Washington State Health Care Authority	**WASHINGTON APPLE HEALTH** **MANAGED CARE DENTAL**	HCA Contract Number: «Contract» Resulting from Solicitation Number: RFP 2516 Contractor Contract Number:

THIS CONTRACT 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 «Organization_Name»	CONTRACTOR doing business as (DBA)	
CONTRACTOR ADDRESS «Mailing_AddressSt_Address» «City», «State» «Zip_Code»	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»	HCA INDEX NUMBER
CONTRACTOR CONTACT «Contact_Fname» «Contact_LName»	CONTRACTOR TELEPHONE «PhoneNo»	CONTRACTOR E-MAIL ADDRESS «EmailAddress»
IS CONTRACTOR A SUB-RECIPIENT UNDER THIS CONTRACT? ☐YES ☒NO	CFDA NUMBER(S)	FFATA Form Required? ☐YES ☒NO

HCA CONTACT NAME AND TITLE Alison Robbins Section Manager	HCA CONTACT ADDRESS Post Office Box 45502 Olympia, WA 98504-5502
HCA CONTACT TELEPHONE 360-725-1634	HCA CONTACT E-MAIL ADDRESS alison.robbins@hca.wa.gov

CONTRACT START DATE January 1, 2019	CONTRACT END DATE December 31, 2020	TOTAL MAXIMUM CONTRACT AMOUNT Per Member/Per Month
PURPOSE OF CONTRACT: Contract for Apple Health Dental Services		

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

☒ Exhibit(s): Exhibit A, Rates; Exhibit B, Dental Benefits Spreadsheet; Exhibit C, Service Area Matrix; Exhibit D, Data Use, Security and Confidentiality.

☒ Attachment(s): Attachment 1 - Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D; Attachment 2 –Monthly Certification Letter.

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

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Exhibits

Exhibit A – Rates (not included)
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Exhibit E – Special Programs (not included)

Attachments

Attachment 1 - Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D
Attachment 2 – Monthly Certification Letter

1 DEFINITIONS

The Contractor shall use the definitions as they appear in this Contract in its subcontracts and materials. Defined terms marked with an asterisk (*) are not used in the Contract, and are provided for reference.

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 Accountable Community(ies) of Health (ACHs)

"Accountable Community(ies) of Health (ACHs)" are regionally situated, self-governing multi-sector organizations with non-overlapping boundaries that also align with Washington's regional service areas for Medicaid purchasing. ACHs are focused on improving health and transforming care delivery for the populations that live within their respective regions. ACHs include managed care, health care delivery, and many other critical organizations as part of their multi-sector governance and as partners in implementation of delivery system reform initiatives.

1.3 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)).

1.4 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.

1.5 Adverse Benefit Determination

"Adverse Benefit Determination" means the denial or limited authorization of a requested service, including: The type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the determination of whether the Enrollee has "good cause" not to cooperate with third party liability procedures when this will result in denial of payment; 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; failure of the Contractor to act within the timeframes for disposition,

resolution, and notification of appeals and grievances; the denial of an enrollee's request to dispute a financial liability, including cost sharing, Copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities; or, for a rural area resident with only one Managed Care Entity (MCE) 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 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. (42 C.F.R. § 438.400(b)).

1.6 **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:

1.6.1 Fraud hotline complaints;

1.6.2 Claims data mining;

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

1.7 **Ambulatory Surgery Center (ASC)**

"Ambulatory Service Center (ASC)" are certified by Medicare as an entity operating exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

1.8 **American Indian / Alaska Native (AI/AN) / Indian**

"American Indian / Alaska Native (AI/AN) / Indian" means any individual defined at U.S.C. 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. 136.12. This means the individual: (1) is a member of a federally recognized Indian tribe; or (2) resides in an urban center and meets one or more of the following criteria: (a) is a member of a tribe, band, or other organized group of Indians, including those tribes, bands , or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such member; (b) is an Eskimo or Aleut or other Alaska Native; (c) is determined to be an Indian under regulations issued by the Secretary; (d) is considered by the Secretary of the Interior to be an Indian for any purpose; or (e) is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

1.9 **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).

1.10 **Appeal**

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

1.11 **Appeal Process**

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

1.12 **Behavioral Health Organization (BHO)**

"Behavioral Health Organization (BHO)" means a single or multiple-county authority or other entity operating as a prepaid inpatient health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health and substance use disorder services in a defined geographic area to Enrollees who meet Access to Care Standards.

1.13 **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:

1.13.1 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.

1.13.2 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;

1.13.3 Acquisition or modification of equipment or devices; and

1.13.4 Other similar services and actions.

1.14 **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.

1.15 **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 Personal Health Information (PHI) in accordance with HIPAA guidelines.

1.16 **Business Day**

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

1.17 **Capacity Threshold**

"Capacity Threshold" means the capacity to serve a minimum percentage of Apple Health eligibles in a service area in each of the following two critical provider types: general Dentists, and pediatric Dentists.

1.18 **Care Coordination**

"Care Coordination" means an approach to healthcare in which all of an Enrollee's needs are coordinated with the assistance of a care coordinator. The 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.

1.19 **Care Management**

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

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

1.19.2 Utilization of evidence-based clinical practices in screening and intervention;

1.19.3 Coordination of care across the continuum of medical, behavioral health, oral health,

and long-term services and supports, including tracking referrals and outcomes of referrals;

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

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

1.20 **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.

1.21 **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.

1.22 **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:

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

1.22.2 Eligible for Medicaid under section 1902(e)(3) of the Act;

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

1.22.4 Receiving foster care or adoption assistance; and/or

1.22.5 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.

1.23 **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.

1.24 **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.

1.25 **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)).

1.26 **Comparable Coverage***

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

1.27 **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.

1.28 **Continuity of Care**

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions to maintain care that has started or been authorized in one setting as the Enrollee transitions between dental provider and medical provider, between general Dentist to dental specialty or from inpatient or emergency department to the dental office.

1.29 **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.

1.30 **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.

1.31 **Contracted Services**

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

1.32 **Copayment**

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

1.33 **Covered Services**

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

1.34 **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).

1.35 **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

1.36 **Dental Education in Care of Persons with Disabilities (DECOD)**

"Dental Education in Care of Persons with Disabilities (DECOD)" is a program at the University of Washington (UW), School of Dentistry for Enrollees meeting DECOD eligibility criteria.

1.37 **Dental Access Payment (DAP) Program**

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

1.38 **Dentist**

"Dentist" means an individual licensed to practice dentistry in the state of Washington.

1.39 **Department of Children, Youth, and Families**

"Department of Children, Youth, and Families (DCYF)" means the Washington State agency responsible for providing a broad array of services to ensure Washington state's children and youth grow up safe and health-thriving physically, emotionally, and academically, nurtured by family and community.

1.40 **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:

1.40.1 Behavioral Health Administration is responsible for providing mental health services in state psychiatric hospitals and community settings, and chemical dependency inpatient and outpatient treatment, recovery and prevention services.

1.40.2 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.

1.40.3 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.

1.41 **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.

1.42 **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 for Apple Health.

1.43 **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, and chapter 182-534 WAC, and described in the HCA EPSDT and Provider Billing Guide.

1.44 **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.

1.45 **Eligible Clients**

"Eligible Clients" means individuals certified eligible by HCA, living in the service area, and eligible to enroll for health care services under the terms of this Contract.

1.46 **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 department, 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.

1.47 **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)).

1.48 **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)).

1.49 **Enrollee**

"Enrollee" means an Eligible Client who is enrolled in managed care through a Managed Care Entity (MCE) having a Contract with HCA (42 C.F.R. § 438.10(a)).

1.50 **Exception to Rule**

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

1.51 **Excluded Services**

"Excluded Services" means health care services and benefits the Contractor does not pay for or cover. Exception to Rule (ETR) is not applicable to an Excluded Service.

1.52 **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).

1.53 **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).

1.54 **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.

1.55 **Family Connect**

"Family Connect" means enrolling a family member into the same Apple Health Dental Managed Care plan that other family members are enrolled in.

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

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

1.57 **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).

1.58 **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).

1.59 **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.

1.60 **Grievance Process**

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

1.61 **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).

1.62 **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.

1.63 **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.

1.64 **Health Care Professional**

"Health Care Professional" means a physician or any of the following acting within his or her scope of practice; a general Dentist, pediatric Dentist, oral surgeon, orthodontist, endodontist, denturist, or other licensed dental providers.

1.65 **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, dental care, behavioral health care, and long-term services and supports.

1.66 **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.

1.67 **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 which is then reviewed by a committee of practicing clinicians. The purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. HTA contracts for scientific, evidence-based reports about whether certain medical devices, procedures and tests are safe and work as promoted.

1.68 **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.

1.69 **Independent Hygienist**

"Independent Hygienist" is a licensed hygienist with 2 years' practical clinical experience with a licensed Dentist within the previous 5 years. May be employed, retained, or contracted by health care facilities, senior centers, and schools to perform authorized dental hygiene operations and services without dental supervision (RCW 18.29.056 and 18.29.220). For the purposes of this definition, "health care facilities" are limited to hospitals; nursing homes; home health agencies: group homes serving the elderly, individuals with disabilities, and juveniles; state-operated institutions under the jurisdiction of the Department of Social and Health Services (DSHS) or the Department of Corrections (DOC); and federal, state, and local public health facilities, state or federally funded community and migrant health centers, and tribal clinics. For the purposes of this definition, "senior center" means a multipurpose community facility operated and maintained by a nonprofit organization or local government for the organization and provision of a combination of some of the following: health, social, nutritional, educational services, and recreational activities for persons sixty years of age or older.

1.70 **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.

1.71 **Individual with Special Health Care Needs**

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

1.71.1 Has a biologic, psychologic, or cognitive basis;

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

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

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

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

1.72 **Interim Therapeutic Restoration (ITR)**

"Interim Therapeutic Restoration (ITR)" is the placement of an adhesive restorative material following caries debridement by hand or other method for the management of early childhood caries. It is not considered a definitive restoration.

1.73 **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.

1.74 **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.

1.75 **Managed Care**

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

1.76 **Managed Care Entity (MCE)**

"Managed Care Entity (MCE)" 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.

1.77 **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 MCE 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 MCE. 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).

1.78 **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)).

1.79 **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.

1.80 **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).

1.81 **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 which investigates and prosecutes abuse of clients or fraud committed by any entity, facility, agency, health care professional, health care provider, primary care provider, primary dental provider, provider or individual.

1.82 **Medically Necessary Services**

"Medically Necessary" 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 client 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).

1.83 **Medical Loss Ratio (MLR)**

"Medical Loss Ratio" 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. Additional clarification can be found in the Congressional Research Service report dated August 26, 2014, found here: http://fas.org/sgp/crs/misc/R42735.pdf

1.84 **Mental Health Professional**

"Mental Health Professional" means:

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

1.84.2 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;

1.84.3 A person with a master's degree or further advanced degree in counseling or one of the social 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;

1.84.4 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

1.84.5 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; or

1.84.6 A person who has been granted a time-limited exception of the minimum requirements of a Mental Health Professional by the DSHS Division of Behavioral Health and Recovery consistent with WAC 388-865-0238.

1.85 **Network**

"Network" means providers that have agreed to provide health care services to enrolled Clients.

1.86 **Network Adequacy**

"Network Adequacy" means a network of providers 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).

1.87 **New Individual**

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

1.88 **Non-Covered Service**

"Non-Covered Service" is a specific health care service (e.g. teeth whitening), contained within a service category that is included in a Washington Apple Health benefits package. HCA or HCA's designee requires an approved Exception to Rule (ETR) for payment of a Non-Covered Service. A Non-Covered Service is not an Excluded Service.

1.89 **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 MCE's provider network, but provides health care services to Enrollees.

1.90 **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.

1.91 **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.

1.92 **Outcomes**

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

1.93 **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.

1.94 **Participating Provider**

"Participating Provider" means a person, health care provider, practitioner, 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.

1.95 **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.

1.96 **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.

1.97 **Physician Incentive Plan (PIP)**

"Physician Incentive Plan (PIP)" 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.

1.98 **Plan**

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

1.99 **Plan Reconnect**

"Plan Reconnect" means an individual who has regained eligibility for Apple Health Dental Managed Care and who was enrolled in Apple Health Dental Managed Care within the six (6) months immediately preceding reenrollment.

1.100 **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.

1.101 **Potential Enrollee**

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

1.102 **Preventive Dental Care**

"Preventive Dental Care" means dental care that includes, but is not limited to: adult and child prophylaxis, fluoride varnish, topical fluoride (not varnish), oral hygiene instructions, sealants, silver diamine fluoride, unilateral space maintainer, bilateral space maintainer, re-cement space maintainer, remove space maintainer, and distal shoe space maintainer.

1.103 **Primary Care Provider (PCP)**

"Primary Care Provider (PCP)" means a physical health provider who has the responsibility for supervising, coordinating, and providing primary health care to Clients. 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.

1.104 **Primary Dental Provider (PDP)**

"Primary Dental Provider (PDP)" means a participating provider who has responsibility for supervising, coordinating, and providing primary dental care to Enrollees, initiating referrals for specialist care, and maintaining the continuity of Enrollee care. PDPs include, but are not limited to: general Dentists, and pediatric Dentists.

1.105 **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.

1.106 **Prior Authorization**

"Prior Authorization**"** means obtaining Contractor approval for a health care service before the service is provided. The approval is required in order for the Contractor to pay the provider for the service.

1.107 **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 12 months based on the patient's disease profile and pharmacy utilization.

1.108 **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 Unit, and other state and federal agencies. See chapter 182-502A WAC.

1.109 **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).

1.110 **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.

1.111 **Regional Service Area (RSA)**

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

1.112 **Regulation**

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

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

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

1.114 **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.

1.115 **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.

1.116 **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.

1.117 **Service Areas**

"Service Areas" means the single county or multi-county grouping in which the Contractor serves Eligible Clients as described in this Contract.

1.118 **Single Case Agreement**

"Single Case Agreement" means a written agreement between the Contractor and a nonparticipating provider to deliver services to an Enrollee.

1.119 **Specialist**

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

1.120 **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.

1.121 **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.

1.122 **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.

1.123 **Substantial Financial Risk**

"Substantial Financial Risk" means a physician or physician group as defined in this Section is at substantial financial risk when more than twenty-five percent (25%) of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 Enrollees' arrangements that cause substantial financial risk include, but are not limited to, the following:

1.123.1 Withholds greater than twenty-five percent (25%) of total potential payments; or

1.123.2 Withholds less than twenty-five percent (25%) of total potential payments but the physician or physician group is potentially liable for more than twenty-five percent (25%) of total potential payments; or

1.123.3 Bonuses greater than thirty-three percent (33%) of total potential payments, less the bonus; or

1.123.4 Withholds plus bonuses if the withholds plus bonuses equal more .than twenty-five percent (25%) of total potential payments; or

1.123.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than twenty-five percent (25%) of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

1.124 **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. Provider listed in the SAM should not be awarded a contract with the Contractor.

1.125 **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.

1.126 **Transport**

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

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

1.126.2 Is accomplished other than via a Trusted System.

1.127 **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.

1.128 **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.

1.129 **Urgent Care**

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

1.130 **Urgent Care Center**

"Urgent Care Center" means a clinic outside of a traditional hospital-based emergency department 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 department visit.

1.131 **Urgent Healthcare Condition**

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

1.132 **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 accord with standards for data collection and analysis (42 C.F.R. § 438.320).

1.133 **Washington Administrative Code (WAC)**

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

1.134 **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.

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

"Washington Apple Health Foster Care (AHFC)" means an HCA managed care program that serves foster children and children receiving adoption support services.

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

"Washington Apple Health –Integrated Managed Care (AH-IMC)" means the program under which behavioral health services are added to the Apple Health Managed Care (AHMC) contract.

2 GENERAL TERMS AND CONDITIONS

2.1 Amendment

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

2.1.1 Any amendment must be in writing and will 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 will 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 will submit all feedback or questions to HCA at contracts@hca.wa.gov.

2.1.4 The Contractor will 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 must return all signed amendments within the written deadline provided by HCA Contracts Office.

2.2 Assignment

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

2.3 Billing Limitations

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

2.3.2 HCA will 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 Medicaid Fraud Control Unit (MFCU) 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 will 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 must 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 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews;

2.4.15 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:

2.4.15.1 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 must be reported to HCA, DHHS, and the EPA.

2.4.15.2 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;

2.4.15.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA);

2.4.15.4 Those specified in Title 18 RCW for professional licensing;

2.4.16 Industrial Insurance – Title 51 RCW;

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

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

2.4.19 EEO Provisions;

2.4.20 Copeland Anti-Kickback Act;

2.4.21 Davis-Bacon Act;

2.4.22 Byrd Anti-Lobbying Amendment;

2.4.23 All federal and state nondiscrimination laws and regulations;

2.4.24 Americans with Disabilities Act of 1990, as amended: The Contractor must make reasonable accommodation for Enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted Services and must assure physical and communication barriers will not inhibit Enrollees with disabilities from obtaining Contracted Services;

2.4.25 The Contractor will not pay for an item or service (other than an emergency item or service, not including items or services furnished in an emergency department 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; and

2.4.26 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 will 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 must 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 must 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 will 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 MFCU, as described below), the parties agree to the following process to address the dispute:

2.8.1 The Contractor will request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and must 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 their 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 their sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, they 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 their sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent them at the dispute conference, the Director will retain all final decision-making authority regarding the disputed issue(s). Under no circumstances will 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 will 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 MFCU are governed by the authorities, laws and regulations under which the MFCU 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 will not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor must commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section will 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 will be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder will be in Superior Court for Thurston County. In the event that an action is removed to U.S. District Court, venue will be in the Western District of Washington in Tacoma.

Nothing in this Contract will 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 will 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 will 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 must, 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 must 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 must permit the state of Washington, including HCA, MFCU and state auditor, CMS, auditors from the federal Government Accountability Office, federal Office of the Inspector General, federal Office of Management and Budget, the Office of the Inspector General, the Comptroller General, and their designees, to access, inspect and audit any records or documents of the Contractor or its subcontractors, at any time and will permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time. Contractor and its subcontractors must forthwith produce all

records, documents, or other data requested as part of such inspection, review, audit, investigation, monitoring, or evaluation. If the requesting agency asks for copies of records, documents, or other data, the Contractor and its subcontractors must make copies of records and will deliver them to the requestor, without cost, within thirty (30) calendar days of request, or a shorter timeframe as authorized by law or court order. Copies of records and documents must 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 must at all times comply with the following insurance requirements:

2.14.1 Commercial General Liability Insurance (CGL): The Contractor must 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 must 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 must be named as additional insureds expressly for, and limited to, Contractor's services provided under this Contract.

2.14.2 Professional Liability Insurance (PL): The Contractor must 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 must comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The state of Washington and HCA will 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 must include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.14.5 Subcontractors: The Contractor must ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor will 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 must contain a "separation of insured's" provision.

2.14.7 Insurers: The Contractor will 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 must 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 must be executed by a duly authorized representative of each insurer.

2.14.9 Material Changes: The Contractor will 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 must 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 will not be construed to relieve the Contractor from liability in excess of the required coverage and limits and will 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 will 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 must 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 will maintain all financial, medical and other records pertinent to this Contract. All financial records must follow generally accepted accounting principles. Other records will 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 must 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 must 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 must retain, as applicable, Enrollee grievance and appeal records (42 C.F.R. § 438.416), base data (42 C.F.R. § 438.5(c)), MLR reports (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 will 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 must provide HCA with ninety (90) calendar days' prior written notice of any change in the Contractor's ownership or legal status. The Contractor will 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 will be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence will 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 Any other term and condition of this Contract and exhibits.

2.19.6 Any other material incorporated herein by reference.

2.20 Severability

If any term or condition of this Contract is held invalid by any court of competent jurisdiction, and if all appeals have been exhausted, such invalidity will 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 will 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 Premiums; 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, MFCU, 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 will not be deemed to be a waiver of any subsequent breach or default. Any waiver will 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 will remain, in compliance with chapter 42.52 RCW, Ethics in Public Service, throughout the term of this Contract.

2.24 Health and Safety

Contractor must 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 will 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 will each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract must 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 will 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 must 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 will 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
PO Box 42702
Olympia, WA 98504-2702

2.28.3 Notices will 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 will 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 If HCA determines it has made an overpayment to the Contractor, then HCA will issue a Notice of Overpayment to the Contractor.

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, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment within sixty (60) calendar days from the date of receipt. 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 will be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data will include the Contractor's interpretation.

2.30.2 The Contractor must 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 will prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

2.31 Ownership of Material

HCA recognizes that nothing in this Contract will 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 will 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 must 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 must 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 will 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 will 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 must 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 must notify HCA within 24 hours after any action by the OIC which may affect the relationship of the parties under this Contract.

2.32.6 The Contractor must 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 must 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 (42 C.F.R. § 438.3(f)(2).

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 will 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, will not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and will 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 by 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 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 will 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 will 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 will 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 will 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 will 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 will 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 will also inform Enrollees that they may change MCEs 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 will provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA will:

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 will 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 must provide HCA, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to Enrollees (42 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 must 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 must use and follow the most recent updated versions of:

- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD)
- Healthcare Common Procedure Coding System (HCPCS)
- CMS Relative Value Units (RVUs)
- CMS billing instructions and rules
- NCPDP Telecommunication Standard D.O.
- 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 must 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 not contain an invitation, implied or implicit, for an Enrollee to change from one Apple Health MCE to the Contractor, or imply that the Contractor's benefits are substantially different from any other Apple Health MCE. This does not preclude the Contractor from distributing state-approved communications to Enrollees regarding the scope of their own value-added benefits.

