it did not hold primary care providers accountable for care coordination and the appropriate utilization of specialty services. Similarly, clinical episode payments tied to conditions (e.g., diabetes or cancer) fall under Category 4, whereas clinical episode payments tied to procedures (e.g., hip replacement or back surgery) fall under Category 3, even if they are made on a per member per month basis. As such, Category 4 payments are more person focused, insofar as they include stronger incentives to promote health and wellness throughout the care continuum.

❹ *Population Based Payment (Category 4):*

Payment models classified as Category 4 involve population based payments, structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined (4A) or overall (4B) budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventive health, health maintenance, and health improvement services, and these payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4A and 4B APMs are held accountable for delivering high quality, clinically necessary, and appropriate care.

The Work Group has split Category 4 into subcategories A and B as outlined below:

- **Category 4A** payments are limited to certain sets of condition specific services (e.g., asthma, diabetes, or cancer), but they remain person focused in the sense that they hold providers accountable for the total cost and quality of care related to that condition. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. The Work Group recognizes that in certain instances patient care will predominantly revolve around the management of particular types of conditions, such as cancer or heart disease. In such cases, we recognize that Category 4A may become a suitable and justifiable endpoint, especially for smaller provider organizations which may never be able to deliver certain types of care (such as transplants). Nevertheless, the Work Group maintains that providers should ideally be paid to maintain health and manage illness for an entire population, rather than compartmentalizing payments according to particular conditions. We also believe that condition specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population. For highly integrated delivery systems, the Work Group envisions that Category 4A payments will evolve into Category 4B.
- Payments in **Category 4B** are capitated or population based for all of the individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements with varying degrees of integration between plans and provider groups. On one end of the spectrum, plans and providers in Category 4B models may be virtually integrated. On the other end of the spectrum are highly integrated arrangements that are characterized by vertical integration of financing and care delivery, common ownership, and strong linkage across strategy, clinical performance, quality, and resource use. These groups may also have a higher percentage of salaried physicians. After reviewing the literature and discussing these highly integrated arrangements with people who operate within them, the Work Group has reached the conclusion that they can be ideally suited for delivering person centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. Although the underlying payment approaches were not sufficiently distinct to warrant the creation of a separate subcategory for highly integrated payment and delivery systems, the Work Group believes that these arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to quality and value incentives.

Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care. Nevertheless, the Work Group recognizes that not every market currently is suited to support APMs in Category 4, and that the journey to Category 4 will occur along different trajectories in different markets, based in significant part on the organization of care delivery systems.

Conclusion

As set forth in this document, the Work Group is committed to the concept that transitioning from FFS to population based payments is critical for health care transformation. Keeping in mind the underlying principles, the APM Framework provides a high level mapping of payment approaches, as well as a pathway for payment reform and a foundation for measuring progress. The Work Group envisions that these mappings will be useful for all stakeholders and prove enduring as they navigate the health care ecosystem.

While the Work Group believes that this Framework identifies and encompasses all models of payment reform and will be enduring, Work Group members hope to return to the White Paper at a later date to take into account new developments in the health care sector. Nevertheless, the Work Group intends the APM Framework to be robust enough to accommodate foreseeable changes, and it strongly believes that this should become the overarching framework for discussing and evaluating payments in the U.S. health care system. The LAN intends to continue compiling and periodically releasing case studies of payment models. (See APM Framework White Paper Addendum.) The Work Group believes this is important because it will disseminate lessons learned and provide the nation with models to consider as public and private plans align around common payment approaches.

Stakeholders and the APM Framework

Patient Advocacy Groups can use the APM Framework to understand the context behind plan and benefit design so that they can identify and communicate desirable elements and become empowered to participate in decisions about how to design payment plans and delivery systems.

Providers can use the APM Framework to make sense of the types of payment reforms underway, to achieve a better understanding of where they are situated, to begin to conceive of where they might like to end up, and—most importantly—to plan for the future.

Plans can use the APM Framework to drive payment and contracting models and as an accounting tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important, because adopting a common classification scheme would represent a first step towards the alignment of payment approaches.

Purchasers can use the APM Framework to engage and educate their employees about the health insurance landscape and to share information for population based plans, along with the safeguards and benefits that would tip them towards enrolling in such plans.

Appendix A: Work Group Members and Staff

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CAMH, sponsored by CMS, is an FFRDC operated by The MITRE Corporation. MITRE is chartered to work in the public interest.

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CPR is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S.

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Attachment B
Table 1
Positive QS(i) and IS(i) - Score Values for Lookup