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

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

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

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

3.1.7 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)).

3.1.8 The Contractor must 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)).

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

3.1.10 The Contractor must 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)).

3.1.11 The Contractor may participate in community events, including health fairs, educational events, and booths at other community events. The Contractor must submit to HCA a quarterly report, listing all AH events in which the Contractor has participated in the previous quarter. Quarterly reports are due on the 15th of January, April, July and October.

3.2 Information Requirements for Enrollees and Potential Enrollees

3.2.1 The Contractor must 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 must be provided at least once a year, upon request and within fifteen (15) business days after the Contractor was notified of enrollment.

The Contractor must 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.

3.2.2 The Contractor must use and disseminate the HCA produced managed care handbook to Enrollees and potential Enrollees. The HCA-produced template and HCA-approved Contractor handbook will provide sufficient, accurate 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)).

3.2.3 The Contractor must provide to each Enrollee, and to each potential Enrollee who requests it, the HCA-approved managed care handbook.

3.2.3.1 The Contractor shall provide the HCA-approved managed care handbook in a translated version or through Auxiliary Aids and Services in a manner that takes into consideration the special needs of Enrollees and potential Enrollees with disabilities or limited English proficiency.

3.2.3.2 The Contractor will develop content for the managed care handbook in the sections labeled for Contractor use in the template.

3.2.4 The Contractor may develop supplemental materials specific to Contractor's programs, in addition to the managed care handbook that is sent to newly enrolled and assigned Enrollees. The supplemental, plan-specific material must be incorporated into the

managed care handbook template as instructed by HCA. The supplemental, plan-specific material will not include mandatory materials such as the annual notices that the Contractor is required to send to Enrollees.

3.2.4.1 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.

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

3.2.6 The Contractor must submit branding materials developed by the Contractor that specifically mention Medicaid, AH, the AH dental managed care program, or the specific benefits provided under this Contract for review and approval. No such materials will be disseminated to Enrollees, potential Enrollees, providers or other members of the public without HCA's prior written approval.

3.2.7 The Contractor must submit Enrollee information developed by the Contractor that specifically mentions AH 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 will 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.

3.2.8 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, as well as notifying pregnant Enrollees in the counties served by the Oral Health Pilot Project of the availability of additional oral health services.

3.2.9 The Contractor must 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 must 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 will notify the Contractor in writing of any significant change (42 C.F.R. § 438.10(f)(4)).

3.3 Equal Access for Enrollees and Potential Enrollees with Communication Barriers

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

3.3.1 Oral Information

3.3.1.1 The Contractor must ensure that interpreter services are provided for Enrollees and Potential Enrollees with a preferred 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 as defined in this Contract. (42 C.F.R. § 438.10(d)(4)). Interpreter Services will 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 encounters with any provider for any covered service;

3.3.1.1.3 Emergency Services; and

3.3.1.1.4 Administrative matters and 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 with disabilities or limited English proficiency. (42 C.F.R. § 438.10(d)(1) and 438.10(d)(6)(iii)).

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 large print tagline and information on how the Enrollee or potential Enrollee can request Auxiliary Aids and Services, including the provision of information in an alternative language and format that is understandable to the Enrollee or potential Enrollee.

3.3.2.1.3 For Enrollees whose preferred 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 of the following:

3.3.2.1.3.1 Translating the material into the Enrollee's or potential Enrollee's preferred reading language.

3.3.2.1.3.2 Providing the material in an audio format in the Enrollee's or potential Enrollee's preferred language.

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

3.3.2.1.3.4 Making the materials available via Auxiliary Aids and Services, or a format acceptable to the Enrollee or potential Enrollee. The Contractor will 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)).

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

3.3.2.2 The Contractor must 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 oral health 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 and 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 42 C.F.R. § 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;

3.4.1.4 Initial Health Screening;

3.4.1.5 Surveys;

3.4.1.6 Disease management information and reminders;

3.4.1.7 Appointment reminders; and

3.4.1.8 Notification of new programs or assistance offered.

3.4.2 Under no circumstances will the Contractor use automated calls for care coordination activities.

3.4.3 The Contractor must 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 Prescription Information

Contractor will develop materials to inform all providers and Enrollees that prescriptions will be covered under Apple Health medical.

3.6 Conscience Clause

The Contractor must 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 CFR § 438.102(b)(1)(ii)(B); 1932(b)(3)(B)(ii); RCW 48.43.065.)

4 ENROLLMENT

4.1 Service Areas

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

4.1.1 The Contractor's service areas are described in Exhibit C. The Health Care Authority may modify Exhibit C, for service area changes as described in this Section.

4.2 Service Area Changes

4.2.1 With the written approval of HCA, and upon execution of a formal contract amendment, the Contractor may either expand into an additional service area (an "Area Expansion") or increase its level of client assignments in a service area if it is already receiving voluntary enrollment, in that service area (an "Area Increase").

4.2.2 To obtain an Area Expansion or an Area Increase, the Contractor must give written notice to HCA, along with evidence, as HCA may require, demonstrating the Contractor's ability to support the Area Expansion or Area Increase.

4.2.2.1 HCA may withhold approval of an Area Expansion or an Area Increase if, in HCA's sole judgment, the request is not in the best interest of HCA.

4.2.2.2 If approved, the timing of the Area Expansion or Area Increase will be at HCA's sole discretion.

4.2.3 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal, i.e., when the Contract is extended as provided herein or when the Contractor's network does not provide adequate access in a service area.

4.2.4 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, HCA will alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

4.2.5 HCA will determine, in its sole judgment, which zip codes fall within each service area.

4.2.6 HCA will use the Enrollee's residential zip code to determine whether an Enrollee resides within a service area.

4.3 Eligible Client Groups

The Health Care Authority will determine eligibility for enrollment under this Contract. The Health Care Authority will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Apple Health (AH) dental managed care. Clients in the following eligibility groups, not including individuals who receive coverage solely through state-funded programs, at the time of enrollment are eligible for enrollment under this Contract.

4.3.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving AH Family and clients who are not eligible for cash assistance who remain eligible for medical services under Medicaid.

4.3.2 Clients receiving Medicaid under the provisions of the ACA effective January 1, 2014.

4.3.3 Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.

4.3.4 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.

4.3.5 Children eligible for the Children's Health Insurance Program (CHIP).

4.3.6 Categorically Needy - Blind and Disabled Children and Adults

4.3.7 Dual Eligible Medicare/Medicaid-eligible Children and Adults.

4.4 Client Notification

HCA will 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 twelve (12) months or at least annually.

4.5 Exemption from Enrollment

A client may request exemption from enrollment for cause at any time. Each request for exemption will be reviewed by HCA pursuant to chapter 182-538 WAC. 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.

4.5.1 If the Contractor receives an exemption request from an Enrollee or potential Enrollee, the Contractor must forward the request to the Medical Assistance Customer Service Center (MACSC) within two (2) Business Days of receipt of the request.

4.6 Enrollment Period

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open. Enrollees will have the right to change enrollment prospectively, from one AH dental managed care plan to another without cause, each month.

4.7 Enrollment Process

4.7.1 Enrollees certifying or renewing Medicaid eligibility through the Health Benefit Exchange may select a dental MCE available in the Enrollee's service area by calling HCA.

4.7.2 HCA will assign the clients who do not select a plan.

4.7.3 HCA will assign all eligible family members to the same AH dental managed care contractor consistent with this Contract.

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

4.7.5 The client, the client's representative or responsible parent or guardian must notify the Health Care Authority if they want to choose another health plan.

4.7.6 The Health Care Authority will attempt to enroll all family members with the same AH dental managed care plan unless the following occurs:

4.7.6.1 The Health Care Authority grants an exception because the family members have conflicting dental needs that cannot be met by a single AH dental managed care contractor.

4.8 Effective Date of Enrollment

4.8.1 HCA will enroll all newly eligible Medicaid clients subject to this Contract into Apple Health Dental Managed 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.

4.8.1.1 Newborn(s) whose mother(s) are Dental Managed Care Enrollees on the date of birth will be deemed Enrollees and enrolled in the same plan as the mother.

4.8.1.2 A newborn whose mother is receiving services FFS when the baby is born will be enrolled in Dental Managed Care and assigned to an MCE according to system rules.

4.8.2 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 4.11.7 and 16.4 of this Contract.

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

4.9 Enrollment Data and Requirements for Contractor's Response

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

4.9.1 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 Health Care Authority Companion Guides.

4.9.4 The Contractor will 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 Health Care Authority's proposed enrollment effective date. Written notice must include the reason for refusal and must be agreed to by the HCA. The effective date of enrollment specified by the HCA will be considered accepted by the Contractor and will 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 for 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 must direct the Enrollee to contact HCA.

4.10.1.2 For the purposes of this Section, the following are cause for disenrollment (42 C.F.R. § 438.56(d)(2)):

4.10.1.2.1 The Enrollee moves out of the Contractor's service area;

4.10.1.2.2 The Contractor does not, because of moral or religious objections, deliver the service the Enrollee seeks;

4.10.1.2.3 The Enrollee needs related services (for example tooth extraction and tori removal) to be performed at the same time; not all related services are available within the network; and the Enrollee's primary dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

4.10.1.2.4 Other reasons, including but not limited to: Poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the Enrollee's health care needs.

4.10.1.3 Enrollees denied disenrollment for cause or a plan change may request an appeal of the decision through an Administrative Hearing.

4.10.1.4 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 Health Care Authority for Ineligibility.

4.10.2.1 The enrollment of any Enrollee under this Contract will 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 will 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 Health Care Authority if it is processed on or before the Health Care Authority cut-off date for enrollment or the Contractor is informed by the Health Care Authority of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the Health Care Authority.

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 Health Care Authority cut-off date for enrollment and the Contractor is not informed by the Health Care Authority of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the Health Care Authority.

4.10.4 Involuntary Termination Initiated by the Contractor

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

4.10.4.1.1 HCA will review each involuntary termination request on a case-by-case basis. The Contractor will 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 will 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)):

4.10.4.1.1.1 The Enrollee purposely puts the safety or property of the Contractor, or the Contractor's staff, providers, patients, or visitors at risk and

Contractor attempts to address this behavior with reasonable accommodations of any disability of the Enrollee have not been successful; and continued enrollment impairs the Contractor's ability to furnish services to this particular Enrollee or other Enrollees;

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

4.10.4.1.1.3 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 must include the Enrollee's right to use the Contractor's Grievance Process to review the request to end the Enrollee's enrollment.

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

4.10.4.3 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 healthcare 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)).

4.10.4.4 The Contractor must 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)).

4.10.5 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.

4.10.6 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:

4.10.6.1 For the provision of information and assistance to transition the Enrollee's

care with another provider.

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

4.10.7 Regardless of the procedures followed or the reason for termination, if a disenrollment request is granted, or the Enrollee's enrollment is terminated by HCA for one of the reasons described in Subsection 4.11.5 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 make a disenrollment determination 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 will pay a monthly premium for each Enrollee in full consideration of the work to be performed by the Contractor under this Contract. HCA will 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 = Regional Base Rate X Regional Age/Sex Adjustment Factor

Base rates and age/sex factors will be unique to each Regional Service Area for each Recipient Aid Category (RAC) grouping.

Additional premium payments will be made as Service Based Enhancements (SBEs) for certain services as described in Subsection 5.17 of this Contract.

5.2.1 The Regional Base Rate is established by HCA and will vary between the Apple Health (AH) Family Adult, AH Family Child, Apple Health State Children's Health Insurance Program (SCHIP), Foster Care Children, Apple Health Aged Blind Disabled (AHBD), Apple Health Community Options Program Entry System (COPES), Developmental Disability Administration (DDA) and Apple Health Adult Coverage – (AHAC) populations. The base rates will vary by contractor based on submitted cost proposals, but may become consistent in future contract years as the program matures.

5.2.2 The Age/Sex Adjustment factors will be established by HCA and will vary by aid category grouping and geographic region. The age/sex factors will vary by contractor based on submitted cost proposals.

5.2.3 HCA will 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.

5.2.4 The Contractor will 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 dental 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 will 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"), will be payable to the Contractor under this Contract, unless the Contractor is exempt from the Annual Fee under federal law.

5.3.5 HCA will 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 will 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 will 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 Risk Corridor and Gain Share Program

5.4.1 HCA will perform risk corridor calculations on experience incurred during the first Contract year to mitigate the risk of overpayment or underpayment for services under the Contract. Thereafter, HCA will perform gain share calculations to mitigate the risk of overpayment for services under the Contract.

5.4.2 The risk corridor and gain share calculations will be limited to the benefit component of the monthly capitation payment rates, which will be measured consistent with the definition of Medical Loss Ratio (MLR) standards defined in 42 C.F.R. § 438.8.

5.4.3 The following methods will be used to calculate the risk corridor and gain share settlements:

5.4.3.1 Total Benefit Expenses will be calculated as defined in 42 C.F.R. § 438.8(e) for the numerator of the benefit ratio. This includes the sum of the Contractor's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities.

5.4.3.2 Total Net Revenue will be calculated as defined in 42 C.F.R. § 438.8(f) for the denominator of the benefit ratio. This includes the Contractor's premium revenue net of Dental Access Payment (DAP) components of capitation revenue, and adjusted to remove taxes and licensing and regulatory fees.

5.4.3.3 Target Benefit Ratio will be calculated as the benefit expenses project in capitation rate development divided by capitation rate payments net of DAP and adjusted to remove taxes and fees. As this ratio may vary by aid category, the Target Benefit Ratio will be calculated based on the composite enrollment experience for the Contractor during the measurement year.

5.4.3.4 Actual Benefit Ratio will be calculated as Total Benefit Expenses divided by Total Net Revenue.

5.4.3.5 Contractor's Gain/Loss will be calculated as the Target Benefit Ratio minus the Actual Benefit Ratio.

5.4.3.6 Risk Corridor and Gain Share Settlements will be calculated as the Target Benefit Ratio minus the Actual Benefit Ratio.

5.4.4 Risk Corridor and Gain Share settlements will be calculated six (6) months following the end of the Contract year, using the financial reports provided by the Contractor.

5.4.5 Under the risk corridor arrangement (first Contract year), if the Contractor experiences a gain or loss exceeding three percent (3%) of the Target Benefit Ratio, HCA will share equally in the gain/loss between three percent (3%) and five percent (5%). If the Contractor experiences a gain or loss exceeding five percent (5%) of the Target Benefit Ratio HCA will recover all gains exceeding five percent (5%) or cover all losses exceeding five percent (5%).

5.4.6 Under the gain share arrangement (subsequent Contract years), if the Contractor experiences a gain exceeding three percent (3%) of the Target Benefit Ratio, HCA will share equally in the gain between three percent (3%) and five percent (5%). If the Contractor experiences a gain exceeding five percent (5%) of the Target Benefit Ratio, HCA will recover all gains exceeding five percent (5%).

5.4.7 If the final calculation of risk corridor or gain share settlements results in an adjusted Actual Benefit Ratio below 85%, Contractor will remit the full amount of the difference such that the final adjusted Benefit Ratio is 85%, as authorized under the minimum MLR requirement defined in 42 C.F.R. § 438.8(c).

5.5 Recoupments

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

5.5.1.1 With Duplicate Coverage.

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

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

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

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

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

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

5.5.2 The Contractor may recoup payments made to providers for services provided to Enrollees during the period for which the HCA recoups premiums for those Enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to the Health Care Authority through its fee-for-service program, if the Enrollee remained eligible for services during the period for which HCA recoups premiums.

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

5.6 Targeted Service Enhancements

The per member per month premium amounts established by HCA will include additional funding for targeted services.

5.6.1 Dental Access Payment (DAP) Program

5.6.1.1 HCA will calculate the per member premium based on the estimated funding

to be collected and the estimated member month premiums to be paid over the contracted period.

5.6.2 Dental Education in Care of Persons with Disabilities (DECOD) Payments

The DECOD Provider is entitled to a training fee, in addition to qualifying services provided to eligible DECOD Enrollees.

5.6.2.1 The Contractor will provide reimbursement for a training fee in addition to qualified services provided to eligible DECOD Enrollees.

5.6.2.2 Upon receipt and acceptance of an encounter for a qualified service provided by the DECOD Provider, HCA will pay the Contractor a Service Based Enhancement (SBE) payment equal to the training fee.

5.6.2.3 The SBE payments will be calculated separately and apart from the risk-based premium payments made to the Contractor by HCA and at no time will the Contractor be at risk for or have any claim to the SBE payments.

5.6.2.4 The Contractor must ensure it has sufficiently trained staff to handle calls and/or inquiries from Providers regarding the reimbursement process.

5.7 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 retroactive modifications to the rate.

5.8 Encounter Data

5.8.1 For purposes of this Subsection:

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

5.8.1.2 "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.

5.8.1.3 "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.

5.8.1.4 "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.

5.8.2 The Contractor must comply with all of the following:

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

5.8.2.2 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:

5.8.2.2.1 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;

5.8.2.2.2 Submitted encounters and encounter records must 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 must 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;

5.8.2.2.3 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

5.8.2.2.4 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.

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

5.8.3 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 will not be utilized in the consideration of a Contractor's assignment percentage or in the evaluation of a Contractor's performance.

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

5.8.5 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:

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

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

5.8.5.3 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.

5.8.6 The Contractor must submit a signed Monthly Certification Letter, incorporated in this Contract as Attachment 2, Monthly Certification Letter. This letter must include a list of all submitted encounter data files and is due within five (5) Business Days from the end of each month. The purpose of this letter is to certify that, based on the best information, knowledge, and belief, the data, documentation, and information submitted is accurate, complete, and truthful in accordance with 42 C.F.R. § 438.606 and this Contract.

5.8.7 The Contractor must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims.

5.8.7.1 Within sixty (60) calendar days of the end of each calendar quarter, the Contractor will provide aggregate totals of all encounter data submitted and accepted within required timing in 5.11.2.2 of this Section during that quarter using the Apple Health Quarterly Encounter/General Ledger Reconciliation (Form D), attached to this Contract as Attachment 1, and will 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 must provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the Contractor of the decision one hundred twenty (120) calendar days of the end of each

calendar quarter.

5.8.7.2 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 one percent (1%) of what HCA captured.

5.8.7.2.1 If the Contractor's encounter data submitted and accepted on Form D is not within one percent (1%) 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.

5.8.7.3 Following the completion of the quarterly validation process described in 5.11.7.1 through 5.11.7.2 of this Subsection, 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 one percent (1%). HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

5.8.8 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, service verification, managed care quality improvement program, utilization patterns and access to care; and research studies.

5.8.9 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract:

5.8.9.1 HCA may change the Encounter Data Reporting Guide with ninety (90) calendar days' written notice to the Contractor.

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

5.8.9.3 The Contractor will, upon receipt of such notice from HCA, provide notice of

changes to subcontractors.

5.9 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 5.5, such changes will only affect premium payments prospectively.

5.10 Renegotiation of or Changes in Rates

The rates set forth herein will 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 program or coverage 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.

5.11 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.

5.12 Provider Payment Reform

HCA intends to reform provider payment. The Contractor must 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.

5.13 Experience Data Reporting

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

5.14 Payment for Services by Providers

5.14.1 The Contractor will pay all Providers for services delivered under this contract that are not part of capitated or value-based purchasing arrangements at reimbursement rates no less than those published by HCA for its fee-for-service program.

5.15 Payment for Services by Non-Participating Providers

5.15.1 The Contractor will limit payment for emergency dental services within the scope of this Contract furnished by a dental 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 Fee-For-Service (FFS) Dental program (Deficit Reduction Act of 2005,

Public Law No. 109-171, Section 6085).

5.15.2 Except as provided herein for emergency dental services, the Contractor will coordinate with and pay a non-participating dental 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 dental providers in the state. For the purposes of this subsection, "contracts with similar dental providers in the state" means the Contractor's contracts with similar dental providers to provide services under the managed care dental program when the payment is for services received by a managed care dental Enrollee.

5.15.3 The Contractor must track and record all payments to participating dental providers and non-participating dental providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating dental providers and non-participating dental providers separately. The Contractor will identify the type of dental providers: general Dentist, pediatric Dentist, endodontist, orthodontist, oral surgeon, denturist, ABCD-certified dental provider, Oral Health Connections Pilot-certified dental provider, Indian/Tribal/Urban (I/T/U) dental provider, FQHC/RHC dental provider, Independent Hygienist, or other licensed dental providers.

5.15.4 The Contractor must also track, document and report to HCA any known attempt by non-participating dental providers to balance bill Enrollees.

5.15.5 The Contractor must provide annual reports to the HCA for the preceding state fiscal year July 1st through June 30th. The reports will indicate the proportion of services provided by the Contractor's participating dental providers and non-participating dental providers, by county in a format provided by HCA. Contractor must submit the report to HCA no later than August 15th of each year, or as required by HCA.

5.16 Data Certification Requirements

Any information and/or data required by this Contract and submitted to HCA must be certified by the Contractor as follows (42 C.F.R. § 438.242(b)(2) and 438.600 through 438.606):

5.16.1 Source of certification: The information and/or data must be certified by one of the following:

5.16.1.1 The Contractor's Chief Executive Officer.

5.16.1.2 The Contractor's Chief Financial Officer.

5.16.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

5.16.2 Content of certification: The Contractor's certification will attest, based on best knowledge, information, and belief, to the accuracy, completeness and truthfulness of the information and/or data.

5.16.3 Timing of certification: The Contractor must submit the certification concurrently with the certified information and/or data.

5.16.4 HCA will identify the specific data that requires certification.

5.17 Sanctions

5.17.1 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).

5.17.2 HCA will notify the Contractor of any default in writing, and will 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.

5.17.2.1 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.

5.17.2.2 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:

5.17.2.2.1 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.

5.17.2.2.2 Imposing on Enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

5.17.2.2.3 Acting to discriminate against Enrollees on the basis of their oral health status or need for oral health 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 oral health condition or history indicates probable need for substantial future oral health services.

5.17.2.2.4 Misrepresenting or falsifying information that it furnishes to CMS, HCA, an Enrollee, potential Enrollee, or any of its subcontractors.

5.17.2.2.5 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.

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

5.17.2.3 HCA may base its determinations regarding Contractor conduct on findings from onsite surveys, Enrollee or other complaints, financial status, or any other source.

5.17.2.4 Except for matters and penalties covered under Chapters 74.09 and 74.66 RCW, intermediate sanctions may include:

5.17.2.4.1 Civil monetary sanctions in the following amounts:

5.17.2.4.1.1 A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to Enrollees, potential Enrollees or dental providers; or marketing violations.

5.17.2.4.1.2 A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or HCA.

5.17.2.4.1.3 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.

5.17.2.4.1.4 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.

5.17.2.4.2 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.

5.17.2.4.3 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA will notify current Enrollees of the sanctions and that they may terminate enrollment at any time.

5.17.2.4.4 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.

5.18 Payments for Services at FQHC, RHC, and IHCP Facilities

The FQHC/RHC or IHCP 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)).

5.18.1 The Contractor will provide reimbursement for encounter qualified services provided at FQHC, RHC, or IHCP facilities at the applicable encounter rate.

5.18.2 Upon receipt and acceptance of an encounter for a qualified service provided at an FQHC, RHC, or IHCP facility, HCA will pay the Contractor a Service Based Enhancement (SBE) payment equal to the difference between the applicable FFS amount for the encounter and the full encounter rate.

5.18.3 The SBE payments will be calculated separately and apart from the risk-based premium payments made to the Contractor by HCA and at no time will the Contractor be at risk for or have any claim to the FQHC, RHC, or IHCP SBE payments.

5.18.4 The Contractor must ensure it has sufficiently trained staff to handle calls and/or inquiries from providers regarding the reimbursement process.

5.19 Billing for Services Provided by Residents

The Contractor will allow teaching providers to submit claims for primary dental care services provided by interns and residents under supervision of the teaching physician.

5.20 Institute for Mental Disease (IMD)

When an Enrollee resides in an IMD for mental health for more than fifteen (15) calendar days within a single calendar month, federal funds may not be used to cover the costs of care for the Enrollee.

5.20.1 By the last calendar day of each month, HCA will provide a report to the Contractor of each Enrollee who had an IMD stay of more than fifteen (15) calendar days within the preceding calendar month.

5.20.2 HCA will recoup the monthly premium payment for Enrollees with stays in an IMD of more than fifteen (15) calendar days within a calendar month.

5.20.3 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 Enrollees' 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.

5.20.4 When the premium payment for an Enrollee is recouped in accordance with subsection 5.19.2, 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 subsection 5.19.3.

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor must maintain and monitor an appropriate 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 last day of the month following the last day of the quarter, the Contractor must provide documentation of its provider network, including the two critical provider types and all contracted specialty providers. This report will provide evidence that the Contractor has adequate provider capacity to deliver services that meet the timeliness standards described in Subsection 6.9 of this Section to all Enrollees and will 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 must include information regarding the Contractor's maintenance, monitoring and analysis of the network. The quarterly reports will 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 must 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 To the extent necessary to comply with the provider Network Adequacy and distance standards required under this Contract, the Contractor must offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure timely access to necessary care 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.

6.1.7 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 will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.1.7.1 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 will be suspended for that service area. Suspension of assignments will continue until the quarter in which the Contractor submits an accurate submission for that service area.

6.1.8 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 nonperformance. HCA will notify the Contractor in writing thirty (30) calendar days before deducting the amount from the next batch payment to the Contractor.

6.1.9 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: general Dentists, pediatric Dentists, oral surgeons, orthodontists, and denturists, 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.

6.1.10 The Contractor must 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 must 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 will not be construed to require the Contractor to cover such services without authorization except as required for Emergency Services.

6.1.11 The Contractor must maintain an online provider directory that meets the requirements listed below. Information must be provided for each of the provider types covered under

this Contract: general Dentists, pediatric Dentists, oral surgeons, orthodontists, and denturists. 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:

6.1.11.1 Maintain a link on the front page of the Contractor's website that immediately links users to the Contractor's online, searchable provider directory.

6.1.11.2 Include a list of all clinics and general and specialty dental providers, including street addresses, telephone numbers, and URLs, as appropriate.

6.1.11.3 Include any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges, or provider groups with which a provider is a member.

6.1.11.4 Includes a description of each primary and specialty provider's languages spoken, including American Sign Language, and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its members, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili", and whether the provider has completed cultural competence training. Also include information about available interpreter services, communication, and other language assistance services.

6.1.11.5 Includes information on each primary and specialty provider's experience working with developmentally disabled Enrollees.

6.1.11.6 Includes information about whether the Contractor's network providers' office/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

6.1.11.7 Indicates whether each primary and specialty provider, are accepting new patients.

6.1.11.8 Include a specific description of how telemedicine is used to render dental services.

6.1.11.9 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)).

6.1.11.9.1 If the Contractor chooses to provide paper provider directories, they must be updated monthly.

6.1.11.10 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 telephone number, dedicated email address and a form on the website so that errors can be reported directly through the website. Errors must be corrected within seven (7) calendar days.

6.1.11.11 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 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)):

6.2.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.

6.2.2 Adequate access to all services covered under this Contract.

6.2.3 The number and types (in terms of training, experience and specialization) of providers required to furnish the Contracted Services, including endodontics, orthodontics, oral surgery, and removable prosthodontics providers by provider type.

6.2.4 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.

6.2.5 The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees or potential Enrollees, and whether the location provides physical access for the Contractor's Enrollees with disabilities.

6.2.6 The cultural, racial/ethnic composition and language needs of Enrollees and the ability of network providers to communicate with limited English proficient Enrollees in their preferred language.

6.2.7 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.

6.2.8 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.

6.2.9 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 Screening and Enrollment of Providers

6.3.1 The Contractor shall ensure that all network providers are enrolled with the state as Medicaid providers consistent with federal disclosure, screening, and enrollment requirements.

6.3.2 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.

6.3.3 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.

6.4 Timely Access to Care

The Contractor must 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 will 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 fee-for-service.

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 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)).

6.6 24/7 Availability

The Contractor must 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)).

6.6.1 Dental advice for Enrollees from licensed Health Care Professionals.

6.6.2 Triage concerning the emergent, urgent or routine nature of dental conditions by licensed Health Care Professionals.

6.6.3 Authorization of urgent and Emergency Services, including emergency care for services provided outside the Contractor's service area.

6.6.4 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.

6.7 Customer Service

The Contractor must 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 will 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 will be provided at the expense of the Contractor.

6.7.1 The Contractor must report by December 1st of each year its scheduled non-Business Days for the upcoming calendar year.

6.7.2 The Contractor and its subcontracted provider help desks, authorization lines, and Enrollee customer service centers, if any, must comply with the following customer service performance standards:

6.7.2.1 Telephone abandonment rate – standard is less than 3%.

6.7.2.2 Telephone response time - average speed of answer within 30 seconds.

6.8 Appointment Standards

The Contractor must comply with appointment standards that are no longer than the following (42 C.F.R. § 438.206(c)(1)(i)):

6.8.1 Non-symptomatic office visits will be available from the Enrollee's assigned Dentist or another provider within sixty (60) calendar days. A non-symptomatic office visit may include, but is not limited to, preventive care such as comprehensive and periodic exams and cleanings for children and adults

6.8.2 Non-urgent, symptomatic office visits will be available from the Enrollee's assigned Dentist 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.

6.8.3 Urgent, symptomatic office visits will be available from the Enrollee's assigned Dentist 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.

6.8.4 Emergency care must be available twenty-four (24) hours per day, seven (7) days per week.

6.8.5 Appointments for consultation of recommended services ("second opinion"), described

in Subsection 16.2.1, 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.

6.8.6 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.

6.9 Provider Database

The Contractor must have, maintain and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the Contractor will 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)).

6.10 Provider Network - Distance and Drive Time Standards

6.10.1 The Contractor's network of providers must 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).

6.10.2 Distance Standards

6.10.2.1 General Dentists

6.10.2.1.1 Urban: 1 within 10 miles.

6.10.2.1.2 Rural: 1 within 25 miles.

6.10.2.2 Pediatric Dentists

6.10.2.2.1 Urban: 1 within 10 miles.

6.10.2.2.2 Rural: 1 within 25 miles.

6.10.2.3 Oral Surgeons

6.10.2.3.1 Urban: 1 within 25 miles.

6.10.2.3.2 Rural: 1 within 25 miles.

6.10.2.4 Orthodontists

6.10.2.4.1 Urban: 1 within 25 miles.

6.10.2.4.2 Rural: 1 within 25 miles.

6.10.2.5 Denturists

6.10.2.5.1 Urban: 1 within 25 miles.

6.10.2.5.2 Rural: 1 within 25 miles.

6.10.3 Drive Time Standards

6.10.3.1 General Dentists

6.10.3.1.1 Urban: 1 within 10 minutes.

6.10.3.1.2 Rural: 1 within 25 minutes.

6.10.3.2 Pediatric Dentists

6.10.3.2.1 Urban: 1 within 10 minutes.

6.10.3.2.2 Rural: 1 within 25 minutes.

6.10.3.3 Oral Surgeons

6.10.3.3.1 Urban: 1 within 25 minutes.

6.10.3.3.2 Rural: 1 within 25 minutes.

6.10.3.4 Orthodontists

6.10.3.4.1 Urban: 1 within 25 minutes.

6.10.3.4.2 Rural: 1 within 25 minutes.

6.10.3.5 Denturists

6.10.3.5.1 Urban: 1 within 25 minutes.

6.10.3.5.2 Rural: 1 within 25 minutes.

6.10.4 HCA may, in its sole discretion, grant exceptions to the distance and drive time standards. HCA's approval of an exception will be in writing. The Contractor must request an exception in writing and will 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.

6.11 Assignment of Enrollees

6.11.1 HCA has the sole and exclusive right to determine the methodology and procedures by which Enrollees are assigned to the Contractor or reassigned to any other Apple Health Dental Managed Care contractors (MCEs).

6.11.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or Enrollees.

6.11.3 HCA will count New Individuals, Family Connects, and Plan Reconnects as part of an MCO's enrollment in all service areas.

6.11.4 Reassignment of Enrollees

6.11.4.1 HCA may, at its sole discretion reassign Enrollees to the Contractor and an individual may choose to voluntarily enroll with the Contractor if the Contractor is eligible to receive enrollment in the individual's service area, consistent with this Subsection.

6.11.5 Assignment of New Individuals

6.11.5.1 The number of New Individuals assigned to the Contractor and to all other MCOs depends on the number of MCOs eligible to receive assignments in a service area and the number of New Individuals eligible for assignment in a service area; and the performance measures of the Contractor and all other MCEs on the Network Adequacy.

6.11.5.2 HCA will assign New Individuals to an eligible MCO in the individual's service area. Once assigned, HCA will notify the Enrollee of his or her assignment and provide information on how the individual can change enrollment to another MCO available in the service area, if any. The effective date of enrollment will be consistent with the enrollment provisions of this Contract.

6.11.6 Service area assignment process:

6.11.6.1 HCA, in its sole discretion, will determine whether the Contractor's provider network meets the required capacity.

6.11.6.1.1 To receive New Individual assignments and voluntary enrollments in a service area, the Contractor must attain a Capacity Threshold as described in this subsection.

6.11.6.1.2 If at any time during the term of this Contract the Contractor's provider network no longer meets the minimum Capacity Threshold in any service area, HCA may, in its sole discretion, reassign all Enrollees covered by the Contractor to another MCO in the service area.

6.11.6.1.2.1 Upon HCA's request, the Contractor must provide a list of current Enrollees and their assigned PDP.

6.11.6.1.2.2 The Contractor must assist HCA in the orderly transition of Enrollees to another MCO, consistent with the Care Coordination provisions of this Contract.

6.11.6.1.3 HCA recognizes that a full complement of critical provider types may not be available in a services area; therefore, HCA may, at its sole discretion, make exceptions to Network Adequacy standards to provide coverage for that service area.

6.11.6.2 Under this Contract, enrollment assignments for each month in the first year will be set by HCA based on Contractor's Network Adequacy in a service area.

6.11.6.3 Enrollment assignments for each month for each subsequent year covered under this Contract will be set by HCA based on the administrative measure (e.g. initial health screen) and selected Clinical Performance Measures to be provided to Contractor.

6.11.6.3.1 Administrative Measure (Initial Health Screen): The Contractor must submit quarterly reports of its performance on completing Initial Health Screens on all New Individual, Family Connect, and Plan Reconnect Enrollees.

6.11.7 Administrative Measure (Initial Health Screen) calculation:

6.11.7.1 The Contractor must calculate and report its performance on completing Initial Health Screens on all New Individual, Family Connect and Plan Reconnect Enrollees on a quarterly basis. HCA will begin using this information to calculate assignments beginning January 1, 2020.

6.11.7.2 To calculate the quarterly screening performance:

6.11.7.2.1 The numerator is the total number of New Individuals, Family Connects, and Plan Reconnects that have received an Initial Health Screen.

6.11.7.2.2 The denominator is the total number of New Individuals, Family Connects, and Plan Reconnects.

6.11.7.2.3 The Contractor shall report its screening performance numerator, denominator and rate (expressed as a percentage) according to the following schedule:

6.11.7.2.3.1 January, February and March – Submitted June 15th of each contract year;

6.11.7.2.3.2 April, May and June – Submitted September 15th of each contract year;

6.11.7.2.3.3 July, August and September – Submitted December 15th of each contract year; and

6.11.7.2.3.4 October, November and December – Submitted March 15th of each contract year.

6.12 Distance Standards for High Volume Specialty Care Providers

The Contractor shall establish, analyze and meet measurable distance standards for high volume specialty care providers, subject to HCA approval. At a minimum the Contractor shall establish, analyze and meet distance standards for endodontists and periodontists.

The Contractor shall ensure pediatric specialists are noted in this list. The Contractor shall analyze performance against standards at minimum, annually and provide a report to HCA upon request detailing the outcomes of this analysis along with the Contractor's analysis of Primary Dental Providers.

6.13 Standards for the Ratio of Primary Dental and Specialty Providers to Enrollees

The Contractor must establish and meet measurable standards for the ratio of both PDPs and high volume Specialty Dental Providers to Enrollees. The Contractor will analyze performance against standards at minimum, annually.

6.14 Access to Specialty Care

6.14.1 The Contractor must 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 time frame described in subsection 6.2 of 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.

6.14.2 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.

6.15 Contracts with Traveling Independent Hygienists

The Contractor shall contract with an adequate number of Independent Hygienists to ensure Enrollees in health care facilities, senior centers, and schools have access to authorized dental hygiene operations and services without dental supervision.

6.16 Enrollees Residing in Rural Areas

If an Enrollee resides in a rural area in which there is mandatory enrollment, the following requirements apply:

6.16.1 The Enrollee must have a choice of two Primary Dental Providers when there is a single plan in the area (42 C.F.R. § 438.52(b)(2)(i));

6.16.2 The Enrollee may seek care from a non-participating provider when the service or type of provider (in terms of training, experience and specialization) is not available within the Contractor's network or when the service or type of provider is available in the Contractor's network, but an appointment with a participating provider cannot be scheduled to provide the service within the time frames listed in subsection 6.5 of this Contract (42 C.F.R. § 438.52(b)(2)(ii)(A));

6.16.3 The Enrollee may seek a service from a non-participating provider when Enrollee's primary dental 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

6.16.4 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)).

6.17 Order of Acceptance

6.17.1 The Contractor must provide care to all Enrollees who voluntarily choose the Contractor and all Enrollees assigned by HCA.

6.17.2 Enrollees will be accepted in the order in which they apply.

6.17.3 HCA will enroll all Eligible Clients with the Contractor of their choice except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

6.17.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of subsections 6.9 Provider Network – Distance and Drive Time Standards and 6.10 Assignment of Enrollees . The Contractor will submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.

6.17.5 The Contractor may request in writing that HCA suspend voluntary enrollment and/or assignments in any service area. HCA will approve the temporary suspension when, in the sole judgment of HCA, it is in the best interest of HCA and/or its clients. The Contractor will submit any information HCA requires to make a final decision on this request.

6.17.6 The Contractor must accept clients who are enrolled by HCA in accord with this Contract and chapter 182-538 WAC.

6.17.7 No eligible client will 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 condition, including the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

6.18 Provider Network Changes

6.18.1 The Contractor must 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.

6.18.2 The Contractor must 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 must 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 will allow affected Enrollees to continue to receive services from the terminating provider, at the Enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies Enrollees or the Enrollee's effective date of enrollment with another plan.

6.18.3 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 will be in addition to any other provisions of this Contract.

6.18.4 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.

6.18.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor must provide documentation of the date of notification along with the notice of loss of a Material Provider.

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Assessment and Performance Improvement (QAPI) Program

7.1.1 The Contractor must have and maintain a quality assessment and performance improvement (QAPI) program for the dental health services it furnishes to its Enrollees that meets the provisions of 42 C.F.R. § 438.330.

7.1.1.1 The Contractor will define its QAPI program structure and processes and assign responsibility to appropriate individuals.

7.1.1.2 The QAPI program structure must include the following elements:

7.1.1.2.1 A written description of the QAPI program including identification and description of the roles of designated providers. The QAPI program description will include:

7.1.1.2.1.1 A listing of all quality-related committee(s);

7.1.1.2.1.2 Descriptions of committee responsibilities;

7.1.1.2.1.3 Contractor staff and practicing provider committee participant titles;

7.1.1.2.1.4 Meeting frequency; and

7.1.1.2.1.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate.

7.1.1.2.2 A Quality Improvement (QI) Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

7.1.1.2.2.1 Recommend policy decisions;

7.1.1.2.2.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data and performance improvement;

7.1.1.2.2.3 Institute actions to address performance deficiencies; and

7.1.1.2.2.4 Ensure appropriate follow-up.

7.1.1.2.3 An annual quality work plan, including objectives for serving Individuals with Special Health Care Needs and Enrollees from diverse communities. The work plan must contain:

7.1.1.2.3.1 Goals and objectives for the year, including objectives for patient safety, serving a culturally and linguistically diverse membership, vulnerable populations including young children (age 0 to 5), individuals with disabilities, individuals experiencing homelessness, and Individuals with Special Health Care Needs;

7.1.1.2.3.2 Timeframe to complete each activity;

7.1.1.2.3.3 Identification of a responsible person for each activity; and

7.1.1.2.3.4 Mechanisms to assess the quality and appropriateness of care furnished to Individuals with Special Health Care Needs; and

7.1.1.2.3.5 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.

7.1.1.2.4 An annual written report of the overall evaluation of the effectiveness of the Contractor QAPI program. (42 C.F.R. § 438.330(c)(2)(i) and (ii)). The report must include at minimum:

7.1.1.2.4.1 Findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care for dental health (42 C.F.R. § 438.330(b)(3)). The following minimum measure set must be reported on in the annual QAPI program evaluation about over and under-utilization:

7.1.1.2.4.1.1 Avoidable emergency department visits (HCA will provide needed ED data to Contractor);

7.1.1.2.4.1.2 Adults who have at least one preventive dental service during the year (HCA will provided Preventive Dental Care codes to Contractor);

7.1.1.2.4.1.3 Children (21 and under) who have at least one preventive dental service during the year (HCA will provide Preventive Dental Care codes to Contractor); and

7.1.1.2.4.1.4 Children (age 6-14) who have at least one sealant service on one of the permanent molars during the year.

7.1.1.2.4.2 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.

7.1.1.2.4.3 A written assessment of the success of contractually required performance improvement projects.

7.1.2 Upon request, the Contractor will 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 must provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities will 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 must have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. The Contractor must conduct the following PIPs:

7.2.1.1 One clinical PIP to increase use of dental treatment plans and ensure

implementation and completion of the treatment plan; and

7.2.1.2 One non-clinical PIP to improve adult access to preventive dental care.

7.2.2 Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction and must 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 must 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 15th.

7.2.3.2 Each completed project must be documented on a PIP Worksheet found in the CMS protocol entitled “Conducting Performance Improvement Projects”.

7.2.4 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 AHMC.

7.3 Performance Measures

7.3.1 The Contractor must report the following required Performance Measures annually to HCA:

7.3.1.1 Percentage of all Enrollees who received at least one dental service within the reporting year by the following age groups (in years): 0-20; and 21+.