Exhibit D, VBP, Attachment B - QIS Lookup Table

Horizontal Axis

Vertical Axis	0.01	0.02	0.03	0.04	0.05	0.06	0.07	0.08	0.09	0.10	0.11	0.12	0.13	0.14	0.15	0.16	0.17	0.18	0.19	0.20	0.21	0.22	0.23	0.24	0.25	0.26	0.27	0.28	0.29	0.30	0.31	0.32	0.33	0.34	0.35	0.36	0.37	0.38	0.39	0.40	0.41	0.42	0.43	0.44	0.45	0.46	0.47	0.48	0.49	0.50	0.51	0.52	0.53	0.54	0.55	0.56	0.57	0.58	0.59	0.60	0.61	0.62	0.63	0.64	0.65	0.66	0.67	0.68	0.69	0.70	0.71	0.72	0.73	0.74	0.75	0.76	0.77	0.78	0.79	0.80	0.81	0.82	0.83	0.84	0.85	0.86	0.87	0.88	0.89	0.90	0.91	0.92	0.93	0.94	0.95	0.96	0.97	0.98	0.99	1.00
0.01	1.52	1.93	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.02	0.92	1.52	1.81	1.93	1.97	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.03	0.64	1.17	1.52	1.74	1.86	1.93	1.96	1.98	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.04	0.49	0.92	1.27	1.52	1.70	1.81	1.88	1.93	1.96	1.97	1.98	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.05	0.39	0.76	1.07	1.33	1.52	1.67	1.77	1.84	1.89	1.93	1.95	1.97	1.98	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.06	0.33	0.64	0.92	1.17	1.36	1.52	1.65	1.74	1.81	1.86	1.90	1.93	1.95	1.96	1.97	1.98	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.07	0.28	0.56	0.81	1.03	1.23	1.39	1.52	1.63	1.72	1.78	1.83	1.87	1.90	1.93	1.95	1.96	1.97	1.98	1.98	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.08	0.25	0.49	0.72	0.92	1.11	1.27	1.41	1.52	1.62	1.70	1.76	1.81	1.85	1.88	1.91	1.93	1.94	1.96	1.97	1.97	1.98	1.98	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.09	0.22	0.44	0.64	0.83	1.01	1.17	1.30	1.42	1.52	1.61	1.68	1.74	1.79	1.83	1.86	1.89	1.91	1.93	1.94	1.95	1.96	1.97	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.10	0.20	0.39	0.58	0.76	0.92	1.07	1.21	1.33	1.43	1.52	1.60	1.67	1.72	1.77	1.81	1.84	1.87	1.89	1.91	1.93	1.94	1.95	1.96	1.97	1.97	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.11	0.18	0.36	0.53	0.70	0.85	0.99	1.12	1.24	1.35	1.44	1.52	1.59	1.66	1.71	1.75	1.79	1.83	1.85	1.88	1.90	1.91	1.93	1.94	1.95	1.96	1.96	1.97	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.12	0.17	0.33	0.49	0.64	0.79	0.92	1.05	1.17	1.27	1.36	1.45	1.52	1.59	1.65	1.70	1.74	1.78	1.81	1.84	1.86	1.88	1.90	1.92	1.93	1.94	1.95	1.96	1.96	1.97	1.97	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.13	0.15	0.31	0.45	0.60	0.73	0.86	0.98	1.10	1.20	1.29	1.38	1.45	1.52	1.58	1.64	1.69	1.73	1.76	1.80	1.82	1.85	1.87	1.89	1.90	1.92	1.93	1.94	1.95	1.95	1.96	1.97	1.97	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.14	0.14	0.28	0.42	0.56	0.69	0.81	0.92	1.03	1.13	1.23	1.31	1.39	1.46	1.52	1.58	1.63	1.68	1.72	1.75	1.78	1.81	1.83	1.86	1.87	1.89	1.90	1.92	1.93	1.94	1.95	1.95	1.96	1.96	1.97	1.97	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.15	0.13	0.27	0.39	0.52	0.64	0.76	0.87	0.98	1.07	1.17	1.25	1.33	1.40	1.46	1.52	1.58	1.62	1.67	1.71	1.74	1.77	1.80	1.82	1.84	1.86	1.88	1.89	1.91	1.92	1.93	1.94	1.94	1.95	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.16	0.12	0.25	0.37	0.49	0.61	0.72	0.82	0.92	1.02	1.11	1.19	1.27	1.34	1.41	1.47	1.52	1.57	1.62	1.66	1.70	1.73	1.76	1.79	1.81	1.83	1.85	1.87	1.88	1.90	1.91	1.92	1.93	1.94	1.94	1.95	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.17	0.12	0.23	0.35	0.46	0.57	0.68	0.78	0.88	0.97	1.06	1.14	1.22	1.29	1.35	1.42	1.47	1.52	1.57	1.61	1.65	1.69	1.72	1.75	1.78	1.80	1.82	1.84	1.86	1.87	1.89	1.90	1.91	1.92	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.18	0.11	0.22	0.33	0.44	0.54	0.64	0.74	0.83	0.92	1.01	1.09	1.17	1.24	1.30	1.36	1.42	1.47	1.52	1.57	1.61	1.65	1.68	1.71	1.74	1.77	1.79	1.81	1.83	1.85	1.86	1.88	1.89	1.90	1.91	1.92	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.19	0.11	0.21	0.31	0.41	0.51	0.61	0.71	0.80	0.88	0.97	1.04	1.12	1.19	1.25	1.32	1.37	1.43	1.48	1.52	1.57	1.60	1.64	1.67	1.70	1.73	1.76	1.78	1.80	1.82	1.84	1.85	1.87	1.88	1.89	1.90	1.91	1.92	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.20	0.10	0.20	0.30	0.39	0.49	0.58	0.67	0.76	0.84	0.92	1.00	1.07	1.14	1.21	1.27	1.33	1.38	1.43	1.48	1.52	1.56	1.60	1.64	1.67	1.70	1.72	1.75	1.77	1.79	1.81	1.83	1.84	1.86	1.87	1.88	1.89	1.90	1.91	1.92	1.93	1.93	1.94	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.21	0.10	0.19	0.28	0.38	0.47	0.56	0.64	0.73	0.81	0.89	0.96	1.03	1.10	1.17	1.23	1.28	1.34	1.39	1.44	1.48	1.52	1.56	1.60	1.63	1.66	1.69	1.72	1.74	1.76	1.78	1.80	1.82	1.83	1.85	1.86	1.87	1.89	1.90	1.90	1.91	1.92	1.93	1.93	1.94	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.22	0.09	0.18	0.27	0.36	0.45	0.53	0.62	0.70	0.78	0.85	0.92	0.99	1.06	1.12	1.19	1.24	1.30	1.35	1.40	1.44	1.48	1.52	1.56	1.59	1.63	1.66	1.68	1.71	1.73	1.75	1.77	1.79	1.81	1.83	1.84	1.85	1.87	1.88	1.89	1.90	1.91	1.91	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.23	0.09	0.17	0.26	0.34	0.43	0.51	0.59	0.67	0.74	0.82	0.89	0.96	1.02	1.09	1.15	1.20	1.26	1.31	1.36	1.40	1.45	1.49	1.52	1.56	1.59	1.62	1.65	1.68	1.70	1.73	1.75	1.77	1.79	1.80	1.82	1.83	1.85	1.86	1.87	1.88	1.89	1.90	1.91	1.91	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.24	0.08	0.17	0.25	0.33	0.41	0.49	0.57	0.64	0.72	0.79	0.86	0.92	0.99	1.05	1.11	1.17	1.22	1.27	1.32	1.36	1.41	1.45	1.49	1.52	1.56	1.59	1.62	1.65	1.67	1.70	1.72	1.74	1.76	1.78	1.79	1.81	1.82	1.84	1.85	1.86	1.87	1.88	1.89	1.90	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.25	0.08	0.16	0.24	0.32	0.39	0.47	0.55	0.62	0.69	0.76	0.83	0.89	0.96	1.02	1.07	1.13	1.18	1.23	1.28	1.33	1.37	1.41	1.45	1.49	1.52	1.56	1.59	1.62	1.64	1.67	1.69	1.71	1.73	1.75	1.77	1.79	1.80	1.82	1.83	1.84	1.85	1.87	1.88	1.89	1.89	1.90	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.26	0.08	0.15	0.23	0.31	0.38	0.45	0.53	0.60	0.67	0.73	0.80	0.86	0.92	0.98	1.04	1.10	1.15	1.20	1.25	1.29	1.34	1.38	1.42	1.45	1.49	1.52	1.55	1.58	1.61	1.64	1.66	1.69	1.71	1.73	1.75	1.76	1.78	1.80	1.81	1.82	1.84	1.85	1.86	1.87	1.88	1.89	1.90	1.90	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.27	0.07	0.15	0.22	0.29	0.37	0.44	0.51	0.58	0.64	0.71	0.77	0.83	0.89	0.95	1.01	1.06	1.12	1.17	1.21	1.26	1.30	1.34	1.38	1.42	1.46	1.49	1.52	1.55	1.58	1.61	1.63	1.66	1.68	1.70	1.72	1.74	1.76	1.77	1.79	1.80	1.82	1.83	1.84	1.85	1.86	1.87	1.88	1.89	1.90	1.90	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.28	0.07	0.14	0.21	0.28	0.35	0.42	0.49	0.56	0.62	0.69	0.75	0.81	0.87	0.92	0.98	1.03	1.08	1.13	1.18	1.23	1.27	1.31	1.35	1.39	1.43	1.46	1.49	1.52	1.55	1.58	1.61	1.63	1.65	1.68	1.70	1.72	1.73	1.75	1.77	1.78	1.80	1.81	1.82	1.83	1.85	1.86	1.87	1.87	1.88	1.89	1.90	1.90	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00	2.00	2.00	2.00
0.29	0.07	0.14	0.21	0.27	0.34	0.41	0.47	0.54	0.60	0.66	0.72	0.78	0.84	0.90	0.95	1.00	1.05	1.10	1.15	1.20	1.24	1.28	1.32	1.36	1.39	1.43	1.46	1.49	1.52	1.55	1.58	1.60	1.63	1.65	1.67	1.69	1.71	1.73	1.75	1.76	1.78	1.79	1.80	1.82	1.83	1.84	1.85	1.86	1.87	1.88	1.88	1.89	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	2.00	2.00	2.00	2.00
0.30	0.07	0.13	0.20	0.27	0.33	0.39	0.46	0.52	0.58	0.64	0.70	0.76	0.82	0.87	0.92	0.98	1.03	1.07	1.12	1.17	1.21	1.25	1.29	1.33	1.36	1.40	1.43	1.46	1.49	1.52	1.55	1.58	1.60	1.62	1.65	1.67	1.69	1.71	1.72	1.74	1.76	1.77	1.78	1.80	1.81	1.82	1.83	1.84	1.85	1.86	1.87	1.88	1.89	1.89	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99
0.31	0.06	0.13	0.19	0.26	0.32	0.38	0.44	0.50	0.56	0.62	0.68	0.74	0.79	0.85	0.90	0.95	1.00	1.05	1.09	1.14	1.18	1.22	1.26	1.30	1.34	1.37	1.40	1.44	1.47	1.50	1.52	1.55	1.57	1.60	1.62	1.64	1.66	1.68	1.70	1.72	1.73	1.75	1.77	1.78	1.79	1.80	1.82	1.83	1.84	1.85	1.86	1.87	1.87	1.88	1.89	1.89	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99
0.32	0.06	0.12	0.19	0.25	0.31	0.37	0.43	0.49	0.55	0.61	0.66	0.72	0.77	0.82	0.87	0.92	0.97	1.02	1.07	1.11	1.15	1.19	1.23	1.27	1.31	1.34	1.38	1.41	1.44	1.47	1.50	1.52	1.55	1.57	1.60	1.62	1.64	1.66	1.68	1.70	1.71	1.73	1.75	1.76	1.77	1.79	1.80	1.81	1.82	1.83	1.84	1.85	1.86	1.87	1.88	1.88	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99
0.33	0.06	0.12	0.18	0.24	0.30	0.36	0.42	0.48	0.53	0.59	0.64	0.70	0.75	0.80	0.85	0.90	0.95	0.99	1.04	1.08	1.12	1.17	1.20	1.24	1.28	1.31	1.35	1.38	1.41	1.44	1.47	1.50	1.52	1.55	1.57	1.59	1.62	1.64	1.66	1.67	1.69	1.71	1.73	1.74	1.75	1.77	1.78	1.79	1.80	1.82	1.83	1.84	1.85	1.85	1.86	1.87	1.88	1.88	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99	1.99	1.99
0.34	0.06	0.12	0.18	0.23	0.29	0.35	0.41	0.46	0.52	0.57	0.63	0.68	0.73	0.78	0.83	0.88	0.92	0.97	1.01	1.06	1.10	1.14	1.18	1.22	1.25	1.29	1.32	1.35	1.39	1.42	1.44	1.47	1.50	1.52	1.55	1.57	1.59	1.61	1.63	1.65	1.67	1.69	1.70	1.72	1.74	1.75	1.76	1.78	1.79	1.80	1.81	1.82	1.83	1.84	1.85	1.86	1.86	1.87	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99	1.99	1.99	1.99
0.35	0.06	0.11	0.17	0.23	0.28	0.34	0.39	0.45	0.50	0.56	0.61	0.66	0.71	0.76	0.81	0.86	0.90	0.95	0.99	1.03	1.07	1.11	1.15	1.19	1.23	1.26	1.30	1.33	1.36	1.39	1.42	1.45	1.47	1.50	1.52	1.55	1.57	1.59	1.61	1.63	1.65	1.67	1.68	1.70	1.72	1.73	1.74	1.76	1.77	1.78	1.79	1.81	1.82	1.83	1.83	1.84	1.85	1.86	1.87	1.87	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.99	1.99	1.99
0.36	0.06	0.11	0.17	0.22	0.28	0.33	0.38	0.44	0.49	0.54	0.59	0.64	0.69	0.74	0.79	0.83	0.88	0.92	0.97	1.01	1.05	1.09	1.13	1.17	1.20	1.24	1.27	1.30	1.33	1.36	1.39	1.42	1.45	1.47	1.50	1.52	1.55	1.57	1.59	1.61	1.63	1.65	1.66	1.68	1.70	1.71	1.73	1.74	1.75	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.84	1.85	1.85	1.86	1.87	1.88	1.88	1.89	1.89	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98	1.98
0.37	0.05	0.11	0.16	0.22	0.27	0.32	0.37	0.43	0.48	0.53	0.58	0.63	0.68	0.72	0.77	0.81	0.86	0.90	0.95	0.99	1.03	1.07	1.10	1.14	1.18	1.21	1.25	1.28	1.31	1.34	1.37	1.40	1.42	1.45	1.48	1.50	1.52	1.55	1.57	1.59	1.61	1.63	1.64	1.66	1.68	1.69	1.71	1.72	1.74	1.75	1.76	1.77	1.78	1.80	1.81	1.82	1.82	1.83	1.84	1.85	1.86	1.86	1.87	1.88	1.88	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.94	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98	1.98	1.98	1.98
0.38	0.05	0.11	0.16	0.21	0.26	0.31	0.36	0.41	0.47	0.51	0.56	0.61	0.66	0.71	0.75	0.80	0.84	0.88	0.92	0.97	1.00	1.04	1.08	1.12	1.15	1.19	1.22	1.25	1.29	1.32	1.35	1.37	1.40	1.43	1.45	1.48	1.50	1.52	1.54	1.57	1.59	1.60	1.62	1.64	1.66	1.67	1.69	1.70	1.72	1.73	1.74	1.76	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.84	1.84	1.85	1.86	1.87	1.87	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.94	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98	1.98	1.98
0.39	0.05	0.10	0.15	0.20	0.26	0.31	0.36	0.40	0.45	0.50	0.55	0.60	0.64	0.69	0.73	0.78	0.82	0.86	0.90	0.94	0.98	1.02	1.06	1.10	1.13	1.17	1.20	1.23	1.26	1.29	1.32	1.35	1.38	1.40	1.43	1.45	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.64	1.65	1.67	1.69	1.70	1.71	1.73	1.74	1.75	1.76	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.84	1.85	1.86	1.86	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97	1.98	1.98
0.40	0.05	0.10	0.15	0.20	0.25	0.30	0.35	0.39	0.44	0.49	0.54	0.58	0.63	0.67	0.72	0.76	0.80	0.84	0.88	0.92	0.96	1.00	1.04	1.07	1.11	1.14	1.18	1.21	1.24	1.27	1.30	1.33	1.36	1.38	1.41	1.43	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.64	1.65	1.67	1.68	1.70	1.71	1.72	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.84	1.84	1.85	1.86	1.86	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97	1.97	1.97
0.41	0.05	0.10	0.15	0.19	0.24	0.29	0.34	0.39	0.43	0.48	0.52	0.57	0.61	0.66	0.70	0.74	0.78	0.83	0.87	0.90	0.94	0.98	1.02	1.05	1.09	1.12	1.15	1.19	1.22	1.25	1.28	1.31	1.33	1.36	1.39	1.41	1.43	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.62	1.63	1.65	1.66	1.68	1.69	1.71	1.72	1.73	1.74	1.76	1.77	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.84	1.85	1.85	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.97	1.97	1.97	1.97
0.42	0.05	0.10	0.14	0.19	0.24	0.28	0.33	0.38	0.42	0.47	0.51	0.56	0.60	0.64	0.69	0.73	0.77	0.81	0.85	0.89	0.92	0.96	1.00	1.03	1.07	1.10	1.13	1.17	1.20	1.23	1.26	1.28	1.31	1.34	1.36	1.39	1.41	1.44	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.61	1.63	1.65	1.66	1.68	1.69	1.70	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.83	1.84	1.85	1.86	1.86	1.87	1.87	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96	1.96	1.96	1.97
0.43	0.05	0.09	0.14	0.19	0.23	0.28	0.32	0.37	0.41	0.46	0.50	0.54	0.59	0.63	0.67	0.71	0.75	0.79	0.83	0.87	0.91	0.94	0.98	1.01	1.05	1.08	1.11	1.14	1.18	1.21	1.23	1.26	1.29	1.32	1.34	1.37	1.39	1.42	1.44	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.60	1.61	1.63	1.64	1.66	1.67	1.69	1.70	1.71	1.72	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.84	1.84	1.85	1.86	1.86	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.95	1.96	1.96	1.96	1.96
0.44	0.05	0.09	0.14	0.18	0.23	0.27	0.32	0.36	0.40	0.45	0.49	0.53	0.57	0.62	0.66	0.70	0.74	0.78	0.81	0.85	0.89	0.92	0.96	0.99	1.03	1.06	1.09	1.12	1.16	1.19	1.21	1.24	1.27	1.30	1.32	1.35	1.37	1.40	1.42	1.44	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.59	1.61	1.63	1.64	1.66	1.67	1.68	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.82	1.83	1.83	1.84	1.85	1.85	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.94	1.95	1.95	1.95	1.95	1.96	1.96
0.45	0.04	0.09	0.13	0.18	0.22	0.27	0.31	0.35	0.39	0.44	0.48	0.52	0.56	0.60	0.64	0.68	0.72	0.76	0.80	0.83	0.87	0.91	0.94	0.98	1.01	1.04	1.07	1.11	1.14	1.17	1.19	1.22	1.25	1.28	1.30	1.33	1.35	1.38	1.40	1.42	1.44	1.46	1.48	1.50	1.52	1.54	1.56	1.58	1.59	1.61	1.62	1.64	1.65	1.67	1.68	1.69	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.84	1.84	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.94	1.95	1.95	1.95	1.95