7.3.1.2 Percentage of all Enrollees aged 14 and younger who are at “elevated” risk (i.e. “moderate” or “high”) who have received sealants on permanent molars within the reporting year by the following age groups (in years): 6-9; and 10-14.

7.3.1.3 Percentage of all Enrollees aged 13 and older with history of periodontitis who received a comprehensive or periodic oral evaluation, or a comprehensive periodontal evaluation within the reporting year by the

following age groups (in years): 13-20; and 21+.

7.3.1.4 Percentage of all Enrollees aged 13 and older with a history of periodontitis who received one of the following within the reporting year:

7.3.1.4.1 An oral prophylaxis; or

7.3.1.4.2 Scaling/root planning; or

7.3.1.4.3 Two (2) periodontal maintenance visits.

7.3.1.5 Percentage of DDA and NH Enrollees with a history of periodontitis who received one of the following within the reporting year:

7.3.1.5.1 An oral prophylaxis; or

7.3.1.5.2 One (1) scaling/root planning; or

7.3.1.5.3 Two (2) periodontal maintenance visits.

7.3.1.6 Percentage of all Enrollees aged 20 and younger who are at "elevated" risk (i.e. "moderate" or "high") who received a topical fluoride application within the reporting year.

7.4 External Quality Review

7.4.1 Validation Activities: The Contractor's quality program must be examined using a series of required validation procedures. The examination will be implemented and conducted by HCA, its agent, or an EQRO.

7.4.2 The following required activities will be validated (42 C.F.R. § 438.358(b)(1)):

7.4.2.1 Performance improvement projects.

7.4.2.2 Performance measures.

7.4.2.3 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.

7.4.3 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.

7.4.4 The Contractor must 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.

7.4.5 The Contractor must submit to annual HCA and EQRO monitoring reviews. 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. § 438.204).

7.4.6 The Contractor must, 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.

7.4.7 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 C.F.R. § 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.

7.4.8 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.

7.4.9 If the Contractor has had an accreditation review or visit by another accrediting body, the Contractor will provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor will allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative must 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.

7.5 Provider Complaints and Appeals

7.5.1 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 provider complaint and appeal data to HCA upon request (42 C.F.R. § 438.66(c)(3)).

7.6 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.

7.6.1 Individual Critical Incident Reporting

The Contractor shall submit an individual Critical Incident report for the following incidents:

7.6.1.1 Homicide or attempted homicide by an Enrollee;

7.6.1.2 The unexpected death or serious injury of an Enrollee;

7.6.1.3 Abuse, neglect or exploitation of an Enrollee; and

7.6.1.4 Violent acts allegedly committed by an Enrollee to include:

7.6.1.4.1 Arson;

7.6.1.4.2 Assault resulting in serious bodily harm;

7.6.1.4.3 Homicide or attempted homicide by abuse;

7.6.1.4.4 Drive-by shooting;

7.6.1.4.5 Extortion;

7.6.1.4.6 Kidnapping;

7.6.1.4.7 Rape, sexual assault or indecent liberties;

7.6.1.4.8 Robbery; and

7.6.1.4.9 Vehicular homicide.

7.6.1.5 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.

7.6.1.6 Any event involving an Enrollee that has attracted or is likely to attract media attention.

7.6.2 The Contractor shall report Critical Incidents within one business day in which the Contractor becomes aware of the event. The report shall include:

7.6.2.1 The date the Contractor becomes aware of the incident;

7.6.2.2 The date of the incident;

7.6.2.3 A description of the incident;

7.6.2.4 The name of the facility where the incident occurred, or a description of the incident location;

7.6.2.5 The name(s) and age(s) of Enrollees involved in the incident;

7.6.2.6 The name(s) and title(s) of facility personnel or other staff involved;

7.6.2.7 The name(s) and relationship(s), if known, of other persons involved and the nature and degree of their involvement;

7.6.2.8 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;

7.6.2.9 Actions planned or taken by the Contractor to minimize harm resulting from the incident; and

7.6.2.10 Any legally required notifications made by the Contractor.

7.6.3 The Contractor shall report Critical Incidents using the Incident Reporting System (Currently called the Behavioral Health and Recovery Incident Reporting System) at https://fortress.wa.gov/dshs/medirhrsa/Login.aspx. If the system is unavailable the Contractor shall report Critical Incidents to HCAMCPrograms@hca.wa.gov.

7.6.4 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:

7.6.4.1 A summary of any debriefings;

7.6.4.2 Whether the Enrollee is in custody (jail), in the hospital or in the community;

7.6.4.3 Whether the Enrollee is receiving services and include the types of services provided;

7.6.4.4 If the Enrollee cannot be located, the steps the Contractor has taken to locate the Enrollee using available, local resources; and

7.6.4.5 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.

7.6.5 Population Based Reporting

The Contractor shall submit a semiannual report of all Critical Incidents tracked by the Contractor. At minimum, the report shall include an analysis of the following incidents:

7.6.5.1 Incidents identified through the Individual Critical Incidents process;

7.6.5.2 A credible threat to Enrollee safety;

7.6.5.3 Any allegation of financial exploitation of an enrollee;

7.6.5.4 Suicide and attempted suicide; and

7.6.5.5 Other incidents as defined in the Contractor's Policies and Procedures.

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.

The report is due no later than the last business day of January and July for the prior six (6) month period.

The Contractor shall also include a data file of all Critical Incidents from which the analysis is made using a template provided by HCA.

7.7 Practice Guidelines

7.7.1 The Contractor shall adopt dental health practice guidelines known to be effective in improving health outcomes. Practice guidelines must meet the following requirements (42 C.F.R. § 438.236):

7.7.1.1 Are based upon the following:

7.7.1.1.1 Valid and reliable clinical scientific evidence;

7.7.1.1.2 In the absence of scientific evidence, on professional standards; or

7.7.1.1.3 In the absence of both scientific evidence and professional standards, a consensus of health care professionals in the particular field.

7.7.2 The Contractor shall adopt accepted national guidelines that promote evidence-based clinical practice guidelines, developed by recognized sources, including but not limited to: United States Preventive Services Task Force (USPSTF), American Dental

Association (ADA), the National Network for Oral Health Access, National Maternal and Child Oral Health Resource Center, American Academy of Pediatric Dentistry, and Indian Health Service. If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines. The guidelines shall:

7.7.2.1 Be age-appropriate to address the special needs or considerations that are driven by age.

7.7.2.2 Consider the needs of Enrollees and support client and family involvement in care plans.

7.7.2.3 Be adopted in consultation with contracting health care professionals within the state of Washington or, when applicable, are adopted in consultation with the dental health professionals in the Contractor's contracted network.

7.7.2.4 Be reviewed and updated at least every two years and more often if national guidelines change during that time.

7.7.2.5 Be disseminated to all affected providers and, upon request, to HCA, Enrollees and potential Enrollees (42 C.F.R. § 438.236(c)).

7.7.2.6 Be distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers.

7.7.2.7 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)).

7.7.3 The Contractor will develop health promotion and preventive care educational materials for Enrollees using both print and electronic media. In developing these materials, the Contractor must:

7.7.3.1 Conduct outreach to Enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.

7.7.3.2 Report on preventive care utilization through required performance measure reporting.

7.8 Health Information Systems

The Contractor shall maintain, and shall require subcontractors to maintain, a health information system that complies with the requirements of 42 C.F.R. § 438.242 and provides the information necessary to meet the Contractor's obligations under this Contract. The Contractor must have in place mechanisms to verify the health information received from subcontractors. The health information system must:

7.8.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility.

7.8.2 Ensure data received from providers is accurate and complete by:

7.8.2.1 Verifying the accuracy and timeliness of reported data;

7.8.2.2 Screening the data for completeness, logic, and consistency; and

7.8.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.8.3 The Contractor must make all collected data available to HCA and the Center for Medicare and Medicaid Services (CMS) upon request.

7.9 Technical Assistance

The Contractor may request technical assistance for any matter pertaining to this Contract by contacting HCA.

8 POLICIES AND PROCEDURES

The Contractor will develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor must 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 will:

8.1.1 Direct and guide the Contractor's employees, subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements;

8.1.2 Fully articulate the Contractor's understanding of the requirements;

8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment of participant knowledge and satisfaction with the training;

8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training; and

8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

8.2 Assessment of Policies and Procedures

The Contractor must 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 must complete and submit the list no later than June 30, 2019 and, thereafter, in response to corrective action and any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor must 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, terminates 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 will 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 will 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 will 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 will 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 must 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 must 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, MFCU, State Auditor, CMS, auditors from the federal Government Accountability Office, federal Office of the Inspector General, federal Office of Management and Budget, the Office of the Inspector General, the Comptroller General, and their designees, to access, inspect, audit and evaluate any records or documents of the subcontractors, and shall permit inspection of the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted, at any time. The subcontractors shall make copies of records and shall deliver them to the requestor, without cost, within thirty (30) calendar days of request, or any shorter timeframe as authorized by law or court order. 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.

9.4.8 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.

9.4.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.

9.4.10 No assignment of a subcontract may take effect without HCA's written agreement.

9.4.11 The subcontractor must comply with the applicable state and federal statutes, rules and regulations, and subregulatory policies as set forth in this Contract, including but not limited to 42 U.S.C. § 1396a(a)(43), 42 U.S.C. § 1396d(r), and 42 C.F.R. § 438.3(l) and § 438.230(c)(2).

9.4.12 Subcontracts will 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).

9.4.13 The Contractor must 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)):

9.4.13.1 The toll-free numbers to file oral grievances and appeals.

9.4.13.2 The availability of assistance in filing a grievance or appeal.

9.4.13.3 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.

9.4.13.4 The Enrollee's right to file grievances and appeals and their requirements and timeframes for filing.

9.4.13.5 The Enrollee's right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.4.13.6 The subcontractor may file a grievance or request an adjudicative proceeding on behalf of an Enrollee in accordance with subsection 13.2.1.

9.4.14 The process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

9.4.15 A process to identify deficiencies and take corrective action for both the Contractor and subcontractor.

9.4.16 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.

9.4.17 Prior to delegation, the Contractor must 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.

9.4.18 The requirement to refer credible allegations of fraud to HCA and the Medicaid Fraud Control Unit as described in subsection 12.6 of this Contract. (42 C.F.R § 455.23).

9.5 Health Care Provider Subcontracts

The Contractor's subcontracts, including those for facilities and pharmacy benefit management, must also contain the following provisions:

9.5.1 A quality improvement system consistent with the Contractor's obligations under sections 7.1 through 7.3, tailored to the nature and type of services subcontracted, which affords quality control for the dental health care provided, including but not limited to the accessibility of medically necessary dental 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 provider subcontractors must 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, Member Rights and Responsibilities, and Credentialing and Recredentialing.

9.5.4 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

9.5.4.1 Assigned responsibilities

9.5.4.2 Delegated activities

9.5.4.3 A mechanism for evaluation

9.5.4.4 Corrective action policy and procedure

9.5.5 Information about Enrollees, including their medical records, must be kept confidential in a manner consistent with state and federal laws and regulations.

9.5.6 The subcontractor accepts payment from the Contractor as payment in full. The subcontractor will not request payment from HCA or any Enrollee for Contracted Services performed under the subcontract, and will comply with WAC 182-502-0160 requirements applicable to providers.

9.5.7 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)).

9.5.8 If the subcontract includes physician services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.

9.5.9 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)(vii)).

9.5.10 A ninety (90) day termination notice provision.

9.5.11 A specific termination provision for termination with short notice when a subcontractor is excluded from participation in the Medicaid program.

9.5.12 The subcontractor agrees to comply with all relevant provisions of this Contract, including but not limited to, the appointment wait time standards for the Contractor's 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)).

9.5.13 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.

9.5.14 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 C.F.R. § 438.230(b)).

9.5.15 The Contractor must document and confirm in writing all Single Case Agreements with providers. The agreement will include:

9.5.15.1 The description of the services;

9.5.15.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.15.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and

9.5.15.4 Any other specifics of the negotiated rate.

9.5.16 The Contractor must supply documentation to the subcontractor no later than five (5) Business Days following the signing of the agreement. Updates to the unique contract, 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).

9.5.17 The Contractor must maintain a record of the Single Case Agreements for a period of six (6) years.

9.6 Health Care Provider Subcontracts Delegating Administrative Functions

9.6.1 Subcontracts that delegate administrative functions under the terms of this Contract will include the following additional provisions:

9.6.1.1 For those subcontractors at financial risk, that the subcontractor will 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 must 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 1st of each year applicable to this Contract and upon request by the HCA.

9.7 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(h), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210). The Contractor must provide written notification to HCA on an annual basis that its physician incentive plans, if any, comply with federal regulations.

9.7.1 Prohibited Payments: The Contractor will 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.

9.7.2 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 will provide the following information about its physician incentive plan, and the physician incentive plans of its subcontractors to HCA:

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

9.7.2.2 If the incentive plan includes referral services, the information provided to HCA shall include:

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

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

9.7.2.2.3 Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.

9.7.2.2.4 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.

9.7.3 If the Contractor, or any subcontractor, places a physician or physician group at substantial financial risk, the Contractor will 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.

9.7.3.1 If aggregate stop-loss protection is provided, it must cover ninety percent (90%) of the costs of referral services that exceed twenty-five percent (25%) of maximum potential payments under the subcontract.

9.7.3.2 If stop-loss protection is based on a per-member limit, it must cover ninety percent (90%) of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

9.7.3.2.1 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.

9.7.3.2.2 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.

9.7.3.2.3 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.

9.7.3.2.4 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.

9.7.3.2.5 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

9.7.3.2.6 25,001 members or more, there is no risk threshold.

9.7.3.3 The Contractor will provide the following information regarding its Physician Incentive Plans to any Enrollee who requests it:

9.7.3.3.1 Whether the Contractor uses a Physician Incentive Plan that affects the use of referral services;

9.7.3.3.2 The type of incentive arrangement; and

9.7.3.3.3 Whether stop-loss protection is provided

9.8 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.

9.8.1 The Contractor must maintain a system for keeping participating providers informed about:

9.8.1.1 Covered services for Enrollees served under this Contract.

9.8.1.2 Coordination of care requirements.

9.8.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.8.1.4 Health Homes.

9.8.1.5 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 which includes the HCA First Steps program website and Provider Directory.

9.8.1.6 Interpretation of data from the Quality Improvement program.

9.8.1.7 Practice guidelines as described in the provisions of this Contract.

9.8.1.8 Behavioral Health resource line (RCW 74.09).

9.8.1.9 Substance Use Disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by the Contractor.

9.8.1.10 Program Integrity requirements.

9.8.1.11 Educational opportunities for primary dental providers, such as those produced by the Washington State Dental Quality Assurance Commission, the Washington State Dental Association, or the University of Washington etc.

9.9 Claims Payment Standards

9.9.1 The Contractor must meet the timeliness of payment standards specified for Medicaid fee-for-service 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 will pay or deny, and must require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) calendar days of receipt and ninety-nine percent (99%) of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.9.1.1 A claim is a bill for services, a line item of service or all services for one Enrollee within a bill.

9.9.1.2 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.

9.9.1.3 The date of receipt is the date the Contractor receives the claim from the provider.

9.9.1.4 The date of payment is the date of the check or other form of payment.

9.9.2 The Contractor will 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.

9.10 Federally Qualified Health Centers / Rural Health Clinics Report

The Contractor will 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 Clinic Billing Guides, published by HCA and incorporated by reference into this Contract.

9.11 Provider Credentialing

The Contractor's must have policies and procedures, in writing, related to the credentialing and recredentialing of health care professionals who have signed contracts or participation agreements with the Contractor. The Contractor will ensure and demonstrate compliance with the requirements described in this Contract (42 C.F.R. § 438.214)..

9.11.1 The Contractor's policies and procedures will ensure compliance with the following requirements described in this Section.

9.11.1.1 The Contractor's dental director or other designated provider will have direct responsibility for and participation in the credentialing program.

9.11.1.2 The Contractor will have a designated Credentialing Committee to oversee the credentialing process.

9.11.2 The Contractor's credentialing and recredentialing program shall include:

9.11.2.1 Identification of the type of providers credentialed and recredentialed.

9.11.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.

9.11.2.3 A process for provisional credentialing that affirms that:

9.11.2.3.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and

9.11.2.3.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.

9.11.2.3.3 Provisional credentialing shall include an assessment of:

9.11.2.3.3.1 Primary source verification of a current, valid license to practice;

9.11.2.3.3.2 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

9.11.2.3.3.3 A current signed application with attestation.

9.11.2.4 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.

9.11.2.5 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.

9.11.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.

9.11.3 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:

9.11.3.1 Review materials.

9.11.3.2 Correct incorrect or erroneous information.

9.11.3.3 Be informed of their credentialing status.

9.11.4 The Contractor's process for notifying providers within fifteen (15) calendar days of the credentialing committee's decision.

9.11.5 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.

9.11.6 The Contractor's process to ensure confidentiality.

9.11.7 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.

9.11.8 The Contractor's process for recredentialing providers at minimum every thirty-six (36) months through information verified from primary sources, unless otherwise indicated.

9.11.9 The Contractor's process to ensure that offices of all health care professionals meet office site standards established by the Contractor.

9.11.10 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).

9.11.11 The Contractor's process and criteria for assessing and reassessing organizational providers.

9.11.12 The criteria used by the Contractor to credential and recredential practitioners shall

include (42 C.F.R. § 438.214(b)(1)):

9.11.12.1 Evidence of a current valid license to practice;

9.11.12.2 A valid DEA or CDS certificate if applicable;

9.11.12.3 Evidence of appropriate education and training;

9.11.12.4 Board certification if applicable;

9.11.12.5 Evaluation of work history;

9.11.12.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and

9.11.12.7 A signed, dated attestation statement from the provider that addresses:

9.11.12.7.1 The lack of present illegal drug use;

9.11.12.7.2 A history of loss of license and criminal or felony convictions;

9.11.12.7.3 A history of loss or limitation of privileges or disciplinary activity;

9.11.12.7.4 Current malpractice coverage;

9.11.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and

9.11.12.7.6 Accuracy and completeness of the application.

9.11.12.8 Verification of the: National Provider Identifier, the provider's enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.

9.11.13 The Contractor must ensure that subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled with HCA, which will require finger-printing as part of the enrollment process. The Contractor must ensure that contracted providers defined as "high categorical risk" revalidate their HCA enrollment every five (5) years in compliance with 42 C.F.R. § 424.515.

9.11.13.1 If a "high categorical risk" subcontracted provider is not enrolled with HCA and delivers a service that is not commonly delivered to a covered subscriber, e.g. someone under twenty-one (21) years of age, the provider must successfully complete the Contractor's credentialing process, which could include a background check.

9.11.14 The Contractor will terminate any provider where HCA 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).

9.11.15 The Contractor must 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.

9.11.16 The Contractor must 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 HCA.

9.11.17 The Contractor’s policies and procedures will 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.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor will 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; 42 C.F.R. § 438.100(a)(2)).

10.1.2 The Contractor will 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 dental coverage in general, and the Contractor's Apple Health Managed Dental 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)).

10.2 Cultural Considerations

10.2.1 The Contractor will 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 will 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 must:

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).

10.3 Enrollee Choice of PDP

10.3.1 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)).

10.3.2 The Contractor will allow, to the extent possible and appropriate, each new Enrollee to choose a participating PDP (42 C.F.R. § 438.3(l)).

10.3.3 In the case of newborns, the parent will choose the newborn's PDP.

10.3.4 In the case of Alaska Native or American Indian Enrollees, the Enrollee may choose a tribal clinic as his or her PDP, whether or not the tribal clinic is a network provider.

10.3.5 If the Enrollee does not make a choice at the time of enrollment, the Contractor will assign the Enrollee to a PDP or clinic, within reasonable proximity to the Enrollee's home, no later than fifteen (15) Business Days after coverage begins.

10.3.6 The Contractor will provide lists of Enrollees to PDPs upon request by HCA or the PDP.

10.3.7 The Contractor will allow an Enrollee to change PDP 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).

10.4 Prohibition on Enrollee Charges for Covered Services

10.4.1 Under no circumstances will 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).

10.4.2 Prior to authorizing services with non-participating providers, the Contractor will ensure that non-participating providers fully understand and accept the prohibition against balance billing Enrollees.

10.4.3 The Contractor will require providers to report when an Enrollee is charged for services. The Contractor will maintain a central record of the charged amount, Enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor will be prepared at any time to report to HCA any and all instances where an Enrollee is charged for services, whether or not those charges are appropriate.

10.4.4 If an Enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the Enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the Enrollee fail, the Contractor will repay the Enrollee the inappropriately charged amount.

10.4.5 The Contractor must have a separate and specific policy and procedure that fully articulates how the Contractor will protect Enrollees from being billed for Contracted Services.

10.4.6 The Contractor will coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the Enrollee for covered services including other insurer's Copayments and coinsurance.

10.5 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)):

10.5.1 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)).

10.5.2 Any information the Enrollee needs in order to decide among all relevant treatment options (42 C.F.R. § 438.102(a)(1)(ii)).

10.5.3 The risks, benefits, and consequences of treatment or non-treatment (42 C.F.R. § 438.102(a)(1)(iii)).

10.5.4 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)).

10.6 Enrollee Self-Determination

The Contractor will 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).

10.7 Enrollment Not Discriminatory

10.7.1 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)).

10.7.2 No eligible person will 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 dental, 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)).

10.7.3 The Contractor will not exclude from participation in any health program or activity, deny benefits to or discriminate against Enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, gender identity, age, veteran or military status, sexual orientation, or the presence of any sensory, 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 or 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 U.S.C. 18116.

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 Prior Authorization Administrative Simplification Initiative

The Contractor must actively participate and assign a representative to the Prior Authorization Simplification Initiative coordinated by the OIC according to RCW 48.165.030. The Contractor will implement the recommendations made in the "Best Practices Recommendations" deliverable produced by the OIC's prior authorization simplification workgroup in order to meet the expectations found in chapter 48.165 RCW, unless HCA has agreed that to do so is in violation of C.F.R.

11.2 Utilization Management General Requirements

The Contractor must 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 must recognize and respect the cultural needs of diverse populations.

11.2.1 The Contractor must 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, 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 oral health needs (42 C.F.R. 438.210(b)(3)).

11.2.2 Medical necessity decisions are to be made by a licensed dental healthcare professional and must be made for an individual Enrollee based on that Enrollee's health condition. The policies and procedures will identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions will be made available to HCA upon request.

11.2.3 The Contractor's policies and procedures related to UM must comply with, and require the compliance of subcontractors with delegated authority for UM, the requirements described in this Section.

11.2.4 The Contractor must have and maintain a Utilization Management Program (UMP) description for the dental services it furnishes its Enrollees. The UMP description will include:

11.2.4.1 The definition of the Contractor's UMP structure and assignment of responsibility for UMP activities to appropriate individuals.

11.2.4.2 Identification of a designated provider responsible for program implementation, oversight and evaluation, and evidence of the provider's involvement in program development and implementation.

11.2.4.3 Identification of the type of personnel responsible for each level of UM

decision–making.

11.2.4.4 The use of dental consultants to assist in making medical necessity determinations with preference to board-certified consultants whenever possible.

11.2.4.5 A written description of all UM-related committee(s).

11.2.4.6 Descriptions of committee responsibilities.

11.2.4.7 Committee participant titles, including UM subcontract, subcontractor representatives and practicing providers.

11.2.4.8 Meeting frequency.

11.2.4.9 Maintenance of signed meeting minutes reflecting decisions made by each committee, as appropriate.

11.2.4.10 Annual evaluation and update of the UMP.

11.2.5 UMP dental health policies and procedures at minimum, must address the following requirements:

11.2.5.1 Assurance that each Enrollee's needs are monitored and that appropriate referrals are made for care coordination consistent with Section 14 of this Contract.

11.2.5.2 Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria.

11.2.5.3 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.

11.2.5.4 Mechanisms for providers and Enrollees on how they can obtain the UM decision-making criteria upon request, including UM Adverse Benefit Determination letter template language reflecting the same.

11.2.5.5 Mechanisms to facilitate communication between UMP staff and providers and Enrollees.

11.2.5.6 Mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

11.2.5.7 Written job descriptions with qualification for providers who review denials of

care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current, non-restricted license.

11.2.5.8 Mechanisms to verify that claimed services were actually provided.

11.2.5.9 Mechanisms to detect both underutilization and over-utilization of services.

11.2.6 The Contractor will ensure evaluation of appeals of Adverse Benefit Determinations by dental providers who were not involved in the initial decision and who have appropriate expertise in the field of dentistry that encompasses the covered person's condition.

11.2.7 The Contractor will ensure documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance and Appeal System Section of this Contract.

11.2.8 The Contractor will follow the dental coverage decisions of the Health Technology Assessment (HTA) program (Chapter 182-55 WAC) specifically endorsed by HCA for the Apple Health population and, upon HCA's request, provide documentation demonstrating compliance (See http://www.hca.wa.gov/about-hca/health-technology-assessment).

11.2.9 Opioid Crisis Engagement. The Contractor's Medical/Dental 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/dental directors to address this health and safety concern.

11.2.10 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)).

11.2.11 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.

11.3 Medical Necessity Determination

The Contractor will collect all information necessary to make medical necessity determinations. (42 C.F.R § 456.111 and 456.211). The Contractor will 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 will 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 will 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.

11.4.2 The Contractor's policies and procedures related to authorization and post-service review of services will 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 182-501-0169, 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.

11.4.3 The Contractor will provide education and ongoing guidance to Enrollees and providers about it's UM protocols and level of care guidelines.

11.4.4 The Contractor will have in effect mechanisms to ensure consistent application of UMP review criteria for authorization decisions (42 C.F.R. § 438.210(b)(1)(i)).

11.4.5 The Contractor will consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(2)(ii).

11.4.6 The Contractor will 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 dental care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease (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 fee-for-service 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 or the appropriate Apple Health medical Managed Care Organization 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 must 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; or

11.5.1.2.6 The Enrollee's PDP prescribes the change in the level of dental care.

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.

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 extensions; 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 will 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 will 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. § 438.404(c)(5) (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.

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 Post-service Authorizations: For post-service authorizations the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.

11.5.1.5.1 The Contractor will notify the Enrollee in writing and the requesting provider either orally or in writing within three (3) Business Days of the Contractor's determination.

11.5.1.5.2 Standard appeal timeframes apply to post-service denials.

11.5.1.5.3 When post-service authorizations are approved they become effective the date the service was first administered.

11.5.1.6 Verified Enrollee Fraud: The Contractor will 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.

11.5.1.7 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)).

11.5.1.8 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 and 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, using an HCA-developed template, and the ordering 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.

11.6.1.1 Adverse Benefit Determinations Involving an Expedited Authorization: The Contractor must notify the Enrollee in writing of the decision. The Contractor may initially provide notice orally to the Enrollee or the requesting provider within seventy-two (72) hours of the request. The Contractor will send the written notice no later than seventy-two (72) hours after receipt of the request for service.

11.6.1.2 The Contractor will 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 will meet the following requirements (42 C.F.R. § 438.210(c) and 438.404):

11.6.1.2.1 The notice to the Enrollee will meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.

11.6.1.2.2 For all authorization decisions, the notice will be mailed as expeditiously as the Enrollee's health condition requires and within three (3) Business Days of the Contractor's decision.

11.6.1.2.3 The notice to the Enrollee and provider will explain the following (42 C.F.R. § 438.404(b)(1-3)(5-7)):

11.6.1.2.3.1 The Adverse Benefit Determination the Contractor has taken or intends to take.

11.6.1.2.3.2 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.

11.6.1.2.3.3 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.

11.6.1.2.3.4 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.

11.6.1.2.3.5 A statement whether or not an Enrollee has any liability for payment.

11.6.1.2.3.6 A toll free telephone number to call if the Enrollee is billed for services.

11.6.1.2.3.7 The Enrollee's or the provider's right to file an appeal and any deadlines applicable to the process.

11.6.1.2.3.8 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.

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.

11.6.1.2.3.9 The procedures for exercising the Enrollee's rights.

11.6.1.2.3.10 The circumstances under which expedited resolution is available and how to request it.

11.6.1.2.3.11 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.

11.6.1.2.3.12 The Enrollee's right to receive the Contractor's assistance with filing the appeal.

11.6.1.2.3.13 The Enrollee's right to equal access to services for Enrollees and potential Enrollees with communications barriers and disabilities.

11.6.1.3 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 will issue a formal Notice of Adverse Benefit Determination to the Enrollee, including the

Enrollee's right to an appeal (42 C.F.R. § 438.404(c)(5)).

11.6.1.4 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:

11.6.1.4.1 Monthly UM authorization determination data that demonstrates timeliness compliance rates separated into Standard, Expedited, and Post-service timelines, including:

11.6.1.4.1.1 Percentage compliance, including those in which the timeline is extended appropriately;

11.6.1.4.1.2 Specific numbers of authorization determinations meeting contractual timeframes and the numbers of those that did not; and

11.6.1.4.1.3 For those authorization determinations that did not meet contractual timeframes, the range of time to complete the authorization determinations.

11.6.1.4.2 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 will 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 fee-for-service 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 Criteria to determine whether an experimental or investigational service is medically necessary will be no more stringent for Medicaid Enrollees than that applied to any other members.

11.7.3 An Adverse Benefit Determination made by the Contractor will 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 must 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.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor will 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 will 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 will 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 will 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 MCE-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 will perform ongoing analysis of its authorization, utilization, claims, provider's billing patterns, and encounter data to detect improper payments, and shall perform audits and investigations of subcontractors, providers and provider entities.

12.1.6.1 When the Contractor or the State identifies an overpayment, pursuant to RCW 74.09.220, 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, including amounts in dispute.

12.1.6.2 To maintain compliance with regulations found in 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**

The Contractor must provide to HCA the following disclosures (42 C.F.R. § 455.103, 42 C.F.R § 455.104(b), SSA §§ 1903(m)(2)(A)(viii), 1124(a)(2)(A)):

12.2.1 The identification of any person or corporation with a direct, indirect or combined direct/indirect ownership interest of five percent (5%) or more of the Contractor's equity (or, in the case of a subcontractor's disclosure, five percent (5%) or more of the subcontractor's equity);

12.2.2 The identification of any person or corporation with an ownership interest of five percent (5%) or more of any mortgage, deed of trust, note or other obligation secured by the Contractor if that interest equals at least five percent (5%) 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 five percent (5%) of the subcontractor's assets);

12.2.3 The name, address, date of birth, and Social Security Number of any managing employee of the managed care organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, corporate officer, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

12.2.4 The disclosures must include the following:

12.2.4.1 The name, address, and financial statement(s) of any person (individual or corporation) that has five percent (5%) or more ownership or control interest

in the Contractor.

12.2.4.2 The name and address of any person (individual or corporation) that has five percent (5%) or more ownership or control interest in any of the Contractor's subcontractors.

12.2.4.3 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.

12.2.4.4 Indicate whether the individual/entity with an ownership or control interest owns five percent (5%) or greater in any other organizations.

12.2.4.5 The address for corporate entities must include as applicable primary business address, every business location, and PO Box address.

12.2.4.6 Date of birth and Social Security Number (in the case of an individual).

12.2.4.7 Other tax identification number (in the case of a corporation) with an ownership or control interest in the managed care organization or its subcontractor.

12.2.5 Contractor must terminate or deny network participation if a provider, or any person with five percent (5%) 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.

12.2.6 Disclosures from the Contractor are due to HCA at any of the following times:

12.2.6.1 When the Contractor submits a proposal in accordance with an HCA procurement process.

12.2.6.2 When the Contractor executes the Contract with HCA.

12.2.6.3 Upon renewal or extension of the Contract.

12.2.6.4 Within thirty-five (35) calendar days after any change in ownership of the Contractor. The Contractor shall report the change on HCA PIR005 – WA MCO Ownership Change Reporting Template.

12.2.6.5 Upon request by HCA.

12.3 Disclosure by Managed Care Organization: Information on Ownership and Control, Subcontractors and Providers

12.3.1 The Contractor will 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).

12.3.2 If the subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and PO Box address. 42 C.F.R. § 455.104(b)(1)(i).

12.3.2.1 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).

12.3.2.2 If the subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. § 455.104(b)(1)(ii).

12.3.2.3 If the subcontractor or provider has a five percent (5%) ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s). 42 C.F.R. § 455.104(b)(1)(iii).

12.3.2.4 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).

12.3.2.5 If the subcontractor or provider has a five percent (5%) 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)(2).

12.3.2.6 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)(3).

12.3.3 Upon request, the Contractor and the Contractor's subcontractors must furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

12.3.3.1 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)).

12.3.3.2 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)).

12.3.4 Upon request, the Contractor and the Contractor's subcontractors must 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):

12.3.4.1 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:

12.3.4.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.

12.3.4.1.2 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.

12.3.4.1.3 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 will 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, will 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.

12.5.1.3 Provision for notification to HCA when the Contractor receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.

12.5.1.4 Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by Enrollees and the application of such verification processes on a regular basis. 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).

12.5.1.5 The requirement for written policies for all employees of the Contractor, and of any subcontractor, agent, or provider, that provide detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, 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 that the Contractor identifies to HCA Program Integrity and to the Medicaid Fraud Control Division pursuant to Subsection 12.6.

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.

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 under 42 C.F.R. § 438.610 to HCA;

12.5.2.2 Provide written disclosures of information on ownership and control required under 42 C.F.R. § 455.104; 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)).

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:

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 12.9.4.

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 will 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 will report at least annually to HCA, or as required in this 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, MFC, 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 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.

12.5.4.5 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.

12.5.4.6 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 Not recoup overpayments until all informal and formal Appeal Processes are completed.

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 subsection 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 MFC'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 program integrity activities, in progress and completed in the monthly Program Integrity Activities Report (PIR002).

12.6 Referrals of Potential of Fraud, Waste and Abuse (FWA) and Provider Payment Suspensions

The Contractor must establish policies and procedures for referrals to HCA and MFCD of all potential fraud, waste and abused identified by Contractor. If HCA notifies the Contractor that a

Credible Allegation of Fraud exists, Contractor shall follow the provisions for payment suspension contained in this section. (42 C.F.R § 455.23).

12.6.1 When the Contractor suspects potential FWA, the Contractor will make a referral to MFCD and HCA within five (5) Business Days of the determination. The referral must be sent to MFCUreferrals@atg.wa.gov with copies to HotTips@hca.wa.gov. The Contractor will report using HCA PIR007-WA Fraud Referral Reporting Template.

12.6.2 HCA will notify the Contractor's compliance officers whether MFCD accepts or declines the referral within five (5) Business Days. If HCA, MFCD, or other law enforcement agency accepts the referral, HCA will notify Contractor's compliance officers within five (5) Business Days of any determination to suspend payments in accordance with 42 C.F.R. § 455.23. Unless otherwise notified by HCA to suspend payment, the Contractor shall not suspend payment of any provider(s) identified in the referral. HCA will notify the Contractor's compliance officers within five (5) Business Days of the determination of payment suspension. 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 will send notice of the decision to suspend program payments to the provider within the following timeframes:

12.6.3.1 Within five (5) calendar days of being notified by HCA to suspend payment, unless a longer notification period is identified by HCA.

12.6.4 The notice 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 or MFCD that there is insufficient evidence

of fraud by the provider; or

12.6.5.2 The Contractor is notified by HCA or MFCD 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 officials 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, that more effectively or quickly 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 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 will 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 accord 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 will 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 must cooperate with all state and federal agencies that investigate fraud, waste and abuse.

12.7.2 The Contractor will suspend its own investigation and all program integrity activities if notified in writing to do so by any applicable state or federal agency (i.e., MFCD, DOH, OIG, CMS).

12.7.3 The Contractor will 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 will comply with directives resulting from state or federal agency investigations.

12.7.5 The Contractor will 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 is 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 must 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 will 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 will 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 ten (10) 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 will 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 will 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 1st of each calendar year.
Records	On Request, or while On-site	By the date specified in HCA's record request or while onsite.
PIR001 – Annual Program Integrity Report for WA State	Annual	March 1st of each calendar year.
PIR002 – WA Monthly Program Integrity Report Form	Monthly	30 days after the end of the reporting month

DELIVERABLES	FREQUENCY	DUE DATE
PIR003 – WA Quarterly Allegation Log	Quarterly	30th of the following month after quarter ends.
PIR004 – WA MCO Provider Termination Reporting Form	Monthly	15th of the following month.
PIR005 – WA MCO Ownership Change Reporting Form	Ad Hoc	Within thirty five (35) calendar days of an owner change
PIR006 – WA Excluded Individual Reporting Form	Ad Hoc	Within five (5) Business Days from the date of discovery.
PIR007 – 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 Quarterly Allegation Log: Notwithstanding the obligation to report suspicions of provider and subcontractor fraud directly to MFCU and HCA as required under 12.9.1 of this Section, the Contractor must, on a quarterly basis (April, July, October, and January), submit to HCA, using HCA PIR003 WA Quarterly Allegation Log. This report shall include all allegations of provider and subcontractor fraud received and reviewed by the Contractor during the previous quarter.

12.9.4 On a monthly basis, the Contractor must submit to HCA using HCA PIR002 WA Monthly Program Integrity Activities Report form. This report will include all program integrity activities performed and indicate any identified and recovered improper payments as well as any prepayment claims adjudication implementations. It is understood that identified improper payments may not be recovered during the same reporting time period.

12.9.5 On an annual basis, the Contractor must submit to HCA:

12.9.5.1 An Annual Program Integrity Plan for WA State. See subsection 12.9.2 for the specific due date.

12.9.5.1.1 A completed Annual Program Integrity Plan of the activities the Contractor plans for the upcoming year. The plan will include all provider and service-specific program integrity activities such as, but not limited to: algorithms, data analytics, clinical reviews, audits, investigations planned, services requiring prior authorization, payment edits and audits, provider credentialing, and COB/TPL identification. See subsection 12.9.2 for the specific due date.

12.9.5.2 A completed HCA PIR001 – WA Annual Program Integrity Report for WA State. See subsection 12.9.2 for the specific due date.

12.9.5.2.1 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 will 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.

12.9.6 If the Contractor suspects client/member/enrollee fraud:

12.9.6.1 The Contractor will notify the HCA Office of Medicaid Eligibility and Policy (OMEP) of any cases in which the Contractor believes there is a serious likelihood of Enrollee fraud by:

12.9.6.1.1 Sending an email to WAHeligibilityfraud@hca.wa.gov; or

12.9.6.1.2 Calling the Office of Medicaid Eligibility and Policy at 360-725-0934 and leave a detailed voice mail message; or

12.9.6.1.3 Mailing a written referral to:

Health Care Authority
Attention: OMEP
PO Box 45534
Olympia, WA 98504-5534

Or

12.9.6.1.4 Faxing the written complaint to Attention Washington Apple Health Eligibility Fraud at 360-725-1158;

12.9.7 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 HCA PIR006- WA Excluded Individual Template.

12.9.8 The Contractor is responsible for investigating Enrollee fraud, waste and abuse and referring Enrollee fraud to HCA OMEP. The Contractor will provide initial allegations, investigations and resolutions of Enrollee fraud to HCA OMEP.

12.9.9 The Contractor will investigate and disclose to HCA, within ten (10) calendar days of Contractor's discovery or upon request of 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) since the inception of those programs and who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor.

12.9.10 The Contractor will, 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.

12.9.11 The Contractor will submit to HCA a monthly List of Terminations Report including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination; provider terminations for convenience; and providers who self-terminated. The report must be completed using HCA PIR004 – WA MCO Provider Termination Reporting Template.

12.9.12 The Contractor will 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 Premium Payment and Other Injury section of the Encounter Data Reporting Guide.

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, CMS, auditors from the federal Government Accountability Office, federal Office of the Inspector General, federal Office of Management and Budget, the Office of the Inspector General, the 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. 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. 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, without cost, 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); 24 C.F.R. § 437.107(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. (24 C.F.R. § 438.3(h). A record includes but is not limited to:

12.10.1.1 Medical records;

12.10.1.2 Billing records;

12.10.1.3 Financial records;

12.10.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service;

12.10.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution; and

12.10.1.6 Any record of a Contractor-paid claim or encounter, or a Contractor-denied claim or encounter.

12.10.2 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.

12.10.3 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 will not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (5%) 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 will not knowingly have a director, officer, partner, or person with beneficial ownership of more than five percent (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 will 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 must 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 will 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 must 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, a single level of appeal, access to the state's Administrative Hearing process, and access to independent review through the Contractor. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor will 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 will provide information on the covered person's right to obtain a second opinion (WAC 284-43-4020(2)(h)).

13.1.4 The Contractor will give 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)).

13.1.5 The Contractor will cooperate with any representative authorized in writing by the Enrollee (WAC 284-43-4020(2)(e)).

13.1.6 The Contractor will consider all information submitted by the Enrollee or representative (WAC 284-43-4020(2)(f)).

13.1.7 The Contractor will acknowledge receipt of each grievance, either orally or in writing, within two (2) Business Days.

13.1.8 The Contractor will 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 will 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 Decisions regarding grievances and appeals will 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)):

13.1.10.1 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.

13.1.10.2 If an Enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.10.3 If the grievance or appeal involves any clinical issues.

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 will accept, document, record, and process grievances forwarded by HCA. The Contractor must 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.

13.2.4 The Contractor will 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.

13.2.5 The Contractor will 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 an extension. For any extension not requested by the 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.

13.2.5.1 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)).

13.2.6 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 communication requirements in subsection 3.2.

13.2.7 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 will 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.

If the Enrollee does wish 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 will 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.

13.3.1.2 For expedited appeals, the Contractor may bypass the requirement for Enrollee written consent and obtain Enrollee oral consent. The Enrollee's oral consent must 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 Adverse 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).

13.3.5.1 The Contractor shall outreach and coordinate to assist the Enrollee in obtaining the appropriate, medically necessary care. 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) calendar 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.

13.3.6 The Appeal Process will 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)(4)).

13.3.7 The Appeal Process will provide the Enrollee and the Enrollee's representative copies of the Enrollee's case file, including medical records, and any 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 free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 C.F.R. § 438.406(b)(5) and § 438.408(b) and (c).

13.3.8 The Appeal Process will 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 will apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.10 The Contractor will 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 or the decision to extend the timeframe and inform the Enrollee of the right to file a grievance if they disagree with that decision.

13.3.11 The Contractor must 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 an 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 must 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, including notice to 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, Contractor 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 they disagree with that decision.

13.4.4 The Contractor will 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 will 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)).

13.4.6 The Enrollee has a right to file a grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor must inform the Enrollee of their right to file a grievance in the notice of denial.