0.46	0.04	0.09	0.13	0.17	0.22	0.26	0.30	0.34	0.39	0.43	0.47	0.51	0.55	0.59	0.63	0.67	0.71	0.74	0.78	0.82	0.85	0.89	0.92	0.96	0.99	1.02	1.06	1.09	1.12	1.15	1.18	1.20	1.23	1.26	1.28	1.31	1.33	1.36	1.38	1.40	1.42	1.45	1.47	1.49	1.50	1.52	1.54	1.56	1.58	1.59	1.61	1.62	1.64	1.65	1.66	1.68	1.69	1.70	1.71	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.79	1.80	1.81	1.82	1.83	1.83	1.84	1.85	1.85	1.86	1.86	1.87	1.88	1.88	1.89	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.94	1.95	1.95
0.47	0.04	0.09	0.13	0.17	0.21	0.25	0.30	0.34	0.38	0.42	0.46	0.50	0.54	0.58	0.62	0.66	0.69	0.73	0.77	0.80	0.84	0.87	0.91	0.94	0.97	1.01	1.04	1.07	1.10	1.13	1.16	1.18	1.21	1.24	1.26	1.29	1.31	1.34	1.36	1.38	1.41	1.43	1.45	1.47	1.49	1.51	1.52	1.54	1.56	1.57	1.59	1.61	1.62	1.63	1.65	1.66	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.84	1.84	1.85	1.85	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.94	1.94	1.94	1.94
0.48	0.04	0.08	0.12	0.17	0.21	0.25	0.29	0.33	0.37	0.41	0.45	0.49	0.53	0.57	0.61	0.64	0.68	0.72	0.75	0.79	0.82	0.86	0.89	0.92	0.96	0.99	1.02	1.05	1.08	1.11	1.14	1.17	1.19	1.22	1.25	1.27	1.29	1.32	1.34	1.36	1.39	1.41	1.43	1.45	1.47	1.49	1.51	1.52	1.54	1.56	1.57	1.59	1.60	1.62	1.63	1.65	1.66	1.67	1.68	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.79	1.80	1.81	1.82	1.82	1.83	1.84	1.84	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.93	1.94	1.94
0.49	0.04	0.08	0.12	0.16	0.20	0.24	0.28	0.32	0.36	0.40	0.44	0.48	0.52	0.56	0.59	0.63	0.67	0.70	0.74	0.77	0.81	0.84	0.88	0.91	0.94	0.97	1.00	1.03	1.06	1.09	1.12	1.15	1.17	1.20	1.23	1.25	1.28	1.30	1.32	1.35	1.37	1.39	1.41	1.43	1.45	1.47	1.49	1.51	1.52	1.54	1.56	1.57	1.59	1.60	1.62	1.63	1.64	1.66	1.67	1.68	1.69	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.77	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91	1.92	1.92	1.92	1.93	1.93	1.93	1.93
0.50	0.04	0.08	0.12	0.16	0.20	0.24	0.28	0.32	0.36	0.39	0.43	0.47	0.51	0.55	0.58	0.62	0.65	0.69	0.73	0.76	0.79	0.83	0.86	0.89	0.92	0.96	0.99	1.02	1.05	1.07	1.10	1.13	1.16	1.18	1.21	1.23	1.26	1.28	1.31	1.33	1.35	1.37	1.39	1.41	1.43	1.45	1.47	1.49	1.51	1.52	1.54	1.56	1.57	1.59	1.60	1.62	1.63	1.64	1.65	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.84	1.84	1.85	1.85	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92	1.93	1.93
0.51	0.04	0.08	0.12	0.16	0.20	0.23	0.27	0.31	0.35	0.39	0.42	0.46	0.50	0.54	0.57	0.61	0.64	0.68	0.71	0.75	0.78	0.81	0.85	0.88	0.91	0.94	0.97	1.00	1.03	1.06	1.09	1.11	1.14	1.17	1.19	1.22	1.24	1.26	1.29	1.31	1.33	1.35	1.37	1.40	1.42	1.43	1.45	1.47	1.49	1.51	1.52	1.54	1.56	1.57	1.59	1.60	1.61	1.63	1.64	1.65	1.66	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.89	1.90	1.90	1.91	1.91	1.91	1.92	1.92	1.92
0.52	0.04	0.08	0.12	0.15	0.19	0.23	0.27	0.31	0.34	0.38	0.42	0.45	0.49	0.53	0.56	0.60	0.63	0.67	0.70	0.73	0.77	0.80	0.83	0.86	0.89	0.92	0.95	0.98	1.01	1.04	1.07	1.10	1.12	1.15	1.17	1.20	1.22	1.25	1.27	1.29	1.32	1.34	1.36	1.38	1.40	1.42	1.44	1.45	1.47	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.60	1.61	1.63	1.64	1.65	1.66	1.67	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.76	1.77	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91	1.91	1.92
0.53	0.04	0.08	0.11	0.15	0.19	0.23	0.26	0.30	0.34	0.37	0.41	0.45	0.48	0.52	0.55	0.59	0.62	0.65	0.69	0.72	0.75	0.79	0.82	0.85	0.88	0.91	0.94	0.97	1.00	1.02	1.05	1.08	1.11	1.13	1.16	1.18	1.21	1.23	1.25	1.28	1.30	1.32	1.34	1.36	1.38	1.40	1.42	1.44	1.46	1.47	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.60	1.61	1.62	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.78	1.78	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.84	1.85	1.86	1.86	1.87	1.87	1.87	1.88	1.88	1.89	1.89	1.90	1.90	1.90	1.91	1.91
0.54	0.04	0.07	0.11	0.15	0.18	0.22	0.26	0.29	0.33	0.37	0.40	0.44	0.47	0.51	0.54	0.58	0.61	0.64	0.68	0.71	0.74	0.77	0.80	0.83	0.86	0.89	0.92	0.95	0.98	1.01	1.04	1.06	1.09	1.12	1.14	1.17	1.19	1.21	1.24	1.26	1.28	1.30	1.32	1.34	1.36	1.38	1.40	1.42	1.44	1.46	1.47	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.60	1.61	1.62	1.63	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.77	1.77	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.88	1.89	1.89	1.90	1.90	1.90
0.55	0.04	0.07	0.11	0.15	0.18	0.22	0.25	0.29	0.32	0.36	0.39	0.43	0.46	0.50	0.53	0.57	0.60	0.63	0.66	0.70	0.73	0.76	0.79	0.82	0.85	0.88	0.91	0.94	0.97	0.99	1.02	1.05	1.07	1.10	1.12	1.15	1.17	1.20	1.22	1.24	1.26	1.29	1.31	1.33	1.35	1.37	1.39	1.41	1.42	1.44	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.59	1.61	1.62	1.63	1.64	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.75	1.76	1.77	1.78	1.79	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.89	1.89	1.89	1.90
0.56	0.04	0.07	0.11	0.14	0.18	0.21	0.25	0.28	0.32	0.35	0.39	0.42	0.46	0.49	0.52	0.56	0.59	0.62	0.65	0.69	0.72	0.75	0.78	0.81	0.84	0.87	0.90	0.92	0.95	0.98	1.01	1.03	1.06	1.08	1.11	1.13	1.16	1.18	1.20	1.23	1.25	1.27	1.29	1.31	1.33	1.35	1.37	1.39	1.41	1.43	1.44	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.59	1.61	1.62	1.63	1.64	1.65	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.76	1.77	1.78	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.83	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.87	1.88	1.88	1.89	1.89
0.57	0.04	0.07	0.11	0.14	0.17	0.21	0.24	0.28	0.31	0.35	0.38	0.41	0.45	0.48	0.51	0.55	0.58	0.61	0.64	0.67	0.71	0.74	0.77	0.80	0.82	0.85	0.88	0.91	0.94	0.97	0.99	1.02	1.04	1.07	1.09	1.12	1.14	1.17	1.19	1.21	1.23	1.25	1.28	1.30	1.32	1.34	1.36	1.37	1.39	1.41	1.43	1.44	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.57	1.58	1.59	1.60	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.76	1.76	1.77	1.78	1.79	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88	1.88	1.88
0.58	0.03	0.07	0.10	0.14	0.17	0.21	0.24	0.27	0.31	0.34	0.37	0.41	0.44	0.47	0.51	0.54	0.57	0.60	0.63	0.66	0.69	0.72	0.75	0.78	0.81	0.84	0.87	0.90	0.92	0.95	0.98	1.00	1.03	1.05	1.08	1.10	1.13	1.15	1.17	1.20	1.22	1.24	1.26	1.28	1.30	1.32	1.34	1.36	1.38	1.39	1.41	1.43	1.45	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.56	1.58	1.59	1.60	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.75	1.76	1.77	1.78	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87	1.88
0.59	0.03	0.07	0.10	0.14	0.17	0.20	0.24	0.27	0.30	0.34	0.37	0.40	0.43	0.47	0.50	0.53	0.56	0.59	0.62	0.65	0.68	0.71	0.74	0.77	0.80	0.83	0.86	0.88	0.91	0.94	0.96	0.99	1.01	1.04	1.06	1.09	1.11	1.14	1.16	1.18	1.20	1.22	1.24	1.27	1.29	1.31	1.32	1.34	1.36	1.38	1.40	1.41	1.43	1.45	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.56	1.58	1.59	1.60	1.61	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.76	1.77	1.77	1.78	1.79	1.79	1.80	1.81	1.81	1.82	1.83	1.83	1.84	1.84	1.85	1.85	1.86	1.86	1.87	1.87
0.60	0.03	0.07	0.10	0.13	0.17	0.20	0.23	0.27	0.30	0.33	0.36	0.39	0.43	0.46	0.49	0.52	0.55	0.58	0.61	0.64	0.67	0.70	0.73	0.76	0.79	0.82	0.84	0.87	0.90	0.92	0.95	0.98	1.00	1.03	1.05	1.07	1.10	1.12	1.14	1.17	1.19	1.21	1.23	1.25	1.27	1.29	1.31	1.33	1.35	1.36	1.38	1.40	1.42	1.43	1.45	1.46	1.48	1.49	1.51	1.52	1.54	1.55	1.56	1.58	1.59	1.60	1.61	1.62	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.71	1.72	1.73	1.74	1.75	1.76	1.76	1.77	1.78	1.78	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.83	1.84	1.84	1.85	1.85	1.86	1.86
0.61	0.03	0.07	0.10	0.13	0.16	0.20	0.23	0.26	0.29	0.32	0.36	0.39	0.42	0.45	0.48	0.51	0.54	0.57	0.60	0.63	0.66	0.69	0.72	0.75	0.78	0.80	0.83	0.86	0.89	0.91	0.94	0.96	0.99	1.01	1.04	1.06	1.08	1.11	1.13	1.15	1.17	1.19	1.21	1.24	1.26	1.28	1.29	1.31	1.33	1.35	1.37	1.38	1.40	1.42	1.43	1.45	1.47	1.48	1.49	1.51	1.52	1.54	1.55	1.56	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.66	1.67	1.68	1.68	1.69	1.70	1.71	1.72	1.73	1.74	1.75	1.75	1.76	1.77	1.77	1.78	1.79	1.79	1.80	1.81	1.81	1.82	1.82	1.83	1.84	1.84	1.85	1.85	1.85
0.62	0.03	0.06	0.10	0.13	0.16	0.19	0.22	0.26	0.29	0.32	0.35	0.38	0.41	0.44	0.47	0.50	0.54	0.56	0.59	0.62	0.65	0.68	0.71	0.74	0.77	0.79	0.82	0.85	0.87	0.90	0.92	0.95	0.97	1.00	1.02	1.05	1.07	1.09	1.11	1.14	1.16	1.18	1.20	1.22	1.24	1.26	1.28	1.30	1.32	1.34	1.35	1.37	1.39	1.40	1.42	1.44	1.45	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.76	1.77	1.77	1.78	1.79	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.83	1.84	1.84	1.85
0.63	0.03	0.06	0.10	0.13	0.16	0.19	0.22	0.25	0.28	0.31	0.35	0.38	0.41	0.44	0.47	0.50	0.53	0.56	0.59	0.61	0.64	0.67	0.70	0.73	0.75	0.78	0.81	0.83	0.86	0.89	0.91	0.94	0.96	0.99	1.01	1.03	1.06	1.08	1.10	1.12	1.14	1.17	1.19	1.21	1.23	1.25	1.27	1.28	1.30	1.32	1.34	1.36	1.37	1.39	1.41	1.42	1.44	1.45	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.72	1.72	1.73	1.74	1.75	1.76	1.76	1.77	1.78	1.78	1.79	1.80	1.80	1.81	1.81	1.82	1.82	1.83	1.83	1.84
0.64	0.03	0.06	0.09	0.12	0.16	0.19	0.22	0.25	0.28	0.31	0.34	0.37	0.40	0.43	0.46	0.49	0.52	0.55	0.58	0.61	0.63	0.66	0.69	0.72	0.74	0.77	0.80	0.82	0.85	0.87	0.90	0.92	0.95	0.97	1.00	1.02	1.04	1.07	1.09	1.11	1.13	1.15	1.17	1.19	1.21	1.23	1.25	1.27	1.29	1.31	1.32	1.34	1.36	1.38	1.39	1.41	1.42	1.44	1.45	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.71	1.72	1.73	1.74	1.75	1.75	1.76	1.77	1.77	1.78	1.79	1.79	1.80	1.80	1.81	1.82	1.82	1.83	1.83
0.65	0.03	0.06	0.09	0.12	0.15	0.18	0.21	0.24	0.28	0.31	0.34	0.37	0.39	0.42	0.45	0.48	0.51	0.54	0.57	0.60	0.62	0.65	0.68	0.71	0.73	0.76	0.79	0.81	0.84	0.86	0.89	0.91	0.94	0.96	0.98	1.01	1.03	1.05	1.07	1.10	1.12	1.14	1.16	1.18	1.20	1.22	1.24	1.26	1.27	1.29	1.31	1.33	1.35	1.36	1.38	1.39	1.41	1.43	1.44	1.45	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.72	1.73	1.74	1.74	1.75	1.76	1.76	1.77	1.78	1.78	1.79	1.80	1.80	1.81	1.81	1.82	1.82
0.66	0.03	0.06	0.09	0.12	0.15	0.18	0.21	0.24	0.27	0.30	0.33	0.36	0.39	0.42	0.45	0.48	0.50	0.53	0.56	0.59	0.62	0.64	0.67	0.70	0.72	0.75	0.78	0.80	0.83	0.85	0.88	0.90	0.92	0.95	0.97	0.99	1.02	1.04	1.06	1.08	1.10	1.12	1.15	1.17	1.19	1.20	1.22	1.24	1.26	1.28	1.30	1.31	1.33	1.35	1.36	1.38	1.40	1.41	1.43	1.44	1.46	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.59	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.67	1.68	1.69	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.75	1.76	1.77	1.77	1.78	1.79	1.79	1.80	1.80	1.81	1.82
0.67	0.03	0.06	0.09	0.12	0.15	0.18	0.21	0.24	0.27	0.30	0.33	0.35	0.38	0.41	0.44	0.47	0.50	0.52	0.55	0.58	0.61	0.63	0.66	0.69	0.71	0.74	0.77	0.79	0.82	0.84	0.86	0.89	0.91	0.94	0.96	0.98	1.00	1.03	1.05	1.07	1.09	1.11	1.13	1.15	1.17	1.19	1.21	1.23	1.25	1.27	1.28	1.30	1.32	1.33	1.35	1.37	1.38	1.40	1.41	1.43	1.44	1.46	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.64	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.71	1.71	1.72	1.73	1.74	1.74	1.75	1.76	1.77	1.77	1.78	1.78	1.79	1.80	1.80	1.81
0.68	0.03	0.06	0.09	0.12	0.15	0.18	0.21	0.23	0.26	0.29	0.32	0.35	0.38	0.41	0.43	0.46	0.49	0.52	0.54	0.57	0.60	0.63	0.65	0.68	0.70	0.73	0.75	0.78	0.80	0.83	0.85	0.88	0.90	0.92	0.95	0.97	0.99	1.01	1.04	1.06	1.08	1.10	1.12	1.14	1.16	1.18	1.20	1.22	1.23	1.25	1.27	1.29	1.30	1.32	1.34	1.35	1.37	1.39	1.40	1.42	1.43	1.44	1.46	1.47	1.48	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.70	1.70	1.71	1.72	1.73	1.74	1.74	1.75	1.76	1.76	1.77	1.78	1.78	1.79	1.79	1.80
0.69	0.03	0.06	0.09	0.12	0.14	0.17	0.20	0.23	0.26	0.29	0.32	0.34	0.37	0.40	0.43	0.46	0.48	0.51	0.54	0.56	0.59	0.62	0.64	0.67	0.69	0.72	0.74	0.77	0.79	0.82	0.84	0.87	0.89	0.91	0.94	0.96	0.98	1.00	1.02	1.04	1.07	1.09	1.11	1.13	1.15	1.17	1.18	1.20	1.22	1.24	1.26	1.27	1.29	1.31	1.32	1.34	1.36	1.37	1.39	1.40	1.42	1.43	1.45	1.46	1.47	1.49	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.75	1.76	1.77	1.77	1.78	1.79	1.79
0.70	0.03	0.06	0.09	0.11	0.14	0.17	0.20	0.23	0.26	0.28	0.31	0.34	0.37	0.39	0.42	0.45	0.48	0.50	0.53	0.56	0.58	0.61	0.63	0.66	0.69	0.71	0.74	0.76	0.78	0.81	0.83	0.86	0.88	0.90	0.92	0.95	0.97	0.99	1.01	1.03	1.05	1.07	1.09	1.11	1.13	1.15	1.17	1.19	1.21	1.23	1.24	1.26	1.28	1.30	1.31	1.33	1.34	1.36	1.37	1.39	1.40	1.42	1.43	1.45	1.46	1.47	1.49	1.50	1.51	1.52	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.68	1.69	1.70	1.71	1.72	1.72	1.73	1.74	1.74	1.75	1.76	1.76	1.77	1.78	1.78
0.71	0.03	0.06	0.08	0.11	0.14	0.17	0.20	0.22	0.25	0.28	0.31	0.33	0.36	0.39	0.42	0.44	0.47	0.50	0.52	0.55	0.57	0.60	0.63	0.65	0.68	0.70	0.73	0.75	0.77	0.80	0.82	0.84	0.87	0.89	0.91	0.94	0.96	0.98	1.00	1.02	1.04	1.06	1.08	1.10	1.12	1.14	1.16	1.18	1.20	1.21	1.23	1.25	1.27	1.28	1.30	1.32	1.33	1.35	1.36	1.38	1.39	1.41	1.42	1.43	1.45	1.46	1.47	1.49	1.50	1.51	1.52	1.53	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.67	1.68	1.69	1.70	1.71	1.71	1.72	1.73	1.74	1.74	1.75	1.76	1.76	1.77	1.77
0.72	0.03	0.06	0.08	0.11	0.14	0.17	0.19	0.22	0.25	0.28	0.30	0.33	0.36	0.38	0.41	0.44	0.46	0.49	0.52	0.54	0.57	0.59	0.62	0.64	0.67	0.69	0.72	0.74	0.76	0.79	0.81	0.83	0.86	0.88	0.90	0.92	0.95	0.97	0.99	1.01	1.03	1.05	1.07	1.09	1.11	1.13	1.15	1.17	1.18	1.20	1.22	1.24	1.25	1.27	1.29	1.30	1.32	1.33	1.35	1.36	1.38	1.39	1.41	1.42	1.44	1.45	1.46	1.47	1.49	1.50	1.51	1.52	1.53	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.66	1.67	1.68	1.69	1.70	1.70	1.71	1.72	1.73	1.73	1.74	1.75	1.75	1.76	1.77
0.73	0.03	0.05	0.08	0.11	0.14	0.16	0.19	0.22	0.25	0.27	0.30	0.33	0.35	0.38	0.41	0.43	0.46	0.48	0.51	0.53	0.56	0.59	0.61	0.63	0.66	0.68	0.71	0.73	0.76	0.78	0.80	0.82	0.85	0.87	0.89	0.91	0.93	0.96	0.98	1.00	1.02	1.04	1.06	1.08	1.10	1.12	1.14	1.15	1.17	1.19	1.21	1.22	1.24	1.26	1.27	1.29	1.31	1.32	1.34	1.35	1.37	1.38	1.40	1.41	1.42	1.44	1.45	1.46	1.48	1.49	1.50	1.51	1.52	1.53	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.64	1.65	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.72	1.72	1.73	1.74	1.74	1.75	1.76