13.5 Administrative Hearing

13.5.1 Only the Enrollee or the Enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an Enrollee.

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 will 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 dental director or designee will 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. § 438.308(c)(3)).

13.5.6 HCA will notify the Contractor of hearing determinations. 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 Administration 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 will be included in the Initial Order from the Administrative Hearing.

13.8 Continuation of Services

13.8.1 The Contractor will 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 Contractor reverses a decision to deny authorization of services, or the denial is reversed through an IR decision or a final order of OAH or the Board of Appeals, and the Enrollee received the disputed services while the appeal was pending, the Contractor will 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 must maintain records of all Adverse Benefit Determinations, grievances, appeals and independent reviews.

13.10.1 The records will 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 will 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.

13.10.3 The Contractor is responsible for maintenance of records for and reporting of any

grievance, Adverse Benefit Determinations, and appeals handled by delegated entities.

13.10.4 Delegated Adverse Benefit Determinations, grievances, and appeals are to be integrated into the Contractor's report.

13.10.5 Data will 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.

13.10.6 The report medium will be specified by HCA and shall be in accord with the Grievance and Appeal System Reporting Requirements published by HCA.

13.10.7 Reporting of Adverse Benefit Determinations will 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.

13.10.8 The Contractor will provide information to HCA regarding denial of payment to providers upon request.

13.10.9 Reporting of grievances will include all expressions of Enrollee dissatisfaction not related to an Adverse Benefit Determination. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

14 CARE COORDINATION

The Contractor will provide the services described in this section for all Enrollees who need care coordination, regardless of acuity level.

14.1 Continuity of Care

The Contractor must ensure Continuity of Care for Enrollees in an active course of treatment for a chronic or acute condition. The Contractor will ensure that medically necessary care for Enrollees is not interrupted in transitions from one Managed Care Entity (MCE), fee-for-service (FFS), or provider (42 C.F.R. § 438.208).

14.1.1 Contractor shall honor prior authorizations issued for services by HCA for the first six (6) months of the program.

14.1.2 When changes occur in the Contractor's provider network or service areas, the Contractor will 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.

14.1.3 The Contractor will make every effort to preserve Enrollee-provider relationships through transitions.

14.1.4 Where preservation of provider relationships is not possible and reasonable, the Contractor will assist the Enrollee to transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the Enrollee's health care condition requires.

14.1.5 The Contractor must allow Enrollees to continue to receive care from non-participating providers with whom an Enrollee has a documented established relationship. The Contractor shall take the following steps:

14.1.5.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

14.1.5.2 Where preservation of provider relationships is not possible and reasonable, the Contractor must facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

14.1.5.3 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.

14.1.5.4 Pay the non-participating provider indefinitely if Contractor chooses when the non-participating provider accepts payment rates the Contractor has

established.

14.1.5.5 Apply utilization management decision-making standards to non-participating providers that are no more stringent than standards for participating providers.

14.2 Population Health Management: Identification and Triage

14.2.1 Initial Health Screen. To screen all new Enrollees to determine the need for an Initial Health Assessment and potential treatment with a focus on Individuals with Special Health Care Needs.

14.2.1.1 The Contractor shall conduct a brief Initial Health Screen (IHS) using an evidence-based screening tool appropriate to the age of the Enrollee, containing oral health questions within ninety (90) 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)).

14.2.1.2 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an Enrollee to complete the IHS and document these attempts in the Enrollee's record.

14.2.2 Initial Health Assessment (IHA): To comprehensively assess Individuals who were identified in the IHS as having dental concerns or Individuals with Special Health Care Needs, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or IHS that indicates the need for care coordination of significant dental health needs. 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 (42 C.F.R. § 438.208(c)(2)).

14.2.2.1 The assessment shall include, at minimum, an evaluation of the Enrollee's 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.

14.2.2.2 The Contractor shall require the Enrollee's primary dental 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 addressing urgent dental needs that may be found in the IHA.

14.2.2.3 The IHA shall be maintained in the Enrollees' dental record and in the Contractor's care coordination file and available during subsequent oral

health visits.

14.3 Care Coordination Services (CCS) General Requirements

14.3.1 The Contractor shall coordinate the dental care services to Enrollees who have been identified as needing assistance in accessing preventive and specialty dental services, including but not limited to, the following activities:

14.3.1.1 Refer individuals identified in the IHS as having a need for Care Coordination services to the Enrollee's Primary Dental Provider and other providers as necessary for follow-up care and needed services within thirty (30) calendar days of screening and identification.

14.3.1.2 Coordinate with the Primary Dental Provider to facilitate assessment and examination of the Enrollee according to the comprehensive dental evaluation assessment requirements and coordinate so an appointment for a comprehensive dental evaluation assessment occurs within 90 calendar days from the date the need is identified.

14.3.1.3 Follow up with the Enrollee to check the appropriate follow-up services have been received, including preventive care, care for serious dental conditions, and referrals to other services as needed.

14.3.2 Care Coordination services are provided by the Contractor, clinic-based care coordinator staff, or community based organizations.

14.3.3 The care coordinator and affiliated staff shall work with Enrollees to promote the following:

14.3.3.1 Improved clinical outcomes;

14.3.3.2 Enrollee participation in care;

14.3.3.3 Continuity of Care;

14.3.3.4 Increased self-management skills;

14.3.3.5 Completion of planned treatment; and

14.3.3.6 Improved access to care or to services that address social needs.

14.3.4 The care coordinator shall provide or oversee interventions that address the physical health, social, economic, behavioral health, functional impairment, cultural, and environmental factors affecting oral health and health care choices.

14.3.5 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 preferred language; with appropriate consideration of

literacy and cultural preference.

14.3.6 The care coordinator is responsible for:

14.3.6.1 Conducting IHS or collecting IHS data, to assess Enrollees for unmet health care or social service needs;

14.3.6.2 Communicating dental utilization patterns to providers and ensuring action by the provider on under or over-utilization patterns requiring action;

14.3.6.3 Ensuring clinical and social service referrals are made to meet identified Enrollee health and community service needs;

14.3.6.4 Verifying services are delivered, including any follow-up action;

14.3.6.5 Use of standardized screening tools; and

14.3.6.6 Ensuring collaboration with the Enrollee's Apple Health MCO when needs are identified that apply to physical and/or behavioral health and dental health needs (42 C.F.R. § 438.208(b)(4)).

14.3.7 The Contractor shall develop policies and, procedures for Care Coordination services that include:

14.3.7.1 Identification of gaps in care through IHS or analysis of claims and encounter data for Enrollee patterns of under- or overutilization.

14.3.7.2 Referral of Enrollees identified through self-referral, the IHS, or IHA as having a gap in oral health services to the Enrollee's Primary Dental Provider and as appropriate, a dental specialist for services and follow-up care within thirty (30) calendar days of screening and identification.

14.3.7.3 Communication with the PDP and other providers regarding:

14.3.7.3.1 The Contractor's medical necessity decisions to authorize care and services.

14.3.7.3.2 Enrollee over-use of emergency department, preventable hospitalizations and re-hospitalizations, crisis service, and opioid use as related to the Enrollee's oral health.

14.3.8 If an Enrollee changes enrollment to another Apple Health Dental MCE, the Contractor shall coordinate transition of the Enrollee to the new MCE's Care Coordination system to ensure services do not lapse and are not duplicated in the transition. The Contractor will coordinate Enrollee information, including initial assessments and care plans, and must also ensure Enrollee confidentiality and Enrollee rights are protected (42 C.F.R. § 438.208 (b)(6)).

14.3.9 Care coordinators shall monitor, and assess referral completion, education, and facilitate and encourage adherence to recommended dental treatment. Nothing in this requirement should be construed to limit in any way the Enrollee's right to refuse treatment.

14.3.10 The Contractor shall provide a toll-free line for PDPs and specialists who seek technical and referral assistance when any condition, requires treatment.

14.3.11 The Contractor shall implement policies and procedures to ensure the completion of Advance Directives (physical health and mental health).

14.3.12 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.

14.3.13 The Contractor shall support a person-centered approach to dental care in which the Enrollee's needs, strength and preferences play a central role in the development and implementation of the care plan by:

14.3.13.1 Ensuring the clinical appropriateness of care;

14.3.13.2 Addressing gaps in care, including appropriate use of culturally appropriate evidence- or research-based practices;

14.3.13.3 Requesting modifications to treatment plans to address unmet service needs that limit progress; and

14.3.13.4 Ensuring coordination of assessments and evaluations with mental health, SUD, and other providers.

14.3.14 The Contractor shall respond to EPSDT referrals by facilitating and ensuring an appointment is made, and providing assistance to Enrollee in getting to the appointment including helping with transportation arrangements. Contractor shall also inform primary medical care providers, by written notice, of date of appointment and name of provider scheduled for appointment.

14.4 Coordination Between the Contractor and External Entities

14.4.1 The Contractor will coordinate with, and refer Enrollees to health care and social services/programs as determined necessary by the Initial Health Screen and Initial Health Assessment, including, but not limited to:

14.4.1.1 Apple Health Managed Care Organizations;

14.4.1.2 The Department of Social and Health Services:

14.4.1.2.1 Aging and Long-Term Support Administration (ALTSA) Home and Community Services including contracted Area Agencies on Aging;

14.4.1.2.2 Skilled nursing facilities and community-based residential programs;

14.4.1.2.3 Behavioral Health Administration, including contracted Behavioral Health Organizations;

14.4.1.2.4 Developmental Disabilities Administration;

14.4.1.2.5 Division of Vocational Rehabilitation; and

14.4.1.2.6 Juvenile Justice and Rehabilitation Administration (JJ&RA).

14.4.1.3 Department of Health (DOH) and Local Health Jurisdiction (LHJ) services, including Title V services for Children with Special Health Care Needs, and local Maxillofacial Review Boards.

14.4.1.4 Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs);

14.4.1.5 Department of Children, Youth and Families: Early Support for Infants and Toddlers;

14.4.1.6 Educational Service Districts (ESDs);

14.4.1.7 Support Services for families and family/kinship caregivers;

14.4.1.8 Tribal entities;

14.4.1.9 Non-Emergency Medicaid Transportation services;

14.4.1.10 Interpreter Services;

14.4.1.11 Women, Infants, and Children (WIC) providers and programs; and

14.4.1.12 HCA's contracted Third Party Administrator for supportive housing and supported employment.

14.4.2 The Contractor will 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.

14.4.3 The Contractor will 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.

14.4.4 The Contractor will participate in the local Accountable Communities of Health (ACH) in each Regional Service Areas in which the Contractor provides services under this Contract. The Contractor is not required to participate in all committees and workgroups that each ACH identifies but must participate as follows:

14.4.4.1 Serve in a leadership or other supportive capacity;

14.4.4.2 Participate in the design and implementation of transformation projects;

14.4.4.3 Collaborate with provider networks to implement Value Based Purchasing Models; and

14.4.4.4 Provide technical assistance as needed on subjects relating to Managed Care programs.

14.5 Care Coordination for American Indians/Alaska Natives

14.5.1 The Contractor must designate a tribal liaison to work with Indian Health Care Providers (IHCPs).

14.5.2 The Contractor must provide for training of its tribal liaison and other employees who work with AI/AN Enrollees or IHCP staff, conducted by 1 or more IHCPs within the RSAs under the Contract 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.

14.5.3 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 other IHCPs in such RSAs.

14.5.4 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 or child or grandchild of 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 federally recognized tribe or other IHCP.

14.6 Care Coordination Oversight

14.6.1 The Contractor will have internal monitoring processes in place to ensure compliance with the 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)).

14.6.2 Quality assurance reviews of documented care coordination activities provided by the care coordinator shall include assessment of:

14.6.2.1 Case identification and assessment according to established risk identification and assessment systems and timeframes;

14.6.2.2 Documented Care Coordination Plans with evidence of periodic revision as appropriate to the Enrollee emerging needs;

14.6.2.3 Effective Enrollee monitoring, including management of barriers;

14.6.2.4 Referral management;

14.6.2.5 Effective coordination of care; and

14.6.2.6 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.

14.6.3 The Contractor must document quality assurance reviews and make them available for HCA review.

14.7 Children Eligible for Apple Health Foster Care

14.7.1 The Contractor shall track enrollment of foster children, including those receiving kinship care, and adoption support to ensure adequate care coordination with the Enrollee's providers and foster parents or guardians.

14.7.2 If the Contractor becomes aware that an Enrollee has been placed in foster care and enrolled in Apple Health Foster care (AHFC), the Contractor will coordinate with the AHFC Contractor to the extent possible to ensure that the AHFC Contractor is aware that the Enrollee is receiving dental care and that any needed coordination between systems occurs.

14.8 Direct Access to Specialists for Individuals with Special Health Care Needs

When the required treatment plan of individuals with special health care or Children with Special Health Care Needs indicates the need for frequent utilization of, a course of treatment with or regular monitoring by a specialist, the Contractor shall allow Individuals with Special Health Care Needs, whose treatment plan indicates the need for frequent utilization of a specialist, to retain the specialist as a PDP, or alternatively, be allowed direct access to specialists for needed care (42 C.F.R. §§ 438.208(c)(4) and 438.6(m)).

15 Special Provisions for IHCPs and American Indian/Alaska Native Enrollees

15.1 Special Provisions for Subcontracts with 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 Model Medicaid and Children's Health Care Program (CHIP) Managed Care Addendum for Indian Health Care Providers (Indian Addendum) issued by 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 Indian Addendum, the provisions of the Indian 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 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 Annual Plan and Report for IHCP Engagement

15.2.1 No later than April 30th of each year, the Contractor must submit to the HCA Tribal Affairs Office a document that includes:

15.2.1.1 A plan that describes the outreach activities the Contractor will undertake 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 AI/AN and non-AI/AN, including coordination with non-IHCP dental providers.:

15.2.1.1.2 Improve access for AI/AN Enrollees (including those who do not receive care at IHCPs) to receive trauma-informed dental care.

15.2.1.2 A report that briefly describes the following:

15.2.1.2.1 IHCPs the Contractor has worked with during the previous year;

15.2.1.2.2 IHCPs with whom the Contractor successfully negotiated collaborative or contractual arrangements; and

15.2.1.2.3 IHCPs to whom the Contractor will reach out during the coming quarter.

15.2.1.3 The Contractor will work with the IHCP to coordinate an annual update to the Tribal Outreach Activity Coordination Plan with each IHCP with whom the Contractor has a Plan.

15.3 Special Provisions for American Indians and Alaska Natives

15.3.1 If an AI/AN Enrollee indicates to the Contractor that they wish to have an IHCP as his or her PCP, the Contractor must treat the IHCP as an in-network PDP under this Contract for such Enrollee regardless of whether or not such IHCP has entered into a subcontract with the Contractor.

15.3.2 In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow AI/ANs 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

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 will cover services that address the following (42 C.F.R. § 438.210(a)(4); WAC 182-501-0060):

16.1.1.1 The prevention, diagnosis, and treatment of Enrollee's disease, condition, 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 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 and 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 will also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but will 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.

16.1.3 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.

16.1.3.1 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)).

16.1.3.2 The Contractor will 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).

16.1.4 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section will 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 fee-for-service program (42 C.F.R. § 438.210(a)(3)(iii)).

16.1.5 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 will have policies and procedures consistent with WAC 182-501-0160, Exception to Rule (ETR). The Contractor will cover a service when the criteria in this WAC are met.

16.1.6 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.

16.1.7 Nothing in this Contract will be construed to require or prevent the Contractor from covering services outside of the scope of Contracted Services (42 C.F.R. § 438.6(e)). Services provided outside the scope of Contracted Services will be reported separately to HCA and will not be included in the rates development process.

16.1.8 The Contractor may limit the provision of Contracted Services to participating providers except for the following:

16.1.8.1 Emergency Services;

16.1.8.2 Services provided outside the Service Areas as necessary to provide medically necessary services; and

16.1.8.3 Coordination of Benefits, when an Enrollee has other primary comparable medical coverage as necessary to coordinate benefits.

16.1.9 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor will cover Enrollees for all medically necessary services.

16.1.10 Outside the Service Areas:

16.1.10.1 For Enrollees who are temporarily outside the service area or who have moved to a service area not served by the Contractor and have not been enrolled with another MCO, the Contractor will cover the following services:

16.1.10.1.1 Emergency dental services provided by dental provider associated with the scope of this Contract.

16.1.10.1.2 Urgent care services associated with the presentation of a dental condition that requires immediate attention, but is 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.

16.1.10.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until Enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access to Care and Provider Network Section of this Contract are not exceeded.

16.2 Second Opinions or Consults for Recommended Dental Care

16.2.1 The Contractor must authorize a second opinion regarding the Enrollee's dental care from a qualified dental 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 dental professional. The appointment for a second opinion must occur within thirty (30) calendar days of the request unless the Enrollee requests a delay for the second opinion to a date later than thirty (30) calendar days.

16.2.2 If the Contractor refuses to authorize a second opinion, or a second opinion from a provider of the Enrollee's choice, the refusal is an Adverse Benefit Determination, which will be subject to appeal under the provisions of the Grievance and Appeal System section of this Contract.

16.2.3 This Section will 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 dental services of the second opinion provider.

16.3 Services Provided in Lieu of

16.3.1 The Contractor may provide services or settings that are in lieu of services or settings covered by the State Plan as follows:

16.3.1.1 At the request of the Contractor, HCA will 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;

16.3.1.2 The Enrollee is not required to use the alternative service or setting;

16.3.1.3 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

16.3.1.4 The utilization of the lieu of services is reported in the Contractor's encounter data submission.

16.4 Enrollee in Orthodontia Treatment

16.4.1 Balance payments for orthodontic treatment for Enrollees who were in a course of treatment prior to implementation of the Apple Health Managed Care Dental Program shall become the financial responsibility of the Contractor for those services provided on or after the date of enrollment until the course of treatment is complete.

16.4.2 If an Enrollee who is in a course of orthodontic treatment, changes from one Apple Health Dental MCE to another and the Enrollee remains with the same Provider who began the treatment, the MCE with whom the Enrollee was enrolled when the treatment began is responsible for payment for all covered orthodontic services until the treatment ends.

16.4.3 If the Enrollee changes Dental MCEs because they have moved to a different service area and are unable to remain with the provider who began the orthodontic treatment, the MCE to which the Enrollee changes will assist in the transfer of the care to an in-network orthodontist and will become financially responsible for treatment from the date of enrollment with the new MCE.

16.4.4 Enrollees who are in a course of orthodontic treatment, and were not previously eligible for Medicaid in the state of Washington, Contractor will become financially responsible for treatment from the date of enrollment.

16.4.4.1 If the Enrollee is able to remain with the same Provider who began the treatment, the Contractor will offer subcontracting with treating orthodontist.

16.4.4.2 If the Enrollee is unable to remain with the Provider who began treatment, the Contractor will assist in the transfer of the care to an in-network orthodontist.

17 General Description of Contracted Services

17.1 Contracted Services

The Contractor will provide the following services, as medically necessary, to Enrollees:

17.1.1 The Contractor will provide a preventative/prophylaxis exam to each Enrollee that documents the Enrollee's baseline health status and allows the Enrollee's provider to monitor dental health improvements and outcome measures.

17.1.2 When an Enrollee has 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 Special Programs

17.1.3.1 Contractor will participate in and coordinate with stakeholders in any HCA-identified special programs, including but not limited to: ABCD Program and Oral Health Connections Pilot Project, described in Exhibit E.

17.1.4 Inpatient Services:

17.1.4.1 The Contractor will cover professional services by an oral surgeon in an inpatient setting. Facility costs will be paid by the Apple Health medical MCO with whom the Enrollee receives medical services, or by HCA if the Enrollee's services are paid through the FFS system.

17.1.4.1.1 Consultations with specialty providers, including oral surgeons, endodontists, prosthodontists, are covered during medical hospital stays or those admissions described in subsection 17.1.3.4.

17.1.5 Outpatient Hospital Services: Provided by acute care hospitals, including surgeries, labs, and diagnostics. As described above, Contractor will cover professional services by dental providers, and Enrollee's Apple Health medical MCO or HCA will cover facility costs.

17.1.6 Ambulatory Surgery Center: Services provided at ambulatory centers.

17.1.7 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency department, school, skilled nursing facility, or home) setting by licensed professionals including, but not limited to, Dentists, and dental hygienists. Provider services include, but are not limited to the services described in Exhibit B, Dental Benefits Spreadsheet and:

17.1.7.1 Dental examinations including preventative/prophylaxis exams for adults,

and referrals for further dental assessment, as needed.

17.1.7.2 Performing and/or reading diagnostic tests.

17.1.7.3 Surgical services.

17.1.7.4 Services to correct defects from birth, illness, or trauma.

17.1.7.5 Telemedicine services, provided in accordance with Substitute Senate Bill 6519 (Chapter 68, Laws of 2016).

17.1.7.6 Anesthesia.

17.1.7.7 Enrollee oral health education.

17.1.8 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

17.1.9 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):

17.1.9.1 The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and Health Care Authority EPSDT WAC 182-534-0100.

17.1.9.1.1 The Contractor shall conduct outreach efforts with Enrollees and providers to promote and provide EPSDT oral health diagnostic, screening, and treatment services required to correct or ameliorate oral health conditions determined to be medically necessary by a physician, ARNP, PA, or dental provider acting within his or her scope of practice (42 U.S.C. § 1396d(r)(2)-(5))..

17.1.9.1.2 The Contractor shall be responsible for all EPSDT oral health screening, diagnostic, and treatment services found to be medically necessary. The Contractor may apply utilization management requirements to screening, diagnostic and treatment services.

17.1.9.2 Pursuant to WAC 182-501-0050, the Contractor shall review any request for a Non-Covered Service to determine the medical necessity of the oral health service, including evaluating the safety and effectiveness of the requested service and to establish it is not experimental. If an oral health service is determined to be medically necessary under the EPSDT benefit, the Contractor will provide the service, whether or not it is a contracted oral health service, unless it is specifically excluded or prohibited by Federal

rules.

17.1.9.3 If any EPSDT service exceeds the “soft” limit placed on the scope, amount or duration of a covered oral health 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.

17.1.9.4 The Contractor shall follow the guidelines found at the following website: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

17.2 Exclusions

The following services and supplies are excluded from coverage under this Contract.

17.2.1 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. snore guards, continuous positive airway pressure (CPAP) machines, or tooth whitening trays/kits).

17.2.2 The Contractor will not provide or pay for services that violate the Assisted Suicide Funding Restriction Act of 1997 (SSA § 1903(i)(16)).

17.2.3 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.

17.2.4 Pharmacy Benefits and Services covered by the Apple Health medical Managed Care, Integrated Managed Care, and Apple Health Foster Care contracts.

17.2.4.1 The Contractor is not responsible for inpatient facility costs.

17.2.5 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.

17.2.5.1 Inpatient Hospital charges at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by HCA;

17.2.5.2 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation and common carriers;

17.2.5.3 Ambulance services, including air and ground ambulance transportation services;

18 Third Party Liability

18.1 Definitions. For the purposes of this Section:

18.1.1 "Cost Avoidance" means a method used by HCA to avoid payment when other primary insurance resources are available to the Enrollee. When claims are submitted on behalf of Enrollees who have other primary insurance on file, payment will be denied and claims returned to the providers, who are then required to bill and collect payment from any liable third parties. (42 C.F.R. § 433.139(b)).

18.1.2 "Cost Recovery" (also known as "pay and chase") means that the payer pays providers for submitted claims and then attempts to recover payments from liable third parties. Payers pay and chase claims for two primary reasons: post- payment identification of primary third party resources and Social Security Act exceptions to cost avoidance that require States to pay and chase claims instead of using cost avoidance. This is required when (1) the service is prenatal care, (2) the service is preventive pediatric care, or (3) coverage is through a parent whose obligation to pay support is enforced by the states' child enforcement agency. (Social Security Act §§ 1902(a)(25)(E) and (F), 42 U.S.C. §§ 1396a(a)(25)(E) and (F). See also 42 C.F.R. § 433.139(b)(3)).

18.1.3 "Post Payment Recovery" means seeking reimbursement from third parties whenever claims have been paid for which there is Third Party Liability (TPL). "Cost Recovery", "Post Payment Recovery" may be referred to as "pay and chase".

18.1.4 "Third Party Liability" means the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a State Plan.

18.2 General Provisions

18.2.1 HCA authorizes the Contractor to obtain TPL reimbursement by any lawful means in accord with 42 C.F.R. § 433.139, and to coordinate benefits for Enrollees. The Contractor will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the Medicaid state plan.

18.2.2 The Contractor will assume full assignment rights as applicable and will be responsible for making every reasonable effort to determine the liability of third parties to pay for services provided to Enrollees under this Contract. The Contractor also will be responsible for identifying existing TPL resources, undertaking cost avoidance, and recovering any liability from the third party. The Contractor will develop and implement policies and procedures to meet its obligations regarding TPL.

18.2.3 For Enrollees who have primary dental insurance, the Contractor will coordinate benefits in accordance with the 42 U.S.C. § 1396a(a)(25) and other applicable law. RCW 41.05A.005. Coordination of Benefits includes paying any applicable cost-sharing on behalf of an Enrollee, up to the Medicaid allowed amount.

18.2.4 Nothing in this Section negates any of the Contractor's responsibilities under this

Contract, including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor will:

18.2.4.1 Identify third party resources consistent with the Contractor's policies and procedures;

18.2.4.2 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts;

18.2.4.3 Attempt to recover any third-party resources available to Enrollees (42 C.F.R. § 433 Subpart D) and will make all records pertaining to coordination of benefits collections for Enrollees available for audit and review under subection 12.10 of this Contract;

18.2.4.4 Pay claims for preventive pediatric care and then seek reimbursement from third parties (42 C.F.R. § 433.139(b)(3));

18.2.4.5 Pay claims for Contracted Services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 C.F.R. § 433.139(c));

18.2.4.6 Coordinate with out-of-network providers with respect to payment to ensure the cost to Enrollees is no greater than it would be if the services were furnished within the network;

18.2.4.7 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them;

18.2.4.8 Deny claims the primary payer denied because the provider or the Enrollee did not follow the payer's payment or adjudication rules; (e.g., claims submission without required prior authorization or untimely claims filing); and

18.2.4.9 Make its own independent decisions about approving claims for payment that have been denied by the primary payer if either (a) the primary payer does not cover the service and the Contractor does, or (b) the service was denied as not medically necessary and the provider followed the dispute resolution and/or Appeal Process of the primary carrier and the denial was upheld.

18.2.5 If the Contractor's allowed amount for a service exceeds the primary insurer's paid amount, the Contractor will pay the subcontractor or provider only the amount, if any, by which the subcontractor's or provider's allowable claim exceeds the amount paid by the primary insurer.

18.2.6 The Contractor will have policies and procedures in place to investigate potential TPL resources related to trauma or accident and pursue recoveries.

18.3 Provider Agreements

18.3.1 All provider agreements executed by the Contractor and all provider agreements executed by subcontracting entities or organizations will define the provider's responsibilities regarding TPL, including the provider's obligation to identify TPL coverage and, except as otherwise provided in this Contract, to seek such third party payment before submitting claims to the Contractor.

18.4 Cost Avoidance

18.4.1 The Contractor will ensure coverage by all potential third-party payers is exhausted before the Contractor makes a payment for Covered Services, by directing subcontracted providers to submit a claim and receive final determination from the identified Third Party payer before billing the Contractor for services.

18.4.2 The Contractor will use a Cost Avoidance procedure for all claims or services subject to third-party payment to the extent permitted by state and federal law. If the Contractor has established the probable existence of TPL at the time the provider submits a claim, the Contractor will deny the claim and provide information about the Third Party payer to the billing provider.

18.5 Post-Payment Recoveries

18.5.1 The Contractor will recover funds post payment in cases where the Contractor was not aware of third-party coverage at the time services were rendered or paid for, or the Contractor was not able to use a Cost Avoidance procedure. The Contractor will identify and pursue all potential TPL payments.

18.5.2 Cost Benefit. (1) The Contractor's Post Payment Recovery processes will not require the Contractor to spend more on an individual claim basis than the threshold limits established by the State Plan. (2) The Contractor will use Cost Avoidance procedures to avoid payment on any claim where TPL is on file, other than those in subsection 18.10 below.

18.5.3 Retention of Recoveries. The Contractor is entitled to retain any amounts recovered through its efforts. Distributions of recoveries will be made to the Contractor, in an amount equal to the Contractor's expenditures for the individual on whose behalf the collection was based, and to the beneficiary, any remaining amount.

18.5.4 Unsuccessful Effort. If the Contractor is unsuccessful in its efforts to obtain necessary cooperation from an Enrollee to identify potential third-party resources after a period of sixty (60) calendar days of such efforts, pursuant to 42 C.F.R. §§ 433.145 and 433.147, the Contractor must inform HCA in a format to be determined by HCA that its efforts have been unsuccessful.

18.6 Data

18.6.1 HCA will include information about known TPL resources on the daily 834 enrollment

files. Any new TPL resources learned of by HCA through its contractor(s) are added to the next available enrollment file.

18.6.2 The Contractor will:

18.6.2.1 Proactively identify those Enrollees with other primary dental insurance including their enrollment and disenrollment dates, and provide this information to HCA on the Enrollees with Other Dental Insurance (ODI) report;

18.6.2.2 Cooperate with HCA in any manner necessary to ensure collection of this information;

18.6.2.3 Include all third party payments by Enrollee in its regular encounter data submissions; and

18.6.2.4 Provide TPL data to any contracted provider having a claim denied by the Contractor based on the third party coverage.

18.7 Reports

18.7.1 The Contractor will submit a quarterly Recovery and Cost Avoidance Report that includes any recoveries for third party resources as well as claims that the Contractor denies due to TPL coverage. The report will include recoveries or denied claim payments for any Covered Service. The Contractor will calculate cost savings in categories described by HCA. The Contractor will treat funds recovered from third parties as offsets to claims payments and reflect those offsets in encounter data submitted to HCA. The report is due by the sixtieth (60th) calendar day following the end of the quarter.

18.7.2 The Contractor will submit to HCA on the 15th of the month a report (Enrollees with Other Dental Insurance (ODI)) of Enrollees with other dental insurance coverage with any carrier, including the Contractor.

18.7.3 The Contractor will submit to HCA on the 20th of the month a report (Subrogation Rights of Third Party Liability (TPL) – Investigations) of any Enrollees who the Contractor newly becomes aware of a cause of action to recover health care costs for which the Contractor has paid under this Contract.

18.7.4 HCA will continue to terminate enrollment for clients who become eligible for Medicare.

18.8 Compliance

18.8.1 HCA may determine whether the Contractor is in compliance with the requirements in this Section by inspecting source documents for:

18.8.1.1 Appropriateness of recovery attempt;

18.8.1.2 Timeliness of billing;

18.8.1.3 Accounting for third party payments;

18.8.1.4 Settlement of claims; and

18.8.1.5 Other monitoring deemed necessary by HCA.

18.8.2 The Contractor will demonstrate, upon request, to HCA that reasonable efforts have been made to seek, collect and/or report third party recoveries. HCA will have the sole responsibility for determining whether reasonable efforts have been demonstrated. In making its determination, HCA will (a) take into account reasonable industry standards and practices and (b) have the right to inspect the Contractor's books and records in accordance with Section 12.10.

18.9 **Subrogation of Rights and Third Party Liability**

18.9.1 For the purposes of this subsection:

18.9.1.1 "Injured person" means an Enrollee who sustains bodily injury.

18.9.1.2 "Contractor's -health care expense" means the expense incurred by the Contractor for the care or treatment of the injury sustained, computed in accord with the Contractor's fee-for-service schedule.

18.9.2 If an Enrollee requires dental care services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a claim of legal liability against the third-party, the Contractor will have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

18.9.3 HCA specifically assigns to the Contractor HCA's rights to such third party payments for health care provided to an Enrollee on behalf of HCA, which the Enrollee assigned to HCA as provided in WAC 182-503-0540.

18.9.4 HCA also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor will be subrogated to HCA's rights and remedies under RCW 74.09.180(2) and 41.05A.050 through 41.05A.080 with respect to Covered Services provided to Enrollees on behalf of HCA under Chapter 74.09 RCW.

18.9.5 The Contractor may obtain a signed agreement from the Enrollee in which the Enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party will be liable to the Contractor for the full cost of dental services provided by the Contractor.

18.9.6 The Contractor will notify HCA of the name, address, and other identifying information of

any Enrollee and the Enrollee's attorney:

18.9.6.1 Who settles a claim without protecting the Contractor's interest in contravention of RCW 41.05A.060; or

18.9.6.2 When a claim has been identified as having potential TPL.

18.10 Good Cause Exemption from Billing Third Party Insurance

18.10.1 The Contractor must have a policy to allow Enrollees the right to be exempt from billing third party insurance due to good cause. This includes a procedure that allows for the good cause process to apply on an individual claim basis. "Good cause" means that the use of the third-party coverage would violate an Enrollee's confidentiality because the third party:

18.10.1.1 Routinely sends verification of services to the third-party subscriber and that subscriber is someone other than the Enrollee;

18.10.1.2 Requires the Enrollee to use a primary dental provider who is likely to report the Enrollee's request for family planning services to the subscriber;

18.10.1.3 The Enrollee has a reasonable belief that cooperating with the Contractor in identifying TPL coverage would result in serious physical or emotional harm to the Enrollee, a child in his or her care, or a child related to him or her; or

18.10.1.4 The Enrollee is incapacitated without the ability to cooperate with the Contractor.

Code Descripiton	Proc Code	PA Req.	ABCD Ages 5 & Younger	ABCD Ages 6 to 12 with Disabilities	Ortho 20 & Younger	Dental 20 & Younger	Dental 21 & Older	General Policy
Periodic Oral Eval	D0120		X	X		X	X	• All ages. • 1x every 6 months per client, per provider. • DDA all ages 1x every 4 months.
limited oral eval problem focused	D0140					X	X	• All ages. • No limit. • Problem focused.
Comprehensive Oral Eval	D0150		X	X		X	X	• 1x per client, per provider every 5 years. • 6 months must have elapsed before billing for periodic exam.
Detailed and extensive oral evaluation-problem focused, by report	D0160				X			• Allowed 1x per client, per provider. • Includes ortho oral exam, clinical photos. • Ortho only
Re-evaluation-limited,problem focused, established patient; not postoperative	D0170				X			• Allowed 1x per client, per provider, per year until appliances are placed. • Not in combination with periodic/limited/comp oral evals. • Ortho only.
Screening of Patient- Dentist or Hygienist	D0190					X	X	• Screening of patient allowed 1x every 6 months per client, per prov, per visit. • Not allowed with assesment or in conjunction with oral eval services. • Performed in settings other than dental offices or clinics.
Assessment of Patient- Dentist or Hygienist	D0191					X	X	• Assessment of patient allowed 1x every 6 months per client, per provider, per visit. • Not allowed with screening or in conjunction with other oral eval services. • Performed in settings other than dental offices.
Intraoral - Complete Series (FMX)	D0210					X	X	• 14 years and older 1x per client every three years if agency has not paid for panoramic xray (D0330) in same three year period.
intraoral first periapical	D0220					X	X	• Medically necessary periapical xrays not included in a complete series for diagnosis in conjunction with definitive treatment such as root canal therapy.
periapical, each addn'l	D0230					X	X	• Medically necessary periapical xrays not included in a complete series for diagnosis in conjunction with definitive treatment such as root canal therapy. • Supporting documentation must be in clients record.
Occlusal Film	D0240					X		• Clients age 20 and younger • 1x per two year period, per arch
BW- 1	D0270					X	X	• All ages • Max up to 4 bitewings in a 12 month period

BW-2	D0272					X	X	• All ages • Max up to 4 bitewings in a 12 month period
BW-3	D0273					X	X	• All ages • Max up to 4 bitewings in a 12 month period
BW-4	D0274					X	X	• All ages • Max up to 4 bitewings in a 12 month period
Panoramic Film	D0330				X	X	X	• All ages • 1x per client every 3 year unless agency has paid for complete series in same three year period. • Exception for oral surgeons and orthodontists are allowed one pre-op and one post-op per surgery.
Cephalometric Film (Oral Surgeons)	D0340				X			• One pre and one post-op per surgery. • Oral surgeons only.
2D Photographic Images	D0350	PA				X		• Clients 20 and younger. • Case by case when requested by the agency.
pulp vitality tests	D0460					X	X	• Clients age 20 and younger. • 1x per visit (not per tooth) for diagnosis only during limited evaluation.
diagnostic casts	D0470	PA			X	X		• Ages 20 and younger.
Prophy- Adult	D1110					X	X	Ages 14-18, and clients (all ages) residing in an ALF or nursing facility 1x every 6 months. • Ages 19 and older 1x every 12 months. • Ages 13-18 (and clients residing in an ALF or nursing facility) at least 6 months after scaling and root planing/perio maint. • Ages 19 and older at least 12 months to have elapsed after scaling and root planing/perio maint. • DDA 14 and older 1x every 4 months.
Prophy- Child	D1120					X		• Ages 13 and under, 1x every 6 months. • DDA 13 and under 1x every 4 months.

Fluoride Varnish	D1206		X	X		X	X	• Ages 6 and younger, 3x within a 12 month period with a minimum of 110 days between applications. • Ages 7 thru 18 and clients all ages residing in ALFS or nursing facilities, 2x within a 12 month period with a minimum of 170 days between applications. • Ages 7-20 recieving ortho treatment, 3x within a 12 month period during treatment with a minimum of 110 days between applications. • Ages 19 and older 1x in a 12 month period.
Fluoride- Topical	D1208		X	X		X	X	• Ages 6 and younger, 3x within a 12 month period with a minimum of 110 days between applications. • Ages 7 thru 18 and clients all ages residing in ALFS or nursing facilities, 2x within a 12 month period with a minimum of 170 days between applications. • Ages 7-20 recieving ortho treatment, 3x within a 12 month period during treatment with a minimum of 110 days between applications. • Ages 19 and older 1x in a 12 month period. • DDA all ages 1x every 4 months.
Oral Hygiene Instructions	D1330							• Ages 8 and younger provided by a hygienist or dentist in a setting other than a dental office or clinic, 1x per client in a 6 month period. • Not to be performed on the same date of service as
Sealants	D1351					X	X	• Age 20 and younger • 1x per tooth every 3 years for teeth 2,3,14,15,18,19,30,31,A,B,I,J,K,L,S,T. • DDA 1x per tooth every two years for teeth A,B,I,J,K,L,S,T,2,3,4,5,12,13,14,15,18,19,20,21,28,29,30,31. • DDA 1x per tooth every two years for teeth A,B,I,J,K,L,S,T,2,3,4,5,12,13,14,15,18,19,20,21,28,29,30,31.
Silver Diammine Fluoride	D1354					X	X	• All ages • 2x per year per tooth not to exceed 6 teeth
Space Maintainer- unilateral	D1510	PA				X		• 1x per quandrant for teeth A,B,I,J,K,L,S,T
Space Maintainer- bilateral	D1515	PA				X		• 1x per quandrant for teeth A,B,I,J,K,L,S,T
recement/rebond space maintainer	D1550					X		• 1x per quandrant for teeth A,B,I,J,K,L,S,T
Remove Space Maintainer	D1555					X	X	• 1x per appl w/diff provider. • 1x per quandrant for teeth A,B,I,J,K,L,S,T • Considered part of Tx with same provider.

Distal Shoe Space Maintainer	D1575		X	X		X		• 1x per quandrant for teeth A,B,I,J,K,L,S,T
Amalgam 1 surface	D2140		X	X		X	X	• All ages • Primary or permanent teeth
Amalgam 2 surface	D2150		X	X		X	X	• All ages • Primary or permanent teeth
Amalgam 3 surface	D2160		X	X		X	X	• All ages • Primary or permanent teeth. • If billed on a primary first molar the agency reimburses at the 2 surface rate
Amalgam 4+ surface	D2161					X	X	• All ages • Primary or permanent teeth. • If billed on a primary first molar the agency reimburses at the 2 surface rate.
Composite 1 surface- Anterior	D2330		X	X		X	X	• All ages • Primary or permanent teeth
Composite 2 surface- Anterior	D2331		X	X		X	X	• All ages • Primary or permanent teeth
Composite 3 surface- Anterior	D2332		X	X		X	X	• All ages • Primary or permanent teeth
Composite 4+ surface- Anterior	D2335					X	X	• All ages • Primary or permanent teeth
Resin Crown/Strip Crown	D2390	PA	X	X		X		• Ages 20 years and younger • For primary anterior teeth, 1x every 3 years: 12 and younger with no PA if the tooth requires a 4 or more surface restoration. • For client 13-20, PA required
Composite 1 surface- Posterior	D2391		X	X		X	X	• All ages • Primary or permanent teeth
Composite 2 surface- Posterior	D2392		X	X		X	X	• All ages • Primary or permanent teeth
Composite 3 surface- Posterior	D2393		X	X		X	X	• All ages • Permanent and primary teeth. • If billed on a primary first molar reimbursed as two surface.