0.74	0.03	0.05	0.08	0.11	0.13	0.16	0.19	0.22	0.24	0.27	0.30	0.32	0.35	0.37	0.40	0.43	0.45	0.48	0.50	0.53	0.55	0.58	0.60	0.63	0.65	0.68	0.70	0.72	0.75	0.77	0.79	0.81	0.84	0.86	0.88	0.90	0.92	0.95	0.97	0.99	1.01	1.03	1.05	1.07	1.09	1.10	1.12	1.14	1.16	1.18	1.19	1.21	1.23	1.25	1.26	1.28	1.29	1.31	1.33	1.34	1.35	1.37	1.38	1.40	1.41	1.42	1.44	1.45	1.46	1.48	1.49	1.50	1.51	1.52	1.53	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.63	1.64	1.65	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.71	1.72	1.73	1.74	1.74	1.75
0.75	0.03	0.05	0.08	0.11	0.13	0.16	0.19	0.21	0.24	0.27	0.29	0.32	0.34	0.37	0.39	0.42	0.45	0.47	0.50	0.52	0.55	0.57	0.59	0.62	0.64	0.67	0.69	0.71	0.74	0.76	0.78	0.81	0.83	0.85	0.87	0.89	0.91	0.93	0.96	0.98	1.00	1.02	1.04	1.05	1.07	1.09	1.11	1.13	1.15	1.17	1.18	1.20	1.22	1.23	1.25	1.27	1.28	1.30	1.31	1.33	1.34	1.36	1.37	1.39	1.40	1.41	1.43	1.44	1.45	1.46	1.48	1.49	1.50	1.51	1.52	1.53	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.62	1.63	1.64	1.65	1.66	1.67	1.68	1.68	1.69	1.70	1.71	1.71	1.72	1.73	1.73	1.74
0.76	0.03	0.05	0.08	0.11	0.13	0.16	0.18	0.21	0.24	0.26	0.29	0.31	0.34	0.36	0.39	0.41	0.44	0.47	0.49	0.51	0.54	0.56	0.59	0.61	0.64	0.66	0.68	0.71	0.73	0.75	0.77	0.80	0.82	0.84	0.86	0.88	0.90	0.92	0.94	0.97	0.99	1.00	1.02	1.04	1.06	1.08	1.10	1.12	1.14	1.15	1.17	1.19	1.21	1.22	1.24	1.25	1.27	1.29	1.30	1.32	1.33	1.35	1.36	1.37	1.39	1.40	1.41	1.43	1.44	1.45	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.56	1.57	1.58	1.59	1.60	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.67	1.67	1.68	1.69	1.70	1.70	1.71	1.72	1.72	1.73
0.77	0.03	0.05	0.08	0.10	0.13	0.16	0.18	0.21	0.23	0.26	0.28	0.31	0.33	0.36	0.38	0.41	0.43	0.46	0.48	0.51	0.53	0.56	0.58	0.60	0.63	0.65	0.67	0.70	0.72	0.74	0.76	0.79	0.81	0.83	0.85	0.87	0.89	0.91	0.93	0.95	0.97	0.99	1.01	1.03	1.05	1.07	1.09	1.11	1.12	1.14	1.16	1.18	1.19	1.21	1.23	1.24	1.26	1.27	1.29	1.30	1.32	1.33	1.35	1.36	1.38	1.39	1.40	1.42	1.43	1.44	1.45	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.57	1.58	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.66	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.72	1.72
0.78	0.03	0.05	0.08	0.10	0.13	0.15	0.18	0.20	0.23	0.26	0.28	0.31	0.33	0.36	0.38	0.40	0.43	0.45	0.48	0.50	0.53	0.55	0.57	0.60	0.62	0.64	0.67	0.69	0.71	0.73	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.92	0.94	0.96	0.98	1.00	1.02	1.04	1.06	1.08	1.10	1.11	1.13	1.15	1.17	1.18	1.20	1.22	1.23	1.25	1.26	1.28	1.29	1.31	1.32	1.34	1.35	1.36	1.38	1.39	1.40	1.42	1.43	1.44	1.45	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.65	1.66	1.67	1.68	1.69	1.69	1.70	1.71	1.71
0.79	0.03	0.05	0.08	0.10	0.13	0.15	0.18	0.20	0.23	0.25	0.28	0.30	0.33	0.35	0.38	0.40	0.42	0.45	0.47	0.50	0.52	0.54	0.57	0.59	0.61	0.64	0.66	0.68	0.70	0.72	0.75	0.77	0.79	0.81	0.83	0.85	0.87	0.89	0.91	0.93	0.95	0.97	0.99	1.01	1.03	1.05	1.07	1.08	1.10	1.12	1.14	1.15	1.17	1.19	1.20	1.22	1.24	1.25	1.27	1.28	1.30	1.31	1.33	1.34	1.35	1.37	1.38	1.39	1.41	1.42	1.43	1.44	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.65	1.65	1.66	1.67	1.68	1.68	1.69	1.70	1.71
0.80	0.02	0.05	0.07	0.10	0.12	0.15	0.17	0.20	0.22	0.25	0.27	0.30	0.32	0.35	0.37	0.39	0.42	0.44	0.47	0.49	0.51	0.54	0.56	0.58	0.61	0.63	0.65	0.67	0.69	0.72	0.74	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.92	0.94	0.96	0.98	1.00	1.02	1.04	1.06	1.07	1.09	1.11	1.13	1.14	1.16	1.18	1.19	1.21	1.22	1.24	1.26	1.27	1.29	1.30	1.31	1.33	1.34	1.36	1.37	1.38	1.40	1.41	1.42	1.43	1.44	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.64	1.64	1.65	1.66	1.67	1.67	1.68	1.69	1.70
0.81	0.02	0.05	0.07	0.10	0.12	0.15	0.17	0.20	0.22	0.25	0.27	0.29	0.32	0.34	0.37	0.39	0.41	0.44	0.46	0.48	0.51	0.53	0.55	0.58	0.60	0.62	0.64	0.67	0.69	0.71	0.73	0.75	0.77	0.79	0.81	0.83	0.85	0.88	0.89	0.91	0.93	0.95	0.97	0.99	1.01	1.03	1.05	1.06	1.08	1.10	1.12	1.13	1.15	1.17	1.18	1.20	1.21	1.23	1.24	1.26	1.27	1.29	1.30	1.32	1.33	1.34	1.36	1.37	1.38	1.40	1.41	1.42	1.43	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.63	1.63	1.64	1.65	1.66	1.67	1.67	1.68	1.69
0.82	0.02	0.05	0.07	0.10	0.12	0.15	0.17	0.19	0.22	0.24	0.27	0.29	0.31	0.34	0.36	0.39	0.41	0.43	0.46	0.48	0.50	0.52	0.55	0.57	0.59	0.61	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.78	0.81	0.83	0.85	0.87	0.89	0.90	0.92	0.94	0.96	0.98	1.00	1.02	1.04	1.05	1.07	1.09	1.10	1.12	1.14	1.15	1.17	1.19	1.20	1.22	1.23	1.25	1.26	1.28	1.29	1.31	1.32	1.33	1.35	1.36	1.37	1.39	1.40	1.41	1.42	1.43	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.62	1.63	1.64	1.65	1.66	1.66	1.67	1.68
0.83	0.02	0.05	0.07	0.10	0.12	0.14	0.17	0.19	0.22	0.24	0.26	0.29	0.31	0.33	0.36	0.38	0.40	0.43	0.45	0.47	0.50	0.52	0.54	0.56	0.58	0.61	0.63	0.65	0.67	0.69	0.71	0.74	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.91	0.93	0.95	0.97	0.99	1.01	1.03	1.04	1.06	1.08	1.09	1.11	1.13	1.14	1.16	1.18	1.19	1.21	1.22	1.24	1.25	1.27	1.28	1.30	1.31	1.32	1.34	1.35	1.36	1.38	1.39	1.40	1.41	1.42	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.62	1.62	1.63	1.64	1.65	1.66	1.66	1.67
0.84	0.02	0.05	0.07	0.10	0.12	0.14	0.17	0.19	0.21	0.24	0.26	0.28	0.31	0.33	0.35	0.38	0.40	0.42	0.44	0.47	0.49	0.51	0.53	0.56	0.58	0.60	0.62	0.64	0.66	0.69	0.71	0.73	0.75	0.77	0.79	0.81	0.83	0.85	0.87	0.89	0.91	0.92	0.94	0.96	0.98	1.00	1.02	1.03	1.05	1.07	1.08	1.10	1.12	1.13	1.15	1.17	1.18	1.20	1.21	1.23	1.24	1.26	1.27	1.28	1.30	1.31	1.33	1.34	1.35	1.36	1.38	1.39	1.40	1.41	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.61	1.62	1.63	1.64	1.65	1.65	1.66
0.85	0.02	0.05	0.07	0.09	0.12	0.14	0.16	0.19	0.21	0.23	0.26	0.28	0.30	0.33	0.35	0.37	0.39	0.42	0.44	0.46	0.48	0.51	0.53	0.55	0.57	0.59	0.61	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.91	0.93	0.95	0.97	0.99	1.01	1.02	1.04	1.06	1.07	1.09	1.11	1.12	1.14	1.16	1.17	1.19	1.20	1.22	1.23	1.25	1.26	1.27	1.29	1.30	1.31	1.33	1.34	1.35	1.37	1.38	1.39	1.40	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.61	1.61	1.62	1.63	1.64	1.65	1.65
0.86	0.02	0.05	0.07	0.09	0.12	0.14	0.16	0.19	0.21	0.23	0.25	0.28	0.30	0.32	0.35	0.37	0.39	0.41	0.43	0.46	0.48	0.50	0.52	0.54	0.57	0.59	0.61	0.63	0.65	0.67	0.69	0.71	0.73	0.75	0.77	0.79	0.81	0.83	0.85	0.87	0.89	0.91	0.92	0.94	0.96	0.98	1.00	1.01	1.03	1.05	1.06	1.08	1.10	1.11	1.13	1.14	1.16	1.18	1.19	1.21	1.22	1.23	1.25	1.26	1.28	1.29	1.30	1.32	1.33	1.34	1.36	1.37	1.38	1.39	1.40	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.60	1.61	1.62	1.63	1.64	1.64
0.87	0.02	0.05	0.07	0.09	0.11	0.14	0.16	0.18	0.21	0.23	0.25	0.27	0.30	0.32	0.34	0.36	0.39	0.41	0.43	0.45	0.47	0.50	0.52	0.54	0.56	0.58	0.60	0.62	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.78	0.80	0.82	0.84	0.86	0.88	0.90	0.92	0.93	0.95	0.97	0.99	1.00	1.02	1.04	1.05	1.07	1.09	1.10	1.12	1.13	1.15	1.17	1.18	1.20	1.21	1.22	1.24	1.25	1.27	1.28	1.29	1.31	1.32	1.33	1.35	1.36	1.37	1.38	1.39	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.60	1.60	1.61	1.62	1.63	1.64
0.88	0.02	0.05	0.07	0.09	0.11	0.14	0.16	0.18	0.20	0.23	0.25	0.27	0.29	0.32	0.34	0.36	0.38	0.40	0.43	0.45	0.47	0.49	0.51	0.53	0.55	0.57	0.60	0.62	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.78	0.79	0.81	0.83	0.85	0.87	0.89	0.91	0.92	0.94	0.96	0.98	0.99	1.01	1.03	1.04	1.06	1.08	1.09	1.11	1.12	1.14	1.16	1.17	1.19	1.20	1.21	1.23	1.24	1.26	1.27	1.28	1.30	1.31	1.32	1.34	1.35	1.36	1.37	1.38	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.59	1.60	1.61	1.62	1.63
0.89	0.02	0.04	0.07	0.09	0.11	0.13	0.16	0.18	0.20	0.22	0.25	0.27	0.29	0.31	0.33	0.36	0.38	0.40	0.42	0.44	0.46	0.48	0.51	0.53	0.55	0.57	0.59	0.61	0.63	0.65	0.67	0.69	0.71	0.73	0.75	0.77	0.79	0.81	0.82	0.84	0.86	0.88	0.90	0.92	0.93	0.95	0.97	0.98	1.00	1.02	1.04	1.05	1.07	1.08	1.10	1.12	1.13	1.15	1.16	1.18	1.19	1.20	1.22	1.23	1.25	1.26	1.27	1.29	1.30	1.31	1.33	1.34	1.35	1.36	1.37	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.59	1.59	1.60	1.61	1.62
0.90	0.02	0.04	0.07	0.09	0.11	0.13	0.16	0.18	0.20	0.22	0.24	0.27	0.29	0.31	0.33	0.35	0.37	0.39	0.42	0.44	0.46	0.48	0.50	0.52	0.54	0.56	0.58	0.60	0.62	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.78	0.80	0.82	0.83	0.85	0.87	0.89	0.91	0.92	0.94	0.96	0.98	0.99	1.01	1.03	1.04	1.06	1.07	1.09	1.11	1.12	1.14	1.15	1.17	1.18	1.19	1.21	1.22	1.24	1.25	1.26	1.28	1.29	1.30	1.32	1.33	1.34	1.35	1.36	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.58	1.59	1.60	1.61
0.91	0.02	0.04	0.07	0.09	0.11	0.13	0.15	0.18	0.20	0.22	0.24	0.26	0.28	0.31	0.33	0.35	0.37	0.39	0.41	0.43	0.45	0.47	0.49	0.52	0.54	0.56	0.58	0.60	0.62	0.64	0.66	0.68	0.70	0.71	0.73	0.75	0.77	0.79	0.81	0.83	0.84	0.86	0.88	0.90	0.92	0.93	0.95	0.97	0.98	1.00	1.02	1.03	1.05	1.06	1.08	1.10	1.11	1.13	1.14	1.16	1.17	1.18	1.20	1.21	1.23	1.24	1.25	1.27	1.28	1.29	1.31	1.32	1.33	1.34	1.35	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.48	1.49	1.49	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.58	1.59	1.60
0.92	0.02	0.04	0.07	0.09	0.11	0.13	0.15	0.17	0.20	0.22	0.24	0.26	0.28	0.30	0.32	0.34	0.37	0.39	0.41	0.43	0.45	0.47	0.49	0.51	0.53	0.55	0.57	0.59	0.61	0.63	0.65	0.67	0.69	0.71	0.73	0.74	0.76	0.78	0.80	0.82	0.84	0.85	0.87	0.89	0.91	0.92	0.94	0.96	0.97	0.99	1.01	1.02	1.04	1.06	1.07	1.09	1.10	1.12	1.13	1.15	1.16	1.18	1.19	1.20	1.22	1.23	1.24	1.26	1.27	1.28	1.30	1.31	1.32	1.33	1.34	1.36	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.45	1.46	1.47	1.48	1.49	1.50	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.58	1.58	1.59
0.93	0.02	0.04	0.06	0.09	0.11	0.13	0.15	0.17	0.19	0.21	0.24	0.26	0.28	0.30	0.32	0.34	0.36	0.38	0.40	0.42	0.44	0.46	0.48	0.50	0.53	0.55	0.56	0.58	0.60	0.62	0.64	0.66	0.68	0.70	0.72	0.74	0.76	0.77	0.79	0.81	0.83	0.85	0.86	0.88	0.90	0.92	0.93	0.95	0.97	0.98	1.00	1.01	1.03	1.05	1.06	1.08	1.09	1.11	1.12	1.14	1.15	1.17	1.18	1.19	1.21	1.22	1.23	1.25	1.26	1.27	1.29	1.30	1.31	1.32	1.34	1.35	1.36	1.37	1.38	1.39	1.40	1.41	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.50	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.57	1.58
0.94	0.02	0.04	0.06	0.09	0.11	0.13	0.15	0.17	0.19	0.21	0.23	0.25	0.27	0.30	0.32	0.34	0.36	0.38	0.40	0.42	0.44	0.46	0.48	0.50	0.52	0.54	0.56	0.58	0.60	0.62	0.64	0.66	0.67	0.69	0.71	0.73	0.75	0.77	0.79	0.80	0.82	0.84	0.86	0.87	0.89	0.91	0.92	0.94	0.96	0.97	0.99	1.01	1.02	1.04	1.05	1.07	1.08	1.10	1.11	1.13	1.14	1.16	1.17	1.18	1.20	1.21	1.22	1.24	1.25	1.26	1.28	1.29	1.30	1.31	1.33	1.34	1.35	1.36	1.37	1.38	1.39	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53	1.54	1.55	1.56	1.57	1.57
0.95	0.02	0.04	0.06	0.08	0.11	0.13	0.15	0.17	0.19	0.21	0.23	0.25	0.27	0.29	0.31	0.33	0.35	0.37	0.39	0.41	0.44	0.46	0.47	0.49	0.51	0.53	0.55	0.57	0.59	0.61	0.63	0.65	0.67	0.69	0.71	0.72	0.74	0.76	0.78	0.80	0.81	0.83	0.85	0.87	0.88	0.90	0.92	0.93	0.95	0.97	0.98	1.00	1.01	1.03	1.04	1.06	1.07	1.09	1.10	1.12	1.13	1.15	1.16	1.17	1.19	1.20	1.22	1.23	1.24	1.25	1.27	1.28	1.29	1.30	1.32	1.33	1.34	1.35	1.36	1.37	1.38	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53	1.54	1.55	1.56	1.57
0.96	0.02	0.04	0.06	0.08	0.10	0.12	0.15	0.17	0.19	0.21	0.23	0.25	0.27	0.29	0.31	0.33	0.35	0.37	0.39	0.41	0.43	0.45	0.47	0.49	0.51	0.53	0.55	0.57	0.59	0.61	0.62	0.64	0.66	0.68	0.70	0.72	0.73	0.75	0.77	0.79	0.81	0.82	0.84	0.86	0.87	0.89	0.91	0.92	0.94	0.96	0.97	0.99	1.00	1.02	1.03	1.05	1.07	1.08	1.09	1.11	1.12	1.14	1.15	1.17	1.18	1.19	1.21	1.22	1.23	1.25	1.26	1.27	1.28	1.29	1.31	1.32	1.33	1.34	1.35	1.36	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53	1.54	1.55	1.56
0.97	0.02	0.04	0.06	0.08	0.10	0.12	0.14	0.16	0.19	0.21	0.23	0.25	0.27	0.29	0.31	0.33	0.35	0.37	0.39	0.41	0.43	0.45	0.47	0.48	0.50	0.52	0.54	0.56	0.58	0.60	0.62	0.64	0.66	0.67	0.69	0.71	0.73	0.75	0.76	0.78	0.80	0.82	0.83	0.85	0.87	0.88	0.90	0.92	0.93	0.95	0.96	0.98	1.00	1.01	1.03	1.04	1.06	1.07	1.09	1.10	1.11	1.13	1.14	1.16	1.17	1.18	1.20	1.21	1.22	1.24	1.25	1.26	1.27	1.29	1.30	1.31	1.32	1.33	1.34	1.36	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53	1.54	1.55
0.98	0.02	0.04	0.06	0.08	0.10	0.12	0.14	0.16	0.18	0.20	0.22	0.24	0.26	0.28	0.30	0.32	0.34	0.36	0.38	0.40	0.42	0.44	0.46	0.48	0.50	0.52	0.54	0.56	0.58	0.59	0.61	0.63	0.65	0.67	0.69	0.70	0.72	0.74	0.76	0.77	0.79	0.81	0.83	0.84	0.86	0.88	0.89	0.91	0.92	0.94	0.96	0.97	0.99	1.00	1.02	1.03	1.05	1.06	1.08	1.09	1.11	1.12	1.13	1.15	1.16	1.17	1.19	1.20	1.21	1.23	1.24	1.25	1.26	1.28	1.29	1.30	1.31	1.32	1.33	1.35	1.36	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53	1.54
0.99	0.02	0.04	0.06	0.08	0.10	0.12	0.14	0.16	0.18	0.20	0.22	0.24	0.26	0.28	0.30	0.32	0.34	0.36	0.38	0.40	0.42	0.44	0.46	0.48	0.49	0.51	0.53	0.55	0.57	0.59	0.61	0.62	0.64	0.66	0.68	0.70	0.71	0.73	0.75	0.77	0.78	0.80	0.82	0.83	0.85	0.87	0.88	0.90	0.92	0.93	0.95	0.96	0.98	0.99	1.01	1.02	1.04	1.05	1.07	1.08	1.10	1.11	1.12	1.14	1.15	1.17	1.18	1.19	1.20	1.22	1.23	1.24	1.26	1.27	1.28	1.29	1.30	1.31	1.33	1.34	1.35	1.36	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52	1.53
1.00	0.02	0.04	0.06	0.08	0.10	0.12	0.14	0.16	0.18	0.20	0.22	0.24	0.26	0.28	0.30	0.32	0.34	0.36	0.38	0.39	0.41	0.43	0.45	0.47	0.49	0.51	0.53	0.55	0.56	0.58	0.60	0.62	0.64	0.65	0.67	0.69	0.71	0.73	0.74	0.76	0.78	0.79	0.81	0.83	0.84	0.86	0.88	0.89	0.91	0.92	0.94	0.96	0.97	0.99	1.00	1.02	1.03	1.05	1.06	1.07	1.09	1.10	1.12	1.13	1.14	1.16	1.17	1.18	1.20	1.21	1.22	1.23	1.25	1.26	1.27	1.28	1.29	1.31	1.32	1.33	1.34	1.35	1.36	1.37	1.38	1.39	1.40	1.41	1.42	1.43	1.44	1.45	1.46	1.47	1.48	1.49	1.50	1.51	1.51	1.52

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Exhibit E-1
Challenge Pool Value-Based Purchasing Incentives

1. Value-Based Purchasing Incentives

1.1. As outlined in HCA's Value-Based Roadmap and Apple Health Appendix, which can be found on HCA's website and is incorporated by reference, funding will be available under the terms of this Exhibit to encourage the transition among MCOs to Alternative Payment Models (APMs). This Exhibit describes the funds that are available and the conditions under which these funds may be earned, including reporting requirements and the performance measures that will be used.

1.2. The Challenge Pool described in this Exhibit, and from which all funds earned under this Exhibit will be drawn, is a pool of funding that will be distributed annually based on reporting and performance metrics that are defined under HCA's Apple Health Contracts, including Apple Health Managed Care, Apple Health Integrated Managed Care, and Apple Health Foster Care contracts. Where more than one of these contracts is effective between HCA and the Contractor, the amount earned under this Exhibit will not be calculated separately for each contract, but will be calculated as a single payment to the Contractor based on data aggregated from each of the Contractor's Apple Health Contract(s). Each Apple Health Contract includes the same Challenge Pool Exhibit, describing the same pool of funding and set of conditions under which these funds may be earned.

1.3. The funding that the Contractor is eligible to receive under this Exhibit draws from annual Delivery System Reform Incentive Payment System (DSRIP) funds via the Healthier Washington Medicaid Transformation (Medicaid Transformation) may be earned under Sections 2, 3 and 4 of this Exhibit. The Total Available Funds per year is set out in Table 1 of this Exhibit. The amounts in Table 1 are subject to amendment by HCA without prior notice to the Contractor and subject to the availability of state and federal funding.

1.4. The Base Earnable Funds (BEF) is the amount that the Contractor can earn under Sections 2 and 3 of this Exhibit. The BEF will be a share of the annual DSRIP Funds based on the Contractor's share of the total attributed member months under signed Apple Health Contracts for the year. The Contractor's BEF shall be calculated as the Contractor's attributed state-wide managed care member months for the Performance Year divided by the state wide managed care member months for the Performance Year, multiplied by total state-wide DSRIP Funds available for that Performance Year. The Contractor's Base Earnable Funds for the Performance Year may be earned on two bases, referred to as Pay for Reporting (P4R) and Pay for Performance (P4P).

1.5. In the event that the Contractor or any other HCA-contracted Apple Health MCO does not earn the full BEF that have been allocated to it for a Performance Year under the P4R and P4P terms set out in the Apple Health Contracts, the unearned Challenge Pool Remaining Funds will be distributed to the MCOs using a formula that accounts for the MCO's achievement related to high level APMs (HCP LAN Categories 3A-4B) as well as the MCO's Quality Improvement Score (QIS) as

calculated under the Contractor's Apple Health Contract(s). The conditions under which the Contractor may earn these Challenge Pool Remaining Funds are set out in Section 4 of this Exhibit.

1.6. For purposes of this Exhibit, reporting and measurement relating to the adoption of APMs will be based on the APM categorization set out in the Health Care Payment Learning and Action Network (HCP-LAN) Alternative Payment Model (APM) Framework Final Whitepaper version dated January 12, 2016, attached as Attachment A (Whitepaper) of the VBP Exhibit. The performance measures will assess the percentage of Contractor payments to providers that fits into each APM category under the Whitepaper.

1.7. The Challenge Pool will operate over the five-year period as set out in Table 1.Table 1 shows the relevant time periods, and the division of funding in each year between P4R and P4P.

Table 1
Performance Years, Time Periods and Thresholds

Time Periods			Funding			
Year	Performance Year	Improvement Baseline Year	Total Available (millions)	Base Earnable Funds (BEF)	P4R Portion of BEF	P4P Portion of BEF
PY1	1/1/17 – 12/31/17	1/1/16 – 12/31/16	$0	$0	75%	25%
PY2	1/1/18 – 12/31/18	1/1/17 – 12/31/17	$8	TBD	50%	50%
PY3	1/1/19 – 12/31/19	1/1/18 – 12/31/18	$8	TBD	25%	75%
PY4	1/1/20 – 12/31/20	1/1/19 – 12/31/19	$8	TBD	0%	100%
PY5	1/1/21 – 12/31/21	1/1/20 – 12/31/20	$8	TBD	0%	100%

1.8. The conditions for earning full or partial payment of the funds identified in Table 1 are set out below.

1.9. During the Performance Year, the Contractor may, at its discretion, seek feedback from HCA on whether provider payment arrangements qualify as APMs that will result in earned Challenge Pool funds.