Composite 4+ surface- Posterior	D2394					X	X	• All ages • Permanent and primary teeth. • If billed on a primary first molar will be reimbursed as a two surface.
Crown- indirect Composite	D2710	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- resin with high noble metal	D2720	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- resin with base metal	D2721	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- resin with noble meal	D2722	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown-Porcelain	D2740	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- Porcelain fused to high noble metal	D2750	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- Porcelain fused to base metal	D2751	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
Crown- Porcelain fused to noble metal	D2752	PA				X		• Ages 15-20 • Permanent anterior teeth only, per tooth, 1x every 5 years
recement inlay only or veneer	D2910					X		• Age 20 and younger • All permanent inlay, onlay, veneer, or partial coverage restoration. • DDA all ages.
re-cement post and core	D2915					X		• Age 20 and younger • All permanent crowns. • DDA all ages.
re-cement Crown	D2920					X	X	• All ages for all crowns
prefabricated Porcelain Crown - primary tooth	D2929	PA	X	X		X		• Age 20 and younger • Clients 12 and under w/o pa if the tooth requires a 4 or more surface restoration. • Clients 13-20 with pa requires xray justification. Allowed 1x every 3 yrs. • DDA 1x every 2 years for primary anterior teeth. 1x every 2 years for primary posterior teeth if criteria is met.

prefabricated Stainless Steel Crown- primary tooth	D2930	PA	X	X		X		• Age 20 and younger, • Clients 12 and under w/o pa if the tooth requires a 4 or more surface restoration. • Clients 13-20 with pa requires xray justification. Allowed 1x every 3 yrs. •DDA 1x every 2 years for primary anterior teeth. 1x every 2 years for primary posterior teeth if criteria is met.
prefabricated Stainless Steel Crown- permanent tooth	D2931					X		• Age 20 and younger 1x every 3 years excluding 1,16,17,32. • Permanent posterior teeth only • DDA all ages 1x every 2 years excluding 1,16,17,32.
prefabricated resin crown	D2932					X		• Ages 20 and younger • Primary anterior teeth only, 1x every 3 years
prefaf SSC with resin window	D2933		X	X		X		• Age 20 and younger • 1x every 3 years
prefab esthetic coated SSC- primary tooth	D2934					X		• Age 20 and younger • 1x every 3 years
Interim therapeutic restoration/primary tooth	D2941	PA	X	X				• This procedure is only allowed for ages 0-5 enrolled in the ABCD program
core build up (bill with Crown)	D2950	PA				X		• Ages 20 and younger 1x every 3 years. • Must be billed in conjunction with CDT code D2710 or D2752 or D2931
post and core (bill with crown)	D2952	PA				X		• Ages 20 and younger 1x every 3 years. • Must be billed in conjunction with CDT code D2710 or D2752 or D2931
pre-fab post and core (bill with crown)	D2954	PA				X		• Ages 20 and younger 1x every 3 years. • Must be billed in conjunction with CDT code D2710 or D2752 or D2931
Pulpotomy, primary tooth	D3220		X	X		X		• Ages 20 and younger • Primary teeth only, 1x per tooth
pulpal debridement, permanent tooth	D3221					X	X	• All ages • Permanent teeth only, excluding 1, 16, 17, 32
pulpectomy- anterior, primary	D3230					X		• Only for anterior primary teeth, 1x per tooth
pulpectomy- posterior, primary	D3240					X		• Only for posterior primary teeth, 1x per tooth

Endodontic Therapy, permanent anterior tooth	D3310					X	X	• All ages
Endodontic Therapy, permanent bicuspid tooth	D3320					X		• Ages 20 and younger.
Endodontic Therapy, permanent molar tooth	D3330					X		Ages 20 and younger excluding 1, 16, 17, 32
Retreat of Endodontic Therapy, permanent anterior	D3346	PA				X	X	• All ages
Retreat of Endodontic Therapy, permanent bicuspid	D3347	PA				X		• 20 and younger • Premolar teeth
Retreat of Endodontic Therapy, permanent molar	D3348	PA				X		• Age 20 and younger • Permanent molar teeth excluding 1, 16, 17, 32
Apexification/Recalification- initial visit	D3351					X		• 20 and younger • Initial visit
Apexification/Recalcification- subsequent medication placement	D3352					X		• 20 and younger • Interim visit
Apicoepictomy	D3410					X		• 20 and younger • Anterior teeth only
Retrogradefilling of a root	D3430					X		• 20 and younger • Anterior teeth only
gingivectomy/gingivoplasty 4+teeth	D4210	PA				X	X	• 20 and younger • Per quad case by case • DDA 1x every 3 years with no PA?
gingivectomy/gingivoplasty 1-3 teeth	D4211	PA				X	X	• 20 and younger • Per quad case by case • DDA 1x every 3 years with no PA?
perio scaling and root planing 4+teeth	D4341	PA				X	X	• Ages 13-18 years 1x per quad every 2 years with PA • Ages 19 and older 1x per quad every 2 years with no PA • DDA 13 and older 1x per quad every 12 months with No PA
perio scaling and root planing 1-3 teeth	D4342	PA				X	X	• Ages 13-18 years 1x per quad every 2 years with PA • Ages 19 and older 1x per quad every 2 years with no PA • DDA 13 and older 1x per quad every 12 months with No PA

scaling with generalized inflammation- full mouth	D4346					X	X	• Ages 13 and older 1x per whole mouth in a 12 month period. • Cannot be billed in conjunction with prophy, scale and root planing, full mouth debridement, gingivectomy/plasty
full mouth debridement to enable comp eval	D4355					X	X	• This procedure is only allowed for DDA clients of all ages to enable comprehensive evaluation and diagnosis. • 1x per 12 months
Periodontal Maintenance	D4910	PA				X	X	• ALF or nursing home clients 1x every 6 mos can substitute for an eligible scaling and root planing. • Allowed 6 months after scaling and root planing. • Ages 13-18 1x in 12 months case by case only after client has received scaling and root planing, gingevectomy/plasty. • Must be done 12 after scaling and root planing. • Ages 19 and older 1x in 12 month period. • DDA 13 and older, 2x in 12 months, allowed 6 months after scaling and root planing.
Complete Denture Maxillary	D5110	PA				X	X	• One replacement per client lifetime if the replacement occurs at least 5 years after the delivery date of the initial denture.
Complete Denture Mandibular	D5120	PA				X	X	• One replacement per client lifetime if the replacement occurs at least 5 years after the delivery date of the initial denture.
Maxillary Partial Denture	D5211	PA				X	X	• Covers initial partial denture. • Covers replacement with new partial or full denture at least 3 years from date of delivery of initial partial.
Mandibular Partial Denture	D5212	PA				X	X	• Covers initial partial denture. • Covers replacement with new partial or full denture at least 3 years from date of delivery of initial partial.
Adjust Complete Denture Max	D5410					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis, must be 90 days after the placement date
Adjust Complete Denture Mand	D5411					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
Adjust Partial Denture Max	D5421					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
Adjust Partial Denture Mand	D5422					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
Repair broken CD base	D5511/ D5512					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis

Replace missing or broken teeth (per tooth)	D5520					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
Repair resin denture base	D5611/ D5612					X	X	1x every 12 months per arch with additional repairs on a case by case basis
repair cast framework	D5621/ D5622					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
repair or replace broken clasp- per tooth	D5630					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
replace broken teeth- per tooth	D5640					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
add tooth to exisiting parital denture	D5650					X	X	• 1x per tooth every 12 months
add clasp to exisiting partial denture- per tooth	D5660					X	X	• 1x every 12 months per arch with additional repairs on a case by case basis
rebase complete maxillary denture	D5710					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
rebase complete mandibular denture	D5711					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
rebase maxially partial denture	D5720					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
rebase mandibular partial denture	D5721					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
reline complete maxillary denture	D5750					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
reline complete mandibular denture	D5751					X	X	• 1x in a 3 year period when performed at least 6 months after the placement date
reline maxillary parital denture	D5760					X	X	• 1x every 3 years all ages when provided 6 months after the placement date

reline mandibular partial denture	D5761					X	X	1x every 12 months per arch with additional repairs on a case by case basis.
overdenture- complete maxillary	D5863	PA				X	X	• 1 per lifetime
overdenture- complete mandibular	D5865	PA				X	X	• 1 per lifetime
unspecified removable pros procedure, by report	D5899	PA				X	X	• By report case by case
recement fixed partial denture	D6930					X	X	• 1 x every 12 months
Extraction, coronal remnants, permanent tooth	D7111					X	X	• All ages
Extraction, erupted tooth or exposed root	D7140	PA				X	X	• All ages. No PA required if extracting 3 or fewer teeth
Extraction, erupted tooth surgical	D7210	PA				X	X	• All ages. No PA required if extracting 3 or fewer teeth
Extraction, soft tissue impaction	D7220					X	X	• All ages
Extraction, partially bony	D7230					X	X	• All ages
Extraction, complete bony extraction	D7240					X	X	• All ages
Extraction, complete bony extraction with complications	D7241	PA				X	X	• All ages
Surgical removal of tooth roots	D7250					X	X	• All ages
Tooth reimplantation or stabilixation of evulsed or displaced	D7270					X	X	• All ages

Surgical access of an unerupted tooth	D7280	PA				X		• 20 and younger
Placement of device to faciliater eruption of impacted tooth	D7283	PA				X		• 20 and younger
incisional biopsy of oral tissue-hard (bone or tooth)	D7285					X	X	• All ages
incisional biopsy of oral tissue-soft	D7286					X	X	• All ages
brush biopsy	D7288					X	X	• All ages
Alveoplasty with ext of 4+ teeth	D7310	PA				X	X	• All ages
Alveoplasty with ext of 1-3 teeth	D7311	PA				X	X	• All ages
Alveoplasty not in conjuction with ext 4+teeth	D7320	PA				X	X	• All ages
Alveoplasty not in conjuction with ext 1-3 teeth	D7321	PA				X	X	• All ages
Excision of benign lesion up to 1.25 cm	D7410					X	X	• All ages
Removal of Lateral Exostosis	D7471	PA				X	X	• All ages
Removal of Torus Palatinus	D7472	PA				X	X	• All ages
Removal of Torus Mandibularis	D7473	PA				X	X	• All ages
Surgical Reduction of Osseous Tuberosity	D7485	PA				X	X	• All ages

Incision and drainage of abscess- intraoral	D7510					X	X	• All ages
Incision and drainage of abscess- extraoral	D7520					X	X	• All ages
Removal of foreign body from mucosa, skin or tissue	D7530	PA				X	X	• All ages
Occlusal Orthotic Device	D7880	PA				X		• Ages 12- 20 only case by case
Frenuletomy	D7960	PA				X		• Age 6 and younger with no PA. • Ages 7-12 with PA.
Frenuloplasty	D7963	PA				X		• Age 6 and younger with no PA. • Ages 7-12 with PA.
Excision of Hyperplastic Tissue	D7970	PA				X		• Ages 20 and younger
Excision of Pericoronal Gingiva	D7971	PA				X		• Ages 20 and younger
Surgical Reduction of Fibrous Tuberosity	D7972	PA				X		• Ages 20 and younger
Limited orthodontic treatment of transitional dentition	D8020	PA			X			• The first three months of treatment starts on the date the initial appliance is placed and includes active treatment for the first three months. • The provider must bill the agency with the date of service that the initial appliance is placed. • The agency's initial payment includes replacement of brackets and lost or broken orthodontic appliances, appliance removal, initial and first replacement retainer fees within six months after debanding, and final records (photos, panoramic x-rays, cephalometric films, and final trimmed study models). • Follow-up treatment must be billed after each three-month treatment interval. • Treatment must be completed within twelve months of the date of appliance placement. • Remaining units covers additional 3 month period per unit • Initial Placement and first 3 months

Limited orthodontic treatment of the adolescent dentition	D8030	PA			X			• The first three months of treatment starts on the date the initial appliance is placed and includes active treatment for the first three months. • The provider must bill the agency with the date of service that the initial appliance is placed. • The agency's initial payment includes replacement of brackets and lost or broken orthodontic appliances, appliance removal, initial and first replacement retainer fees within six months after debanding, and final records (photos, panoramic x-rays, cephalometric films, and final trimmed study models). • Follow-up treatment must be billed after each three-month treatment interval. • Treatment must be completed within twelve months of the date of appliance placement. • Remaining units covers additional 3 month period per unit • Initial placement and first 3 months
Interceptive orthodontic treatment of the transitional dentition	D8060	PA			X			
Comprehensive orthodontic treatment of the adolescent dentition	D8080	PA			X			• The first six months of treatment starts on the date the initial appliance is placed and includes active treatment for the first three months. • The provider must bill the agency with the date of service that the initial appliance is placed. • The agency's initial payment includes replacement of brackets and lost or broken orthodontic appliances, appliance removal, initial and first replacement retainer fees within six months after debanding, and final records (photos, panoramic x-rays, cephalometric films, and final trimmed study models). • Continuing follow-up treatment must be billed after each three-month treatment interval, with the first three-month interval beginning six months after the initial appliance placement. • Treatment must be completed within twelve months of the date of appliance placement. • Treatment provided after thirty months from the date the appliance is placed requires a limitation extension. • Remaining units covers additional 3 month period per unit • Initial placement and first six months
Fixed appliance therapy	D8220	PA			X			

Pre-orthodontic treatement examination to monitor growth and development	D8660	PA			X			• Use this code for Orthodontist Case Study. • Billable only by the treating orthodontic provider. • Includes preparation of comprehensive diagnostic records (additional photos, study casts, cephalometric examination film, and panoramic film), formation of diagnosis and treatment plan from such records, and formal case conference.
Replacement of lost or broken retainer	D8692	PA			X			
Orthodontic retention (removal of appliances, construction and placement of retainers)	D8680	PA			X			• Appliance Removal if originally placed by different provider
Palliative Emergency Txt of Dental Pain	D9110					X	X	• All ages • Not allowed same day as definitive treatment
Office Based General Anesthesia first 15 minutes	D9222	PA				X	X	• Age 8 and younger and DDA (all ages) with no PA • Age 9-20 with diagnosis of Cleft Palate or in conjunction with a surgical procedure with no PA • Ager 21 and older with PA
Office Based General Anesthesia additional 15 minutes	D9223	PA				X	X	• Age 8 and younger and DDA (all ages) with no PA • Age 9-20 with diagnosis of Cleft Palate or in conjunction with a surgical procedure with no PA • Ager 21 and older with PA
Analgesia, Anxiolysis, inhalation of Nitrous Oxide	D9230					X	X	• All ages
intravenous moderate concious sedation first 15 minutes	D9239	PA						• Age 8 and younger and DDA (all ages) with no PA • Age 9-20 with diagnosis of Cleft Palate or in conjunction with a surgical procedure with no PA • Ager 21 and older with PA
intravenous moderate concious sedation additional 15 minute increments	D9243	PA				X	X	• Age 8 and younger and DDA (all ages) with no PA • Age 9-20 with diagnosis of Cleft Palate or in conjunction with a surgical procedure with no PA • Ager 21 and older with PA
Oral Conscious sedation	D9248	PA				X	X	• Age 8 and younger and DDA (all ages) with no PA • Age 9-20 with diagnosis of Cleft Palate or in conjunction with a surgical procedure with no PA • Ager 21 and older with PA
Professional Consultation with another provider	D9310	PA				X	X	• One per day per client per provider all ages
house/extended care facility call	D9410					X	X	• One per day per client per provider all ages

hospital call	D9420					X	X	• One per day per client per provider all ages
Office Visit after regularly scheduled hours	D9440					X	X	• One per day per client per provider all ages
Therapeutic Parenteral Drug, Single Administration	D9610					X	X	• All ages
Therapeutic Parenteral Drugs, two or more administrations, different medications	D9612					X	X	• All ages
other drugs and medicaments by report	D9630					X		• 20 and younger
Behavior Management	D9920	PA	X	X		X	X	• Age 8 & younger with no PA • DDA (any age) with no PA • ALF or SNF client with no PA • All others age 8 - 20 with PA
Treatment of Complications post surgical, Unusual Circumstances	D9930					X	X	• All ages
Occlusal Guard, by report	D9940	PA				X		• Ages 12-20 case by case
	D9999		X	X				• ABCD: Family Oral Health Ed. ABCD ONLY

Exhibit D

DATA USE, SECURITY AND CONFIDENTIALITY

1. Definitions

The definitions below apply to this Exhibit G:

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 G, 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 derivative data products created to be published for external customers, or use, not including care coordination, must be sent to HCA for review and approval. 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 G 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.

Apple Health Quarterly Encounter/General Ledger Reconciliation

General Ledger Paid Claims Reconciliation Form

Reporting Period	Quarter Drop Down	Year Drop Down
Contractor	Plan Name	
Contact Name	Contact Person's Name	
Contact Phone Number	(206) 111-1111	
Contact Email Address	Contractor@Healthplan.com	
ETRR Date	MM/DD/YYYY	

	Encounters Total	GL Paid Claims Total	Discrepancy
Month 1			
All Inpatient/Outpatient Claims	$0.00	$0.00	0.00%
All Physician/Other Claims	$0.00	$0.00	0.00%
Prescription Drugs	$0.00	$0.00	0.00%
Dental	$0.00	$0.00	0.00%
Month 1 Total	$0.00	$0.00	0.00%
Month 2			
All Inpatient/Outpatient Claims	$0.00	$0.00	0.00%
All Physician/Other Claims	$0.00	$0.00	0.00%
Prescription Drugs	$0.00	$0.00	0.00%
Dental	$0.00	$0.00	0.00%
Month 2 Total	$0.00	$0.00	0.00%
Month 3			
All Inpatient/Outpatient Claims	$0.00	$0.00	0.00%
All Physician/Other Claims	$0.00	$0.00	0.00%
Prescription Drugs	$0.00	$0.00	0.00%
Dental	$0.00	$0.00	0.00%
Month 3 Total	$0.00	$0.00	0.00%
Total for Quarter	$0.00	$0.00	0.00%
Discrepancies	$0.00		
Total for Quarter + Discrepancies	$0.00	$0.00	0.00%

Apple Health Quarterly Encounter/General Ledger Reconciliation

Encounter Financial Data Monthly Summary

Reporting Period	Quarter Drop Down	Year Drop Down
Contractor	Plan Name	
Contact Name	Contact Person's Name	
Contact Phone Number	(206) 111-1111	
Contact Email Address	Contractor@Healthplan.com	

Program d 999999999

Submitted Paid & Accepted Encounters			
Type of Service	**Encounters**	**Encounter Records**	**Total Paid**
All Inpatient/Outpatient Encounters	0	0	0
All Physician/Other Encounters	0	0	0
All Prescription Drug Encounters	0	0	0
All Dental Encounters	0	0	0
Total Submitted Paid Encounters	0	0	$0.00

Program Program Name 999999999

Submitted Paid & Accepted Encounters			
Type of Service	**Encounters**	**Encounter Records**	**Total Paid**
All Inpatient/Outpatient Encounters	0	0	0
All Physician/Other Encounters	0	0	0
All Prescription Drug Encounters	0	0	0
All Dental Encounters	0	0	0
Total Submitted Paid Encounters	0	0	$0.00

Program Program Name 999999999

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All Dental Encounters	0	0	0
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Program Program Name 999999999

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Program Program Name 999999999

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All Dental Encounters	0	0	0
Total Submitted Paid Encounters	0	0	$0.00

Program All - Totals

Submitted Paid & Accepted Encounters			
Type of Service	**Encounters**	**Encounter Records**	**Total Paid**
All Inpatient/Outpatient Encounters	0	0	$0.00
All Physician/Other Encounters	0	0	$0.00
All Prescription Drug Encounters	0	0	$0.00
All Dental Encounters	0	0	$0.00
Total Submitted Paid Encounters	0	0	$0.00

Apple Health Quarterly Encounter/General Ledger Reconciliation

Encounter Financial Data Monthly Summary

Reporting Period	Quarter Drop Down	Year Drop Down
Contractor	Plan Name	
Contact Name	Contact Person's Name	
Contact Phone Number	(206) 111-1111	
Contact Email Address	Contractor@Healthplan.com	

Program Program Name 999999999

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All Dental Encounters	0	0	0
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Program All - Totals

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All Prescription Drug Encounters	0	0	$0.00
All Dental Encounters	0	0	$0.00
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Apple Health Quarterly Encounter/General Ledger Reconciliation

Encounter Financial Data Monthly Summary

Reporting Period	Quarter Drop Down	Year Drop Down
Contractor	Plan Name	
Contact Name	Contact Person's Name	
Contact Phone Number	(206) 111-1111	
Contact Email Address	Contractor@Healthplan.com	

Program Program Name 999999999

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Program Program Name 999999999

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Program All - Totals

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All Prescription Drug Encounters	0	0	$0.00
All Dental Encounters	0	0	$0.00
Total Submitted Paid Encounters	0	0	$0.00

Discrepancy Category	Discrepancy Item & Description for Quarter	MCO Encounter Count	MCO Encounter Record Count	MCO Amount Total	Documentation Allowing Item to be Listed on Discrepancy Page for the Quarter
Category Drop Down	Discrepancy Item 1	0	0	$0.00	
Category Drop Down	Discrepancy Item 2	0	0	$0.00	
Category Drop Down	Discrepancy Item 3	0	0	$0.00	
Category Drop Down	Discrepancy Item 4	0	0	$0.00	
Category Drop Down	Discrepancy Item 5	0	0	$0.00	
Category Drop Down	Discrepancy Item 6	0	0	$0.00	
Category Drop Down	Discrepancy Item 7	0	0	$0.00	
Category Drop Down	Discrepancy Item 8	0	0	$0.00	
Category Drop Down	Discrepancy Item 9	0	0	$0.00	
Category Drop Down	Discrepancy Item 10	0	0	$0.00	
Totals		0	0	$0.00	

TO: Health Care Authority

[TODAYS DATE]

RE: Certification of the Encounter Data Files
For: **[TRANSMITTAL PERIOD – Month and Year]**

To the best of my knowledge, information and belief as of the date indicated, I certify that the encounter data or other required data, reported by **[MCO/BHO/QHH Name]** to the State of Washington in the submission is accurate, complete, truthful and is in accordance with 42 CFR 438.606 and the current Managed Care/BHO/QHH lead entity Contract in effect.

MCOs and QHHs ADD: I also certify that any claims cost information within the submitted encounter data is proprietary in nature and assert that it is protected from public disclosure under Revised Code of Washington 42.56.270(11).

The following electronic data files for **[MCO/BHO/QHH Name]** were uploaded to ProviderOne on the following dates during the transmittal period:

File/Batch Number	Date Submitted (MM/DD/YYYY)	Number of Encounters	Number of Encounter Records	File Reject [R] Partial File [P] Accepted [A]
Total Number of Encounters, Encounter Records/Lines, and Files:				

Sincerely,

Authorized Signature (CEO, CFO or Authorized Designee)
Title