2. Pay for Reporting (P4R)

2.1. The Pay for Reporting (P4R) portion of the Base Earnable Funds will be available to the Contractor for the complete and timely reporting of data required to assess the Contractor's progress toward meeting performance targets. The amount of the P4R portion of Base Earnable Funds will be determined by HCA as set out in Table 1.

2.2. The required data to be submitted under this Section is set out in the VBP Exhibit to the Contractor's Apple Health Contract(s) with HCA. All terms for the submission of data in the VBP Exhibit identified in this subsection are applicable here and must be met for HCA to deem that the Contractor has met the terms of this Section.

2.3. If all requirements are met under this Section, then the full amount of the P4R portion will be due to the Contractor. If all requirements under this Section are not met, then no funds will be paid to the Contractor under this Section.

3. Pay for Performance (P4P)

3.1. The Pay for Performance (P4P) portion of Base Earnable Funds will be available to the Contractor based on its performance in adopting Alternative Payment Models as set out in this Section. The amount of the P4P portion of Base Earnable Funds will be determined by HCA as set out in Table 1.

3.2. The amount of the P4P Portion of the Base Earnable Funds that the Contractor earns will be determined by a model that incorporates attainment of thresholds and targets, and improvement over the Contractor's APM adoption levels in the Baseline Year. Each of these elements is set out in Table 2.

Table 2
P4P Weights, Targets and Thresholds

Year	Performance Targets & Thresholds			Calculation Weight		
	HCP LAN 2C-4B Target	HCP LAN 3A-4B Threshold Score*	MACRA A-APMs Target	Achievement Score	Achievement Subset Score	Improvement Score
PY1	30%	N/A	N/A	40%	0%	60%
PY2	50%	10%	N/A	35%	5%	60%
PY3	75%	20%	10%**	45%	5%	50%
PY4	85%	30%	TBD	50%	5%	45%
PY5	90%	50%	TBD	55%	5%	40%

* In all years the HCP LAN 3A-4B Threshold Score applies under Section 4 of this Exhibit. In PY4 and PY5 the HCP LAN 3A-4B Threshold Score is additionally applicable under subsection 3.3.5 of this Exhibit.
**This percentage is subject to approval by the Centers for Medicare and Medicaid Services (CMS).

3.3. By meeting each of the Performance Targets and Thresholds set out in Table 2, the Contractor can earn all or part of the P4P portion of the Total Earnable Funds available to the Contractor. HCA will determine the amount of Base Earnable Funds that the Contractor can earn as follows.

3.3.1. The Contractor's Achievement Percentages for the Performance Year will be established using the data submitted by the Contractor and

validated as set out in the Contractor's Apple Health Contract(s), the definition of "Assessed Payments," and other terms included in Contractor's Apple Health Contract(s). VBP adoption Achievement Percentages are measured as the share of MCO Assessed Payments to providers via one or more specified APMs out of total MCO Assessed Payments to providers. For purposes of these measures, MCO Assessed Payments by category of APM and total MCO Assessed Payments to providers will be aggregated across Contracts identified in this subsection. Failure to provide data by the deadlines set out in any of the Contracts referenced in this subsection may result in loss of eligibility to earn any funds under this Exhibit.

3.3.2. Achievement Score*:* In each Performance Year HCA will calculate an Achievement Score for the Contractor. The Contractor will have reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1) if the Contractor's Achievement Percentage for HCP LAN categories 2C-4B is equal to or greater than the HCP LAN 2C-4B Target for the Performance Year. The Contractor will have reached or exceeded the HCP LAN 3A-4B Threshold Score for the Performance year (AS Item 2) if the Contractor's Achievement Percentage for HCP LAN categories 3A-4B is equal to or greater than the HCP LAN 3A-4B Target for the Performance Year. The Contractor will have reached or exceeded the MACRA A-APMs Target for the Performance Year (AS Item 3) if the Contractor's Achievement Percentage for MACRA A-APMs is equal to or greater than the MACRA A-APMs Target for the Performance Year.

3.3.2.1. For PY2: If the Contractor has reached or exceeded the HCP LAN 2C-4B Target for the Performance Year (AS Item 1), then the Achievement Score will be 100 percent. If not, the Achievement Score shall be zero percent.

3.3.2.2. For PY3, PY4 and PY5: The Achievement Score will consist of three additive parts. If the Contractor has reached or exceeded AS Item 1 under subsection 3.3.2 for the Performance Year, the Contractor earns 50 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 2 under subsection 3.3.2 for the Performance Year, the Contractor earns 40 percent toward the Achievement Score. If the Contractor has reached or exceeded AS Item 3 for the Performance Year, the Contractor earns 10 percent toward the Achievement Score. For instance, if the Contractor has reached or exceeded AS Item 1 and AS Item 3, but not AS Item 2, then the Achievement Score shall be 60 percent for the Performance Year (50 percent + 10 percent). If the Contractor has not reached or exceeded any of the three AS Items for the Performance Year, then the Achievement Score shall be zero percent.

3.3.3. Achievement Subset Score: In PY2, PY3, PY4, and PY5 HCA will assess whether the Contractor has met an annual Subset Attainment Target. In PY2, the Subset Attainment Target requires that the Contractor have at least one VBP contract in HCP-LAN category 3B or above. In PY3, the Subset Attainment Target additionally requires that the Contractor achieve certification from CMS for at least one VBP arrangement as an Other Payer Advanced Alternative Payment Model under the MACRA Quality Payment Program. A single contract may satisfy the PY2 and PY3 requirements in this subsection. If the Contractor has met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be 100 percent, and if the Contractor has not met the Subset Attainment Target for the Performance Year, then the Achievement Subset Score will be zero percent.

3.3.4. Improvement Score*:* In each Performance Year HCA will calculate an Improvement Score for the Contractor. If the Contractor has met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be 100 percent. If the Contractor has not met the HCP LAN 2C-4B Performance Target for the Performance Year, then the Improvement Score shall be calculated as the percent change from the Improvement Baseline Year achievement percentage for HCP LAN 2C-4B to the Performance Year achievement percentage for HCP LAN 2C-4B such that Improvement Score = (Performance Year Achievement Percentage – Improvement Baseline Year Achievement Percentage) / Improvement Baseline Year Achievement Percentage). Where the prior calculation produces a negative percentage, the Improvement Score shall be zero percent. The Improvement Score is capped at 100 percent.

3.3.5. HCP LAN 3A-4B Threshold Score: An achievement threshold applies in years four and five for HCP LAN 3A – 4B such that no funds under the P4P portion of Base Earnable Funds may be earned by the Contractor unless the threshold is met.

3.3.6. In each year, the Contractor's total P4P Score will be calculated as follows. First, the Achievement Score, Achievement Subset Score, and Improvement Score will each be multiplied by their respective weights as set out in Table 2. The resulting products will be summed to produce the provisional P4P score. In PY2 and PY3 the provisional P4P score will be the final P4P score for the Contractor. In PY4 and PY5 the provisional P4P score will be the final P4P score for the Contractor if the Contractor has met the HCP LAN 3A-4B Threshold Score, but if the Contractor has not met the HCP LAN 3A-4B Threshold Score then the final P4P score will be zero percent. In all years the final P4P score will range from zero percent to 100 percent.

3.3.7. The Contractor's final P4P Score will represent the percent of the P4P Portion of the Contractor's Base Earnable Funds that the Contractor is eligible to receive.

4. Remaining Challenge Pool Funds Share

4.1. If funds remain in the Challenge Pool for a given Performance Year as described in subsection 1.5 of this Exhibit, the Challenge Pool Remaining Funds will be distributed as set out in this Section.

4.2. Each MCO with Apple Health Contract(s), will be eligible to earn a Challenge Pool Remaining Funds Share that is determined by two factors as follows.

4.2.1. HCP LAN 3A-4B Threshold Score: First HCA will determine if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year set out in Table 2. To make this determination, HCA will use the data and methodology outlined in subsection 3.3.1 of this Exhibit to establish the HCP LAN 3A-4B achievement percentage for the MCO. If the MCO's annual HCP LAN 3A-4B achievement percentage is less than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share for the MCO will be zero percent of the Challenge Pool Remaining Funds. If the MCO's annual HCP LAN 3A-4B achievement percentage is equal to or greater than the annual HCP LAN 3A-4B Threshold Score then the Challenge Pool Remaining Funds Share shall be calculated under subsection 4.2.2 below.

4.2.2. Relative QIS Adjusted for Relative Membership: Second, if the MCO has met the HCP LAN 3A-4B Threshold Score for the Performance Year then the MCO will receive a percentage of the Challenge Pool Remaining Funds that is determined by the relative magnitude of each MCO's all-contract QIS score established under the Contractor's Apple Health Contract(s), adjusted for attributed member months per MCO.

4.2.2.1. To calculate the Contractor's all-contract QIS score, HCA will calculate an average of the Contractor's QIS score calculated under the Contractor's Apple Health Contract(s), weighted by the share of Apple Health Managed Care Member Months attributable to each contract for the Performance Year. The same methodology will be used to calculate an all-contract QIS score for each of HCA's contracted Apple Health MCOs.

4.2.2.2. The all-contract QIS scores of all MCOs that meet the HCP LAN 3A-4B Threshold Score will be summed to find the Challenge Pool Remaining Funds Denominator. For each MCO that meets the HCP LAN 3A-4B Threshold Score, the preliminary Challenge Pool Remaining Funds Share for the MCO shall then be calculated as the all-contract QIS for the MCO divided by the Challenge Pool Remaining Funds Denominator times the total Challenge Pool Remaining Funds under subsection 1.5 of this Exhibit. Finally, the preliminary Challenge Pool Remaining Funds Share for the MCO will be adjusted for attributed member months to produce the final Challenge Pool Remaining Funds Share for the MCO. For this adjustment, HCA will multiply the preliminary Challenge Pool

Remaining Funds Share by a Member Months Index and readjust the resulting product for each qualifying MCO on a proportional basis so that the percentage share for all MCOs adds up to 100 percent of Challenge Pool Remaining Funds.

4.2.2.3. The Member Months Index referenced in subsection 4.2.2.2 will be calculated for each MCO by dividing attributed member months for the MCO over the Performance Year by the average MCO attributed member months over the Performance Year.

5. Payment

5.1. The total amount that the Contractor is eligible to receive under this Exhibit will be the sum of the amounts earned under Sections 2 and 3 of this Exhibit for Reporting (P4R) and Performance (P4P), plus the Challenge Pool Remaining Funds Share for the Contractor under Section 4 of this Exhibit.

5.2. On or before October 30th following the end of each Performance Year, HCA will provide the Contractor with a completed Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit to notify the Contractor in writing of its Challenge Pool Value-Based Purchasing Incentives Earned based on the calculations described in this Exhibit.

5.3. The Contractor will have 20 calendar days from the date the Contractor is notified of its Challenge Pool Value-Based Purchasing Incentives Earned to review and sign the Challenge Pool Calculation Summary Form provided in Attachment 1 to this Exhibit and return to HCA, in writing, of any alleged discrepancies with the calculations.

5.4. If the Contractor submits in writing any alleged discrepancies with the calculations, HCA will respond in writing to the Contractor within 10 calendar days following HCA's receipt.

5.5. HCA will schedule payment for the percentage of the Challenge Pool Value-Based Purchasing Incentives Earned no later than June 30th following the receipt of Challenge Pool Calculation Summary Form.

Exhibit E-1, Attachment 1
Challenge Pool Calculation Summary Form

Contractor/Vendor Name: _____

Contract No: _____

Performance Period: _____ to _____

Base Earnable Funds
Base Earnable Funds for Performance year: _____
P4R Portion For Performance Year: _____
P4P Portion For Performance Year: _____

P4R
All Reporting requirements met: _____
Reporting elements not met: _____

Percent of P4R Portion of Base Earnable Funds Earned: _____

P4P
Assessed Payments
Total Assessed Payments: _____
Assessed Payments Categories 2C-4B: _____
Assessed Payments Categories 3A-4B: _____

Percent of all-contract payments in Categories 2C-4B
Performance Year:_____
Improvement Baseline Year:_____

All Subset Attainment Target Requirements Met: _____
Thresholds Met or Not Applicable for Performance Year: _____

Achievement Score: _____
Performance Weight: _____
Achievement Subset Score: _____
Achievement Subset Weight: _____
Improvement Score: _____
Improvement Weight: _____
Performance Threshold Score: _____

Percent of P4P Portion of Base Earnable Funds Earned: _____

Challenge Pool Remaining Funds and Share
Challenge Pool Remaining Funds Available to all HCA MCOs: _____
Contractor's all-contract QIS Score: _____
Challenge Pool Remaining Funds Denominator: _____
Member Months Index: _____

Percent of all-contract Assessed Payments in Categories 3A-4B: _____
HCP-LAN 3A-4B Threshold Score for Performance Year: _____
HCP-LAN 3A-4B Achievement Score for Performance Year: _____

Percent of Challenge Pool Remaining Funds Earned: _____

Totals
P4R Funds Earned: _____
P4P Funds Earned: _____
Challenge Pool Remaining Funds Share: _____
Total Challenge Pool Value-Based Purchasing Incentives Earned:_____

Washington State Health Care Authority Chief Financial Officer Signature:

Signature Date

Print Name & Title

Email Address

Contractor hereby agrees to the accuracy of this Challenge Pool Calculation Summary and the underlying calculations.

Contractor Authorized Agent Signature

Signature Date

Print Name & Title

Email Address

Exhibit F
Washington State Health Care Authority
Instructions for MLR Reporting
Apple Health Integrated Foster Care

Table of Contents

Introduction

These instructions are for the Excel-based MLR Reporting Template. The Excel workbook is designed to collect all information needed for MLR reporting as required by CMS in 42 CFR §438.8. The federal rule regarding MLR requires that all Medicaid managed care contracts require the contracted managed care organizations to calculate and report a MLR.

The MLR Reporting Template is to be completed and submitted to the Health Care Authority (HCA) via MC-Track by May 31st of the year following the MLR reporting year. For example the first report is due May 31, 2020.

If the state were to make a retroactive change to the capitation payments for a MLR reporting year where the MLR report has already been submitted to the state, the Contractor must re-calculate the MLR for all MLR reporting years affected by the change and submit new MLR reports to the state for all impacted reporting years.

Throughout these instructions there will be references to the 2016 Medicaid/CHIP Managed Care Final Rule and other regulations. All regulations are part of 42 CFR unless cited otherwise. The information requested by the report follow regulation § 438.8(k).

General Requirements

The Contractor will aggregate data for all Medicaid eligibility groups covered under this contract unless the state requires separate reporting and a separate MLR calculation for specific populations. If the data is aggregated, a description of the aggregation method used to calculate total incurred claims for each reporting year.

The Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

Plan Information

Please fill out the contact information of your MCO.

Numerator

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one MCO that is later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

The expenditures reported by the Contractor shall include non-claims costs and expenditures related to activities compliant with program integrity requirements 438.608(a)(1) - (5); 438.608(a)(7) - (8); and 438.608(b).

Please fill in the cells that are formatted with blue font.

Detail for each line can be found here:

NUMERATOR: INCURRED CLAIMS

Line 1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year: Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. See §§ 438.8(e)(2)(i)(A) and 438.8(e)(2)(i)(B):

(A) Direct claims that the MCO paid to providers for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees.

(B) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported.

Line 1.2 Incurred but not reported (IBNR) for claims incurred in the period expected to be paid in months after the known runout. This requires the MCO to estimate the cost of claims owed but not yet received. See § 438.8(e)(2)(i)(F)

Line 1.3 Withholds from payments made to network providers: See § 438.8(e)(2)(i)(C)

Line 1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers: See § 438.8(e)(2)(iii)(A)

Line 1.5 Changes in other claims-related reserves: See § 438.8(e)(2)(i)(G)

Line 1.6 Reserves for contingent benefits and the medical claim portion of lawsuits: See § 438.8(e)(2)(i)(H)

Line 1.7 Net payment or receipts related to state-mandated solvency funds: See § 438.8(e)(2)(iv)

Line 1.8a Amount spent on fraud reduction: See § 438.8(e)(2)(iii)(B)

The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. The amount of fraud reduction expenses must not include fraud prevention activities specified in paragraph (e)(4) of this section.§ 438.8(e)(4): *Fraud prevention activities. MCO expenditures on activities related to fraud prevention as adopted for the private market at 45 CFR part 158. Expenditures under this paragraph must not include*

expenses for fraud reduction efforts in paragraph (e)(2)(iii)(B) of this section.

Line 1.8b Amount of claims payments recovered through fraud reduction: See also Line 1.8a.

Items Deducted from Incurred Claims

Line 1.9 Claims that are recoverable for anticipated coordination of benefits (payments from third party payors): See § 438.8(e)(2)(i)(D)

Line 1.10 Claims payments recoveries received as a result of subrogation: See § 438.8(e)(2)(i)(E)

Line 1.11 Overpayment recoveries received from network providers: The State expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system. See § 438.8(e)(2)(ii)(A)

Line 1.12 Prescription drug rebates received and accrued: See § 438.8(e)(2)(ii)(B)

NUMERATOR: ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY

Line 2.1 MCO activity that meets 45 CFR § 158.150(b) and is NOT EXCLUDED under 45 CFR § 158.150(c): See § 438.8(e)(3)(i)

Line 2.2 MCO activity related to any EQR-related activity as described in §§ 438.358(b) and 438.358(c): See § 438.8(e)(3)(ii)

Line 2.3 MCO expenditure that is related to Health Information Technology and meaningful use: See § 438.8(e)(3)(iii)

Excluded Non-Claim Costs

This worksheet collects information for items excluded from the numerator, but is required to be reported. Note that incurred claims by one MCO that are later assumed by another entity must be reported by the assuming MCO for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 3.1 Amounts paid to third party vendors for secondary network savings: See § 438.8(e)(2)(v)(A)(1)

Payments made by one managed care plan to another vendor to purchase their network

for use as a secondary network. In practice, the managed care plan purchases another managed care plan's network to serve as contracted, out-of-network providers so as to avoid single-case agreements with those providers, resulting in savings on out-of-network service costs.

Line 3.2 Amounts paid to third party vendors for network development, admin fees, claims: processing, and utilization management: See § 438.8(e)(2)(v)(A)(2)

Line 3.3 Amounts paid to a provider for professional or administrative services outside of providing services to enrollees: See § 438.8(e)(2)(v)(A)(3)

Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in § 438.3(e) and provided to an enrollee.

§ 438.3(e): See Line 1.1

Line 3.4 Fines and penalties assessed by regulatory authorities: See § 438.8(e)(2)(v)(A)(4)

Line 3.5 Amounts paid to the State as remittance for prior MLR experience: See § 438.8(e)(2)(v)(B)

Remittance to the State if specific MLR is not met.

Line 3.6 Amounts for pass-through payments under § 438.6(d): See § 438.8(e)(2)(v)(C) Amounts paid to network providers under to § 438.6(d).

Denominator

DENOMINATOR: PREMIUM REVENUE

This worksheet collects information for the denominator. Note that the total amount of the denominator for a MCO, which is later assumed by another entity, must be reported by the assuming MCO for the entire MLR reporting year, and no amount for that year may be reported by the ceding MCO.

Please fill in the cells that are formatted with blue font.

Line 4.1 State capitation payments, including adjustments, excluding pass-through payments: See § 438.8(f)(2)(i)

State capitation payments, developed in accordance with § 438.4, to the MCO for all enrollees under a risk contract approved under § 438.3(a), excluding payments made under to § 438.6(d).

Line 4.2 State developed one time payments for specific life events of enrollees: See §

438.8(f)(2)(ii)

Line 4.3 Earned premium withholds approved under § 438.6(b)(3): See § 438.8(f)(2)(iii) Other payments to the MCO approved under § 438.6(b)(3)

Line 4.4 Unpaid cost-sharing amount that the health plan could have collected from enrollees under the contract: See § 438.8(f)(2)(iv)

Unpaid cost-sharing amounts that the MCO could have collected from enrollees under the contract, except those amounts the MCO can show it made a reasonable, but unsuccessful, effort to collect.

Does not apply.

Line 4.5 All changes to unearned premium reserves: See § 438.8(f)(2)(v)

Does not apply.

Line 4.6 Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms referenced in § 438.5 and § 438.6 are risk adjustment, risk corridors, reinsurance, and stop loss limits: See § 438.8(f)(2)(vi)

DENOMINATOR: FEDERAL, STATE, AND LOCAL TAXES

Taxes paid by the MCO if applicable.

Line 5.1 Statutory assessments to defray the operating expense of any state or federal department: See § 438.8(f)(3)(i)

Does not apply.

Line 5.2 Examination fees in lieu of premium taxes as specified by state law: See § 438.8(f)(3)(ii)

Does not apply.

Line 5.3 Federal taxes and assessments allocated to MCOs: See § 438.8(f)(3)(iii)

Federal taxes and assessments allocated to MCOs, excluding Federal income taxes on investment income and capital gains and Federal employment taxes.

Line 5.4 State and local taxes and assessments: See § 438.8(f)(3)(iv)

(iv) State and local taxes and assessments including:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.

(B) Guaranty fund assessments.

(C) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(D) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.

(E) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures: See § 438.8(f)(3)(v)

45 CFR § 158.162(c)

(c) Community benefit expenditures. Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:
  (1) Are available broadly to the public and serve low-income consumers;
  (2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
  (3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
  (4) Leverage or enhance public health department activities such as childhood immunization efforts; and
  (5) Otherwise would become the responsibility of government or another tax-exempt organization.

MLR Calculation

This worksheet takes the prior amounts and summarizes them into subtotals and calculates the unadjusted MLR. There are also inputs for member months and credibility adjustments if applicable. The Contractor may add a credibility adjustment to a calculated MLR if the MLR reporting year experience is partially credible but the Contractor may not add a credibility adjustment to a calculated MLR if the MLR reporting year experience is fully credible. If the Contractor's experience is non-credible, it is presumed to meet or exceed the MLR calculation standards.

The MCO should enter the number of member months in the appropriate cell.

The State has elected a minimum MLR of 85%

Expense Allocation

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document: See § 438.8(g)

Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the

remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on pro rata basis.

Expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results and shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

Remittance Calculation

Remittance of amounts owed to the State will be calculated as described in Gain Share Program section of the IFC contract.

Financial Comparison

Per § 438.8(k)(1)(xi), a comparison of the financial amounts included in this report and what is reported in audited financials is required. Show the comparison in this worksheet or reference an attached document with the comparison.

MLR Report Summary

This worksheet summarizes the information requested by CMS and meets § 438.8 (k).

Attestation

An attestation to the accuracy of this MLR report is required per § 438.8(n), § 438.604(a)(3), and § 438.606.

Exhibit G

DATA USE, SECURITY AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit:

1.1. **"Authorized User"** means an individual or individuals with an authorized business need to access HCA's Confidential Information under this Contract.

1.2. **"Breach"** means the unauthorized acquisition, access, use, or disclosure of Data shared under this Contract that compromises the security, confidentiality or integrity of the Data.

1.3. **"Data"** means the information that is disclosed or exchanged as described by this Contract. For purposes of this Exhibit, Data means the same as "Confidential Information."

1.4. **"Disclosure"** means the release, transfer, provision of, access to, or divulging in any other manner of information outside the entity holding the information.

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

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

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

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

1.6. **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 ("ARRA"), Sec. 13400 – 13424, H.R. 1 (2009) (HITECH Act).

1.7. **"HIPAA Rules"** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160 and Part 164.

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

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

1.10. **"Protected Health Information"** or **"PHI"** means information that relates to the provision of health care to an individual; the past, present, or future physical or mental health or condition of an individual; or past, present or future payment for provision of health care to an individual. 45 C.F.R. §160 and 164. PHI includes demographic information that identifies the individual or about which there is reasonable basis to believe, can be used to identify the individual. 45 C.F.R. § 160.103. PHI is information transmitted, maintained, or stored in any form or medium. 45 C.F.R. § 164.501. PHI does not include education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. § 1232g(a)(4)(b)(iv).

1.11. "ProviderOne" means the Medicaid Management Information System, which is the State's Medicaid payment system managed by HCA.

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

1.13. **"Trusted System(s)"** means the following methods of physical delivery: (1) hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt; (2)

United States Postal Service ("USPS") first class mail, or USPS delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail; (3) commercial delivery services (e.g. FedEx, UPS, DHL) which offer tracking and receipt confirmation; and (4) the Washington State Campus mail system. For electronic transmission, the Washington State Governmental Network (SGN) is a Trusted System for communications within that Network.

1.14. **"U.S.C."** means the United States Code. All references in this Exhibit to U.S.C. chapters or sections will include any successor, amended, or replacement statute. The U.S.C. may be accessed at http://uscode.house.gov/

1.15. **"Use"** includes the sharing, employment, application, utilization, examination, or analysis, of Data.

2. Data Classification

2.1. The State classifies data into categories based on the sensitivity of the data pursuant to the Security policy and standards promulgated by the Office of the state of Washington Chief Information Officer. (See Section 4, *Data Security*, of *Securing IT Assets Standards* No. 141.10 in the *State Technology Manual* at https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets. Section 4 is hereby incorporated by reference.)

The Data that is the subject of this Contract is classified as Category 4 – Confidential Information Requiring Special Handling. Category 4 Data is information that is specifically protected from disclosure and for which:

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

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

3. Constraints on Use of Data

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

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

3.3. The Contractor must comply with the *Minimum Necessary Standard*, which means that Contractor will use the least amount of PHI necessary to accomplish the Purpose of this Contract.

3.3.1. Contractor must identify:

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

3.3.1.2. For each such person or class of persons, the category or categories of PHI to which access is needed and any conditions appropriate to such access.

3.3.2. Contractor must implement policies and procedures that limit the PHI disclosed to such persons or classes of persons to the amount reasonably necessary to achieve the purpose of the disclosure, in accordance with this Contract.

4. Security of Data

4.1. Data Protection

4.1.1. The Contractor must protect and maintain all Confidential Information gained by reason of this Contract, information that is defined as confidential under state or federal law or regulation, or Data that HCA has identified as confidential, against unauthorized use, access, disclosure, modification or loss. This duty requires the Contractor to employ reasonable security measures, which include restricting access to the Confidential Information by:

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

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

4.2. Data Security Standards

4.2.1. Contractor must comply with the Data Security Requirements set out in this section and the Washington OCIO Security Standard, 141.10, which will include any successor, amended, or replacement regulation (https://ocio.wa.gov/policies/141-securing-information-technology-assets/14110-securing-information-technology-assets.) The Security Standard 141.10 is hereby incorporated by reference into this Contract.

4.2.2. Data Transmitting

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

4.2.2.2. When transmitting Data via paper documents, the Contractor must use a Trusted System.

4.2.3. Protection of Data. The Contractor agrees to store and protect Data as described.

4.2.3.1. Data at Rest:

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

4.2.3.2. Data stored on Portable/Removable Media or Devices

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

4.2.3.2.2. HCA's Data must not be stored by the Contractor on Portable Devices or Media unless specifically authorized within the Contract. If so authorized, the Contractor must protect the Data by:

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

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

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

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

4.2.3.2.2.5. Maintaining an inventory of devices; and

4.2.3.2.2.6. Ensuring that when being transported outside of a Secured Area, all devices containing Data are under the physical control of an Authorized User.

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

4.2.4. Data Segregation

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

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

4.2.4.1.1. On media (e.g. hard disk, optical disc, tape, etc.) which contains only HCA Data;

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

4.2.4.1.3. In a database that contains only HCA Data;

4.2.4.1.4. Within a database – HCA data must be distinguishable from non-HCA Data by the value of a specific field or fields within database records;

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

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

4.3. Data Disposition

4.3.1. Upon request by HCA, at the end of the Contract term, or when no longer needed, Confidential Information/Data must be returned to HCA or disposed of as set out below, except as required to be maintained for compliance or accounting purposes.

Media are to be destoryed using a method documented within NIST 800-88 (http://csrc.nist.gov/publications/PubsSPs.html).

4.3.2. For Data stored on network disks, deleting unneeded Data is sufficient as long as the disks remain in a Secured Area and otherwise meet the requirements listed in Section 4.2.3, above. Destruction of the Data as outlined in this section of this Exhibit may be deferred until the disks are retired, replaced, or otherwise taken out of the Secured Area.

5. Data Confidentiality and Non-Disclosure

5.1. Data Confidentiality.

5.1.1. The Contractor will not use, publish, transfer, sell or otherwise disclose any Confidential Information gained by reason of this Contract for any purpose that is not directly connected with the purpose of this Contract, except:

5.1.1.1. (a) as provided by law; or

5.1.1.2. (b) with the prior written consent of the person or personal representative of the person who is the subject of the Confidential Information.

5.2. Non-Disclosure of Data

5.2.1. The Contractor will ensure that all employees or Subcontractors who will have access to the Data described in this Contract (including both employees who will use the Data and IT support staff) are instructed and aware of the use restrictions and protection requirements of this Exhibit before gaining access to the Data identified herein. The Contractor will ensure that

any new employee is made aware of the use restrictions and protection requirements of this Exhibit before they gain access to the Data.

5.2.2. The Contractor will ensure that each employee or Subcontractor who will access the Data signs a non-disclosure of confidential information agreement regarding confidentiality and non-disclosure requirements of Data under this Contract. The Contractor must retain the signed copy of employee non-disclosure agreement in each employee's personnel file for a minimum of six years from the date the employee's access to the Data ends. The Contractor will make this documentation available to HCA upon request.

5.3. Penalties for Unauthorized Disclosure of Data

5.3.1. The Contractor must comply with all applicable federal and state laws and regulations concerning collection, use, and dislosure of Personal Information and PHI. Violation of these laws may result in criminal or civil penalties or fines.

5.3.2. The Contractor accepts full responsibility and liability for any noncompliance with applicable laws or this Contract by itself, its employees, and its Subcontractors.

6. Data Shared with Subcontractors

6.1. If Data access is to be provided to a Subcontractor under this Contract, the Contractor must include all of the Data security terms, conditions and requirements set forth in this Exhibit in any such Subcontract. However, no subcontract will terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor.

7. Data Breach Notification

7.1. The Breach or potential compromise of Data must be reported to the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov and to the Managed Care Contract Manager at hcamcprograms@hca.wa.gov within five (5) business days of discovery. If the Contractor does not have full details, it will report what information it has, and provide full details within 15 business days of discovery. To the extent possible, these reports must include the following:

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

7.1.2. The nature of the unauthorized use or disclosure, including a brief description of what happened, the date of the event(s), and the date of discovery;

7.1.3. A description of the types of PHI involved;

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

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

7.1.6. Any other information HCA reasonably requests.

7.2. The Contractor must take actions to mitigate the risk of loss and comply with any notification or other requirements imposed by law or HCA including but not limited to 45 C.F.R. Part 164, Subpart D; RCW 42.56.590; RCW 19.255.010; or WAC 284-04-625.

7.3. The Contractor must notifiy HCA in writing, as described in the *General Terms and Conditions* section, *Notices*, within two (2) business days of determining notification must be sent to enrollees.

7.4. At HCA's request, the Contractor will provide draft Enrollee notification to HCA at least five (5) business days prior to notification, and allow HCA an opportunity to review and comment on the notifications.

7.5. At HCA's request, the Contractor will coordinate its investigation and notifications with HCA and the Office of the State of Washington Chief Information Officer (OCIO), as applicable.

8. HIPAA Compliance

8.1. The Contractor must perform all of its duties, activities, and tasks under this Contract in compliance with HIPAA, the HIPAA Rules, and all applicable regulations as promulgated by the U.S. Department of Health and Human Services, Office for Civil Rights, as applicable. The Contractor and Contractor's subcontracts must fully cooperate with HCA efforts to implement HIPAA requirements.

8.2. Within ten business days, Contractor must notify the HCA Privacy Officer at PrivacyOfficer@hca.wa.gov, with a copy to the Managed Care Contract Manager at hcamcprograms@hca.wa.gov, of any complaint, enforcement, or compliance action initated by the Office for Civil Rights based on an allegation of violation of HIPAA or the HIPAA Rules and must inform HCA of the outcome of that action. Contractor bears all responsibility for any penalties, fines, or sanctions imposed against Contractor for violations of HIPAA or the HIPAA Rules and for any sanction imposed against its Subcontractors or agents for which it is found liable.

9. Inspection

9.1. HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of Enrollees collected, used, or acquired by Contractor during the terms of this Contract. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

10. Material Breach

10.1. The Contractor must indemnify and hold HCA and its employees harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of Enrollees.

EXHIBIT H

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EXHIBIT I

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Exhibit J-1, RAC Codes

Integrated Foster Care

Apple Health Integrated Foster Care (AH-IFC)			
Category	**Description**	**IFC**	**Current RACS**
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1014 Categorically Needy Medicaid; receives SSI cash; Title IV-E Federal Foster Care, under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1015 Categorically Needy Medicaid; receives SSI cash; Non IV-E State Foster Care; under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1016 Categorically Needy Medicaid; receives SSI cash; Title IV-E Federal Adoption Support, under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1017 Categorically Needy Medicaid; receives SSI cash; Non IV-E State Adoption Support, under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1019 Categorically Needy Medicaid; Title IV-E Federal Foster Care; under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1020 Categorically Needy Medicaid; Non IV-E State Foster Care; under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1021 Categorically Needy Medicaid; Title IV-E Federal Adoption Support; under 21
Apple Health Foster Care = Healthy Options Foster Care	Apple Health Managed Care Program for Foster Care Children	X	1022 Categorically Needy Medicaid; Non IV-E State Adoption Support; under 21
CNP, Foster Care Alumni	Categorically Needy, Foster Care under 26 (if in Foster Care at age 18)	X	1196 Former Foster Care. Categorically Needy Medicaid; Title IV-E Federal Foster Care; under 26 (if in Foster care at age 18)

ATTACHMENT 1

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Attachment 2
2019 HEDIS Performance Measures

Apple Health Managed Care
Fully Integrated Managed Care (FIMC)
Integrated Foster Care (IFC)

The Contractor shall report the following HEDIS measures statewide for all eligible Enrollees enrolled through AHMC, FIMC, and IFC contracts. All measures must be publically reported by plan name to the NCQA Quality Compass. If "Hybrid" is noted in the Notes column, the Contractor is contractually required to report using this methodology. This is for 2019 HEDIS reporting year (performance year 2018).

NCQA Abbreviation	Measure	Notes
Prevention and Screening		
ABA	Adult BMI Assessment	**Hybrid**
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	**Hybrid**
CIS	Childhood Immunization Status	**Hybrid**
IMA	Immunizations for Adolescents	**Hybrid**
LSC	Lead Screening in Children	**Hybrid**
BCS	Breast Cancer Screening	
CCS	Cervical Cancer Screening	**Hybrid**
CHL	Chlamydia Screening in Women	
Respiratory Conditions		
CWP	Appropriate Testing for Children With Pharyngitis	
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	
PCE	Pharmacotherapy Management of COPD Exacerbation	
MMA	Medication Management for People With Asthma	
AMR	Asthma Medication Ratio	
Cardiovascular		
CBP	Controlling High Blood Pressure	**Hybrid**
PBH	Persistence of Beta-Blocker Treatment After a Heart Attack	
SPC	Statin Therapy for Patients With Cardiovascular Disease	
Diabetes		
CDC	CDC: Hemoglobin A1c (HbA1c) Testing	**Hybrid**
CDC	CDC: HbA1c Poor Control (>9.0%)	**Hybrid**
CDC	CDC: HbA1c Control (<8.0%)	**Hybrid**
CDC	CDC: Eye Exam	**Hybrid**
CDC	CDC: Medical Attention for Nephropathy	**Hybrid**

NCQA Abbreviation	Measure	Notes
CDC	CDC: Blood Pressure Control (<140/90 mm Hg)	**Hybrid**
SPD	Statin Therapy for Patients With Diabetes	
Musculoskeletal		
ART	Disease Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	
Behavioral Healthcare		
AMM	Antidepressant Medication Management	
ADD	Follow-Up Care for Children Prescribed ADHD Medication	
FUH	Follow-Up After Hospitalization for Mental Illness	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
FUM	Follow-Up After Emergency Department Visit for Mental Illness	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
FUA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	
SMD	Diabetes Monitoring for People With Diabetes and Schizophrenia	
SMC	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Medication Management		
MPM	Annual Monitoring for Patients on Persistent Medication	
Overuse/Appropriateness		
NCS	Non-Recommended Cervical Cancer Screening in Adolescent Females	
URI	Appropriate Treatment for Children With Upper Respiratory Infection	
AAB	Avoidance of Antibiotic Therapy for Adults With Acute Bronchitis	
LBP	Use of Imaging Studies for Low Back Pain	
APC	Use of Multiple Concurrent Antipsychotics in Children and	

NCQA Abbreviation	Measure	Notes
	Adolescents	
UOD	Use of Opioids at High Dosage	
UOP	Use of Opioids from Multiple Providers	
Access/Availability of Care		
AAP	Adults' Access to Preventive/Ambulatory Health Services	
CAP	Children and Adolescents' Access to Primary Care Practitioners	
ADV	Annual Dental Visit	NO BENEFIT for AHMC, FIMC, and IFC
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
PPC	Prenatal and Postpartum Care	**Hybrid**
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	
Use of Services		
W15	Well-Child Visits in the First 15 Months of Life	**Hybrid**
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	**Hybrid**
AWC	Adolescent Well-Care Visits	**Hybrid**
FSP	Frequency of Selected Procedures	
AMB	Ambulatory Care	
IPU	Inpatient Utilization–General Hospital/Acute Care	
IAD	Identification of Alcohol and Other Drug Services	AHMC: No Benefit FIMC: Required IFC: No Benefit for RY2019
MPT	Mental Health Utilization	AHMC and IFC: Report the Outpatient/ED category only. NO BENEFIT for the following categories: Inpatient Intensive Outpatient/ Partial Hospitalization, or Telehealth. FIMC: Report all

NCQA Abbreviation	Measure	Notes
		categories
ABX	Antibiotic Utilization	
Risk Adjusted Utilization		
PCR	Plan All-Cause Readmission	
NCQA Abbreviation	**Health Plan Descriptive Information**	**Notes**
ENPA	Enrollment by Product Line - Total	
EBS	Enrollment by State	
LDM	Language Diversity of Membership	
RDM	Race/Ethnicity Diversity of Membership	
TLM	Total Membership	
NEW HEDIS MEASURE 2019		
COU	Risk of Chronic Opioid Use	**To be reported to HCA**

HCA reserves the right to issue changes to this attachment or measure requirements, such as due to changes in HEDIS technical specifications.

ATTACHMENT 3

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Attachment 6
Oral Health Connections Pilot Project

In Section 213(1)(nn) of the Substitute Senate Bill 5883 (2017) and Section 213(1)(oo) of SSB 6032 (2018), HCA was directed to implement the Oral Health Connections Pilot Project, modeled after the ABCD program . The directive to HCA and Arcora (previously known as Washington Dental Foundation) is to work jointly from inception to completion of the program. Implementation is set for January 1, 2019 and the pilot project will run for three (3) years.

The Oral Health Connections Pilot Project's purpose is to integrate oral-systemic health care in two predetermined populations, in three select counties in anticipation of influencing health outcomes and controlling chronic disease. Adults with diabetes and pregnant women (not including Dual-Eligible Clients), located in Cowlitz, Thurston, or Spokane counties are the target populations of the Oral Health Connections Pilot Project.

Arcora is responsible for:

- Financing and developing, in partnership with the University of Washington (UW), a training module and exam for participating dental providers;
- Providing the exam, in partnership with UW;
- Notifying HCA, within 5 business days, of successful course completion by participating dental providers;
- Developing tools and systems to assist medical providers with oral assessments;
- Developing referral and patient care coordination tools;
- Developing systems and processes to facilitate shared care between medical and dental providers;
- Developing systems and processes to assist dental provider offices in scheduling and keeping appointments;
- Recruiting dental providers to participate in the program;
- Attending local and statewide dental provider association meetings;
- Educating providers about the pilot, including background, duration, enhanced fees, and indicators;
- Recruiting and educating of medical providers on demographics of Oral Health Connections Pilot Project target populations;
- Training medical providers about oral systemic link between oral health and diabetes and/or pregnancy, including how to address oral health in medical settings while reinforcing the importance of medical and dental collaboration; and
- Developing and implementing an Oral Health Connections Pilot Project evaluation tool.

Both medical and dental Oral Health Connections Pilot Project providers will use a referral tool developed by Arcora, called DentistLink, to connect Clients to dental providers in the following ways:

- Medical provider will refer Clients diagnosed with diabetes or pregnancy to a trained dental provider participating in the Oral Health Connections Pilot Project through DentistLink;
- Medical Managed Care Organizations (MCOs) will refer Enrollees, with flagged qualifying diagnosis(es), through care coordination and DentistLink;

Dental providers will coordinate with medical providers through DentistLink to receive referrals for patients who are in the two identified target populations. Dental providers will be educated in the specifics of intervention and training for the identified Client population. The Oral Health Connections Pilot Project will also test the effects an enhanced dental benefit has on access to dental care, health care outcomes, and related medical costs.

Trained, participating dental providers will be eligible for enhanced reimbursement rates for specific CDT codes per Oral Health Connections Pilot Project guidelines. Periodontal health, in specific, will be the target of the enhancements. Medicaid will pay enhanced fees for codes D0150 (Comprehensive Oral Exam), D0210 (Intraoral complete series of radiographic images), D0274 (Bitewings four radiographic images), D4341 (Periodontal Scaling and Root Planing-4 or more teeth), D4342 (Periodontal Scaling and Root Planing 3 or more teeth per quadrant), D4910 (Periodontal maintenance). The Client will be eligible to receive up to three (3) additional D4910 (periodontal maintenance) per twelve-month period.

The Oral Health Connections Pilot Project success will be determined through measures evaluating access, cost, and health outcomes.